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To eliminate TB

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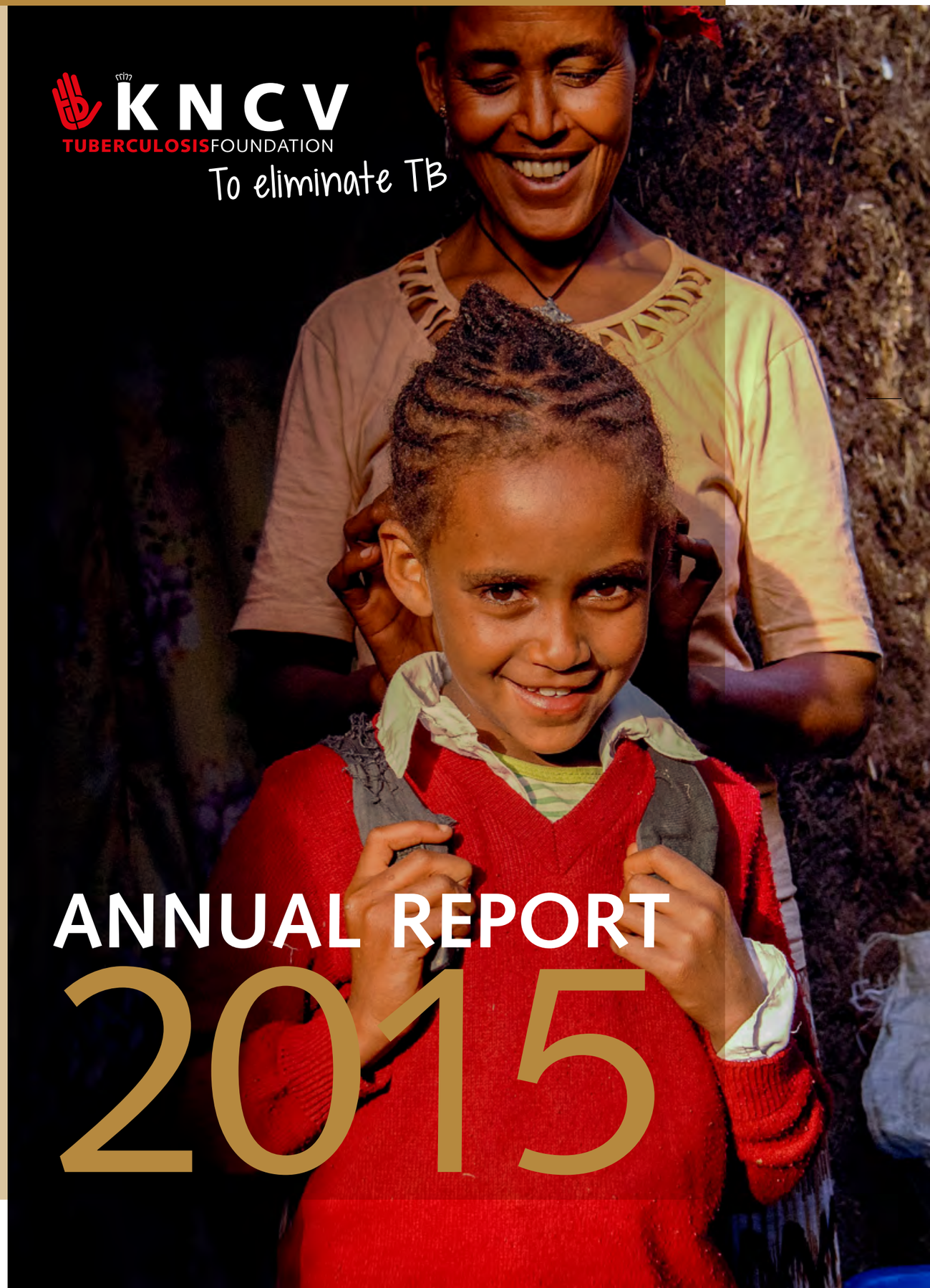

ANNUAL REPORT 2015

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Photo: Actress Imanuelle Grives, KNCV ambassador and a former TB-patient, meets 9-year old MDR-TB survivor Workinesh.

Colophon

This Annual Report is a publication of KNCV Tuberculosis Foundation
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Cover photo: Nine year old Workinesh is getting ready to go to school again in Ethiopia. She is a MDR-TB survivor.

DIRECTORS' REPORT

2015: start of a new mindset

January 2015 marked the beginning of working under the guidance of our new Strategic Plan 2015-2020 in a revised organizational structure. The KNCV strategy is fully aligned with the new World Health Assembly endorsed Global Strategy for tuberculosis prevention, care and control after 2015, the so called 'End TB Strategy'. In this all global partners expressed the bold ambition to eliminate this curable disease as a public health problem. This is not about semantics, not just another step, but indeed a different mindset and a giant leap. A leap that will require many simultaneous steps forward in multiple areas, ranging from increased political commitment to development and introduction of new tools and interventions. The KNCV Strategic Plan 2015-2020 describes the role of KNCV during the first five crucial years of implementing the End TB strategy. We recognize that we can only realize these plans thanks to the support of the U.S. Agency for International Development (USAID) under the Challenge TB project and other donors such as the Dutch Ministries of Foreign Affairs (DGIS) and Health (VWS), Eli Lilly Foundation, our member associations and the many private donors that support our work.

So, what did the first year of the five-year plan bring? And what was the 2015 baseline?

> This is not about semantics, not just another step, but indeed a different mindset and a giant leap

The 2015 baseline

In 2014 TB killed more people than any other infectious disease in the world. A total of 1.5 million people - 890,000 men, 480,000 women and 140,000 children - died of a disease which can be cured. Worldwide, 9.6 million people are estimated to have fallen ill with TB in 2014, including approximately 1.0 million children and people with HIV co-infection. Importantly, only two-thirds (63%) of these 9.6 million TB patients were reported to WHO, leaving a gap of 3 million missing patients who may not have had access to diagnosis and quality care. Figures about the involvement of the private health care sector in TB diagnosis and care are incomplete. Only a quarter of the estimated 480,000 cases of multidrug-resistant TB (MDR-TB) and a very small fraction of children with TB were detected and reported, with very low cure rates (50%) among MDR-TB patients. On the positive side, surveillance systems are strengthening and cure rates remained high among detected drug susceptible patients. Other good news is that more TB patients have been tested and treated for TB/ HIV and TB drug resistance in 2014 than ever before.

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Yet, despite all the progress made, the current global TB situation is unacceptable given that TB is both detectable and curable. KNCV recognizes the underlying problems, such as fragile health systems, donor dependency, and insufficient linkage with the private sector - but we saw also new opportunities. Opportunities that come with political initiatives such as the antimicrobial resistance and universal health care coverage agendas, the inclusion of civil society and private sector in patient awareness and service delivery and new technologies that facilitate diagnosis and patient centered treatment at the point of care.

KNCV activities and contributions

In 2015, KNCV activities covered all aspects of TB control, with focus on programmatic support to high TB burden countries, on finding the missing cases, >>

Photo:
Tajikistan children's hospital

>> research and innovation, and global policy development.

Country programmatic support was mainly delivered through the new global U.S. Agency for International Development (USAID) Flagship Project, called Challenge TB (CTB). The CTB project followed the USAID funded global TB CARE I project, which we successfully closed in 2015. CTB is not business as usual and is characterized by closer technical collaboration with the donor, increased involvement of local partners and further decentralization of KNCV

> KNCV plays an important role in implementation science. For instance, we continued preparing countries for the introduction of new drugs and the required pharmacovigilance systems to ensure their proper use and prevent new drug resistance.

support services at the country level. As the lead partner of the CTB project, KNCV supported the fight against TB in 21 countries worldwide. With 2 regional offices, 10 country offices, several sub-national offices and strong support teams in KNCV Central Office, we work closely with National TB Programs (NTPs) to strengthen TB control interventions and Global Fund implementation. We designed country specific workplans based on local epidemiology and related priority setting. And our support made a difference! For instance, MDR-TB cure rates in countries where the KNCV-led TB CARE I project was executed are 69%, significantly higher than the global average of 48%.

In 2015, we also started the implementation of the 5-year Dutch Ministry of Foreign Affairs grant which is implemented in alignment with Challenge TB. The project focuses on enhancing the investments made by the Global Fund to combat TB/HIV co-infection and on private sector involvement. In the context of that grant, KNCV works with CTB countries Kazakhstan and Nigeria and started the preparation of activities in three new countries: Swaziland, Nepal and the Philippines. We highly welcome this renewed commitment by the Netherlands Government to global TB-HIV control and Global Fund support.

KNCV contributed to finding more **missing cases**, TB patients who are not found or registered. We did this by targeting key affected populations, the scale-up of rapid diagnostics and the involvement of private providers and communities in referral and care of patients. The Eli Lilly funded project targeting private health care providers in India and the GeneXpert scale-up projects in Nigeria are just two examples. Recognizing the challenges that countries face detecting and treating children with TB, KNCV staff developed and tested a Childhood TB Benchmarking Tool which was embraced at both country and global level.

Research is an important pillar of the KNCV Strategic Plan and the Global END TB strategy. Without innovation the world will not be able to eliminate TB. Although we are not directly involved in basic research and development, we continued to work closely with Dutch and international partners that do. Our presence in Africa, Central Asia and South East Asia offers excellent opportunities to develop, evaluate, introduce and scale-up new tools and interventions. KNCV plays an important role in this **implementation science**. For instance, we continued preparing countries for the introduction of new drugs and the required pharmacovigilance systems to ensure their proper use and prevent new drug resistance. Also, KNCV continued to assist countries with E&M health solutions for data-collection and with the analysis of barriers to health systems for poor and marginalized populations, through for instance cost-effectiveness studies.

In September 2015, KNCV and Dutch partners presented a White Paper on 'Tuberculosis Research in the Netherlands: Innovation to accelerate global tuberculosis elimination'. It describes four areas of Dutch scientific excellence in TB, which together can be regarded as the Dutch TB research agenda. With this White Paper, we called on Dutch policymakers to lend their efforts towards the realization of our ambitions by (1) explicitly recognizing and addressing TB research as a Dutch area of excellence; (2) actively positioning Dutch TB research in diplomatic and trade engagement; and (3) strategically positioning TB research in the EU research agenda (Horizon 2020).

In 2015, many KNCV staff members contributed to global, regional and national **policy development** through memberships of regional Green Light Committees for MDR-TB, WHO Expert committees on new tools and WHO guidelines committees. The aforementioned guidelines range from technical subjects, such as treatment of drug-resistant TB, to social contexts such as ethical guidance on TB control. In addition, KNCV served as a member on important forums such as the WHO Strategic Advisory Group (STAG), the Stop TB Coordinating Board, the Finance and Operational Performance Committee (FOPC) of the Global Fund Board and the global TB/HIV Committee. Lastly, KNCV staff members contributed significantly to the preparation of regional and global conferences, such as the UNION Global Conference on Lung Health.

All activities and initiatives listed above will not lead to results, unless Governments of key effected countries and affluent countries commit to sustainable funding and health systems support to TB control. The TB community has too often been preaching to the converted and needs to find more effective ways of sharing the stories of the deadliest disease in human history with those who can make a change at the political level. While global advocacy is not KNCV's core business, we did contribute in modest ways through country based advocacy and TB and HIV advocacy with our Dutch partner Aids Fonds in the Capital for Good project and by sharing global evidence that investment in TB is a 'no brainer'. Our communication outreach strengthened through social media and our much improved website.

In the Netherlands, the agenda in 2015 was dominated by the development of the National Tuberculosis Control Plan 2016-2020 and policy development in relation to the influx of asylum seekers. KNCV led the ad-hoc committee that advised the Ministry of Health to defer the screening of Syrian refugees and conducted an evaluation to inform policy makers. The Netherlands Organization for Health Research and Development (ZonMw) awarded a 4-year research project to study the optimization of latent TB infection diagnosis and treatment among immigrants and asylum seekers. A PhD student was recruited for the project, which started in December. In 2015, a patient platform was established that brought together six former TB patients who shared their personal experiences. These former patients are now connected through a Facebook account and give advice to other (new) patients. KNCV organized the Wolfheze Workshops together with WHO European Region and the European Centre for Disease Prevention and Control. The conference was attended by 176 public health physicians, researchers, policy makers and advocates from the European Region and had the central theme: "End TB in Europe: shifting the gears".

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Internal developments: making KNCV fit for the future

In January 2015, the new KNCV organizational structure was introduced, which was designed to create an optimal supportive environment to pursue our mission. This structure builds on three divisions: Technical (consultancy), Operations (project management) and Finance. The aim of the restructuring was to strengthen both technical performance and project management capacity. From 2015 onwards, >>

Risk management

In 2015 KNCV management has intensified risk analysis and risk mitigation. Clearly, the size of the Challenge TB project and the related decentralization within the countries we support, require robust mechanisms to prevent, monitor and mitigate potential risks. We acknowledge the importance of internal control and risk management systems. The Executive Director reports about these subjects to the Board of Trustees on a regular basis. Once every year a risk analysis is done, assessing risks, controls and mitigating actions. This assessment involves senior management and is discussed in the Management Team meeting. In addition, once a year, the Executive Director discusses the internal risk analysis, as well as significant changes and major improvements in internal controls, with the Audit Committee and the full Board of Trustees. In that context we have also designed a procedure to carefully screen the local partners we consider working with. KNCV's Executive Director is currently not aware of any significant change in the organization's internal control that occurred during 2015 that has materially affected, or is reasonably likely to materially affect, the organization's internal control over financial reporting.

>> technical staff members focus on technical subjects only, whereas project management and finance are in the hands of experts in those fields. In addition, we set up country teams with representatives from all three divisions and the country office, to ensure optimal coordination, country-specific support and efficiency.

In June 2015, KNCV moved to a new office at the Benoordenhoutseweg 46 in The Hague which combines modern functionalities and old charm with a much cheaper price tag than the previous premises. With all staff working on the same floor in an inspiring bright interior, internal communication and sharing has improved considerably.

2015 also beat all records in the history of KNCV recruitment. Due to Challenge TB and other projects, the number of staff grew by 50%, mostly in country offices. The complexity of international recruitment put a major burden on the small HRM team, which was eventually strengthened to cope with the increasing workload.

While 2015 brought many new talented staff members, the organization was also confronted by the departure of some of our most prominent colleagues. Our Director in Indonesia, Jan Voskens, fell seriously ill from a tropical disease. He was brought home to The Netherlands for treatment but sadly he will not be able to return to his post and the team that he led with such passion. At the end of the year it was announced that KNCV's Chief Scientific Officer, Frank Cobelens, would be appointed as the Chair of the Executive Board of Amsterdam Institute of Global Health and Development (AIGHD) as of January 1, 2016. Although everybody at KNCV was truly disappointed to see Frank leave as CSO, we are also proud that he will take this prestigious position and follow in the footsteps of the late Professor Joep Lange, who played such an important role in global health and at the Board of Trustees of KNCV.

Our work is not possible without the contribution of KNCV partners: the governments in the countries we assist, our technical partners, donors, communities and patient organizations, and the KNCV Board of Trustees. We are thankful for their continuing support.

I want to finish this report by thanking our own KNCV staff both in The Hague and our offices abroad. Many of you invested so many private hours, beyond official worktime and in weekends, during a year that was characterized by change and an increasing workload. As such you played a crucial role in pursuing KNCV's mission in a year that marks the beginning of the END TB strategy. Together we can make it happen. ■

Dr. Kitty van Weezenbeek, Executive Director

KNCV TUBERCULOSIS FOUNDATION IN KEY FIGURES

COUNTRIES WHERE WE WORKED IN 2015 AND CORE COUNTRY HIGHLIGHTS

Africa

Botswana	We evaluated the TB information system policy, software readiness and infrastructure to prepare for the national roll–out of the GxAlert data management system and to strengthen the interface with HIV programs.
Ethiopia	The finalization and endorsement of the National childhood TB prevention and control roadmap will lead to a structural approach to fighting TB in children.
East Africa/Kenya	We finalized an operational guide to address challenges in cross-border TB control and promote regional collaboration in 4 high-volume border areas in East Africa and the Horn of Africa.
Malawi	To improve the procurement and supply chain management of TB drugs we offered long term assistance. We built local knowledge and helped to develop systems for TB drug forecasting, ordering drugs, monitoring warehouses and drug issuing facilities.
Namibia	In four clinics with the highest TB and HIV prevalence we installed prefab containers for TB treatment support and outdoor booths for sputum collection, to reduce the chance of TB patients infecting others whilst waiting to see a doctor.
Nigeria	We enhanced the early diagnosis of drug-resistant TB by installing GeneXpert machines in tertiary and secondary health facilities and shortened the time that people have to wait to start treatment.
Tanzania	Tanzania's only drug-resistant TB treatment initiation site in Kilimanjaro was strengthened, and we supported the decentralization of quality programmatic management of drug-resistant TB services and short-course drug regimens.

Asia

Indonesia	The National Peer Educators Association (Perhimpunan Organisais Pasien TB Resistan Obat) was launched to represent all drug-resistant TB patients' groups in Indonesia and empower patients and ex-patients through psychosocial support and advocacy.
Vietnam	We assisted Vietnam to become one of the first countries with programmatic access to Bedaquiline, the first life-saving new medication for pre-XDR TB and XDR-TB patients. Vietnam also embarked on a shorter, more effective and patient-friendly treatment regimen for MDR-TB, with the patient triage approach.
Kazakhstan	The private sector and NGOs were engaged for the first time, through stakeholder meetings and a mapping exercise for TB and TB/HIV control. Plans were also drawn up for a formal NGO network and STOP TB partnership in Kazakhstan.
Kyrgyzstan	With our help local civil society organizations organized support to patients with drug-resistant TB, as well as the representation of TB patients' interests in for example the Global Fund Country Coordinating Mechanism.
Tajikistan	We helped to develop a country implementation plan to introduce shortened drug-resistant TB treatment and new TB drug regimens including an active drug safety monitoring system.
Uzbekistan	Preparations were made to modernize TB infection control, increase diagnostic testing capacity in two regions and introduce shorter and new drug regimens with appropriate pharmacovigilance and drug forecasting management.

Europe

The Netherlands	To keep the screening of the large number of asylum seekers manageable, we evaluated and revised the screening policy.

Other countries where we worked

OUR ACTIVITIES IN 2015

The activities of KNCV are guided by our three strategic objectives:

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

3. To bolster the governance and management capacity of the National TB programs (NTPs) to ensure robust, responsive and inclusive national TB control systems.

Under strategic objective 1, we are working to ensure that everyone infected with TB is identified, diagnosed and treated. Knowing that almost one third of all TB patients are still being missed, we design programs to reach out to vulnerable populations and improve access to quality diagnostics.

Under strategic objective 2, we gather and share knowledge to better understand the epidemic and the most effective methods to fight it.

Under strategic objective 3, we reinforce the local infrastructure in cooperation with governments, social partners and private parties

In 2015 KNCV was active in more than 25 countries in Europe, Africa and Central and South East Asia. In the next pages we like to share with you some of our challenges and achievements in Vietnam, The Netherland, Central Asia, Nigeria and Malawi.

Photo: Indonesia Training Lab Staff

HOW TO STOP THE TICKING TIME BOMB

Fighting Childhood TB in Vietnam

More than 140,000 children die of TB every year, and it is unclear how many more are infected. Experts call this a 'hidden epidemic', since many national TB programs still do not address children, and also a 'ticking time bomb' because infected children may develop and spread TB much later in life. KNCV works with countries to find and treat children with TB and get childhood TB on the national public health agenda. In Vietnam we prepared for and tried out a new, preventive approach and an analytical benchmark tool that can guide countries to improve their national fight against childhood TB.

What does KNCV do to combat childhood TB in Vietnam?

Vietnam is one of the first nations striving to control childhood TB in a systematic and inclusive way. KNCV, has been a major partner in Vietnam's TB control since 1986, and assists the National TB Program (NTP) in achieving this goal. In 2015, we helped the country to complete and analyze the pilot phase of a preventive approach to childhood TB. Meanwhile we drew a road map for 2015-2020 together with the NTP and other partners to expand the new approach from four pilot provinces to the whole country. This translates to 10,732 communes in 63 provinces. Last but not least, Vietnam and KNCV cooperated in piloting the international Childhood TB Benchmarking Tool.

What kind of tool is this?

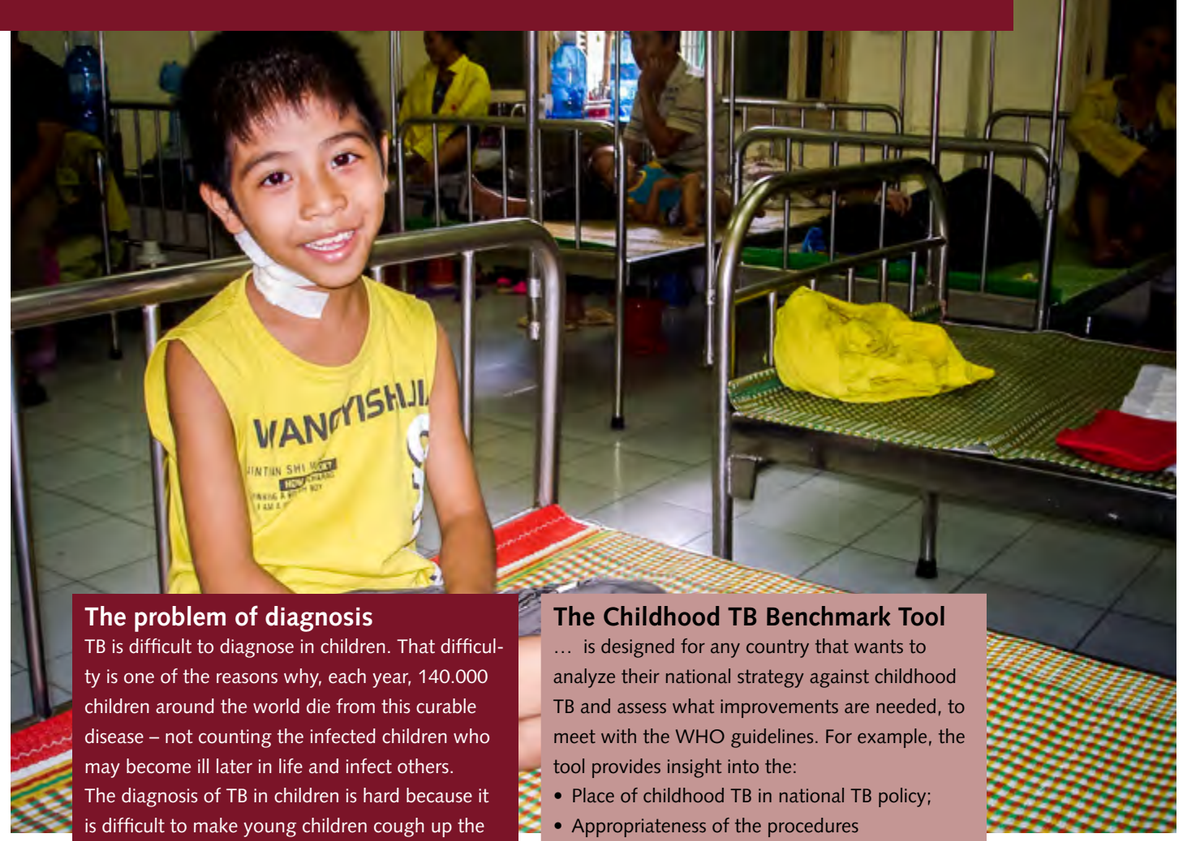
The Childhood TB Benchmarking Tool is a self-assessment instrument that helps a country to analyze their national strategy against childhood TB. Ideally, all partners and stakeholders involved in managing childhood TB should be involved in conducting the assessment. This collective exercise results in a 'gap analysis'; it helps to identify policy gaps for planning purposes and shows what improvements are necessary. The tool contributes to consensus building on priorities, streamlining of activities and planning. It can also be useful for monitoring and evaluating progress.

What role did Vietnam play in the development of the tool?

Vietnam was the first country to try it out. They organized a benchmark assessment in March 2015 in Hanoi. The more than 25 participants included staff from KNCV, the Childhood TB group, the NTP and other stakeholders.

Our impact in short

KNCV has helped improve the diagnosis and care for thousands of children with TB in Vietnam, laying the groundwork for a large-scale roll-out of preventive treatment that can reduce the number of child patients by 70% to 90%.



The problem of diagnosis

TB is difficult to diagnose in children. That difficulty is one of the reasons why, each year, 140.000 children around the world die from this curable disease – not counting the infected children who may become ill later in life and infect others.
The diagnosis of TB in children is hard because it is difficult to make young children cough up the necessary sputum. The TB diagnostic tests for children are also less reliable than for adults because they often develop non-pulmonary TB. This also means that TB in children is generally less infectious than in adults. Consequently, childhood TB has been less of a priority in public health and TB control programs, because it seems less of an epidemiological risk.
Partly because of this lack of priority, parents and health workers have limited knowledge of childhood TB. For example, many erroneously believe that children are immune to TB if they have had a Bacillus Calmette-Guérin (BCG) vaccination. Research shows that this vaccine prevents about 20% of children from getting infected, and protects only 50% of those who do become infected from developing the disease. BCG is, however, effective in preventing TB meningitis: the most deadly form of TB in children.

The Childhood TB Benchmark Tool

… is designed for any country that wants to analyze their national strategy against childhood TB and assess what improvements are needed, to meet with the WHO guidelines. For example, the tool provides insight into the:

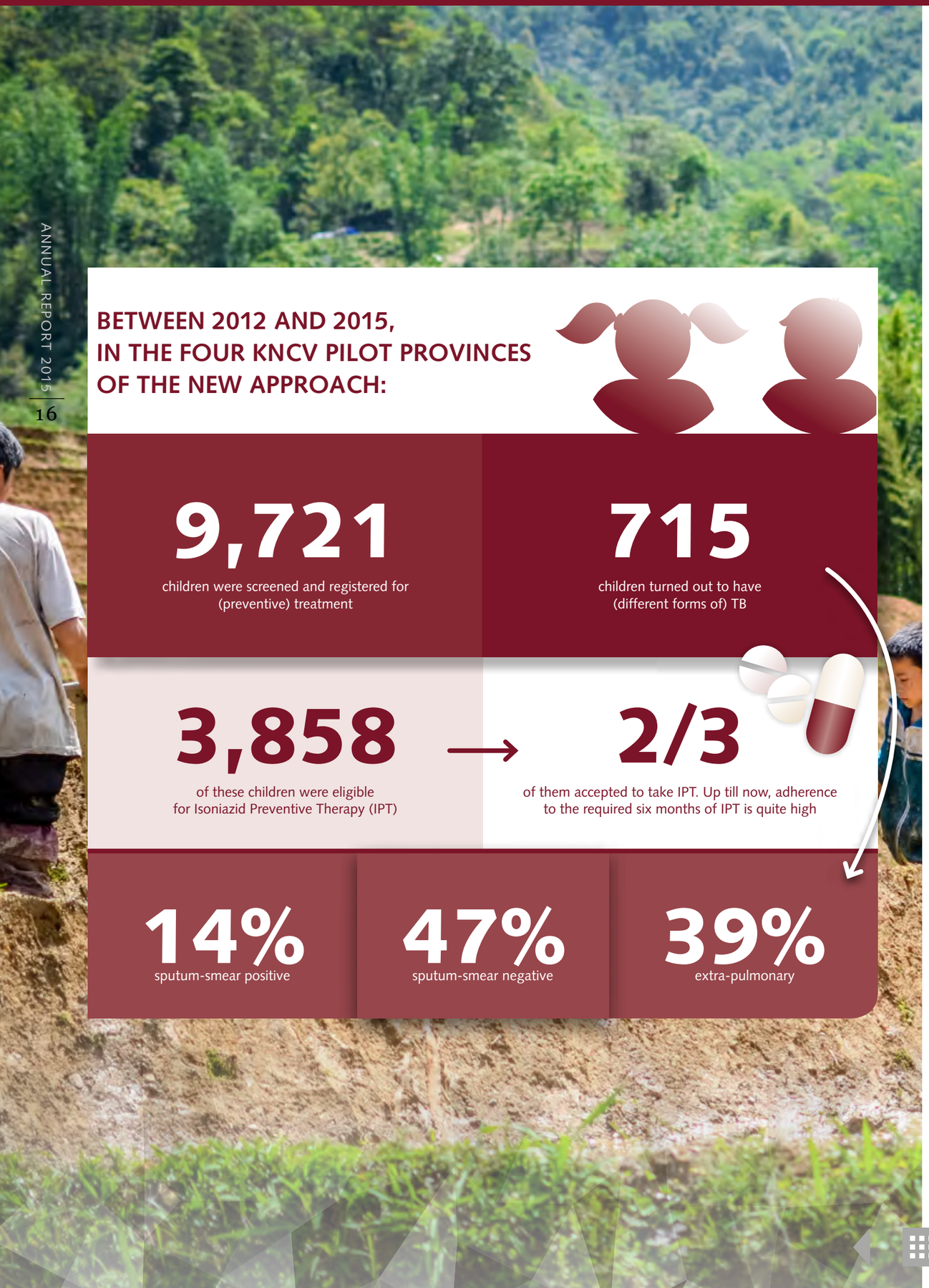
- Place of childhood TB in national TB policy;
- Appropriateness of the procedures to identify TB in children;
- Quality of case management of children with TB;
- Appropriateness of data collected on childhood TB;
- Actions that need to be taken to improve approaches on childhood TB.

The tool is available in English and Russian and can be found on kncvtbc.org.

Two months later the tool was presented to representatives of countries from the European Region at the Wolfheze conference in The Hague, and they were encouraged to also put it to the test and share their experiences. Based on this feedback some revisions were made and the tool was officially launched >>

"It is important to diagnose and treat TB in children and give preventive treatment to children at risk. No generation should grow up with a latent TB 'time bomb' that could be transmitted to future generations"

– Dr. Agnes Gebhard, senior consultant KNCV



BETWEEN 2012 AND 2015, IN THE FOUR KNCV PILOT PROVINCES OF THE NEW APPROACH:

9,721
children were screened and registered for (preventive) treatment

715
children turned out to have (different forms of) TB

3,858
of these children were eligible for Isoniazid Preventive Therapy (IPT)

→

2/3
of them accepted to take IPT. Up till now, adherence to the required six months of IPT is quite high

14%
sputum-smear positive

47%
sputum-smear negative

39%
extra-pulmonary

The patient

Nguyen Thi Kha Vy is 7 years old and living in Vinh City, Nghe An Province. For three months she suffered from coughing, slight fever, weight loss and fatigue. When she was admitted to the National Lung Hospital she could hardly walk. Based on her clinical symptoms and abnormal chest x-ray she was diagnosed with pulmonary TB. After only one month of TB treatment, she had no more clinical symptoms, had gained a full kilogram of weight and could walk on her own again.

>> during The Union World Conference on Lung Health in Cape Town in December 2015. Dr. Nguyen Thien Huong (Co-Chair of the WPRO Regional Task force on TB in Children, as well as the KNCV's director in Vietnam) presented the tool and Vietnam's experiences with it to the Stop TB Working Group on Childhood TB. This working group includes program managers, pediatricians, TB doctors and others involved in promoting access to quality TB diagnostics and care for children with TB and their families. The benchmark tool is now available in English and Russian and is being translated into various other languages.

While piloting the benchmark tool, KNCV also worked on a new approach to childhood TB

That's right – a new approach to intercept TB among children at an early stage. It is more pro-active, community-based and focused on prevention than the approaches before. The idea is to find, register and screen all children who are living with an adult who has transmittable TB. Those who are visibly sick are treated with TB medicine. Those who don't show any symptoms undergo preventive treatment, since they are likely to be infected and develop the disease later in life.

Why is this so urgent?

In Vietnam alone, more than 100,000 people are found and treated for TB every year, but only 1,500 (1.5%) of them are children. This can only mean a significant under-diagnosis, allowing childhood TB to remain a hidden epidemic (for more about the causes of under diagnosis). We don't know how many children are infected, but we know there are more and we need to find them before they die or infect other people. If we don't, we will not be able to eradicate TB. Many other countries suffer from exactly the same under-diagnosis.

> Preventive treatment has the potential to save 70 to 90% of the people from becoming a TB patient, including children, so it has great promise if it can be successfully implemented on a broader scale - not just nationwide in Vietnam, but in all countries. The urgency is immense.

>>

The medical doctor

Dr. Dung works as medical doctor in the Hanoi Lung Hospital and was a participant in the childhood TB pilot program. From her work with children with TB and their parents, she became convinced that paying more attention to prevention and early diagnosis can save children's lives. "The results of the childhood TB program are promising", she says. "Parents have become more aware of the risk of TB and take their children to the hospital for diagnosis." Dr. Dung explains that in the beginning, parents were reluctant to give Isoniazid Preventive Treatment (IPT) to children who were infected but not yet sick, but now the number of children preventively receiving IPT is increasing, specifically in the urban areas. "The program's health education in the communes was important in showing parents why IPT is necessary."

>> Is there already evidence that the preventive, community-based screening approach works?

The initial outcomes are promising and have led to expanding our approach to more provinces. To date, KNCV and local organizations have trained 500 doctors and other health workers in recognizing and preventively treating childhood TB in Vietnam. Diagnosis and care have visibly improved. Both are being offered more and more at the community and district levels; closer to infected or sick children. Thanks in part to the high commitment of health workers and the excellent collaboration between the NTP, KNCV and health facilities at all levels, the public and medical attention to childhood TB has grown. Hundreds of children have undergone preventive treatment with Isoniazid Preventive Therapy (IPT). Thanks to a greater awareness among parents and communities of the risk of TB in children, there has also been greater acceptance of IPT for young children.

Does KNCV lead the program?

No, that is the role of Vietnam's National TB Program. It initiated and rolled out the community-based screening program, engaging the country's child health sector with the wider health sector. The NTP's leadership shows a high level of commitment to improving the prevention, diagnosis and treatment of TB among children. Other important partners are WHO, USAID and Global Fund. KNCV lends its international technical expertise in TB control to the program, giving guidance and sharing skills on issues such as screening methods, treatment regimens, data management and the training of local staff. We will continue to do so: on December 18, 2015 KNCV signed a Memorandum of Understanding with the Vietnam NTP for their collaboration in TB control from 2016 to 2020. At the same event a Cooperation Agreement was also signed to establish a joint platform for implementing the USAID-funded, KNCV-led Challenge TB Project in Vietnam. ■

The role of health care workers

Communal and national health care workers were essential to the success of the new community-based approach to fighting childhood TB. Thanks to them, the childhood TB screening, diagnosis and care at both community and district levels improved. Supportive supervision and interprofessional sharing proved to be effective ways of building the skills and commitment of clinicians. They have shown a strong commitment to learning more about childhood TB and to improve their medical practice. The Provincial Health Department played a major role in involving pediatricians in the TB program, as they are vital in reaching more children and for building childhood TB expertise.

The pediatrician

Dr. Tue worked for more than twenty years as a pediatrician in Vietnam, seeing at first hand the suffering of children with TB. He is currently the chair of the Childhood TB group that is responsible for Vietnam's childhood TB policy and activities. Dr. Tue strongly feels that preventive treatment of latent TB, early diagnosis and improved treatment of TB among children is necessary to reduce suffering and eventually eliminate TB in Vietnam. "Since 2012 we wanted to improve the prevention and early diagnosis of TB among children, in line with the WHO's guidelines. With the technical and financial support of KNCV through the USAID funded TB CARE I project and working in four provinces with a high HIV burden, we started to offer IPT for children who are at higher risk of TB, and to improve TB diagnosis and treatment among children. There was a strong commitment from the NTP leadership to strengthen the diagnosis and treatment of childhood TB. Both parents and health workers must become more aware of TB in children. More and better health education is necessary and health workers at all levels need to be trained."

The effect of training

Dr. Dung participated in the childhood TB training provided by the program. She learned a lot about new screening methods, new treatment regimens and IPT specifically for children. Having increased her knowledge and motivation, she took the program as an opportunity to train doctors herself at the District TB Unit (DTU). These DTU doctors in turn trained the communal level doctors. "Many DTU doctors have extensive practical experience", Dr. Dung says. "So the training is an excellent opportunity for doctors and trainers to share experiences and learn from each other".

Dr. Dich of the Provincial Hospital in Thai Binh also participated in the training. Afterwards, he started a TB doctors' consultation group with eight colleagues. The group meets twice a week to discuss the diagnosis and treatment of all patients. This is very important: doctors learn a lot by participating in the group, and how to improve patient care.

Dr. Dung and Dr. Dich suggest training all pediatricians and nurses on childhood TB. They requested more supportive supervision from the clinicians of the National Lung hospital in Hanoi, in order to improve their clinical practice. "Next to this supervision district TB staff could also visit their colleagues in other districts and learn from each other", says Dr. Dung. She wonders whether there will be sufficient qualified TB doctors in the near future. "To invest in the training of people is essential. At this moment I am the only doctor in my department with a background in childhood TB – and I will retire soon. Who will take over from me?"

STEPPING UP TOWARDS ELIMINATION

Preventing TB among asylum seekers in the Netherlands

The Netherlands, the cradle of KNCV, is well on its way to TB elimination. But after years of decline the number of TB cases rose again in 2015 – mainly because of the recent increase in the number of asylum seekers. Three-quarters of TB patients in the Netherlands are foreign born and many of them are already infected with TB when they enter the country. This called for a review of the existing screening policy and latent TB infection screening to be an important part of the new five-year strategy for TB control.

Did the rising number of asylum seekers in The Netherlands lead to the review of the TB screening policy in 2015? Or was this part of a new strategic direction?

Both. In line with the global End TB Strategy, the National Tuberculosis Control Plan for the Netherlands (2016-2020) strives to reduce the incidence of TB by 25% by 2020. To reach this goal, new strategies that are directed at high-risk populations are necessary. Seventy-three percent of all TB cases in the Netherlands are among foreign-born people; migrants form the largest and most important group to target for prevention and further reduction of TB.

There was also the matter of urgency, as by September 2015, the number of asylum seekers had risen to 2,000 per week, which is almost 300 per day. The regular reception centers could not cope with this influx, and new reception centers were established across the country. This had consequences for the standard screening protocol that all asylum seekers should be screened for TB within two days of entry. Screening in all these facilities was not logistically feasible.

KNCV initiated an ad hoc working group consisting of key members of the standing Committee for Practical TB Control (CPT). KNCV holds the secretariat of the CPT, in which the municipal public health services (GGDs), pulmonologists, sanatoria and Centre for Infectious Diseases (CIb) come together to agree on national regulations and protocols. The ad hoc working group reviewed the existing screening policy for asylum seekers and proposed a customized solution for screening without compromising on health safety.

> Only people from countries with a high TB incidence are now eligible for screening.

What solution was that?

The proposed solution was to for the time being exclude Syrian refugees from the screening, since their risk of TB is low, and prioritize the screening of asylum seekers from high-risk countries. The Minister of Health endorsed our recommendation and informed the Parliament of the temporary change in policy. At the same time the Ministry requested KNCV to evaluate the screening of asylum seekers from all countries with a low TB incidence. We presented our findings within two months to the CPT. As a result the CPT advised the Ministry of Health to stop screening of asylum seekers from all low TB incidence countries, including Syria.

So, the adapted screening solution is now official policy?

Yes, the Minister has accepted our recommendations. Only people from countries with a high TB incidence are now eligible for screening.

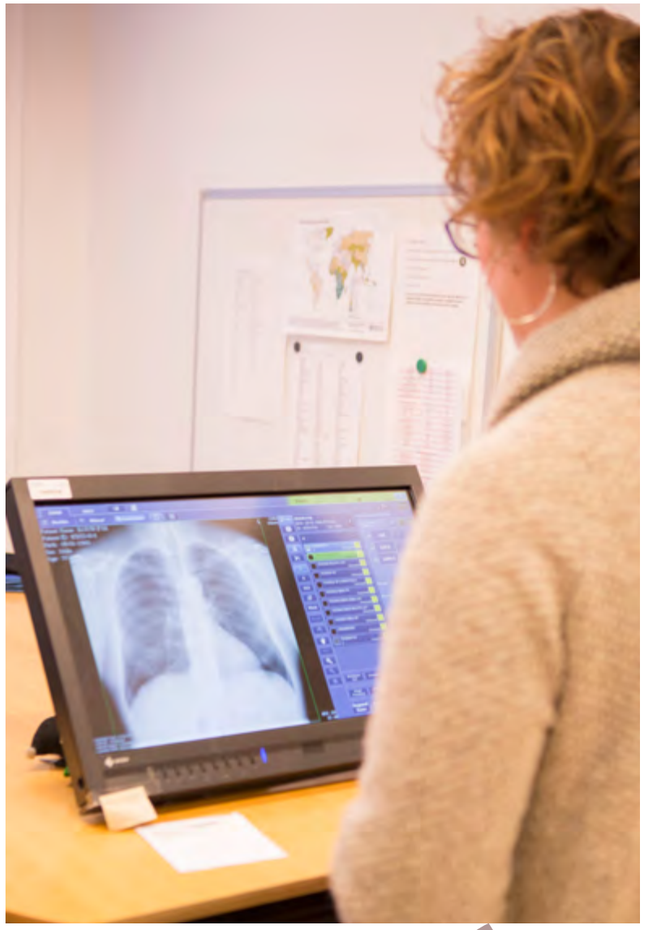
>>

Our impact in short

KNCV has a leading role in optimizing the approach and policy to eliminate TB in The Netherlands. The newly developed five year strategy focuses on active case finding and latent TB screening.

The partner

"In the Netherlands we are not just narrowing down the target group for TB screening, but concentrating our efforts on people from high-risk regions, we're also broadening our screening methods", says prof. Jaap van Dissel, director of the Centre for Infectious Disease Control (CIb). "Thereby we hope to find people who are infected with latent TB infection before they develop the disease. As a result, those people require a less intensive treatment."
CIb is part of the Dutch National Institute for Public Health and the Environment (RIVM), and a prime partner of KNCV in the Netherlands. CIb has in recent years taken over the TB data surveillance management in the Netherlands, a process that was previously developed and carried out by KNCV.
"Strong partnerships are essential in preventing an outbreak of TB and eliminating the disease in The Netherlands", says Van Dissel. "Luckily we have a great network of partners, not least KNCV. KNCV's history of fighting TB goes back more than 110 years. They share their expertise in TB control with other professionals and organizations, such as RIVM and public health services. These partners are rapidly developing their skills on TB matters, but KNCV remains the expert to turn to in times of need."



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Since people from Syria do not fall into that category, Syrian asylum seekers can now go directly to newly-opened reception centers where there are no TB screening facilities. Asylum seekers from countries with a high TB-risk are sent to three central reception centers for screening. Thanks to the new measure, the number of asylum seekers who need to be screened has halved. This releases staff capacity and allows professionals to give high priority to people from countries with a high TB incidence, such as Eritrea.

A large proportion of asylum seekers in the Netherlands are from low-risk TB countries. So what explains the recent rise in TB cases?

The recent rise in cases is six per cent. So far, the high number of Syrian asylum seekers had no significant effect on the TB incidence in the Netherlands. A study conducted by KNCV and partners showed that the recent influx of Eritrean asylum seekers has had a considerable effect on the TB incidence. Also, we observed that a relatively high percentage of Eritrean asylum seekers get sick from TB later on. This latent TB infection is something the standard x-ray screening does not show, as it only identifies active forms of lung TB. That is why screening for latent TB infection is also necessary in order to further reduce the number of TB cases in the Netherlands. The evaluation of the screening of asylum seekers from countries with a low TB incidence is expected

> The evaluation of the screening of asylum seekers from countries with a low TB incidence is likely to influence European policy.

to also have relevance outside the Netherlands, and is likely to influence European policy on screening asylum seekers. The evaluation was published in the European Respiratory Journal in March 2016.

How is KNCV embedding this awareness in procedures and policy?

In the National Tuberculosis Control Plan for 2016-2020 we suggest that an evaluation is done every five years. This strategic plan, which we have developed with RIVM and other partners, also highlights the direction in which TB control in the Netherlands should be headed, such as the screening and the preventive treatment of latent TB infections amongst specific risk groups. Without these measures we will not achieve the elimination of TB. We want to introduce screening for latent TB infection in a phased approach, starting by screening children from countries with a high TB risk. Children form a specific group, because the symptoms of TB manifest themselves differently in children and have a major impact on their health.

> "Screening for and treatment of latent TB infection of immigrants and asylum seekers is already starting up. In December 2015 the CPT decided that all young asylum seekers (under 18 years) should be screened for latent TB infection. The current procedure is that asylum seekers who stay in the Netherlands are screened for active TB when they enter the country, and then every half year for two years. If we start by screening for latent TB and, when this is diagnosed, treat people preventively, these follow up routine will not be necessary anymore. In this way, we will prevent people to fall sick or infect others, and further decline TB incidence in the Netherlands as planned."
>
> – Dr. Gerard de Vries, KNCV Team Coordinator

When will the Netherlands start with screening and preventive treatment of latent TB infection?

In 2016, and we will also do additional research. In 2013 a study already found that latent TB infection entry-screening among immigrants was feasible but pointed out the need for additional research to identify and address barriers before a wider implementation of the screening approach. In December 2015 KNCV launched 'TB ENDPoint', a four-year assessment study financed by The Netherlands Organization for Health Research and Development (ZonMW). The study is a collaboration between KNCV and the municipal public health services (GGDs), GGD GHOR Nederland, Erasmus Medical Centre, RIVM and the Central Agency of the Reception of Asylum Seekers. The TB ENDPoint project is designed to conduct additional cost-effectiveness analyses and to determine the choice of target groups for the intervention. What is new is the intention to introduce this on a national scale. ■

WOLFHEZE
TB professionals from across the European region share the latest knowledge

In May 2015 the Netherlands once again hosted the expert meetings of the Wolfheze movement. KNCV organized the three day Wolfheze Workshops in The Hague, together with WHO European Region and the European Centre for Disease Prevention and Control (ECDC). The conference was attended by 176 public health physicians, researchers, policy makers and advocates from the European Region and had the central theme 'End TB in Europe: shifting the gears'.

'Wolfheze', as it is known (named after the town where it was first held) is held every two years, and after thirty years it is still the most valued professional gathering of leading TB researchers and program managers in the European region. It is often the first forum where new research findings, tools and policies are shared and debated, before their official publication or launch.
One highlight in 2015 was the presentation and discussion of the Childhood TB Benchmarking Tool to assess the state of childhood TB in a country, developed by KNCV and members of the Childhood TB Working Group. With feedback from the participants of the workshop and the piloting of the tool in Vietnam, it was finalized and officially launched at the Union World Conference on TB in Capetown in December 2015.
Other topics at Wolfheze 2015 included the presentation of the results of a survey on adolescent TB and a survey on active case-finding and management of latent TB infection.
With twenty years' experience in latent TB infection (LTBI) management, the Netherlands plays an important role as best practice example. A paper outlining the Netherlands' experience in monitoring and evaluation of LTBI is currently in press.

SUSTAINABLE IMPLEMENTATION OF NEW TESTS AND DRUGS

Beating back drug-resistant tuberculosis in Central Asia

After the collapse of the Soviet Union in the 1990s, the health systems of the Central Asian Republics were in disarray. Following decades of poorly managed TB treatment and inadequate regulation and supply of TB drugs, many Central Asian countries now struggle with very high rates of drug-resistant TB. New drugs bring new hope but also new challenges, because if patients also grow resistant to these, there will be no cure for them at all. That is why the operational testing and management of these new drugs and accompanying regimens is of the utmost importance.

What is KNCV's approach in the Central Asian Republics?

Through our regional office in Kazakhstan and country offices in Kyrgyzstan and Tajikistan, KNCV provides support in early diagnosis and treatment of patients with TB, MDR-TB and extensively drug-resistant TB. Thanks to improved diagnostics such as GeneXpert, which determines not only whether patients have TB but also which type of TB, more patients are being accurately diagnosed. To be able to give them the right treatment for the type of TB they have, we help to organize drug management and treatment evaluation. The immediate and appropriate treatment of patients diagnosed with drug-resistant TB will save many lives that are now at risk, as well as avert the emergence of further drug resistance.

Why is it so important to try to prevent drug resistance?

The newest drugs, such as bedaquiline and delamanid, will be of great importance for reducing MDR-TB. Combined with improved treatment regimens, these drugs will not only potentially save many lives; they are also the last known chance to successfully treat patients with drug-resistant TB. We cannot afford to let any new resistance to TB drugs emerge.

What are the challenges that KNCV faces in this area?

Proper drug management is highly dependent on the quality and accuracy of the available data on the number of patients diagnosed, which drugs they need, and the current drug stock situations. KNCV has an extensive track record in supporting countries around the world in the programmatic management of drug-resistant TB. This includes being able to forecast and manage the necessary drug supplies. Internationally, the supply of second-line drugs for the treatment of drug-resistant TB is coordinated by the Global Drug Facility (GDF). For countries to be able to place timely orders they need to have their national TB drug supplies management in order. To help countries manage their local second-line drug supplies, KNCV's partner MSH has developed a software tool called QuanTB.

Why this tool? What does it do?

QuanTB is a management tool which was designed to help predict and estimate the need for TB drugs. It is very helpful for both planning and procurement and can be used for any type of treatment, including the quantification of companion drugs. This is very important, now that new drugs and regimens are being implemented to fight MDR-TB. An additional advantage of the use of the tool is that is also enhances the quality of patient data, which is needed to evaluate and further improve treatment regimens.>>

Our impact in short

Together with the Central Asian Republics, KNCV is striving to stop the spread of drug-resistant TB by supporting and facilitating the introduction and management of new diagnostic tools and drugs. A safe and sustainable use of new drugs and treatment regimens is crucial to save the lives of people with drug-resistant TB now and in the future.

The added value of QuanTB in Kazakhstan

KNCV has supported TB control in Kazakhstan for many years and has achieved significant impact. The annual estimated incidence of TB (all new cases occurring in one year) declined by over fifty percent in the past ten years: from 147 TB cases per 100,000 people in 2005 to 58,5 cases per 100,000 people in 2015.

Year by year, the Kazakhstan Government has been significantly raising its national budget for TB control, with a focus on the rapid scale-up of treatment for people with MDR-TB. However, now that new drugs are available, it is important to further improve on drug management and quantification. That is why in 2015, we helped to introduce the use of QuanTB to Kazakhstan's NTP.

The QuanTB tool helps to predict and estimate the needed volume of TB drugs. The tool that was formerly being used to manage this, was not designed for shortened treatment regimens and new or non-standard drug combinations. Therefore it could not be used for country-wide management and control of drug stocks for drug-resistant TB. With QuanTB this is now possible.

An additional reason to introduce QuanTB in Kazakhstan is that the use of the tool requires accurate and complete data on TB patients. So by introducing QuanTB, the quality of patient data will also be improved.

Saving lives with new treatment regimens in Kyrgyzstan

Each year, around 100 patients are diagnosed with XDR-TB in Kyrgyzstan, for which there has been little to no effective treatment. Patients have been dying as a result. The introduction of the treatment regimens containing new drugs for these patients is a matter of life and death. In recent years, more patients with drug-resistant TB in Kyrgyzstan have been diagnosed thanks to the introduction of new diagnostics. Within five years, the detection of drug-resistant TB increased by a factor of 1.5: from 835 MDR-TB cases in 2009 to 1,223 cases in 2013. This makes the need for specific drug-resistant treatment regimens more urgent than ever before.

In September 2015, the Global Fund approved the Kyrgyzstan Concept Note for a grant application. This will enable the procurement of second-line TB drugs for the next two years, with technical assistance from KNCV for the introduction of the new TB drugs and shortened regimens in Kyrgyzstan.
All stakeholders including civil society need to be involved in the Country Coordinating Mechanism for the implementation of the country-wide Global Fund-financed program. For our approach on this, see the question 'How does KNCV involve the local community in fighting drug-resistant TB?' page 28.

Pharmacovigilance

Pharmacovigilance is a system for the safe use of TB drugs. It consists of two parts:

1. The clinical monitoring of treatment with TB drugs. It is important that doctors who are treating TB patients report adverse treatment effects in patients, in a nationwide system.
2. The collection of data on the use of the drugs and the subsequent analysis and monitoring of the adverse effects of TB drugs.

A pharmacovigilance center has specific expertise and the authority to collect and analyze adverse effects. It is authorized to give permission to import equipment and drugs. Effective pharmacovigilance relies on the close collaboration between the pharmacovigilance center and the National TB Program (NTP). Clinicians can report the adverse events of TB treatment regimens to a center of excellence on pharmacovigilance or to the NTP. In either case, the information is shared between both organizations.

>> How is KNCV involved in the implementation of QuanTB, and how is it funded?

In April 2015, KNCV and the Lilly MDR-TB Partnership signed an agreement for a project of two years with the purpose of strengthening MDR-TB drug management and quantification in several countries. Within this project funded by Lilly, KNCV is supporting the introduction of QuanTB and supply chain management in the Central Asian countries Kazakhstan and Kyrgyzstan, with the objective to improve the uninterrupted supply and availability of first- and second-line TB drugs.

> KNCV stimulates pharmacovigilance by giving technical support to the NTP and health service, and training to relevant health providers.

In 2015, KNCV organized several meetings to prepare for the introduction of QuanTB, as well as a workshop on drug management and the use of QuanTB in Kazakhstan and Kyrgyzstan. We also organized trainings on the use of the tool.

Is this new tool enough to ensure effective drug management?

QuanTB is a very helpful tool to ensure TB drug supplies are managed and coordinated effectively, but it is also important that clinicians who administer the new drugs and treatment regimens are using and sharing the latest knowledge and expertise, especially on the effects of the treatment. This is where pharmacovigilance comes in: it is a system for the safe use of the both existing TB drugs and new drugs coming onto the market. This system consists of gathering and analyzing treatment experiences and creating protocols for administering the new drugs.
It is also important that there is a legal foundation for the procurement of the drugs and that information about both the use and effect of the drugs is collected and reported. Lastly, reporting forms, and if possible an electronic recording and reporting system should be in place. >>

The Kyrgyzstan TB Patients Coalition, with in the middle director Indira Kaziyeva

The Director of the TB Patients Coalition

Indira Kaziyeva is the Director of the Kyrgyzstan TB Patients Coalition. She used to work as a TB doctor in a hospital for patients with MDR-TB and was trained as a lawyer. She became sick with TB herself, and while she was undergoing treatment, her four children developed TB. Although Dr. Kaziyeva also has an education as a lawyer, she was not able to protect her own rights.

"A lot of patients do not know their rights, and feel under pressure. They do not have access to services because they don't know their rights and don't know how to protect themselves. They are very afraid. Patients need legal protection as well as medical support."

With the Coalition Indira Kaziyeva wants to work more broadly, and more globally. "It is like building a big ship for patients. The ship will protect TB patients through their treatment journey by helping them to understand their rights. For a safe trip we need special laws and regulations, and the involvement of civil society organizations."

She stresses the importance of case management for TB patients, as some patients have no family support or have a lack of money for food. Referring these patients – migrants, ex-prisoners or the homeless – to outpatients care can be a problem, as they run a risk of stopping before they complete their treatment. "Case management of TB patients helps reduce TB and the number of treatment failures. This is good, not only for the patients themselves, but also for the entire country", says Dr. Kaziyeva.

>>Why does a country need pharmacovigilance?

Pharmacovigilance plays an important role in collecting the information that is needed for the successful registration of new drugs. In Kyrgyzstan the Ministry of Health decided not to seek registration until all necessary information about effectiveness of treatment and drugs safety has been gathered, including developing a protocol to decide which patients are eligible for the new drugs and under which conditions they should be administered. This protocol also includes the criteria for excluding the use of new drugs or shortened regimens. The very strict rules of the protocol are necessary for the responsible introduction of the drugs with a minimum of risk to patients. KNCV stimulates pharmacovigilance by giving technical support to the NTP and health services, and training to relevant health providers.

How does KNCV involve the local community in fighting drug-resistant TB?

Local non-governmental organizations (NGOs) play an important part in the implementation of TB control in a country. That is why involving these organizations is an essential part of our mission. For example, as patients are enrolled on new drugs and shortened drug regimes, we anticipate that many will also be put on ambulatory (outpatient) treatment. Therefore we need to develop a system for supporting these patients. NGOs will be engaged to provide patient support and medical staff will be needed to make sure the patients finish their treatment.

Local TB Civil Society Organizations (CSOs) are also involved, for instance in the Country Coordinating Mechanism (CCM), which oversees the implementation of a country's national TB control activities financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In 2015 KNCV supported two civil society organizations in Kyrgryzstan. One is Socium, a local NGO which fights against HIV, TB and drug abuse, for which we successfully helped to secure funding from the Stop TB Partnership for a proposal to improve the capacity of TB CSOs in representing TB patients' interests. The other is a new CSO established by former TB patients to represent their interests in the CCM: the Kyrgyzstan national TB Patients Coalition (see inset). It was accepted as a CCM member, meaning that now there is a TB patients' civil society representation in the implementation of the Global Fund grant.

The TB Patient Coalition will also be involved in the implementation of new drugs and regimens. There are now fifty members of the Coalition, including TB doctors and former patients from all across Kyrgyzstan, who are active as outreach workers. They provide essential support to patients, because they know the situation these patients find themselves in, and understand the support and help which they need to adhere to their treatment. To prepare for the new TB drugs to be introduced in 2016, KNCV experts will provide technical assistance to the Coalition and organize trainings for the representatives, as well as meetings about patient enrolment and eligibility. ■

The former TB-patient giving support

Sultan first developed TB ten years ago. He does not speak Russian, he speaks the Kyrgyz language. Sultan was sick with TB in another region, where his disease was detected but not treated. Eventually he came from to the city of Bishkek for treatment. "I was a migrant worker, working in construction and also as a taxi driver. I was travelling a lot and I met a lot of people. I was under a lot of stress and did not always have enough food, or a good space to live. This caused me from time to time to stop my TB treatment, which I know was not good." Sultan developed MDR-TB. He is now cured and joined the TB Patient Coalition. "I know what it is like, so I now use my experiences to help other MDR-TB patients through the treatment process."

A PUSH AND PULL STRATEGY TO SAVE LIVES

Finding more missing patients in Nigeria

Nigeria, with a fast growing population of more than 180 million people, has an alarming number of undetected TB-cases every year. It is estimated that two-third of all people falling ill with TB are either not diagnosed or not reported correctly. Finding these missing patients is a matter of the highest priority. Therefore, KNCV works both to improve access as well as raise public awareness to diagnosis and treatment.

Our impact in short

In Nigeria, two out of three TB cases go undetected. Either because they aren't diagnosed or because they are not properly reported. KNCV helps turn the tables by improving access to TB-diagnosis and care, engaging the private sector and raising public awareness.

What's the impact of the missing TB-cases on the public health in Nigeria?

If you take into account that every non-treated person with active lung TB can spread the infection to up to 15 other people every year, leaving them untreated can be catastrophic. TB is especially a risk for vulnerable groups, such as children, pregnant women, elderly people, malnourished people, HIV patients and people who are ill or otherwise 'immunocompromised' (meaning their immune system's ability to fight infectious diseases is compromised or absent). The missing cases of MDR-TB create even more risk, as these specific strains of the disease are considerably more difficult and expensive to treat.

> If you take into account that every non-treated person with active lung TB can spread the infection to up to 15 other people every year, leaving them untreated can be catastrophic.

How are so many TB cases being missed?

This is partly because people with TB disease have not been coming to the TB services for diagnosis or treatment. There are several possible reasons for this. For example, people do not recognize the seriousness of the symptoms in time or are afraid of losing their job when they turn out to be sick. Also the available public services might have been difficult to reach, frequent industrial actions or functioning sub optimally. Many people turn to health facilities outside the government-regulated >>

The doctor

Since more than 20 years, dr. Malik Mudassar Ahmed presides over the Ahmadiyya Muslim Hospital, a faith-based private facility in Kano in the North East of Nigeria.
'In 1997, we started out with twelve beds. We're not a very large hospital, but we have all the basic services. In 2006, we became part of the State TB program – while also officially becoming an HIV center. Since 2013 the facility contains 25 beds, an ER, outpatient clinic, diabetes and hypertension clinics, a medical and a surgical unit and a radiology department.'
In October 2015, rapid diagnostic testing for TB using GeneXpert was added to the services provided by the hospital. 'Thanks to KNCV and their partners, the Ahmadiyya Muslim Hospital is now the only private facility in North-western Nigeria with this instrument', says Mudassar Ahmed. 'Needless to say, we were very happy when the KNCV team approached us with their plans to install a GeneXpert machine in our hospital as part of the Challenge TB project. Since the successful installation and training of the staff, we've been able to test 485 patients with the GeneXpert machine. Of them, 104 were found to be TB positive and four were diagnosed with multidrug-resistant TB.'

>>TB control system. Furthermore, even if people do find their way to the public health system, their treatment is not always registered and monitored properly. Treatment support centers and laboratory sites in Nigeria cope with a variety of obstacles to perform that task; from inadequately equipped facilities to a lack of human resources (there has been a prolonged strike by health workers) and a lack of knowledge and training among staff members.

What does KNCV do to help?

We are supporting various initiatives that are designed to actively find the people with TB who are currently being overlooked. Efforts include scaling up diagnosis and treatment, with the help of the new rapid diagnostic GeneXpert instrument. Furthermore, KNCV is promoting engagement with media and the private sector to raise community awareness about the disease and its prevention.

What exactly does the GeneXpert instrument do and why is it needed?

The GeneXpert test is a molecular test for TB, which diagnoses TB by detecting the presence of TB bacteria, as well as testing for resistance to the drug Rifampicin. It uses a sputum sample and can give a result in less than two hours – much, much quicker than previous tests. KNCV has had a large stake in introducing the GeneXpert testing method country-wide, considering it an extremely important tool: it is of high quality, fast, accurate, and easy to use.

Will GeneXpert replace other tests?

Yes and no. The World Health Organization (WHO) recommends that GeneXpert should be used as the initial diagnosis test in individuals suspected of having MDR-TB, or HIV associated TB. WHO also emphasizes that the test does not eliminate the need for conventional microscopy culture and drug sensitivity testing, as these are still required to monitor treatment progress and to detect other types of drug resistance.

How do we make sure that GeneXpert is available to as many people as possible?

As part of the TB CARE I project and its successor Challenge TB, and other partners, we have up till now established 201 GeneXpert machines throughout the country. Our special team trains the local staff in working with the machine. Also, to ensure the instruments are used and maintained in the right way, KNCV has successfully run a pilot program with GeneXpert developer and producer Cepheid for technical support in Nigeria. The service includes installing the machines, calibrating them, maintenance support and troubleshooting. KNCV also leads a team under the auspices of the National AIDS Control Agency (NACA) to build a GeneXpert network to comprehensively strengthen TB case-detection among people living with HIV. KNCV's role is to provide TB expertise and support to NACA's GeneXpert rollout initiative. A large component of this work is building local capacity. We do so by training technicians, by teaching people how to train others in using the GeneXpert, and by developing a protocol for operational research. >>

> As part of the TB CARE I project and its successor Challenge TB, and other partners, we have up till now established 201 GeneXpert machines throughout the country.

The importance of private facilities

Although the majority of TB services are provided by the public health sector, the private sector is key to finding and curing more TB patients. For the majority of Nigerians the private health sector is often the first point of contact with the health system. The sector is responsible for about 60% of healthcare delivery in the country.
Private facilities, especially if they are faith-based, enjoy the confidence of the people and are well patronized. Furthermore, as a result of frequent industrial actions in the public sector, the private sector offers a veritable alternative by ensuring continued provision of TB services. In addition, the maintenance culture in the private sectors is much better than in the public sector, ensuring a relatively low downtime for the diagnostic GeneXpert machines.

Out of the 201 GeneXpert sites in the country as at December 2015, 22 (11%) are in the private sector. Of these 22, a majority (19, 86%) are in in faith-based hospitals.

An almost missed patient

The KNCV GeneXpert training team's arrival at the St Vincent Hospital in Benue State proved very timely for a particular patient. He had been diagnosed with HIV but his sputum microscopy test results came back as negative for TB. He was about to be discharged when the KNCV team announced that, as part of the on-job training of the local staff, all hospital patients with HIV would be tested on TB with the new GeneXpert machine. The first three samples included sputum from the man who was about to be discharged. He tested positive for TB. The staff were astonished that a man whose sputum was negative for TB on microscopy was actually infected with tuberculosis. The accuracy of the new instrument and a lucky timing made all the difference to this patient.

>> Does KNCV only work with the public sector?

No, not only the public sector, although KNCV does always work in close collaboration with local government partners, both in Nigeria and other countries. But to really be able to find all the missing patients it is important to also involve and educate other facilities. Therefore, we're supporting the engagement of private (often faith-based) health facilities in ten Nigerian states. By doing so we make TB diagnostics and proper treatment available to more people. While up to now most (89%) GeneXpert machines have been installed in government-owned facilities, private hospitals are also being involved in the scale-up of GeneXpert services, and results are promising.

> To give more specific information we have established a call center with a toll-free line to answer people's questions about TB and TB services.

What else does KNCV do to find missing TB cases?

Besides improving access to diagnostics we also work on outreach programs, especially to people who are most vulnerable to fall ill with TB. In 2015 we conducted active case finding in vulnerable populations in twelve Nigerian states. First, we established a system of targeted tracing and TB screening of people around TB patients, like children or elderly. Also TB patients who were lost to follow-up in the records are now tracked in order to identify why they stopped treatment or were never reported to be cured. This is important to ensure fewer patients are lost in the future. In addition, we improved patients' access to reliable TB services by providing assistance to poorly functioning and non-functioning TB treatment clinics, hospitals, and diagnostic laboratories.

If people don't know what TB is, finding the missing cases is going to be complicated, to say the least. So how well informed is Nigeria's population?

Knowledge and attitude towards TB is generally poor, especially in rural communities. A Knowledge Attitude & Practice Survey in 2012 found that only 13% of the general population had correct knowledge about TB. Even morwe surprising and shocking: only nineteen out of every 100 people already living with the disease had that correct knowledge!

How does KNCV inform the public about the risks and symptoms of TB?

The radio is a very important source of information for many Nigerians. That is why we produced radio jingles and participated in a radio show to raise public awareness (see the inset 'TB on the radio'). To give more specific information we have established a call center with a toll-free line to answer people's questions about TB and TB services. Also, we helped to develop and distribute informational and educational materials.

TB on the radio

KNCV and Challenge TB Country Director Gidado Mustapha is a public health physician with over 16 years of experience in both clinical and programmatic management of TB, leprosy & HIV. In 2015 he became a well-known public authority on TB, by appearing on Brekete Family, Abuja's most popular radio, television & social media talk-show. During the show, he explained what TB is, answered listeners' questions and broadcasted the number of the TB call center. The program is loved by thousands of households in Abuja and the surrounding states. Thanks to Dr. Mustapha's appearances on the radio show, the monthly calls to the TB call center have increased from 179 to 1,071.

What is the role of local organizations?

To improve community education and outreach we teamed up with local community based organizations. These organizations can play a major role in raising awareness about TB, but also in supplying treatment support. This support is important, since people will get ill again – and may infect others – if they don't complete their treatment. Therefore, we held meetings with community-based organizations in four Nigerian states. Together we are mapping potential sites and settings for intensified TB case-finding activities, looking especially at areas with low case detection and a high proportion of patients who are lost to follow up during treatment. ■

> Local organizations can play a major role in raising awareness about TB, but also in supplying treatment support.

The patient

Said Mahmood (26) was coughing non-stop and was tested for TB with the GeneXpert. Within a few hours it was clear that he had TB, and also what type: rifampicin-resistant TB. Therefore he could immediately start with the necessary second line anti-TB medicines. "After that, a lot of things changed immediately", he comments. "For example, about a week after I started my treatment, I began to sleep more peacefully and eat more regularly. I used to be very skinny, but my friends say I have put on some weight since the treatment started." Said receives help from his health worker, who accompanies him to the hospital and checks up on him every day, to remind him to take his medicine. "He goes out of his way to make sure I get better and don't miss an appointment with my doctor. Fortunately, I get a monthly stipend for the transport costs. Since I have no work, I could not pay for any of this by myself. I am grateful because the treatment is free and the support I get is priceless."

JOINING FORCES TO COMBAT CO-INFECTION

Implementing a one-stop approach to TB/HIV in Malawi

When someone is HIV positive, he or she runs a 26 to 31 times greater risk of becoming a TB patient as well, the WHO estimates. Worse still, in the case of such a co-infection, the diseases intensify each other. In many developing countries TB is the major cause of death for HIV patients. In Malawi, 54% of the TB patients are co-infected with HIV. To save more lives, the TB and the HIV program has to work hand in hand. This is why KNCV is working in Malawi to realize one stop TB/HIV care.

When did KNCV start working in Malawi?

KNCV has provided technical assistance to Malawi since the early 80's. In 2015 we opened a country office with a number of permanent staff to implement the Challenge TB (CTB) project.

How severe is the co-infection in Malawi?

Among all Malawians, the HIV prevalence is 10.8% and remains the most important risk factor for developing active TB disease. In 2015, 54% of TB patients were co-infected with HIV. To reduce the risk to die, those patients who are dually infected require both treatment for TB as well as antiretroviral treatment for HIV. To save lives, we have to combat both diseases together, starting with testing and diagnoses.

Fighting the diseases simultaneously calls for close cooperation. How exactly does that go about?

Under CTB, we have extended our reach from central to the zonal and district levels, closer to the facilities where services are provided. From the facility level into the communities we support the National TB Program in their efforts to expand a well-coordinated and integrated approach to prevention, diagnosis and care of both diseases. Together with staff of the HIV and TB program our KNCV country staff visit facilities that provide services either in TB, HIV or both. We learn from each other, cooperate, and work with local staff gaining new perspectives on the TB/HIV situation, discover problems and discuss solutions on the spot.

Sounds like a true investment ...

Yes, it is. Together we need to develop a shared understanding of the complexities of dealing with >>

Our impact in short

As over half of Malawi's TB patients suffer from a HIV co-infection, KNCV supports the National TB Program to better integrate both TB and HIV programs. This will help to improve access to quality TB/HIV care, that ultimately will reduce the burden of disease and mortality.

The three strategic objectives of KNCV in Malawi

1. Reduction of TB related mortality by 50% by the end of 2020 from the 2014 baseline.
2. Increase in Case Norification Rate (CNR) from 121 per 100,000 (2013) to 252/100,000 in 2020.
3. Increase treatment success rate for new smear positive TB cases from 84% in 2014 to 90% by the end of 2020.

To achieve this KNCV works closely together with the Malawian Ministry of Health, PEPFAR and USAID.

The country representative

Being a public health physician for over twenty years, and having lead programs in this capacity in Uganda, Ethiopia, Kenya, South Sudan and Somalia, Dr. Anthony Abura was recruited as KNCV's Country Representative in Malawi last October. The integration of TB and HIV control services is, in the area of management, the closest thing to his heart. "And not only because it is logical," he says, "given the interconnections between the diseases. The collaboration in Malawi is also born out of pragmatic reasons. In the recent past, there was a lack of funding for TB control, and as a result the supervision and monitoring of the TB program was not taking place on a regular basis."

Because the funding for monitoring HIV services has been secured, it was agreed to combine the monitoring of TB and HIV services and develop joint protocols. The preparations were finished in 2014, and in January 2015 the first joint visit was held. From this year on, they will take place on a quarterly basis. "Joint supervisory visits with the HIV officers are useful." Dr. Abura explains, "because KNCV's staff can observe how the HIV teams monitor the services, and vice versa: we can learn from each other. The group is quite large, where each of the joint teams consist of ten or more officers, all working in different areas and often splitting up when entering a center – focusing on their particular expertise." HIV specialists, for example, work on antiretroviral therapy and prevention of mother to child transmission, among other things.

"We are supporting the government's effort to improve the systems needed to support comprehensive integrated TB/HIV services. This includes joint program monitoring, training health care workers on the clinical management of both TB and HIV, joint mentorship and improvement of TB infection control. KNCV is also looking to support the establishment of an electronic recording and reporting system to capture patient-specific information."

>> two diseases in one patient. Timely access to reliable information on all patients is very important for all of us – without this information, we quite simply can't be efficient in combatting TB and HIV. Collecting data for both TB and HIV needs to be well supervised, well planned, well organized – and resources need to be well harmonized. Now data gathering is being integrated. This means the HIV and TB information now enters into one single data governmental system. Collecting, analyzing and sharing results have become more efficient and accessible for professionals.

How about drug management, is that also integrated?

Unfortunately, to a large degree this is not yet the case. Both HIV and TB medicines and supplies are managed separately. However, the project has made this one of the first priorities. We contracted a procurement and supply chain expert, who works in the NTP office to help strengthening all aspects of the supply chain for TB medicines and supplies. Proper drug management is very important, to prevent stock out drugs in the facilities and ultimately interruptions in patients/ treatment. Moreover, KNCV will support the procurement of life saving medicines for drug sensitive and drug resistant TB which is funded through the Global Fund. Timely quantification, procurement and distribution systems are key to ensure that the right drugs get to the right patient.

The zonal approach in detail

KNCV's three zonal advisors, who have allocated the five zones among themselves, have one clear and plain but great task – in the words of Anthony Abura, KNCV's Representative in Malawi: "To strengthen the health system, through cooperation with the national TB control program."

The zonal advisors' role is primarily to strengthen and advise. In their position they are familiar with what is going on in the zones and they can support implementation at zonal level or even down to the district levels (they are of great help to the staff in the district facilities). A large part of what they do is facilitating quality training and supportive supervision. Since the advisors collaborate closely with the zonal TB officers, they are housed in the same offices in Lilongwe, Zomba and Blantyre. "This is advantageous", Abura says, "because it improves communication and strengthens the exchange of information. Reports are more easily shared, this way. I call it a three-way beneficial communication, between us and them and the zones. It is mutually reinforcing."

The zonal TB advisors and the zonal TB officers all have the same level of TB expertise: in fact, before they joined KNCVs program, the advisors were also working within the NTP

"It is important to realize", Dr. Abura stresses, "that the contribution of the KNCV advisors is not solely providing technical expertise, but they also provide financial resources." Their work is complementary and supportive of the work of the NTP zonal TB officers. "Having great ideas is easy," Dr. Abura continues, "but you also need the resources to carry them through. Our advisors call workshops and organize training sessions, mobilize participation and work with the zonal TB staff to create a work plan. The advisors can also identify grey areas that need to be discussed and assessed."For example, the quality standard of sputum collection sites was identified as one such grey area that warranted further analysis and discussion. The advisors can identify opportunities and call in the assistance of the consultants in The Hague. "KNCV is present in the field", says Abura, "and can follow and report back on any implementation, and any issues arising in the field can usually be sorted out directly. That's what makes this approach a success."

What about preventing people from getting co-infected? What does KNCV do to improve infection control?

The policies and practices of infection and prevention control have been scaled up into health facilities across Malawi, although they still have to be integrated. KNCV continues to support improving the health care workers' capacity to assess and implement infection control measures.

Malawi isn't the largest of countries, but North to South still covers a great distance. How does KNCV deal with this?

Malawi indeed has a very characteristic, 'thin' shape, almost like Chile. A car ride from East to West might take two hours, but from North to South it is a fifteen hour drive. The country is divided into three administrative regions and five zones. These zones are subdivided into 28 districts. We have appointed three zonal advisors, who are cooperating locally with the Malawian government's zonal TB services, collaborating with 15 district TB officers, communities and health facilities. In this way, the CTB zonal advisors are present where the implementation is taking place and can provide capacity strengthening or give feedback wherever required.

> Collecting, analyzing and sharing results have become more efficient and accessible for professionals.

How will KNCV develop its work in Malawi over the next years?

We will focus on our objectives which correlate with the National TB Strategic Plan. The CTB project allows for a multi-year approach which we have just started and already begins to bear fruit. We will focus on active case finding among key populations, including children; further strengthening TB/HIV integration; and strengthening the diagnostic laboratory network and supply chain management. We will contribute to provide targeted technical assistance to improve TB infection control and the national TB surveillance system. Moreover, we will support the NTP's efforts to engage the non-public sector and finally, assist the country to make the Global Fund Investments a success. ■

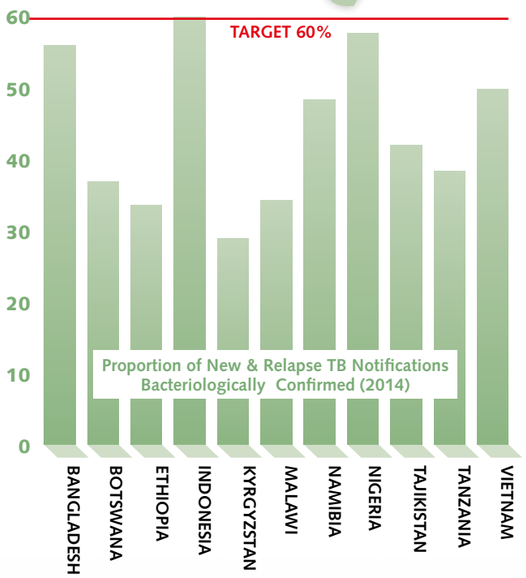
Photo Patrick Gomani, Zonal TB Advisor, Malawi. Patrick on the left is discussing safe sputum storages at Mangochi District Hospital.

The zonal advisor

Patrick Rex Gomani is one of the three KNCV zonal advisors. He is based in Zomba, the old capital of Malawi located in the south east zone. There a 6 districts in the zone with an estimated population of 3,8 million people. The zone has 1,374 health facilities (4 district hospitals, 1 central hospital, 6 mission hospitals, 159 health centers and 1,204 health posts). "I have worked in fighting TB and HIV for 17 years now," says Gomani. "It is my passion to improve care for patients by sharing my knowledge and experience with fellow health workers." Gomani travels within the district every day to visit health facilities and help them improve their services. He provides mentorship on case management organizes trainings and checks whether TB/HIV integration is evolving according to plan. "When I visit the Health Surveillance Assistant asks me 'could you tell us how we are performing at this facility?' Then together we look into the registers and see if they are progressing or when needed I help."

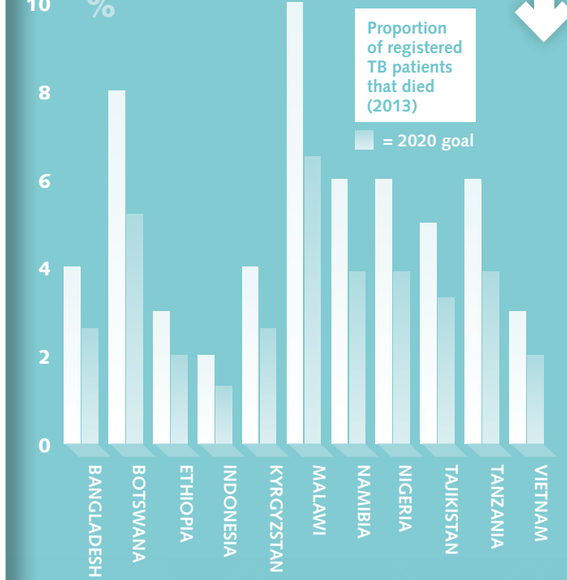
STRATEGIC GOALS 2020 RE PORT

FIND MORE MISSING PATIENTS



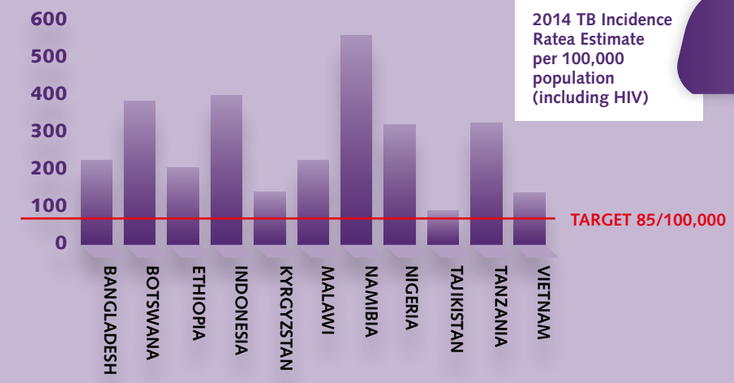
Increase the percentage of bacteriologically confirmed TB cases to 60%.
To be able to give TB patients the right treatment it is necessary to have a confirmed diagnosis.

REDUCE THE PERCENTAGE OF REGISTERED TB PATIENTS THAT DIE OF THE DISEASE BY 35%



We measure this indicator to monitor the progress being achieved toward the ultimate goal of TB care and control 'Zero TB deaths from TB' - to reduce the burden of human suffering and death caused by a treatable disease.

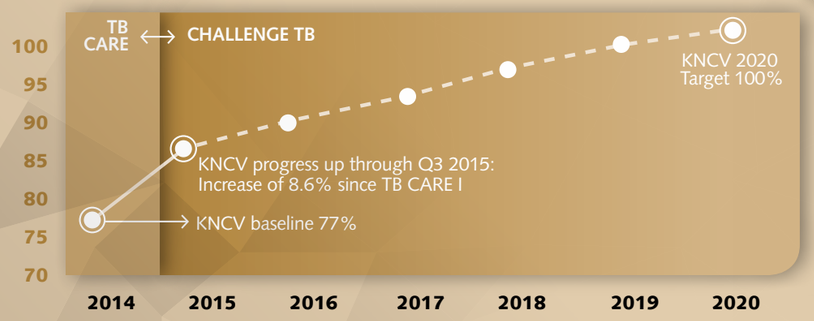
PREVENT MORE PEOPLE FROM DEVELOPING ACTIVE TB DISEASE



Reduce the number of people getting ill from TB to below 85/100,000 population.

Our ultimate goal is to eliminate TB.

MAKE SURE THAT ALL DIAGNOSED MDR-TB PATIENTS ARE STARTED ON TREATMENT



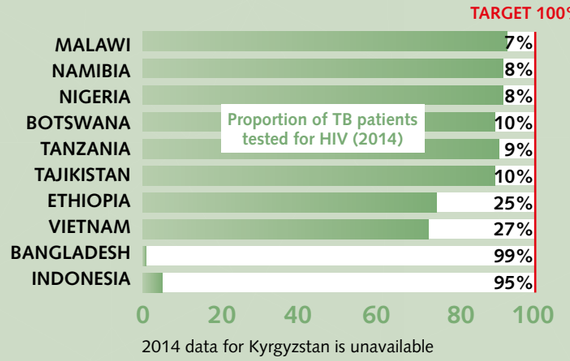
Starting all identified drug-resistant patients on appropriate treatment is an essential early step in preventing the spread of these forms of TB.

Proportion of detected MDR-TB patients enrolled on treatment

MDR treatment initiation Rate in KNCV Countries

Target MDR Treatment inititation Rate in KNCV Countries

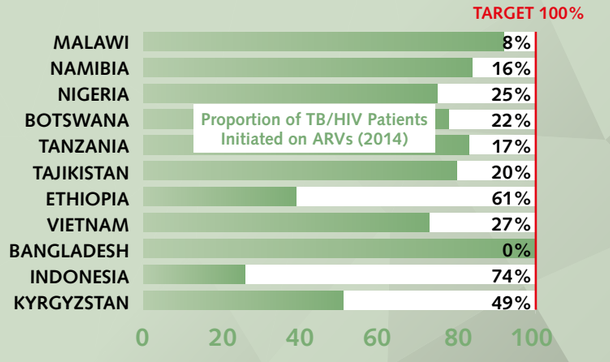
TEST ALL REGISTERED TB PATIENTS FOR HIV



2014 data for Kyrgyzstan is unavailable

In many settings with vulnerable populations, people with TB disease are also infected with HIV. Measuring this is an indicator of the important collaboration between TB and HIV programs.

START ALL REGISTERED TB/HIV CO-INFECTED PATIENTS ON ANTI-RETROVIRAL THERAPY (ARV)



All TB/HIV co-infected patients should be started on anti-retroviral therapy, as this greatly improves their chances of getting cured of TB.

ORGANIZATIONAL HIGHLIGHTS IN 2015

For us at KNCV Tuberculosis Foundation, 2015 was very much about moving forward. After being awarded the new USAID Challenge TB project at the end of 2014, this year the project picked up momentum in over twenty countries. Twelve of these have a KNCV office, of which three, Tanzania, Malawi and Kenya, were new. The KNCV team grew by more than 50% to accommodate all expanded activities. In The Hague, we moved to a nice but much more cost effective office building.

Implementing ambition

The Challenge TB project offers an exceptional opportunity to further our mission to eliminate TB. Leading a coalition of nine international partners, KNCV oversees and manages the project which is running in 21 countries and 1 region. The Project Management Unit is housed in the KNCV central office in The Hague. Implementation of this multi-year multi-partner project demands a tight organization and teamwork between technical consultancy, project management and finance. In 2014 we prepared for an adaption of the KNCV organization structure to optimize this teamwork, and the new structure was implemented in January 2015. Three divisions work closely together, with complementing responsibility and expertise: operations (project management), technical consultancy and finance. They are supported by units dedicated to communication & fundraising, resource mobilization and HRM.

Children in Tajikistan

Country director Jan Voskens seriously ill

In the summer our country director for Indonesia, Jan Voskens, fell very seriously ill. After several weeks in intensive care in Bangkok and Singapore he was brought to The Netherlands for further treatment. We are extremely sad that he will not be able to return to KNCV. His compassion, leadership and wealth of experience are greatly missed.

New office

In May the KNCV central office moved to a pleasant but far less expensive new office space at the Benoordenhoutseweg in The Hague. Existing furniture was re-used in this bright and inspiring place, which accommodates the whole team on one floor. Because the building also houses several shared meeting rooms of different sizes, it is also ideally suited to host larger meetings for internal knowledge exchange, such as the International Meeting Week, lunch presentations and workshops.
At the same time as the physical relocation we also moved our documents to 'the Cloud'. After some initial technical hiccups this allowed for better remote access to files, an important feature because KNCV consultants work from many different locations. Relocation of shared files will be the next step.

Broadening our funding base

Alongside the USAID funded Challenge TB project, in 2015 we implemented several other multi-year projects and partnerships. The DGIS project, which focuses on strengthening private sector engagement and enhancing investments made by the Global Fund to combat TB/HIV co-infection, was implemented in two countries, with three more to follow in 2016. Collaboration with Cepheid, the producer of the GeneXpert diagnosis machine, was extended.

Additionally, KNCV submitted proposals to potential new donors, including DGIS/RVO, Bill and Melinda Gates Foundation, the Eli Lilly and Company Foundation, ZonMW, the European Union, EDCTP, the Rabobank and JV Inkai LLP (a mining company in Kazakhstan). Two of these proposals explored opportunities for new types of co-operation: corporate (JV Inkai LLP) and a major donor foundation (through Rabobank). Both proposals were not accepted, but important lessons were learned and KNCV will certainly continue to explore these types of funding sources.

Management changes in 2015

In April, Michael Kimerling joined KNCV as Director of the newly formed Technical Division, coming from the Bill and Melinda Gates Foundation and the University of Washington.
KNCVs Scientific Director Frank Cobelens was appointed as the new Chairman of the Board of the Amsterdam Institute for Global Health and Development (AIGHD) in Amsterdam, beginning January 1, 2016. As such he is the successor of Joep Lange, who died in the crash of Flight MH17 in July last year. Professor Cobelens continues to be attached to KNCV as a scientific advisor in charge of large research projects.
Three new members of the Board of Trustees were appointed in 2015, bringing additional and much valued expertise and experience:
Jan Hendrik Ricardus, Maria van der Sluijs and Mirella Visser.

Through a special financial contribution from the De Langen Stichting voor Mondiale Tuberculosebestrijding (SMT) we were given the opportunity to invest in research and planning for future core funding. This resulted in a set of priorities and an action plan for 2016, the implementation of which is also being supported by SMT.

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>> The Young Professional program was started in 2015 with the support of SMT and the 's-Gravenhaagse Stichting tot Steun aan de bestrijding van Tuberculose. Through this program we are investing in a new generation of TB experts with solid knowledge combined with new skills and working dynamics.

Campaigning and private fundraising in the Netherlands

Since TB is under control in The Netherlands, many people think it is no longer an issue. To raise awareness on the major health impact that the disease still has in the world, we stepped up our communication efforts. Building on the success of the 2014 campaign around World Stop TB Day, we again engaged Dutch celebrities to reach a broad audience via social media. The surgical mask was again used as a symbol to remind people of the infectious airborne disease that TB is. Together with partners such as the local municipality health services, we placed surgical masks on statues throughout the Netherlands, generating a lot of free publicity. A second campaign highlighted TB in children. Both campaigns resulted in a growing number of followers on twitter, subscribers to our newsletter and more than doubling of Facebook fans.

In October we launched our new KNCV website at kncvtbc.org. This website replaces the four different websites we previously had for different audiences. The new platform offers a far better possibility to tell our story and engage people in our mission. To attract more visitors we also requested and were awarded a Google grant, which allows free advertising on the Google website. In the last quarter of 2015 we saw a rise of 28% in the number of website visitors.

To further enhance our visibility we also redesigned the KNCV logo. The separate brand used for fundraising in The Netherlands, 'Stop tbc', was integrated. The lettering was also modernized, to be more recognisable when used together with partner and project logos. We restyled the logo in such a way that it can be used alongside to the old logo, which will be phased out, thereby avoiding extra costs for rebranding.

In 2015 the results of our private fundraising where higher compared to 2014. This was largely due to more income from private institutions and legacies. We have been diversifying our methods of fundraising, working on a more segmented approach, including door-to-door appeals, online marketing and donations via SMS. A new donor database was installed to further enhance this. We have also been preparing for a major donor program to be implemented in 2016. These investments in new approaches have not yet made up for the decline in the number of donors, but the percentage of regular givers is on the rise, and the average gift is higher than the previous year.

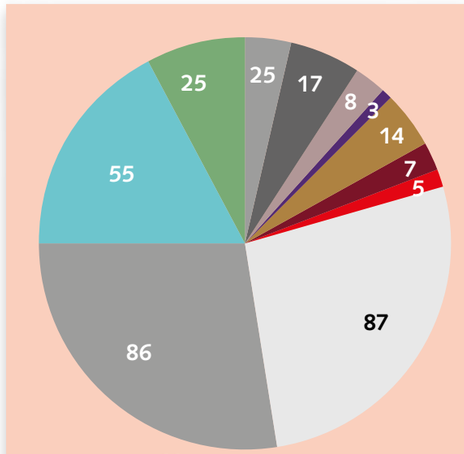
The continuing support of the Vriendenloterij and Lotto is of great importance to KNCV. Both are instrumental in the continuation of our programs and the support of patients in the Netherlands, for which no other regular financing is available. ■

> In 2015 the results of our private fundraising where higher compared to 2014. This was largely due to more income from private institutions and legacies.

More expertise in KNCV country offices

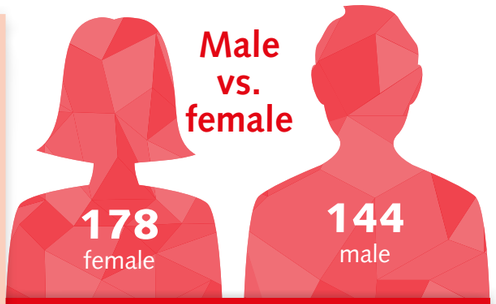
Due to the implementation of several projects, most notably Challenge TB, KNCV experienced an almost 50% growth in number of staff in 2015. Technical expertise was expanded in important fields such as MDR-TB and laboratory management. Project management was also strengthened, as KNCV is leading the coalition of nine organizations that together implement Challenge TB throughout the world. However, most staff were added at the country level. New offices were established in Malawi, Kenya and Tanzania, while additional projects in Ethiopia and Nigeria also demanded a growth in personnel. To enhance sustainability KNCV works increasingly at the local level, building skills and transferring knowledge within districts and communities close to the patient.

SOCIAL REPORT 2015

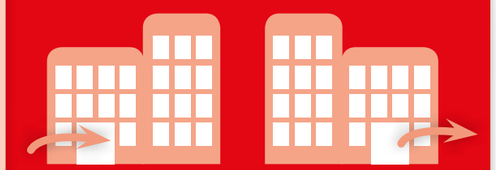


Staffing per country

Nigeria 55
Ethiopia 25
Malawi 12
Tanzania 17
Namibia 8
Botswana 3
Kyrgyzstan 14
Kazakhstan 7
Vietnam 5
Indonesia 86
Central Office

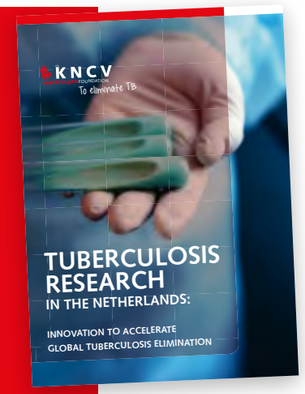


Inflow/outflow



Sick leave at The Hague office was **4.0%** in 2015 versus **5.8%** in 2014, mainly due to a reduction in long-term sick leave.

White paper on Dutch role in international TB research



In September 2015 we organized our yearly symposium for an audience of politicians, partner organizations and other stakeholders. This year's theme was 'Innovation is everything', which was chosen to highlight the extraordinary position of the Netherlands in research and innovation for TB. Several Dutch research institutes are among the world-leading groups in various aspects of TB research, owing to their expertise, research capacity, international networks and product innovation. Together they can make major contributions to the global TB research agenda. KNCV Tuberculosis Foundation and the Netherlands Tuberculosis Research Platform joined forces and brought together 21 research groups for an inventory process. The outcomes of this process were presented in the white paper "Dutch Research for Global TB Elimination", which can be downloaded from our website.

In the white paper four specific areas of excellence in TB research are identified in which a collaborative Dutch effort brings major, cutting-edge value to the global End TB strategy. These are:

(1) fundamental scientific research into host-pathogen interaction;
(2) epidemiological research into understanding and reducing transmission;
(3) studying treatment optimization; and
(4) improving the health system response, including cost-effectiveness.

In addition to these four areas of excellence, Dutch researchers play important roles in building research capacity.

BOARD OF TRUSTEES REPORT

Three new members join KNCV Board of Trustees in 2015

Matching KNCV's new ambitions and expanding operations globally, the Association of Members in May 2015 appointed three new members to the KNCV Board of Trustees: Prof. Dr. Jan Hendrik Richardus, Drs. Maria C. van der Sluijs, and Mirella Visser, LLM. They strengthen the Board of Trustees with competencies and perspectives based on prominent careers in international business, public health, and leadership development.

Supervisory governance in 2015

Following a period of consolidation of the organization during years of an uncertain funding outlook, supervisory governance in 2015 focused on oversight on the quantitative expansion and qualitative strengthening of the organization, including overall staffing, leadership at management team level, structural adaptations and firmly embedding the significantly expanding operations required to implement the Challenge TB project. In the course of 2015, the organization expanded rapidly with staff growing 50% and the organization branching out into more countries and increasingly de-centralizing operations. Risk management continued to receive due attention.

While currently the organization is heavily focused on implementation of Challenge TB, funding diversification in the medium term remains a key area of attention for the Board of Trustees. This topic featured on the agenda of the annual retreat with the management team. Re-establishing the relationship with the Ministry of Foreign Affairs (DGIS) as a funding agency met the longstanding aspirations of the Board of Trustees.

Key areas governed

The key areas of attention and oversight for the Board of Trustees throughout 2015 were:

- The move to new premises and continued oversight on establishing a healthy cost structure;
- Strengthening the human capital base of the organization and staffing of key leadership positions;
- Funding diversification, including positioning with key potential funders, such as DGIS and the Bill and Melinda Gates Foundation;
- Risk management and mitigation:
  - o Related to the expanded and de-centralizing operations
  - o Related to staff security in the current international social and political environment;
- The organization's review and implementation of the code of conduct was highlighted by the Board of Trustees as an opportunity to strengthen KNCV culture and ethical standards in a complex and cross-cultural global organization;
- Leadership transition in the Executive Board.

Looking ahead into 2016

At the end of 2015 Frank Cobelens announced his resignation from KNCV Tuberculosis Foundation to assume the prestigious position as Chair of the Amsterdam Institute for Global Health and Development (AIGHD). In this position he is the successor to our late colleague in the Board of Trustees, Joep Lange. The KNCV Board of Trustees gratefully acknowledges the scientific leadership by Frank Cobelens, jointly with Kitty van Weezenbeek, during his tenure at KNCV. Looking ahead, strengthened ties with AIGHD and the University of Amsterdam will serve the KNCV mission.

The Board of Trustees, in considering several options for succession, assessed the team of key staff in the organization to have strengthened substantially in competencies. It was therefore decided that from January 1, 2016 onwards Kitty van Weezenbeek will solely head the organization. An Executive Committee, comprised of the division directors and the Challenge TB director, will support the Executive Director and will serve as advisors for executive decision making.

The Board of Trustees commends the organization for transition to a strengthened and much expanded organization over the year of 2015. The Board looks ahead to the coming years with confidence and takes pride in the evolving mission and role of KNCV in ending tuberculosis.

The Board of Trustees,

Chair **Vice Chair**
Dina Boonstra **Dirk Dotinga**

Family in Bangladesh, Bihari community Dhaka

Conducting laboratory assessment in Taung Gyi Center

Child in Tajikistan

GOVERNANCE REPORT AND EXTERNAL COMMUNICATION

Statutory name, legal state and place of residency

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

General Assembly

The members of KNCV are organizations with a mission or task in the field of TB control. KNCV's General Assembly, comprising of 10 members, appoints the Board of Trustees and governs the activities of KNCV, thereby contributing to the statutory mission of the organization. The General Assembly may advise the Board of Trustees and the Executive Board. The General Assembly met on May 20th 2015. The members as per 2015 year end are:

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

Photo: Ethiopia, Collecting sputum sample

Honorary members

During the summer of 2015 our honorary member Dr. Annik Rouillon passed away. KNCV mourns the loss of a unique person who dedicated her life to TB control. Dr. Rouillon, together with Dr. Karel Styblo, was a driving force behind the development of the DOTS strategy. From 1979 – 1991 she led the scientific work of the International Union Against Tuberculosis and Lung disease, eventually serving as Executive Director. KNCV Executive Director, Kitty van Weezenbeek, attended the memorial service honoring Dr. Rouillon.
Honorary members of KNCV are individuals who made a significant contribution to TB control and/or to KNCV as an organization. At present our honorary members are Dr. M.A. Bleiker and Dr. H.B. van Wijk.

Board of Trustees

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

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

- An agenda setting committee to prepare the board agenda;
- An audit committee to assess in detail the annual plan, annual report and the findings of the external auditor;
- An appraisal and remuneration committee to assess the performance of the members of the Executive Board.

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

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The Board of Trustees, at 31 December 2015 was as follows:

Member	Appointed	Expiring
Drs. Dina Boonstra, chair	May 2014 (2nd term)	2016
Drs. Dirk Dotinga, vice-chair	May 2012 (1st term)	2016, eligible for 2nd term
Mr. Ton van Dijk	May 2013 (1st term)	2017, eligible for 2nd term
Drs. Maurits Verhagen	May 2015 (2nd term)	2019
Prof. Dr. Jan Hendrik Richardus	May 2015 (1st term)	2018, eligible for 2nd term
Drs. Maria van der Sluijs-Plantz	May 2015 (1st term)	2018, eligible for 2nd term
Drs. Mirella Visser, LLM	May 2015 (1st term)	2019, eligible for 2nd term

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

Member	Positions
Dina Boonstra	CEO NDC Media Group
Maurits Verhagen	Medical doctor TB control Municipal Health Service 'Limburg-Noord', chair of the Committee Practical TB Control in The Netherlands
Dirk Dotinga	Chair Alzheimer Netherland – region Haaglanden, member of the Board of Trustees Haagse Milieu Services, boardmember Stichting Noodopvang Haaglanden
Ton van Dijk	Director of public health (region Haaglanden) and director of medical disaster management (region Haaglanden)
Jan Hendrik Richardus	Professor, Department of Public Health, Erasmus University Medical Center; numerous scientific advisory committee positions in the Netherlands and overseas; Chair Committee Research, infectious disease association the Netherlands; Chair IDEAL consortium;
Maria van der Sluijs-Plantz	TMF Orange Holding B.V. non-executive Board Member; Telefonica Europe B.V. non-executive Board Member; various advisory and volunteer positions; Member of college financial supervision Curaçao and Sint Maarten, on the recommendation of Sint Maarten
Mirella Visser	Center for Inclusive Leadership, Founder and Managing Director; Member Advisory Council International Affairs for Dutch Ministry of Foreign Affairs;

The members of the Executive Board during 2015 held the following relevant positions and responsibilities:

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

>> Supervisory governance during 2015

In May 2015 the General Assembly reappointed Maurits Verhagen for a second term of four years and appointed three new members for a first term: Maria van der Sluijs, Jan-Hendrik Richardus and Mirella Visser. With the on-boarding of these three members, the competencies and perspectives strengthened include international business, public health, legal and human resource/leadership development.

In 2015, the Board of Trustees held four regular meetings (February, April, September and November). Following the September regular Board of Trustees meeting a retreat took place with Executive Board and Management Team. The Audit Committee met twice (April and October). The appraisal and remuneration committee conducted performance assessments with Executive Board, sharing outcomes with the full Board. In view of the on-boarding of three new members in the September meeting a self-assessment was viewed to be premature and it was postponed to 2016. Two members of the Board of Trustees attended the Works' Council meeting in the November.

GGD Amsterdam, The Netherlands

Executive Board

The Executive Board governs the organization. Up until January 2016 the Executive Board was composed of an Executive Director (who holds statutory powers solely) and a Chief Scientific Officer.

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

During 2015 the Executive Board met bi-weekly to discuss and formalize all required decisions concerning strategy, planning and control, monitoring and annual reporting, as well as to discuss issues arising from operational management. The Executive Board was supported by a Management Team, which is composed of the three division directors (Finance, Operations and Technical Services), the Challenge TB Director and the heads of the supporting units and the board secretary/advisor public affairs.

On January 1, 2016 Frank Cobelens resigned as CSO with KNCV and assumed a position to lead the Amsterdam Institute for Global Health and Development in Amsterdam. The Executive Board per this date shifted to a one-person Board advised by a newly installed Executive Committee composed of the three division directors and director Challenge TB. Per January 2016 the Management Team has been expanded to include the technical coordinators; portfolio managers will be regularly invited as well. Management Team meetings are held every two months and focus on medium term strategic issues.

The Executive Director has indefinite employment contract. Her performance is assessed by the appraisal and remuneration committee of the Board of Trustees. The committee reports their findings to the full Board of Trustees.

International Advice and Counsel meeting

In 2015 the International Advice and Counsel meeting did not take place; it will be convened in the fall of 2016.

Works Council

In 2015 the chair of the Works Council, Ineke Huitema, temporarily re-located to Nigeria to support the implementation of the GeneXpert roll-out project in Nigeria. Up until her return to the KNCV office in The Hague, slated for July 2016, Irma Lamp has assumed the duties as Chair of the Works Council. During the same period the Works Council is strengthened with an extra member: Sara Massaut.

In the course of 2015, the Works Council provided advice on the following issues: the organizational structure, change of reporting line ICT & facility management. They gave consent for the new Code of Conduct and the Employment Conditions Scheme (which includes last legislative changes). Furthermore, the Works Council has discussed several other topics with the director and HRM; such as communication about pension, sick leave, the analysis of the reservoir of leave hours and workload.

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

At the end of December 2015, the Works Council members were:

Member	Appointed	Expiring
I. Huitema	2014 *(2nd term)*	2018, *eligible for 3rd term*
J. Klein	2012 *(1st term)*	2016, *eligible for 2nd term*
I. Lamp, chair while I. Huitema is working in Nigeria	2012 *(1st term)*	2016, *eligible for 2nd term*
S. Massaut (temporary during absence I. Huitema)	Starts 2015	End 2016
J. van Rest	2015 *(1st term)*	2016, *eligible for 2nd term*
E. Tiemersma	2014 *(2nd term)*	2018, *eligible for 3rd term*

Quality control

KNCV considers quality as an essential hallmark of all the work we do. To ensure quality in our activities, deliverables, and results in 2015 the organization implemented processes that support standardized, high-quality performance. This includes standards of excellence and review processes for key KNCV technical functions, such as providing short-term technical assistance through consultancies at country level and developing high-quality work plans and reports. KNCV now tracks and reports on the outcomes of all short-term technical assistance and provides systematic technical quality review for deliverables generated by its USAID-funded Challenge TB project.
To ensure that KNCV staff are up-to-date on the latest technical developments in TB control and elimination, the Technical Division has instituted 'home weeks' when key technical staff from headquarters and the field gather in The Hague for week-long technical discussions on innovations. KNCV has also drafted an 'innovations paper' to help the organization focus its contributions to the global evidence base on promising new approaches and technologies for TB control.

To sustain the quality of internal management and processes within the organization, KNCV uses a cycle of strategic and annual planning, implemen- >>

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

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

Risk management

In 2015, the organizational risks were identified and updated in a risk assessment report using a survey among all country directors and unit heads. The following risks were identified as subjects for further improvement:

a. The various insurances related to liability need to be assessed on completeness and updated.
b. The KNCV Field Office Manual was updated in 2015. The section on procurement needs to be extended.
c. A plan for retention of key staff will be drafted in 2016.
d. In light of the new law a section on data protection has been added to the risk assessment. The information security policy will be finalized in the first quarter of 2016.
e. KNCV is bound by tax regulation in the countries we operate in. Misinterpretation or lack of (local) knowledge could result in non-compliance and associated fines/ penalties. Hiring local expertise is part of the Terms of reference for setting up a new office. Annual local checks will be performed by external auditors.

External Quality Hallmarks

KNCV is subject to the governance and quality requirements of the CBF and has, since July 1998, received the CBF certificate up to 2015. CBF in April 2015 renewed the certificate for the coming five years following the submission of all required documentation early February 2015. The document 'Management and governance at KNCV - the code for Good Governance Code application' describes our governance structure, management procedures and regulations in detail. This document will be revised in 2016 to reflect changes in internal governance bodies. A summary of the accountability report, outlined below, is sent annually to the CBF.

Codes of conduct

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

- General code of conduct, updated 2015 and re-introduced during the International Meeting Week in January 2016 to strengthen staff awareness and compliance monitoring;
- Code of Conduct for the use of E-mail, Social Media, Internet and Telephone Facilities;
- Policy and protocol for undesirable behavior at work;
- Whistle blower policy.

Media policy

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

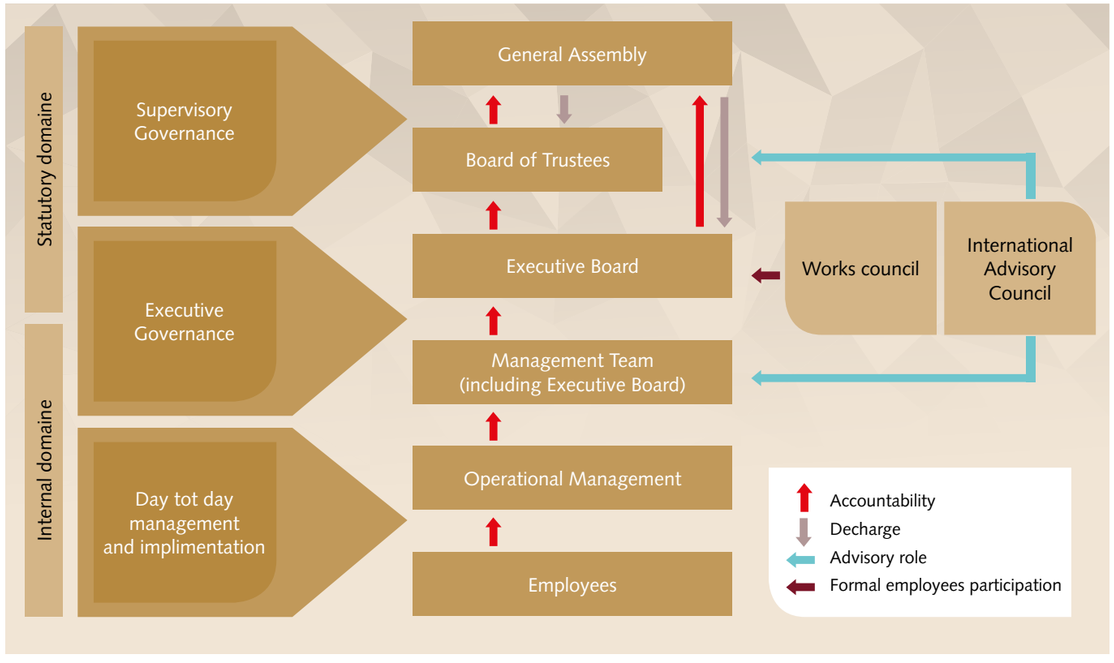


Figure 11.1: KNCV model for governance and management

Summary of the CBF accountability report on management and governance

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

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

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

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

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

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

In figure 11.1 a schematic overview of the governance structure is explained.

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

- Rules and Regulations for the General Assembly; >>

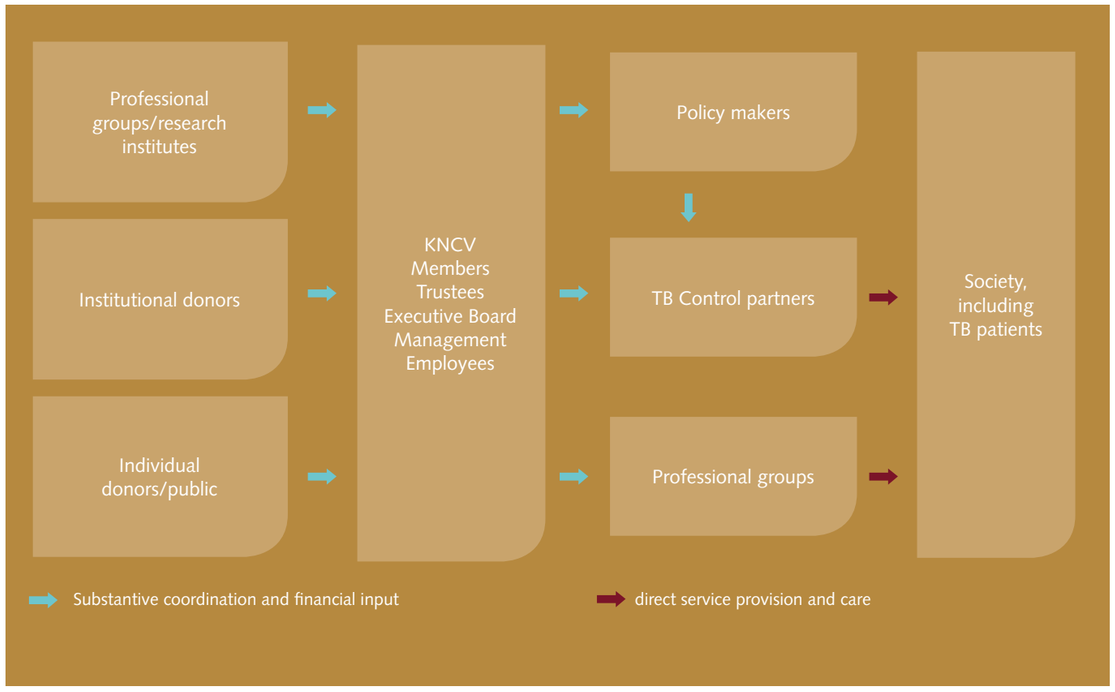


Figure 11.2: KNCV partner network


Bangladesh


Ethiopia, GeneXpert

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

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

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

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

Ad 3. Optimizing the communication and relationships with stakeholders

KNCV is part of a large partner network of public and private organizations and individuals, all contributing to the realization of our mission. The structure and composition of our network is outlined in figure 11.2.

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

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

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

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

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

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

FINANCIAL INDICATORS AND MONITORING DATA

The financial results for 2015 show a positive result. Our income grew compared to 2014.

KNCV Tuberculosis Foundation is pleased with the increase in income from private fundraising. Income from legacies is highly unpredictable, but showed an increase in 2015 compared to 2014 due to one larger legacy of € 108,000. Income from endowment funds also increased due to some additional grants for our Young Talent program and support to develop our core funding strategy. Income from corporate partners increased due to project grants for projects in India, Nigeria and Vietnam among others. From the perspective of diversification of funding we are pleased to see this part of our income growing.

Income from the Vriendenloterij decreased compared to 2014, we learned at the annual Goed Geld Gala. This is a result of the fact that KNCV Tuberculosis Foundation has been less successful than other organizations in acquiring income from lottery tickets sold earmarked for KNCV. A campaign to achieve higher numbers of earmarked lottery tickets has started in November 2015 and the results will be clear in 2016. Lotto income also decreased compared to 2014.

Income from government grants showed a significant increase in 2015. This is mainly related to the fact that activities for the 5 year USAID program Challenge TB have started after an initial startup period in 2014. 2015 was also the first year of activities for the 5 year DGIS grant, that counts as cost share towards the Challenge TB program.

Other income increased due to positive investment results. Part of our investment portfolio was sold at (in hindsight) a very good moment, resulting in high realized investment gains. Unfortunately the developments in the stock market were such that no unrealized investments gains can be reported.

Expenses in 2015 increased compared to 2014, but less than planned. The first quarter of 2015 was used to draft plans for various Challenge TB and DGIS country work plans. Only after approval of these work plans activities could start full speed.

Expenses for TB control in low prevalence countries (mainly The Netherlands) decreased as planned, due to lower out of pocket expenses.

Expenses for TB control in high prevalence countries increased both for KNCV and for its coalition partners in Challenge TB. Combined expenses are reported in the annual accounts as KNCV is lead partner for the entire project.

Expenses for research increased. In cooperation with USAID through the Challenge TB program KNCV is working on two large research projects focused on Transmission and Prevention. In 2015 these projects were in the set up phase. We expect the first activities in countries to take place in 2016.

Expenses for education and awareness increased in 2015 as was planned. For the first time in many years we organized two awareness campaigns, one around World Stop TB Day and the other about Childhood TB.

Expenses for private fundraising decreased in 2015 due to the fact that some activities are no longer outsourced, which resulted in cost savings.

Expenses for administration and control are in line with budget.

A proposal for allocation of the result 2015 is presented on page 90.

Table 8: Financial monitoring data compared to standards

MONITORING DATA	Standard	Actual 2011	Actual 2012	Actual 2013	Actual 2014	Actual 2015	Budget 2016	Average for 3 years
Spent on the mission compared to total expenses	not applicable	95,6%	96,6%	96,7%	95,7%	95,9%	96,9%	96,1%
Spent on the mission compared to total income		98,1%	95,4%	96,0%	95,2%	94,1%	97,7%	95,1%
Spent on private fundraising compared to private fundraining income[1]	max. 25%	20,4%	23,8%	17,4%	24,6%	12,6%	22,7%	17,6%
Spent on administration and control compared to total expenses	2.5 - 5%	2,6%	1,9%	2,0%	2,5%	2,6%	1,7%	2,3%
Spent on administration and control compared to total expenses excluding TBCTA coalition share in activities[2]	2.5 - 5%	4,9%	3,8%	5,1%	5,0%	5,1%	3,7%	4,6%

Financial data 2011-2016

The financial statements have been prepared in accordance with the Dutch Accounting Standard for Fundraising Institutions (RJ650). According to the 650 Guideline for annual reporting of charities and the requirements from the CBF a number of financial monitoring data is shown for a longer period in table 8. In total KNCV Tuberculosis Foundation generated less income in 2015 (49.6 million) than was planned (55.8 million), but more than 2014 (€ 45.2 million).

Total expenditures in 2015 were € 48.7 million, which is € 8.1 million lower than budgeted. The decrease is caused by lower expenditures in the category “TB in high prevalence countries”. Expenditures in the categories “fundraising” showed a decrease compared to budget and expenses for “administration and control” showed a slight increase compared to budget.

[1] The percentage spent on private fundraising compared to private fundraising income has decreased due to additional income from corporate funders
[2] TB CARE I and Challenge TB are partly implemented by partners in the Tuberculosis Coalition for Technical Assistance (TBCTA)

Expenditures on the mission (R7)

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

KNCV's policy for costs for fundraising (R8)

With regards to expenditures for fundraising, KNCV Tuberculosis Foundation complies to the guidelines issued by the CBF. Calculated as an average over a 3 year period, the costs cannot be higher than 25% of the income from own fundraising activities. As a consequence of our ambitions and modest position in the private fundraising market, we have chosen to stay close to the possible
maximum, as witnessed in 2015, and reflected in the budget for 2016. Uncertain and unpredictable factors in this strategy are the level of success of using new fundraising methods and the income from legacies. KNCV's internal policy on level of costs for fundraising is that if, in the course of a budget year, the results are not satisfactory, we adjust our budgets downwards in order to prevent a percentage above the 25% standard. Expenses in 2015 are 12.6% of the income from own fundraising activities, well below the 25% maximum. The 3-year average is 17.6%. The budgeted percentage for 2016 is below the 25% maximum. This is related to an investment in new fundraising approaches in 2015, which we expect to show results from 2016. The three year average based on 2014, 2015 and the budget for 2016 is at 20.0%.

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

The allocation of costs to the category 'administration and control' is done using the guideline and recommendations of Goede Doelen Nederland, published in January 2008. The CBF requires an organization to have an internal standard for this cost category. KNCV uses 2.5% of the total costs as a minimum and 5% as a maximum. The reasons for this range of percentages are:

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

The range has been adjusted downwards in 2015 from 5-10% as a result of the fact that volume of activities has increased due to the five year Challenge TB award, allowing for an overall percentage reduction. In 2015, the percentage of 2.6% is slightly higher than what was budgeted for (2.2%). Additional expenses for consultants (HRM and IT) and incidental moving costs related to moving to a new office are the cause of this increase. Also, due to the decreased level of coalition activities compared to budget (related to startup of Challenge TB) the percentage of costs spent on administration and control is higher than planned.

Internal monitoring data

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

- The number of project days realized compared to planned days; In 2015 a total number of 12,205 project days were planned and 12,801 were realized, which is 105% of the planned days. In 2014 this was also 105%.
- Indirect costs compared to direct personnel costs made in The Hague, as an internal method;
  All project days in total represent an amount in direct personnel costs. All other personnel costs and costs for facilities are accounted for as indirect costs. In 2015, the planned percentage of indirect costs on direct costs was 82.33%, and realized is 80.93%. The decrease in 2015 compared to the budget is due to a higher number of direct days.
- Indirect costs compared to direct personnel costs made in The Hague, in compliance with the USAID rules for accounting;
  Although the methodology does not differ drastically from our internal methodology, some cost categories and personnel categories included in our internal method have to be excluded as indirect costs in the USAID method. According to the USAID calculation the percentage for 2015 is 69.19%, while 68.58% was planned. In 2014 the percentage was 88.03%. The decrease in percentage is caused by a higher number of direct days. The decrease in indirect cost percentage is line with our long-term aim to be more cost effective.

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

Budget 2016 and possible risks

The full budget for 2016 is shown in the Statements of Income and Expenditure. The total income is budgeted on a consolidated level of €76.2 million. Of that amount, €41.4 million is compensation for implemented activities by the coalition partners of Challenge TB. Therefore, excluding consolidation, the total income is budgeted at €34.8 million, which is €10.9 million higher than the actual for 2015.
Income from government grants is budgeted to increase, related to the plans for activities in the second year of Challenge TB. Income from our share in third parties activities (e.g. lottery income) is budgeted to increase slightly. Investment income is budgeted conservatively at a slightly reduces level from the budget for 2015. No unrealized gains and losses on investments are budgeted.
The total level of consolidated expenditures amounts to €76.8 million. Excluding the partners' activities, this leads to a total budgeted cost level of €35.4 million, which is €10.7 million higher than the actual for 2015. TB control in high prevalence countries is increasing compared to 2015, related to the activities in the second year of the Challenge TB project.

A number of budgetary and control risks can be identified:

- Controlling the balance between direct and indirect days is crucial for the financial results.
- A large part of KNCV's income for personnel fees is in US dollars. We have included an exchange rate in the budget of US$1.12 against €1. Careful liquidity planning and making use of simple hedging techniques will be needed to further control the risk. A strong dollar improves our competitive position and cost effectiveness in US$.
- A large part of the budget is for material costs in countries for the Challenge TB program. There is a risk that costs are identified as unallowable for USAID by independent auditors in countries or by the independent auditor who executes the overall audit.
- The income from legacies is budgeted at €350,000. This is an average amount reached in the past years, but this income is very difficult to estimate and the amount can be significantly higher or lower.

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

Long-term financial plan

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

Table 9: Long-term Financial Plan 2016-2019

PROFIT & LOSS ACCOUNT	Budget 2016	Long-term forecast 2017	Long-term forecast 2018	Long-term forecast 2019
	In € 1 mln	*In € 1 mln*	*In € 1 mln*	*In € 1 mln*
Organizational costs				
Personnel related costs	10,40	10,61	10,82	10,83
Other indirect costs	1,56	1,59	1,62	1,66
Subtotal organizational costs	11,96	12,20	12,44	12,49
Charged to projects	-11,66	-11,89	-12,13	-12,57
Total organizational costs not charged to projects	0,30	0,31	0,31	-0,08
Investment and general income	0,11	0,12	0,12	0,12
Net result organizational costs	-0,19	-0,19	-0,19	0,20
Activity costs				
Costs for fundraising	0,48	0,49	0,50	0,51
Other activity costs	0,16	0,16	0,16	0,16
Total Activity costs	0,64	0,65	0,66	0,67
Activity income				
Own fundraising	1,10	1,12	1,14	1,15
Lotteries	1,09	1,09	1,09	1,09
Total Activity income	2,19	2,21	2,23	2,24
Net result Activities	1,54	1,56	1,57	1,57
Project costs				
Charges organizational costs	11,66	11,89	12,13	12,37
Travel and accommodation	0,72	0,74	0,75	0,77
Material costs	22,06	25,00	25,00	25,00
Expenses coalition partners Challenge TB	41,39	45,00	45,00	45,00
Total Project costs	75,83	82,63	82,88	83,14
Project income				
Funding donors - fee	9,73	9,93	10,13	10,33
Funding donors - travel and accommodation	0,64	0,65	0,66	0,68
Funding donors - other direct project costs	21,70	24,70	24,70	24,70
Endowment funds contribution	0,39	0,31	0,31	0,31
Other income for projects	0,01	0,01	0,01	0,01
Income coalition partners Challenge TB	41,39	45,00	45,00	45,00
Total Project income	73,85	80,59	80,80	81,02
Net result Projects	-1,98	-2,04	-2,08	-2,12
General Result (minus is a deficit)	**-0,62**	**-0,67**	**-0,70**	**-0,35**
Covered by earmarked reserves / donated to earmarked reserves	**-0,71**	**-0,70**	**-0,70**	**-0,40**
Influence on/movements other reserves	**0,09**	**0,03**	**-0,00**	**0,05**

FINANCIAL STATEMENTS 2015

BALANCE SHEET KNCV TUBERCULOSIS FOUNDATION PER 31 DECEMBER 2015

In Euro, after result appropriation

Assets		31-12-15		31-12-14	
Office construction work		233.944		20.961	
Office inventory		77.552		41.993	
Computers		277.918		177.670	
Fixed Assets	B2		589.414		240.624
Accounts Receivable	B3	59.916.705		31.527.842	
Investments					
Shares	B4	1.417.448		1.729.494	
Bonds	B4	3.075.108		2.965.492	
Alternatives	B4	707.116		922.029	
Cash and Banks	B5	15.871.523		13.497.523	
Current Assets			80.987.900		50.642.380
Total			**81.577.314**		**50.883.004**

Liabilities		31-12-15		31-12-14	
Reserves and funds	B6				
Reserves					
Continuity reserve		7.694.196		7.180.533	
Decentralization reserve		1.063.137		1.084.791	
Earmarked project reserves		1.644.080		1.497.168	
Unrealized exchange differences on investments		657.175		651.136	
Fixed Assets reserve		589.414		240.624	
			11.648.002		10.654.252
Funds					
Earmarked by third parties		437.064		476.515	
			437.064		476.515
Various short-term liabilities	B7				
Taxes and social premiums		434.546		318.587	
Accounts payable		297.592		552.270	
Other liabilities and accrued expenses		68.760.110		38.881.380	
Earmarked by third parties					
			69.492.248		39.752.237
Total			**81.577.314**		**50.883.004**

STATEMENT OF INCOME AND EXPENDITURE KNCV TUBERCULOSIS FOUNDATION 2015

in euro

		Budget 2016	Budget 2015	Actual 2015	Actual 2014
Income					
- Private fundraising	R1	1.609.100	1.360.300	2.189.882	1.593.139
- Share in third parties activities	R3	1.092.500	1.092.500	1.066.763	1.075.270
- Government grants		73.327.000	53.134.300	45.961.624	42.051.486
- Investment income	R5	135.700	145.000	369.717	480.559
- Other income	R6	16.400	18.700	17.716	15.300
Total Income		76.180.700	55.750.800	49.605.702	45.215.754
Expenses					
Increase 2015					
- TB control in low prevalence countries		820.200	1.087.700	805.955	1.021.907
- TB control in high prevalence countries		71.243.300	50.850.100	43.807.623	40.289.380
- Research		1.475.300	1.654.200	1.243.902	1.140.021
- Education and awareness		869.900	834.400	812.487	580.628
		74.408.700	54.426.400	46.669.966	43.031.936
Expenses to fundraising					
- Expenses private fundraising		365.900	410.800	275.412	392.094
- Expenses share in fundraising with third parties		51.500	51.100	49.608	21.240
- Expenses government grants		622.700	573.600	352.867	375.810
- Expenses on investments		42.800	43.500	50.103	44.439
		1.082.900	1.079.000	727.990	833.582
Administration and control	R9				
- Expenses administration and control		1.310.200	1.244.100	1.253.448	1.102.062
Total Expenses		76.801.800	56.749.500	48.651.403	44.967.580
Surplus / Deficit		**-621.100**	**-998.700**	**954.299**	**248.174**
Spent on mission compared to total expenses		96,9%	95,9%	95,9%	95,7%
Spent on mission compared to total income		97,7%	97,6%	94,1%	95,2%
Spent on private fundraising compared to income		22,7%	30,2%	12,6%	24,6%
Spent on administration and control compared to total expenses		1,7%	2,2%	2,6%	2,5%
Result appropriation					
Surplus / Deficit appropriated as follow					
Continuity reserve		86.800	-202.400	513.663	468.021
Decentralization reserve		-171.100	-289.500	-21.654	-64.752
Earmarked project reserves		-536.800	-448.900	146.912	-183.730
Unrealized differences on investments		_	_	6.039	145.199
Fixed Assets reserve		_	_	348.790	-129.798
Earmarked by third parties		_	-57.900	-39.451	13.234
Total		-621.100	-998.700	954.299	248.174

EXPENSE ALLOCATION KNCV TUBERCULOSIS FOUNDATION 2015

in euro

Expenses

	Budget 2016	Budget 2015	Actual 2015	Actual 2014
Grants and contributions	28.000	28.000	23.437	21.975
Purchases and acquisitions	22.930.200	15.832.600	13.863.222	12.210.704
Outsourced activities	41.390.000	30.000.000	23.987.470	23.134.198
Publicity and communication	710.000	756.000	570.218	612.483
Personnel	10.534.100	8.811.000	8.878.609	7.756.300
Housing	295.800	447.500	493.066	486.646
Office and general expenses1)	661.900	649.200	548.468	537.194
Depreciation and interest	251.800	225.200	286.913	208.079
Total	**76.801.800**	**56.749.500**	**48.651.403**	**44.967.580**

Allocation to destination	Related to the mission goals			
Actual 2015	Low prevalence countries	High prevalence countries	Research	Education and Awareness
Grants and contributions	18.187	-	5.250	-
Purchases and acquisitions	135.925	13.661.393	27.062	-
Outsourced activities	-	23.987.470	-	-
Publicity and communication	-	-	-	440.702
Personnel	582.522	5.529.146	1.110.765	321.562
Housing	31.740	322.750	46.221	23.478
Office and general expenses	20.380	142.231	29.556	14.021
Depreciation and interest	17.201	164.632	25.049	12.724
Total allocated	**805.955**	**43.807.623**	**1.243.902**	**812.487**

Allocation to destination	Income fundraising				Administration & Control
Actual 2015	Private fundraising	Share in third parties activities	Grants	Investments	
Grants and contributions	-	-	-	-	-
Purchases and acquisitions	-	36.300	2.280	-	262
Outsourced activities	-	-	-	-	-
Publicity and communication	122.469	-	-	-	7.047
Personnel	106.543	12.281	308.944	18.735	888.111
Housing	9.097	480	19.467	649	39.185
Office and general expenses	32.373	287	11.626	387	297.607
Depreciation and interest	4.930	260	10.550	30.332	21.236
Total allocated	**275.412**	**49.608**	**352.867**	**50.103**	**1.253.448**

CASH FLOW STATEMENT KNCV TUBERCULOSIS FOUNDATION 2015

in euro

	Actual 2015		Actual 2014	
Surplus excl interest	935.314		236.689	
Interest paid/ received	18.985		11.485	
Total surplus	954.299		248.174	
Depreciation - Fixed Assets	222.336		180.240	
Cash Flow from income and expenditure		**1.176.635**		**428.414**
Investments	417.343		87.860	
Accounts receivable	-28.388.863		-7.853.525	
Non-current liabilities	-		-	
Current liabilities	29.740.011		12.098.483	
Increase 2015		1.768.491		4.332.818
Cash flow from operational activities		**2.945.126**		**4.761.232**
Disinvestments fixed assets	35.393		4.602	
Investments fixed assets	-606.519		-55.044	
Cash flow from investments fixed assets	**-571.126**		**-50.442**	
Net cash flow	**2.374.000**		**4.710.790**	
Cash and banks as at 1 January	13.497.523		8.786.733	
Cash and banks as at 31 December	15.871.523		13.497.523	
Increase/ (Decrease) Cash on hand	**2.374.000**		**4.710.790**	

13. Notes to the Financial Statements

Guideline 650 for accounting and reporting

KNCV Tuberculosis Foundation is subject to the 650 Guideline for Annual Reporting by Fundraising organizations. In the attached statements, the financial results of all activities and projects are presented according to the formats of the 650 Guideline. In the following notes the composition of the Balance Sheet is analyzed and commented. Furthermore, significant deviations between the 2015 results and budget and between 2015 and 2014 as shown in the Statement of Income and Expenses are clarified.

Consolidation

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

BALANCE SHEET PER 31 DECEMBER 2015 - ASSETS

Assets

B2 Fixed Assets

Movements in the tangible fixed assets are as follows:

	Office reconstruction work	Office inventory	Computers	Total
as at 1 January, 2015				
Cost / Actual value	377.637	363.991	804.233	1.545.861
Accumulated depreciation	-356.676	-321.998	-626.563	-1.305.237
Book value	**20.961**	**41.993**	**177.670**	**240.624**
Increase 2015				
Acquisitions	287.033	80.904	238.582	606.519
Disinvestments	-320.137	-223.511	-186.444	-730.092
Depreciation on disinvestments	286.720	223.512	184.467	694.699
Depreciation	-40.633	-45.346	-136.357	-222.336
	212.983	**35.559**	**100.248**	**348.790**
as at 31 December, 2015				
Cost / Actual value	344.533	221.384	854.395	1.420.312
Accumulated depreciation	-110.589	-143.832	-576.477	-830.898
Book value	**233.944**	**77.552**	**277.918**	**589.414**

The book value of fixed assets ultimo 2015 amounts to € 589,414, which is higher than 2014 as a result of relocating to new offices. All fixed assets are used for operational management of the organization, like office inventory, office reconstructions and ICT equipment. KNCV does not possess any mission related assets which are activated on the balance sheet. Investments in new fixed assets for 2015 amounting to €606,519 were for housing, ICT equipment. Total depreciation is calculated at € 222,336. Assets that are no longer in use and are completely depreciated have been divested for an amount of € 730,092.
Tangible fixed assets are those assets needed to operationally manage the business. No assets have been included in the tangible fixed assets figures that have been directly used in the scope of the main activities.

B3 Accounts receivable	31/12/2015	31/12/2014
Dr. C. de Langen Foundation for Global TB control	-	55.033
Interest (on bonds)	18.927	33.228
Lotteries	245.546	231.489
Current Accounts project countries	-788	2.997
Receivable USAID TB CARE I	-	334.989
Receivable USAID Challenge TB	345.254	210.312
Debtors	104.412	63.844
Payments in advance general	404.438	364.176
Payments in advance projects	146.182	46.213
Legacies in process	220.861	112.909
Other receivables	54	2.772
Accounts receivable USAID based on agreement	58.431.819	30.069.880
	59.916.705	**31.527.842**

Accounts receivable (B3)

The balance of accounts to be received is €59.9 million, which is €28.4 million higher than in 2014. The bulk of this amount consists of current account balances with projects, accounts receivables from donors and the financial contractual relation with coalition partners. Overall, the annual level of activities executed influences this balance significantly. Acquiring more or less grants from institutional donors can lead to a structural and significant decrease or increase of the amount.

The total account receivable from USAID for the TBCARE I and Challenge TB project, based on approved project work plans, increased with € 28.4 million to € 58.4 million. This amount is directly related to the work still to be performed for the Challenge TB project amounts under projects to be executed and accounts payable to coalition partners represented under liabilities. The receivables include an amount of EUR 0 in receivables that fall due in more than one year.

Investments (B4)

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

- The risk of revaluation has to be minimized and a sustainable result has to be achieved by spreading tactics (allocation, time planning) and careful selection of new investments;

TABLE 10: COMPOSITION OF THE INVESTMENT PORTFOLIO AND HISTORICAL VALUES

Fund	Interest %	Nominal value	Historic purchase value	Value in balance sheet	Transactions in reporting year nominal			Transactions in reporting year in actual prices			Nominal value	Historic purchase value	Value in balance sheet
		1/1	1/1	1/1	Purchased	Sold	Redemption of bonds	Purchased	Sold	Redemption of bonds	31/12	31/12	31/12
Shares													
ABN Amro Global Sust Equit acc			121.336	137.679					73.393			60.405	81.929
ASN Duurzaam Fund 3			94.708	144.159				-	61.387			64.727	112.499
ASN Environment and Waterfund			70.775	105.277				1.467	14.245			63.585	109.834
Luxellence sust Europe eq			104.172	158.021				-	37.929			84.763	148.155
Calvert Soc. Inv. Fd equity clas			160.797	227.190				-	81.850			114.339	149.023
Calvert World Int. Equity I share			125.968	156.373				-	44.656			98.336	130.019
Celsius Sust Emerging Markets			199.313	215.118				-	58.170			148.515	140.887
F&C Stewardship Internat.			106.631	120.571				-	37.894			50.894	102.922
Henderson Global Care Fd			113.580	119.732					34.743			54.419	99.239
NN Duurzaam Aandelen Fonds			82.580	112.953				-	24.585			67.640	101.732
Kempen Sust small cap			84.145	134.750				412	25.604			73.398	142.297
Triodos Sust. Equity Fund dis			63.440	97.671				2.935	15.248			55.703	98.912
Subtotal shares		**-**	**1.327.445**	**1.729.494**				**5.348**	**509.704**	**-**	**-**	**936.724**	**1.417.448**
Real estate/Alternatives													
Previum Sustainable Alternatives			892.400	922.028				-	278.447			622.900	707.116
Subtotal real estate/altern.			**892.400**	**922.028**				**-**	**278.447**			**622.900**	**707.116**
Bonds													
Duitsland 09-20	1,750	290.000	345.422	325.188							290.000	345.422	318.150
Ierland 04-20	4,500	230.000	272.504	265.420							230.000	272.504	258.336
Ierland t bonds 13-23	3,900	-	-	-	94.000			118.055			94.000	118.055	115.048
Ned.Water. Bank 12-19	1,625	100.000	102.072	101.382			100.000			105.880	-	-	-
Ned.Water. Bank 05-20	3,875	140.000	160.272	152.872			140.000			163.114	-	-	-
Ned.Water. Bank 08-18	4,375	175.000	204.340	192.604			175.000			194.338	-	-	-
Nederland 09-19	4,000	195.000	221.968	210.731			195.000			229.437	-	-	-
Rabobank 10-17	3,375	150.000	150.000	150.000			150.000			158.160	-	-	-
SSGA euro sustainable corp bonds	perp	1.535.076	1.438.094	1.567.295				860.874	-		2.298.968	1.438.094	2.383.574
Subtotal bonds		2.815.076	2.894.672	**2.965.492**	**94.000**	-	**760.000**	978.929	-	850.929	2.912.968	2.174.075	**3.075.108**
Total		2.815.076	5.114.517	**5.617.014**	94.000	-	760.000	984.277	788.151	850.929	2.912.968	3.733.699	**5.199.672**

B4 Investments	Shares	Bonds [2]	Alternatives	Total
Balance as at 1 January, 2015	1.729.494	2.965.492	922.029	5.617.015
Purchases and sales	-502.657	128.000	-278.448	-653.105
Redemption of bonds	-	-	-	-
Realized stock exchange result	194.565	43.340	8.947	246.852
Unrealized stock exchange result	-3.954	-44.595	54.588	6.039
Amortization	-	-17.128	-	-17.128
Balance as at 31 December, 2015	**1.417.448**	**3.075.108**	**707.116**	**5.199.672**

- Consistency in growth and composition of the portfolio, i.e. no significant fluctuations over time;
- Leading to a predictable cash flow, which supports the annual budget of the organization without being too dependent on its results;
- Maintaining the long-term value the of investments, i.e. the value of invested assets have to keep pace with the evolution of inflation;
- The influence on the whole portfolio of yield reduction of individual segments is limited;
- The portfolio only consists of sustainable investments, i.e. complies with the general definition of sustainability as used by investment banks and in relation to KNCV's mission.

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

The composition and results of the portfolio is described below and depicted in tables 10 to 13. As far as is relevant a comparison with 2014 is shown.

To determine the maximum level of investments, the level of the existing reserves and funds is used as a guiding target. In principle, 10% of total reserves are kept as liquidity, which leads to a maximum available level for investments of 90%. Calculations based on this principle shows that as per 1 January 2015, € 9.0 million was available and as per 1 January 2016, € 10.8 million. Both balance value (€6.3 million) and market value (€6.4 million) of the investments are below the maximum. Naturally, apart from this mathematical approach, an assessment of the situation on the market is also taken into account when transactions take place.

In table 10 the allocation of assets according to the reporting of ABN AMRO/MeesPierson is shown . Part of the bank balance is attached to the investment portfolio and is kept as revolving fund for transactions in investments. This amount is therefore taken into account in the table. In 2015 this amount increased due to sale of bonds and stocks. Ultimo 2015 bonds are underweighted compared to the target. The total of shares, real estate and alternatives is also underweighted. All asset categories stay within the range allowed according to the investment policy.

Table 11: Asset allocation ultimo 2015 compared to the policy
(source: Quarterly report ABN AMRO/MeesPierson)

Investment	Investment policy		1 January 2015		31 December 2015	
	Range	Target	In € million	%	In € million	%
Bonds	80-50%	70%	3,10	49,2%	3,10	49,2%
Shares/Real Estate/Alternatives	0-50%	30%	2,60	41,3%	2,10	33,3%
Liquidities		0%	0,60	9,5%	1,10	17,5%
Total			**6,30**	**100,0%**	**6,30**	**100,0%**

[2] Stock Exchange value of bonds as at 31 December, 2015 is € 3.135.893,-
[3] These figures differ from the figures in the financial statements due to valuation based on market value.

Bonds are mostly from the national government and from national financial institutions. Shares and real estate funds are all tested against sustainability criteria with underlying values in European and worldwide operating companies. In principle, bonds are bought with a long- term investment horizon. The remaining running period is categorized in table 12.

Table 12: Maturity of bonds

Duration bonds Running period remaining	2013	2014	2015
0 to 2 years	0%	0%	0%
2 to 5 years	28%	22%	19%
5 to 8 years	24%	25%	4%
>8 years	48%	53%	77%

An overall result of 4.5% (benchmark: 3.6%; 2014: 8.3%) is realized. Below, a comparison between our 2015 portfolio, the benchmark and the results for 2014 is shown per asset category:

- Bonds; 2015 0.1 %, benchmark 1.5% , 2014 6.1%
- Shares; 2015 12.5%, benchmark 8.1 % , 2014 13.6%.
- Real estate/alternative assets; 2015 10.8 %, benchmark 7.6% , 2014 15.1%.
- Liquidity available for investments; 2015 1,2 % (includes investment expenses), benchmark 0 % , 2014 1.5%.

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

In table 13 and figure 10, as required by the sector organization for charities, Goede Doelen Nederland (previously VFI), the investments results over a 5 year period are depicted. The figure also shows the accumulated result over the years.

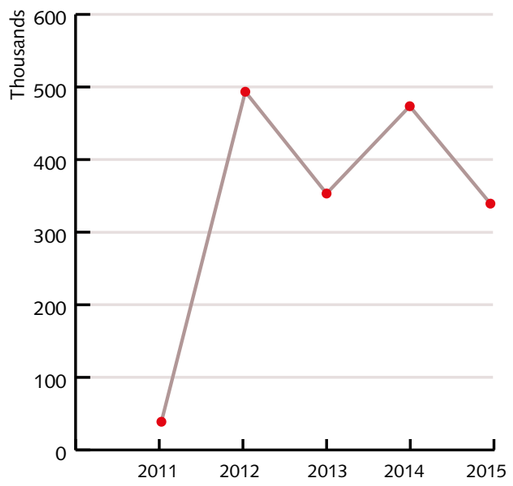
Table 13: Investment results 2011-2015

Description	2011	2012	2013	2014	2015
Bond income	105.740	88.899	109.447	78.764	64.538
Depreciation of amortization	-	-12.496	-35.906	-26.842	-17.128
Dividend	18.094	34.085	28.435	44.986	48.736
Realized exchange results	8.366	99.942	-6.075	226.913	246.851
Unrealized exchange results	-104.208	275.842	250.743	145.253	7.735
Interest on cash on hand and deposits	25.585	17.948	16.676	11.485	18.985
Gross investment income	53.577	504.220	363.320	480.559	369.717
Investment expenses	28.690	17.500	19.754	26.320	29.980
Net investment income	**24.887**	**486.720**	**343.566**	**454.239**	**339.737**

BofA Merril Linch Euro Government 1-10 year
50% MSCI Europe, 40% MSCI World ex-Europe, 10% MSCI Emerging Markets
50% GPR-250 Property, 50% Euribor + 2%.

The Executive Board confirms that all transactions in 2015 have been executed in compliance with the Investment Policy. This has been monitored by analyzing the monthly and quarterly reports of the investment bank and by discussing the results during periodical meetings.

Figure 10: Net investment income 2011-2015



Cash and banks (B5)

The balance of cash and banks increased compared to 2015, with €2.4 million to a level of €15.9 million. The main reason for this increase is that an advance payment for project expenses Challenge TB for the first two months of 2016 was received at the end of December. Also at the end of December 2015 the advance for project activities for DGIS 2016 was received in full. Ultimo 2015 no deposits were available, because interest rates on deposits during 2015 were still not more beneficiary to the result than balances on savings accounts.
Part of the bank balance is still available for long-term investment in shares or bonds, once there are more positive developments in the global financial markets.

	31-12-2015	31-12-2014
B5 Cash and banks		
Immediately available		
Petty cash	11.722	5.941
ING	105.884	284.326
ABN AMRO bank	1.876.042	1.151.155
ABN AMRO (USD account)	6.939.828	4.828.865
ABN AMRO investment account	1.101.346	575.706
ABN AMRO Challenge TB	2.958.143	3.302.993
ABN AMRO TBCARE I	-	1.097.827
Bank accounts country offices	2.878.558	2.250.710
Total	**15.871.523**	**13.497.523**

Balance sheet per 31 December 2015 - Liabilities

Reserves (B6)

- Continuity reserve

The continuity reserve serves as a buffer for unexpected fall backs, both in expenditures and in income. The objective of the reserve is to temporarily guarantee the continuity of the activities, while having enough time to take measures to adjust the organizational structure and –volume to fluctuations in the volume of mission related activities. For this continuity demand, the Board has not earmarked the reserve with a specific spending destination.

Euribor I month.

We use 1 to 1.5 times the estimated and budgeted expenditures for the organization for one year as a reasonable maximum level of the reserve. Mission related activity expenditures are excluded of the calculation. Based on the budget for 2016 for organizational costs (€12.0 million) the continuity reserve's maximum is €12.0 to €18.0 million. The reserve ultimo 2015, €7.7 million, stays well within the maximum (0.64 times the budget for organizational costs in 2016). The underlying risks to be covered by the continuity reserve are analyzed each year during the annual planning and budgeting process. At that point possible risks are identified and, if possible, quantified to calculate the maximum amount needed in the continuity reserve. It is expected that the risk of discontinuity of (parts of the) organization and long-term commitments can be covered by the current level of the continuity reserve.

	Balance as at 1/1/2015	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2015
Continuity reserve	718.0533		-	513.663	7.694.196

- Earmarked project reserves

Some parts of our equity have been earmarked by the Board to a number of specific objectives, with approval of the Board of Trustees. This gives the organization the possibility to either anticipate on unexpected opportunities or to give extra focus to strategic areas. In the coming years, parts of the reserves will be used for extra activities in innovation, research and high- and low prevalence TB control. In 2015, an amount of €153,088 has been withdrawn from the earmarked project reserves for these kinds of activities. The budget had an amount of € 434,000 planned to be deducted from the earmarked reserves. Due to prioritization of Challenge TB activities the actual deduction was lower. For 2016 €536,800 is budgeted to be used. At the end of 2015 two new reserves have been created: a reserve for new monitoring tools (including a planning tool and an online appraisal tool) for € 150,000 and a reserve for international advocacy for € 150,000.

	Balance as at 1/1/2014	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2014
Fund national policy planning	201.799	-	-	-17.356	184.443
Fund international policy planning	232.966	-	-	-	232.966
Fund research policy planning	199.026	-	-	-16.682	182.344
Fund special needs	131.077	-	-	-	131.077
Fund E-learning (SVOP)	10.223	-	-	-10.223	-
Fund innovations	260.502	-	-	-45.384	215.118
Fund capacity building	461.575	-	-	-63.443	398.132
Fund monitoring tools	-	-	-	150.000	150.000
Fund advocacy	-	-	-	150.000	150.000
Total earmarked by the board	**1.497.168**	**-**	**-**	**146.912**	**1.644.080**

- Decentralization reserve

The Decentralization Reserve is the portion of reserves which is dedicated by the Board of Trustees to serve as a buffer for expenses related to the planned decentralization of the organization.
In 2015, the decentralization reserve was allocated towards expenses to be incurred for the capacity building of country office staff in the years 2014-2017. In 2015, the amount of €21,654 was withdrawn from this reserve.

	Balance as at 1/1/2015	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2015
Decentralization reserve	1.084.791	-	-	-21.654	1.063.137

- Unrealized exchange difference on investments

  This reserve serves as a revolving fund for unrealized exchange results on investments, which are not available for mission related activities until they are actually realized. In compliance with Guideline 650, unrealized exchange results are accounted for in the Statement of Income and Expenditure and are therefore part of the surplus or deficit in the annual accounts. Ultimo 2015 the reserve contains € 657,175.

	Balance as at 1/1/2015	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2015
Total revaluation reserve	651.136	-	-	6.039	657.175

- Fixed Assets reserve

  KNCV Tuberculosis Foundation separates equity, needed to finance the remaining value of fixed assets, which is allowed by Guideline 650. In 2015, the reserve increased to an amount of € 589,414 due to investments in the new office.

Balance at 1 January, 2015		**240.624**
Add: purchases fixed assets	606.519	
Less: sale of fixed assets	-730.092	
Less: depreciation of fixed assets	-222.336	
Add: depreciation on sale or disinvestments	694.699	
Movement in continuity reserve		348.790
Balance at 31 December, 2015		**589.414**

Funds earmarked by third parties (B6)

In the past, some resources received from third parties have not been used in full and still have an earmarked spending purpose. In the coming years, parts of these funds will be used for international and research activities. Most of the funds do not have spending deadlines. Use of the funds is budgeted according to the activity plans. In 2015 an amount of € 33,102 is used.
In 2014 an amount of € 55,000 was received the Dr. C. de Lange Stichting voor Mondiale Tuberculosebestrijding (SMT) for a KNCV Young Talent Scholarship program. Part of this amount was used in 2014, an amount of € 48,217 was added to an earmarked fund to be used in 2015. Of this an amount of €23,217 was spent in 2015.

	Balance as at 1/1/2015	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2015
Fund TSRU	159.048	-	-	-1.175	157.873
Fund Special Needs	255.610	-	-	-	255.610
Funds Van Geuns	7.875	-	-	-7.875	0
Unspent Funds for objectives	5.765	-	-	-838	4.927
Young Talent Scolarship	48.217	-	-	-29.563	18.654
Total	**476.515**	**-**	**-**	**-39.451**	**437.064**

Fund Tuberculosis Surveillance and Research Unit (TSRU)

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

Fund special needs

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

Unspent funds for mission related goals

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

Various liabilities (B7)

The total of Various liabilities has increased from €38.9 million in 2014 to €68.8 million in 2015 and includes under Other liabilities €40.0 million of contractual committed projects still to be executed for USAID and €19.2 million value of sub-agreements with coalition partners. As clarified on the Accounts receivable side, the level of projects and activities agreed in grants is the main cause for fluctuation in the liabilities. A large part of Other Liabilities and Accrued Expenses is taken up by a provision for leave hours, which have not been used by employees up to now. The level of the amount for this provision at the end of 2015 is €644,060, which is slightly higher than the amount in 2014. The increase is a result of an increase of outstanding leave days for a limited number of staff members.

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

B7 Various short-term liabilities

	31/12/2015	31/12/2014
Taxes and social premiums		
Income tax and VAT	400.454	296.610
Social premiums	34.092	21.977
	434.546	**318.587**
Accounts payable	297.592	552.270
Other liabilities and accrued expenses		
Provision for holiday pay	275.324	210.770
Provision for annual leave	644.060	639.599
Declarations from staff	33.208	24.670
Audit fees	63.629	40.104
Current Accounts project countries	17.701	-
Payable WHO	63.029	77.610
Current account - Dutch Ministery of Foreign Affairs	1.768.088	710.077
Other donors	853.938	534.776
Other liabilities	174.497	67.591
Project payables KNCV country offices	698.730	863.841
Current account USAID	3.074.406	2.541.192
KNCV projects to be executed	-266.126	-112.767
Other	3.927	1.423
Accruals TBCTA partners balance	2.180.495	300.301
Projects to be executed under TB CARE I/ Challenge TB	39.959.295	27.918.184
Accounts payable TBCTA coalition partners	19.215.908	5.064.010
	68.760.110	**38.881.381**

Liabilities not included in the balance sheet

Office rental contract
In 2015 a rental contract was signed by KNCV Tuberculosis Foundation with a third-party lessor for offices on Benoordenhoutseweg 46 in the Hague (Van Bylandthuis). The rental contract is for 5 years, ending on 31 May 2020, with an option to extent for 5 years. The annual rent is € 248,369 including maintenance fee and VAT). A € 62,092 bank guarantee will be issued in favor of the lessor.

The rental contract for KNCV Tuberculosis Foundation's regional office in Almaty, Kazakhstan is € 13,872 annually. This contract ends 31 December 2016.

Conditional commitments

TBCARE I
Of the total amount of US$ 229,990,000 (€ 211,650,096) in the cooperative agreement for TB CARE I (2010-2015) an amount of US$ 226,003,683 (€ 207,981,657) has been obligated and expensed. The required cost share of US$ 34,714,166 (€ 31,945,983) was more than achieved. The actual cost share is US$ 45,262,212 (€ 41,652,905).

Challenge TB
On 30 September 2014 KNCV Tuberculosis Foundation signed a cooperative agreement with USAID for a five year program with a ceiling of US$ 524,754,500 (€ 482,909,432) and a cost share of US$ 36,732,815 (€ 33,803,660). Until 31 December 2015 the declared cost share is US$ 171,215 (€ 157,562), including DGIS funding.

TBCARE I and Challenge TB
The audit according to the USAID guidelines of the fifth year of TB CARE I and the first year of Challenge TB still has to be conducted. As a consequence, the indemnities of the related project expenditures have not been finalized. Their costs and revenues are accounted for in the profit and loss statement for 2015. For this uncertainty, which is based on currently known data, the financial impact cannot be estimated.

DGIS
On 29 January 2014 KNCV Tuberculosis Foundation received a 5 year grant from DGIS (Dutch Ministry of foreign affairs) of € 7,500,000 as cost share towards the USAID Challenge TB award. The first audited cost-share contribution was reported in 2015, covering only the period October 2014-December 2015. The first full year of audited cost-share will be reported in June 2016.

Statement of Income and Expenditure

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

Income

In total KNCV Tuberculosis Foundation generated more income in 2015 (€ 49.6 million), compared to 2014 € 45.2 million).

In table 14 the total income for 2015 is compared with the budget and with 2014. In the tables to follow each income category is further clarified.

Table 14: Total income

Total income	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
Own share	25,75	25,62	22,12	-1%	14%
Coalition partners share	30,00	23,99	23,10	-20%	4%
Total	**55,75**	**49,61**	**45,22**	**-11%**	**9%**

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

Table 15: Private fundraising (R1)

Private fundraising	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
	1,36	**2,19**	**1,59**	**61%**	**27%**

Private fundraising income was 61% higher than planned, mostly due to higher legacy income and income from other private donors, such as the Eli Lilly Foundation, Cepheid, the Dr. C. de Langen Foundation for global Tuberculosis control (SMT) and 's-Gravenhaagse stichting tot steun aan de bestrijding der tuberculose. The income is approximately the same as 2014.

R1 Income from private fundraising	Budget 2016	Budget 2015	Actual 2015	Actual 2014
Donations and gifts				
Sonnevanck Foundation	22.500	15.000	22.500	18.000
Mr. Willem Bakhuijs Roozeboom Foundation	20.000	15.500	10.000	20.000
Dr. C. de Langen Foundation for global Tuberculosis	283.900	223.000	352.500	330.500
-Gravenhaagse stichting tot steun aan de bestrijding der tuberculose	59.400	60.000	60.000	-
Direct marketing activities	745.000	545.000	521.683	574.327
Gifts- other	-	50.000	89.343	61.405
Total donations and gifts	**1.130.800**	**908.500**	**1.056.026**	**1.004.232**
Contributions by association members	500	500	390	440
Sponsoring	-	50.000	-	-
Legacies and endowments	350.000	300.000	401.903	316.604
Other income from private fundraising	127.800	101.300	731.563	271.863
Total income from private fundraising	**1.609.100**	**1.360.300**	**2.189.882**	**1.593.139**

Table 16: Share in third parties activities (R3)

Share in third party activities	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
	1,09	**1,07**	**1,08**	**-2%**	**-1%**

Income from third party campaigns decreased with 2% compared to budget, and 1% compared to 2014 due to the fact that income from non-earmarked lottery tickets from the Vriendenloterij decreased in 2015.
The income from third party campaigns consists of contributions from two large Dutch lottery organizations: the VriendenLoterij and De Lotto. The amount consists of earmarked sold lottery tickets, general participation in the lotteries and settlements from previous years. The latter is caused by the fact that each year at the time of the closing date, the contribution from De Lotto is not announced yet and is therefore based on an estimate. Deviations from this estimate are accounted for as settlements from previous years.

R3 Income from fundraising by third parties		Budget 2016	Budget 2015	Actual 2015	Actual 2014
Settlement previous years		-	-	72.861	-19.495
Vriendenloterij	earmarked lottery tickets	770.000	770.000	80.676	73.213
Vriendenloterij	non-earmarked lottery tickets			635.101	709.677
De Lotto		322.500	322.500	278.125	311.875
Total from fundraising third parties		**1.092.500**	**1.092.500**	**1.066.763**	**1.075.270**

Table 17: Government grants (R4)

Government grants	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
Own share	23,13	21,97	18,95	-5%	14%
Coalition partners share	30,00	23,99	23,10	-20%	4%
Total	**53,13**	**45,96**	**42,05**	**-13%**	**9%**

KNCV's 2015 share in the USAID funded programs TBCARE I and Challenge TB, with € 43.1 million, amounts to 94% of the total figure for government grants. The DGIS income from 2015 was € 0.40 million. This income counts as cost share towards the USAID Challenge TB project.
The contribution to TB control in The Netherlands from the CIb has decreased to €0.55 million in 2015, as a result of an announced three year grant reduction. The budgeted amount for this grant in 2015 will be € 0.51 million.
From a large group of other smaller government donors, a total of €1.6 million was received, which is lower than the budgeted amount, but significantly higher than 2014. For 2015, government grants determined 93% of KNCV's budget.

R4 Government grants	Budget 2016	Budget 2015	Actual 2015	Actual 2014
Center for disease control	512.800	554.590	556.737	611.956
DGIS	759.300	-	395.259	-
USAID	28.682.400	18.433.381	19.068.337	17.335.128
WHO			164.414	118.204
Global Fund/GFATM	401.800		181.136	243.860
Other Donors	1.580.700	4.146.329	1.608.271	608.140
Subtotal	31.937.000	23.134.300	21.974.154	18.917.288
USAID grants coalition partners	41.390.000	30.000.000	23.987.470	23.134.198
Total government grants	**73.327.000**	**53.134.300**	**45.961.624**	**42.051.486**

Table 18: Investment income and Other income (R5 and R6)

Investment income and other income	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
	0,16	**0,39**	**0,50**	**144%**	**-28%**

	Budget 2016	Budget 2015	Actual 2015	Actual 2014
R5 Income from investments				
Dividends	31.400	25.000	48.736	44.986
Bond earnings	71.300	90.000	46.538	60.764
Bond earnings on behalf of Fund Special Needs	18.000	18.000	18.000	18.000
Realized exchange gains	-	-	246.851	226.913
Unrealized exchange results	-	-	7.735	145.253
Interest on cash on hand and deposits	15.000	12.000	18.985	11.485
Depreciation of amortization of bond value	-	-	-17.128	-26.842
Total from investments	**135.700**	**145.000**	**369.717**	**480.559**
Total cost investments (Reported under expenses investments)	26.000	26.000	29.980	26.320
Net investment income	**109.700**	**119.000**	**339.737**	**454.239**
R6 Other Income				
Endowment funds fee on administration & control costs	3.000	5.500	2.479	5.500
Miscellaneous	13.400	13.200	15.237	9.800
Total Other Income	**16.400**	**18.700**	**17.716**	**15.300**

With the investment portfolio and interest on bank balances KNCV we earned an amount of €0.36 million as realized income and made a profit of €0.08 million as unrealized exchange differences. The unrealized part was not budgeted for, which explains the difference with the budget. In 2014, the unrealized exchange differences were a profit of €0.15 million. The decrease compared to 2014 is caused by the stock market developments in 2015.

Expenditure

Total expenditures in 2015 were € 48.65 million, which is € 8.1 million lower than budgeted. The decrease is caused by lower expenditures in the category "TB in high prevalence countries", mainly for TBCTA coalition partners. Expenditures in the category "fundraising" showed a decrease compared to budget and expenditures in the category "administration and control" are at the budgeted level.

In table 19 the total expenses for 2015 are compared with the budget and with 2014. In the tables to follow each income category is further clarified.

Table 19: Total expenditure

Total expenditure	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
Own share	26,75	24,66	21,87	-8%	11%
Coalition partners share	30,00	23,99	23,10	-20%	4%
Total	**56,75**	**48,65**	**44,97**	**-14%**	**8%**

96% of the total expenses is spent on mission related activities. The increase of € 3.7 million compared to 2014 is, again, caused by higher expenses for KNCV and coalition partners, mainly due to the startup of Challenge TB.

Table 20: Expenses to mission related goals (R7)

Expenses to mission related goals	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
Own share	24,43	22,68	19,90	-7%	12%
Coalition partners share	30,00	23,99	23,10	-20%	4%
Total	**54,43**	**46,67**	**43,00**	**-14%**	**8%**

In 2015, 95,9% of all expenses are spent on mission related activities. In 2014, this percentage was 95.7%. The activities in low prevalence countries took 2% of the total amount, high prevalence countries 94%, research activities 3% and education/awareness 2%.

R 7 Expenses to mission related goals	Budget 2016	Budget 2015	Actual 2015	Actual 2014
Total surplus	820.200	1.087.700	805.955	1.021.907
- TB control in low prevalence countries				
- TB control in high prevalence countries	29.853.300	20.850.100	19.820.153	17.155.182
-- executed by KNCV	41.390.000	30.000.000	23.987.470	23.134.198
-- executed by TB CARE I coalition partners	1.475.300	1.654.200	1.243.902	1.140.021
- Research	869.900	834.400	812.487	580.628
- Education and awareness	**74.408.700**	**54.426.400**	**46.669.966**	**43.031.936**

Specification - per country, independent from nature of the project	Budget 2016	Budget 2015	Actual 2015	Actual 2014
Netherlands	817.400	1.028.900	954.581	1.235.380
Africa				
- Regional Office	-	-	838	14.742
- Botswana	433.400	386.200	398.739	260.700
- Congo	81.800	-	35.989	13.117
- Ethiopia	4.007.000	2.111.300	1.417.220	2.053.850
- Ghana	-	7.400	-	111.559
- Kenya	6.300	162.300	-	101.661
- Liberia	-	-	-	1.731
- Malawi	3.903.100	-	645.481	341
- Mozambique	146.600	199.900	91.110	196.688
- Namibia	932.400	2.597.500	2.661.254	1.268.741
- Nigeria	4.556.900	2.953.900	4.456.368	2.896.351
- Rwanda	-	-	53	50.919
- South Sudan	22.000	29.800	18.149	8.671
- Tanzania	2.140.500	-	1.113.690	96.029
- Uganda	-	-	-	15.631
- Zambia	-	185.900	-	285.747
- Zimbabwe	32.700	124.100	66.977	272.017
Subtotal Africa	16.262.700	8.758.300	10.905.868	7.648.495
Asia				
- Afghanistan	4.600	-	6.549	56.126
- Bangladesh	340.600	-	366.208	44.745
- Cambodia	19.700	16.300	9.634	15.745
- India	165.000	-	185.938	15.498
- Indonesia	6.760.000	4.124.500	3.745.678	3.297.135
- Myanmar	130.000	-	115.975	-
- Pakistan	-	-	11.226	66.135
- Sri Lanka	-	-	28.028	-
- Vietnam	769.800	714.500	628.846	858.949
Subtotal Asia	8.189.700	4.855.300	5.098.082	4.354.333
Eastern Europe				
- Regional office	254.000	-	174.494	51.393
- Kazakhstan	456.600	81.300	66.439	1.030.701
- Kyrgyzstan	241.600	635.100	210.897	647.510
- Moldova	-		-	5.606
- Ukraine	188.200	-	102.986	16.332
- Uzbekistan	439.200	41.900	137.760	153.846
- Tajikistan	696.800	1.104.800	814.572	1.021.151
Subtotal Eastern Europe	2.276.400	1.863.100	1.507.148	2.926.539
Non-country or region related projects	7.220.300	8.931.300	5.296.333	4.699.880
TB CARE I coalition partners	41.390.000	30.000.000	23.987.470	23.134.198
Expenses charged to other expenditure categories [5)]	-1.747.800	-1.010.500	-1.079.516	-966.889
Total expenses to the mission	**74.408.700**	**54.426.400**	**46.669.966**	**43.031.936**

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

Table 21: Expenses to fundraising (R8)

Expenses to fundraising	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
	1,08	**0,73**	**0,83**	**-32%**	**-14%**

In all categories of fundraising and acquisition activities, including those for private fundraising, €0.7 million was spent. This was lower than the budget and also lower than the level of 2014, due to the fact that some activities were postponed and some activities were no longer outsourced, which resulted in cost savings. For private fundraising a percentage of 12.6% of the income has been spent as costs. This is below the CBF maximum %.

Table 22: Administration and control (R9)

Administration and control	Budget 2015 in € million	Actual 2015 in € million	Actual 2014 in € million	% difference budget	% difference last year
	1,24	**1,25**	**1,10**	**1%**	**12%**

Costs for administration and control were as planned. Compared to 2014, the costs increased due to incidental costs related to moving to a new office.

	Budget 2016	Budget 2015	Actual 2015	Actual 2014
Personnel expenses				
Salaries	7.896.600	6.443.200	6.565.348	5.703.331
Accrued annual leave	60.000	46.600	34.388	74.326
Social security premiums	791.600	643.000	630.838	463.133
Pension premiums	729.300	647.700	574.330	518.970
External staff/temporary staff	155.000	150.000	404.243	393.386
Expenses regional offices	210.400	188.300	101.734	74.976
Capacity building decentralization	-	2.500	2.629	17.961
Sub total	9.842.900	8.121.300	8.313.510	7.246.083
Additional staff expenses				
Commuting allowances	115.500	98.350	112.412	91.066
Representation	6.100	6.000	3.638	1.055
Social event	6.100	5.200	18.420	9.396
Congresses and conferences	48.500	52.000	49.868	42.532
International contacts	58.600	56.500	53.577	48.003
Training & Education	158.500	129.800	72.007	76.090
Recruitment	15.000	10.000	52.065	9.499
Insurance personnel	22.000	20.000	16.289	15.584
Catering	22.000	22.000	21.385	16.959
Works council	22.300	21.600	20.575	16.977
Expenses regional offices	3.200	19.900	21.858	50.382
Other	157.400	218.350	115.216	104.181
Sub total	635.200	659.700	557.310	481.724
Other human resource management costs				
Development of tools	20.000	20.000	2.245	25.832
Safety training	36.000	10.000	5.544	2.661
Sub total	56.000	30.000	7.789	28.493
Total personnel expenses	**10.534.100 0**	**8.811.000 0**	**8.878.609**	**7.756.300**
Average number of fte's	105,8	87,6	86,0	71,4

	Budget 2016	Budget 2015	Actual 2015	Actual 2014
Housing expenses				
Rent	160.000	273.400	249.489	314.198
Repairs and maintenance	4.000	4.000	8.143	5.011
Cleaning expenses	30.000	40.000	43.651	42.230
Utilities	65.000	71.100	68.186	67.688
Insurance and taxes	1.800	1.800	1.318	3.081
Plants and decorations	16.000	28.000	101.142	12.900
Housing expenses regional offices	19.000	29.200	21.137	41.538
Total housing expenses	**295.800**	**447.500**	**493.066**	**486.646**
Office and general expenses				
General office supplies	15.500	18.500	10.097	8.876
Telephone	57.000	39.000	43.905	31.892
Postage	12.000	12.000	8.245	9.908
Copying expenses	30.000	33.000	27.603	31.064
Maintenance - machines, furniture	1.000	1.000	183	566
Professional documentation	4.300	4.200	2.502	3.625
IT costs	177.200	180.700	142.813	102.730
Audit fees	85.000	73.500	101.282	93.014
Board of Trustees	10.000	10.000	49.103	8.237
Consultancy	52.500	52.500	77.339	128.170
Bank charges	25.000	20.000	34.045	20.746
Reorganization expenses	-	-	-	10.460
Other	172.300	175.500	90.868	78.463
Office and general expenses regional offices	20.100	29.300	-39.517	9.443
Total office and general expenses	**661.900**	**649.200**	**548.468**	**537.194**
Depreciation and interest				
Office reconstruction work	32.800	22.500	74.050	37.612
Office inventory	41.000	42.600	45.346	34.295
Computers	151.000	131.600	136.357	108.636
Regional offices	1.000	2.500	1.179	1.378
Investment costs	26.000	26.000	29.981	26.158
Total depreciation and interest	**251.800**	**225.200**	**286.913**	**208.079**

The audit expenses can be broken down in various categories:

Audit costs	2015	2014
Audit of the annual accounts	67.034	53.906
Other audit assignments	22.766	22.658
Tax advice	11.482	16.450
Other assignments	-	-
Total	**101.282**	**93.014**

Audit costs are charged to the year they relate to.

Operating result

The balance between income and costs is a surplus of €1.0 million, while a deficit of €1.0 million was planned. The main causes of the difference with the budgeted figures are incidental: a realized investment income of €0.3 million, higher income from private fundraising, mainly legacies and other income € 0.3 million and lower fundraising costs € 0.1 million, and fewer expenses for projects to be covered from earmarked reserves € 0.5 million. Also positive currency exchange gains were realized for € 0.2 million and a contingency amount in the budget of € 0.2 million for unexpected unrecoverable costs was not needed.
More direct days were charged to projects resulting in higher project income of 0.5 million.
A proposal for appropriation of the result is presented as part of the annual report, on page 90.

Cash flow statement

The increase in cash and banks in 2015 is caused by a positive cash flow from income and expenses and a positive cash flow resulting from the increase in project liabilities compared to project receivables. This results in a positive cash flow from operational activities and a negative cash flow from tangible fixed assets (investments).

Accounting policies

Organizations' general data

The 'Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose' (KNCV, using the name KNCV Tuberculosis Foundation) resides at Benoordenhoutseweg 46 in The Hague, The Netherlands. Under its Articles of Association, KNCV Tuberculosis Foundation has as its statutory objective:
The promotion of the national and international control of Tuberculosis by, amongst others:

a. Creating and maintaining links between the various institutions and people in the Netherlands and elsewhere in the world who are working to control tuberculosis;
b. Generating and sustaining a lively interest in controlling tuberculosis through the provision of written and verbal information, holding courses and by promoting scientific research relating to tuberculosis and the control of it;
c. Performing research in relation to controlling tuberculosis;
d. Providing advice on controlling tuberculosis, and
e. All other means which could be beneficial to the objective.

As a subsidiary activity, it may develop and support similar work in other fields of public health.

General accounting policies

The accounting policies are unchanged compared to the previous year.

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

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

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

Balance sheets of local KNCV representative offices
The balance sheets of KNCV representative offices are consolidated in KNCV Tuberculoses Foundations' balance sheet per asset/ liability group against the exchange rates as at 31 December 2015.

Accounting policies - assets and liabilities

Tangible fixed assets

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

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

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

Investments

With respect to investments, KNCV has set-up an investment policy. The essence of the policy is to invest only when it concerns such an excess of liquidities that they cannot be used in the short-term for the main activities. As far as that is the case the derived objectives will be: risk avoiding investments and realizing as optimum as possible returns which will be durable for the duration. For that reason KNCV is investing predominantly in bonds. The policy of the board will also be directed at hedging price risks by reserving unrealized exchange differences in the reserve 'unrealized gains/losses on investments'. Shares are revaluated at market value.

Direct investments in bonds are valued at amortized costs, as they are not held for trade. The difference between acquisition price and the redemption value are brought to the Statement of Income and Expenditure over the remaining term of the bond.

Investments in bond funds are recognized at fair value. Unrealized capital gains will be accounted for in the reserve for 'unrealized gains/losses on investments'.

Cash and banks

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

Receivables and liabilities concerning projects

Receivables and liabilities concerning projects consist of received respectively paid advances in behalf of various international projects. They are valued at nominal value.

The actual expenses are deducted from the advances. Reservations for bad debts are deducted from the book value of the receivable.

Coalition consolidation

In the annual accounts 2015 all receivables and liabilities concerning the USAID program have been fully consolidated, including those sub-agreed to coalition partners. The receivables represent the amount obligated to the coalition on both contracts minus the amounts already received. The liabilities represent the part of the obligation that still needs to be executed. This liability is shown separately for KNCV and other coalition partners.

Accounting policies – Statement of Income and Expenditure

Allocation to accounting year

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

Depreciation fixed assets

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

Legacies and endowments

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

Grants

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

Coalition consolidation

In the annual accounts 2015 all income and expenses concerning TBCARE I/ Challenge TB have been included, including the part sub-agreed to coalition partners.

Share in fundraising third parties

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

Income and expenses concerning projects

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

Pension contribution

KNCV Tuberculosis Foundation's pension scheme qualifies as a defined benefit plan. The defined benefits are based on an average pay system. The pension scheme has been effectuated with the sector pension fund for health care (PFZW). In accordance with an exemption in the guidelines for annual reporting the defined benefit plan has been accounted as a defined contribution plan in the annual statements. This means that the pension premiums are charged in the income statement as incurred. Risk due to salary increases, indexation and return on fund capital could change KNCV's yearly contribution paid to the pension fund. With respect to these risks no provision has been taken into account in the financial statements. Information with regard to any deficits and consequences hereto for future pension premiums is not available.

The pension funds coverage grade ultimo 2015 was 97%. Pension premiums compared to the previous year remained unchanged at 24.4% for retirement. The percentage for disability remained at a level of 0.4%.

Allocation expenditure

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

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

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

Accounting policies – cash flow statement

The cash flow statement is determined using the indirect method, presenting the cash flow separately as the sum of the shortage or surplus and the costs for depreciation.
Cash flows in foreign currencies are included using an average exchange rate. Currency fluctuations and income and expenses from interest are added to the cash flow from operational activities.
No loans, advances nor guarantees are issued to members of the Executive Board or members of the Board of Trustees. The members of the latter are only reimbursed for expenses made.

Notes to the remuneration of the management

The Board of Trustees has, upon the recommendation of the Remuneration Committee, determined the amount of the management remuneration and additional benefits to be paid to management. The remuneration policy is regularly reviewed, most recently in September 2013, when a new Board of Directors was installed. In determining the remuneration policy and remuneration, KNCV Tuberculosis Foundation adheres to Goede Doelen Nederland's advisory scheme for the remuneration of the management of charitable organizations ("Adviesregeling Beloning Directeuren van Goede Doelen") and the code of governance for charitable organizations ("Code Wijffels"; see www.goededoelennederland.nl).
Under the advisory scheme , a maximum annual remuneration is determined on the basis of weighted criteria. At KNCV Tuberculosis Foundation, this weighting was performed by the Remuneration Committee. This resulted in a so-called basic score for management positions ("Basis Score voor Directiefuncties" - BSD) of 500 points (J) and a maximum annual remuneration of 92% of €140,046 for 1 FTE in 12 months for the statutory director, which is €128,842.
The maximum annual remuneration for the Scientific Director is 80% of € 140,046 for 1 FTE, € 56,018 for 0.5 FTE.
In 2015, the actual incomes of management for the purposes of assessment of compliance with Goede Doelen Nederland's maximum annual remuneration were as follows:

K. van Weezenbeek € 125,000 (1 FTE/ 12 months)
F. Cobelens € 64,679 (0.5 FTE/ 12 months)
KNCV's directors are contracted for a 40-hour workweek.

The annual income for the Executive Director is within the limit of EUR 128,842/ 12 months according to the Regeling beloning directeuren van goede doelen ten behoeve van besturen en raden van toezicht. The total remuneration 2015 (gross income, taxable allowances, employer's contribution to pension premiums and pension compensation and other allowances) is above the maximum

8 Advisory scheme for remuneration of directors, VFI, September 2011

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

Name	C.S.B. van Weezenbeek		F. Cobelens	
Position in the board	Executive Director		Scientific Director	
	Indefinite		Indefinite	
Contract	40		20	
Legal status	100%		50%	
Number of hours	1/1 - 31/12		1/1 - 31/12	
FTE				
Period for reporting year				
Remuneration				
Annual income				
Gross salary	106.838		52.991	
Holiday allowance	9.259		7.272	
Extra month	8.903		4.416	
Variable/performance allowance				
Subtotal		125.000		64.679
Social securities, employers part	9.173		8.772	
Taxable allowances	-		-	
Pension premium, employers part	10.622		5.453	
Pension compensation	33.344		-	
Other allowance, long-term	9.816		-	
Payment in relation to beginning of end of contract	-		-	
		62.956		14.224
Total remuneration 2015		**187.956**		**78.903**
Total remuneration 2014		**187.905**		**77.584**

set in the Regeling due to an incidental pension compensation of EUR 33,344 that was agreed in 2013. From 2016 the total remuneration is below the maximum.

The income for Mr. Cobelens, in absolute terms, is above the Goede Doelen Nederland standard by 15%. The total remuneration (gross income, taxable allowances, employer's contribution to pension premiums and pension compensation and other allowances) is below the maximum.
The Board of Trustees takes the view that the salary matches the skills and competencies required for successfully fulfilling a position in the (inter)national medical and scientific environment. A lower remuneration would make it impossible to recruit a scientific director with the expertise and background needed to advocate for KNCV's viewpoints in the global policy development fore for TB control.
In the financial statements, the size and composition of the management remuneration is reported in the notes to the statement of operating income and expenditure. Besides the annual income, management remuneration also includes the national insurance and pension contributions and, if applicable, any severance payments upon termination of employment.
Apart from compliance with the Goede Doelen Nederland remuneration advisory scheme, KNCV Tuberculosis Foundation also has to comply with the rules and standards of the Dutch Government, being an organization which receives government funds. The income of the directors complies with the standard as used by the Dutch Government.

Result appropriation

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

To the Board of Trustees and the General Assembly, in their respective meetings of 4 may 2016 and 18 May 2016, we propose to appropriate the surplus of 2014 according to the following division:

	In €
Continuity reserve, contribution	513,663
Decentralization reserve, withdrawal	-/-21,654
Earmarked project reserves, contribution	300,000
Earmarked project reserves, withdrawal	-/-153,088
Unrealized exchange differences on investments, contribution	6,039
Fixed asset fund, contribution	348,790
Third party earmarked funds, contribution	
Third party earmarked funds, withdrawal	-/-39,451
	954,299

The withdrawals are specified on pages 73, 74 and 75 of the financial statements. KNCV Tuberculosis Foundation's policy towards reserves and funds is clarified in chapter Accounting policies.

Events occurring after the balance sheet date

There have been no material post balance sheet events that would require adjustments to KNCV Tuberculosis Foundation's Financial Statements per 31 December 2015.

Dina Boonstra
Chair of the Board of Trustees

Dirk Dotinga
Vice chair of the Board of Trustees

Kitty van Weezenbeek
Executive Director

POLICY BODIES IN WHICH KNCV WAS ACTIVE IN 2015

In 2015, KNCV was actively involved in:

- Important global WHO fora, such as: STAG-TB (Strategic and Technical Advisory Group); Global Task Force on TB Impact Measurement ; Global Task Force on Latent TB Infection; Expert Committees; Task Forces;
- Several regional WHO TB Technical Advisory Groups on TB Control (TAG-TB SEARO; WPRO; EURO); Regional TB Action Plan (TBAP) Advisory Committee;
- Stop TB Partnership's Coordinating Board;
- Several Stop TB Partnership working groups, sub-working groups and task forces, such as: GLI (Global Laboratory Initiative); GDI (Global Drug resistant TB Initiative); GDI DR–TB Research; TB/HIV Co-infection (STBP); TB-Infection Control; Public Private Mix; TB REACH PRC (Proposal Review Committee);
- The Union: Europe Region Executive Committee; HIV Working Group;
- Global Fund: TRP (Technical Review Panel); Global Fund Board's FOPC (Finance and Operational Performance Committee); TB/HIV working group; NGO North Contact Group, Board; CCM (Country Coordinating Mechanism) of Kazakhstan;
- EDCTP (European and Developing Countries Clinical Trials Partnerships), Scientific Advisory Committee;
- Alliances, Associations, Coalitions: GHWA (Global Health Workforce Alliance); TB Alliance SHA (Stakeholders Association); TBEC (TB Europe Coalition);
- Research Collaboration: TSRU (Tuberculosis Surveillance and Research Unit); RESIST-TB (Research Excellence to Stop TB Resistance) Steering Committee;
- AIGHD (Amsterdam Institute for Global Health and Development) Steering Committee;
- Wolfheze: Program Committee; Working Groups (Financing; Active Case Finding);
- Steering Committees, Professional Associations in the Netherlands: CPT (Netherlands Committee for Practical TB Control); GGD (Municipal Public Health Services) Tuberculosis Steering Committee in the Netherlands; V&VN/OGZ (Professional Association of Nurses), TB Control Committee; MTMBeVe (Professional Association of Medical Technical Assistants);
- Board member of/advisor to Foundations, NGOs in the Netherlands: Eijkman Stichting; Netherlands Leprosy Relief; Dr. Wessel Stichting; 's-Gravenhaagse Stichting tot Steun aan de Bestrijding van Tuberculose; SMT (Stichting Mondiale Tuberculosebestrijding); Stichting Lampion (nationwide information point for care for undocumented immigrants).

KNCV staff were also on the Editorial Board of:

- IJTLD (International Journal of Tuberculosis and Lung Disease);
- BMC (BioMed Central) Public Health, as TB Section Editor;
- Periodical "Tegen de Tuberculose" (Against Tuberculosis). ■


Malawi, CTB Zonal Advisor during TB/ HIV joint supervision in Mulanje district

KNCV PARTNERS IN 2015

KNCV Tuberculosis Foundation thanks all partners for their collaboration and support.

In the Netherlands:

- Academic Medical Centre Amsterdam (AMC)
- Aids Foundation East West (AFEW)
- Aids Fonds
- Amsterdam Institute for Global Health and Development (AIGHD)
- Center for Infectious Disease Control (CIb), at National Institute for Health and the Environment (RIVM)
- Central Bureau for Fundraising
- Committee for Practical TB Control (CPT) Netherlands
- Municipal Public Health Services in the Netherlands (GGD Nederland, vereniging voor GGD'en)
- Delft Imaging Systems BV
- Dr. C. de Langen Stichting voor Mondiale Tuberculosebestrijding (SMT)
- Erasmus University Rotterdam
- 's-Gravenhaagse Stichting tot Steun aan de Bestrijding der Tuberculose
- HIVOS
- Leids Universitair Medisch Centrum
- Lotto
- KLM Royal Dutch Airlines - KLM Flying Blue program
- Madurodam Support Fund (Stichting Madurodam Steunfonds)
- Medical Committee Netherlands-Vietnam
- Ministry of Security and Justice - Penitentiary Services (Ministerie van Veiligheid en Justitie - Dienst Justitiële Inrichtingen)
- Mr. Willem Bakhuys Roozeboomstichting
- Nederlandse Vereniging van Artsen voor Longziekten en Tuberculose
- Nederlandse Vereniging voor Medische Microbiologie
- Ministry of Foreign Affairs / Development Cooperation (DGIS)
- Netherlands Ministry of Health, Welfare and Sport (VWS)
- NWO-WOTRO
- Our private donors
- PharmAccess Foundation
- Radboud University Nijmegen
- Royal Tropical Institute (KIT)
- Stichting Loterijacties Volksgezondheid
- Stichting Suppletiefonds Sonnevanck
- Stop Aids Now!
- Tuberculosis Vaccine Initiative (TBVI)
- University Medical Center Groningen
- Vereniging van Artsen werkzaam in de Tbc-bestrijding (VvAwT)
- Verpleegkundigen & Verzorgenden Nederland, Platform Verpleegkundigen Openbare Gezondheidszorg (V&VN/OGZ)
- VriendenLoterij
- ZonMW
- And many others…

In other countries and globally:

- Action Aid, Malawi
- Adelaide Supranational TB Reference Laboratory
- AIDS Center of Almaty City, Kazakhstan
- AIDS Foundation East West (AFEW) Kazakhstan
- ALERT, Ethiopia
- American Thoracic Society (ATS)
- Armauer Hansen Research Insititute (AHRI), Ethiopia
- Association of Family Doctors, Kazakhstan
- Aurum Insititute, South Africa
- Avenir Health
- Bill & Melinda Gates Foundation
- Capital for Good, USA
- Centers for Disease Control and Prevention (CDC)
- Club des Ami Damien (CAD) Democratic Republic Congo
- Damien Foundation Belgium (DFB)
- Development Aid from People to People (DAPP),Zimbbawe
- Duke University, USA
- DZK (German Central Committee against Tuberculosis)
- Eli Lilly MDR-TB Partnership
- Ethiopian Public Health Institute (EPHI, former EHNRI)
- European Centers for Disease Prevention and Control (ECDC)
- European and Developing Countries Clinical Trials Partnership
- Federal Office of Public Health (Switzerland)
- FHI360
- The Finnish Lung Health Association (Filha)
- Foundation for Innovative New Diagnostics (FIND)
- German Leprosy Relief Association (GLRA)
- Regional GLCs (Green Light Committees)
- Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)/ Project Implementation Unit (PIU) Global Fund
- GHC Global Health Committee
- Gondar University, Ethiopia
- GSK Biomedicals
- Hain Life Sciences
- Haramaya University, Ethiopia
- Harvard Medical School
- Indonesian Association against Tuberculosis (PPTI)
- Initiative Inc, Democratic Republic Congo
- Institute of Human Virology, Nigeria
- IRD (Interactive Research and Development)
- Japan Anti-Tuberculosis Association (JATA)
- Kazakhstan Union of People Living with HIV (PLHIV)
- Kazakhstan Prison System
- Korean Institute of Tuberculosis
- Korea International Cooperation Agency (KOICA)
- La Fondation Femme Plus, Democratic Republic Congo
- Latvia TB Foundation
- Leprosy Mission International
- Les ambassadeurs de Sud-Kivu, Democratic Republic Congo
- Ligue national contre la lèpre et la tuberculose du Congo (LNAC)
- Liverpool School of Tropical Medicine (LSTM)
- London School of Hygiene and Tropical Medicine (LSHTM) Tuberculosis Modelling Group
- Makerere University, Uganda
- Malawi TB Research Network
- Management Sciences for Health (MSH)
- Maternal and Child Health Integrated Program (MCHIP), Zimbabwe
- McGill University
- Medecins Sans Frontières (MSF)
- Mekelle University, Ethiopia
- Ministry of Health (in many countries)
- Namibian Red Cross Society
- National Agency for Control of AIDS (NACA), Nigeria
- National TB Reference Laboratories in the countries
- Netherlands-African partnership for capacity development and clinical interventions against poverty-related diseases (NACCAP)
- National TB Control Programs (NTPs) in many countries
- NGO Doverie Plus, Kazakhstan
- NGO Zabota, Kazakhstan
- Office of the US Global AIDS Coordinator
- Organization for Public Health Interventions and Development (OPHID) Trust, Zimbabwe
- Partners in Health (PiH)
- Penduka, Namibia
- Population Services International (PSI)
- Private Health Sector Program, Ethiopia
- Program for Appropriate Technology in Health (PATH)
- Project Hope (in Kazakhstan, Kyrgyzstan, Namibia, Tajikistan)
- Regional Center of Excellence on PMDT, Rwanda
- Regional Health Bureaus (Ethiopia)
- Rehabilitation and Prevention of Tuberculosis (RAPT), Zimbabwe
- RESIST-TB
- Resource Group for Education and Advocacy for Community Health (REACH), India
- Riders for Health, Zimbabwe
- St Peter specialized Hospital, Ethiopia
- Stellenbosch University
- Stop TB Partnership
- Swiss Tropical and Public Health Institute
- TB Alliance
- TB Europe Coalition
- TB Proof
- Tuberculosis Modelling and Analysis Consortium (TB MAC)
- Tuberculosis Operational Research Group (TORG), Indonesia (including representatives of University of Indonesia, Padjadjaran University, Gadjah Mada University, Universitas Seblas Maret, Diponegoro University, University of Surabaya, Udayana University, and others)
- Tuberculosis Research Advisory Committee TRAC, Ethiopia
- UNICEF - University Clinical Centre
- The Union (IUATLD)
- United Nations Development Program (UNDP)/Global Fund
- United States Agency for International Development (USAID)
- University of Antwerp, Belgium
- University of California San Francisco (UCSF)
- University of Cape Town - SATVI
- University of Gadjah Mada, Indonesia
- Vanderbilt University, USA
- World Health Organization (Headquarters and Regions)
- Zimbabwe National Network of People Living with HIV (ZNNP+)
- And many others…

Independent auditor's report

To: the board of trustees of KNCV Tuberculosis Foundation

Report on the financial statements 2015

Our opinion

In our opinion the accompanying financial statements give a true and fair view of the financial position of KNCV Tuberculosis Foundation as at 31 December 2015, and of its result for the year then ended in accordance with the Guideline for annual reporting 650 'Charity organisations' of the Dutch Accounting Standards Board.

What we have audited

We have audited the accompanying financial statements 2015 of KNCV Tuberculosis Foundation, The Hague.

The financial statements comprise:

- the balance sheet as at 31 December 2015;
- the statement of income and expenditure for the year then ended;
- the notes, comprising a summary of the accounting policies and other explanatory information.

The financial reporting framework that has been applied in the preparation of the financial statements is the Guideline for annual reporting 650 'Charity organisations' of the Dutch Accounting Standards Board.

The basis for our opinion

We conducted our audit in accordance with Dutch law, including the Dutch Standards on Auditing. Our responsibilities under those standards are further described in the section 'Our responsibilities for the audit of the financial statements' of our report.

We are independent of KNCV Tuberculosis Foundation in accordance with the 'Verordening inzake de onafhankelijkheid van accountants bij assurance-opdrachten' (ViO) and other relevant independence requirements in the Netherlands. Furthermore, we have complied with the 'Verordening gedrags- en beroepsregels accountants' (VGBA).

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

Ref.: e0379878

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Responsibilities of management and the board

Management is responsible for:

- the preparation and fair presentation of the financial statements and for the preparation of the director's report, both in accordance with the Guideline for annual reporting 650 'Charity organisations' of the Dutch Accounting Standards Board; and for
- such internal control as management determines is necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

As part of the preparation of the financial statements, management is responsible for assessing the organisation's ability to continue as a going concern. Based on the financial reporting framework mentioned, management should prepare the financial statements using the going-concern basis of accounting unless management either intends to liquidate the organisation or to cease operations, or has no realistic alternative but to do so. Management should disclose events and circumstances that may cast significant doubt on the organisation's ability to continue as a going concern in the financial statements.

The board is responsible for overseeing the organisation's financial reporting process.

Our responsibilities for the audit of the financial statements

Our responsibility is to plan and perform an audit engagement to obtain sufficient and appropriate audit evidence to provide a basis for our opinion. Our audit opinion aims to provide reasonable assurance about whether the financial statements are free from material misstatement. Reasonable assurance is a high but not absolute level of assurance which makes it possible that we may not detect all misstatements. Misstatements may arise due to fraud or error. They are considered to be material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A more detailed description of our responsibilities is set out in the appendix to our report.

Announcement with respect to the director's report

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

Rotterdam, 18 May 2016
PricewaterhouseCoopers Accountants N.V.

Original has been signed by M. van Ginkel RA

Appendix to our auditor's report on the financial statements 2015 of KNCV Tuberculosis Foundation

In addition to what is included in our auditor's report we have further set out in this appendix our responsibilities for the audit of the financial statements and explained what an audit involves.

The auditor's responsibilities for the audit of the financial statements

We have exercised professional judgement and have maintained professional scepticism throughout the audit in accordance with Dutch Standards on Auditing, ethical requirements and independence requirements. Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error. Our audit consisted, among others of the following:

- Identifying and assessing the risks of material misstatement of the financial statements, whether due to fraud or error, designing and performing audit procedures responsive to those risks, and obtaining audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the intentional override of internal control.
- Obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the organisation's internal control.
- Evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Concluding on the appropriateness of management's use of the going-concern basis of accounting, and based on the audit evidence obtained, concluding whether a material uncertainty exists related to events and/or conditions that may cast significant doubt on the organisation's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report and are made in the context of our opinion on the financial statements as a whole. However, future events or conditions may cause the organisation to cease to continue as a going concern.
- Evaluating the overall presentation, structure and content of the financial statements, including the disclosures, and evaluating whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

ABBREVIATIONS

AFEW AIDS Foundation East-West

AIDS Acquired Immune Deficiency Syndrome

AIGHD Amsterdam Institute for Global Health and Development

ARV Antiretrovirals

ATS American Thoracic Society

BCG Bacillus Calmette-Guérin

BMC BioMed Central (journal)

BSD "Basis Score voor Directiefuncties" - Basic Score for Management positions

CBF Centraal Bureau Fondsenwerving (Central Bureau for Fundraising in the Netherlands)

CCM Country Coordinating Mechanism

CEO Chief Executive Officer

CCHD Catholic Campaign for Human Development (The domestic anti-poverty social justice program of the U.S. Catholic bishops)

CHAI The Clinton Health Access Initiative (Helps to save lives of people with HIV/AIDS)

CIb Centrum Infectieziektebestrijding (Center for Infectious Disease Control)

CNR Case Notification Rate

COA Central Agency for the Reception of Asylum Seekers

CPT Commissie voor Praktische Tuberculosebestrijding (Committee for Practical Tuberculosis Control)

CSO Chief Scientific Officer

CSO Civil Society Organization

CTB Challenge TB, the global mechanism for implementing USAID's TB strategy and TB/HIV activities under PEPFAR

DGIS Directoraat-Generaal Internationale Samenwerking (Netherlands Ministry of Foreign Affairs)

DOT(S) Directly Observed Treatment (Short-course)

DR Congo Democratic Republic of Congo

DTU District TB Unit

EDCTP European and Developing Countries Clinical Trials Partnerships

E&M Health Electronic & Mobile Health

ER Emergency Department

EURO European regional office WHO TB Technical Advisory Groups

FHI Family Health International

FOPC Finance and Operational Performance Committee

FTE Full-time equivalent

GDF Global Drug Facility

GDI Global Drug resistant TB Initiative

GDF Global Drug Facility

GeneXpert® (See Xpert MTB/RIF assay, see page 96)

GGD Municipal Public Health Services

GGD GHOR Nederland Association of GGD's (Municipal Public Health Services) and GHOR (Regional Medical Emergency Preparedness and Planning offices) in the Netherlands

GHWA Global Health Workforce Alliance

GLI Global Laboratory Initiative

Global Fund The Global Fund to Fight AIDS, Tuberculosis and Malaria

GxAlert An online application for Laboratory Information Systems (LIS)

HIV Human Immunodeficiency Virus

HRM Human Resource Management

ICT Information and Communication Technology

IJTLD International Journal of Tuberculosis and Lung Disease

IPT Isoniazid Preventive Therapy

JV Inkai LLP A mining company in Kazakhstan

KNCV Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose

(Royal Netherlands Tuberculosis Association)

LTBI Latent Tuberculosis Infection

M&E Monitoring and Evaluation

MDR Multidrug-Resistant

MDR-TB Multidrug-Resistant Tuberculosis

MPH Master of Public Health

MSH Management Science in Health

MTB Mycobacterium Tuberculosis

MTMBeVE Medisch Technisch Medewerkers Beroepsvertegenwoordiging (Professional Association of Medical Technical Assistants)

NACA National AIDS Control Agency

NGO Non-Governmental Organization

NTP National Tuberculosis Program

NTRP Netherlands Tuberculosis Research Platform

PATH Program for Appropriate Technology in Health

PEPFAR U.S. President's Emergency Plan for AIDS Relief

PFZW Pensioenfonds Zorg en Welzijn (Pension fund for health care)

PhD Doctor of Philosophy

PMDT Programmatic Management of Drug-Resistant TB

PMU Project Management Unit

PRC Proposal Review Committee

Pre-XDR-TB MDR-TB with resistance to either any fluoroquinolone or at least one second-line injectable

QuanTB Quantification and Cost Estimation Tool

QQ Qualitate Qua

RESIST TB Research Excellence to Stop TB Resistance

RIF Rifampicin

RIVM Rijksinstituut voor Volksgezondheid en Milieu (National Institute for Public Health and the Environment)

RJ650 Dutch Accounting Standard for Fundraising Institutions

RVO Rijksdienst voor Ondernemend Nederland (Netherlands Enterprise Agency)

SEARO WHO TB South-East Asia Regional Office

SHA Stakeholders Association

SMT Dr. C. de Langen Stichting voor Mondiale Tbc-Bestrijding / Stichting Mondiale Tuberculosebestrijding (Dr. C. de Langen Foundation for Global TB Control)

STAG / STAG-TB Strategic and Technical Advisory Group

TAG-TB Technical Advisory Group on TB Control

TB Tuberculosis

TBAP Regional TB Action Plan

TB/HIV Tuberculosis and/or Human Immunodeficiency Virus

TBCTA Tuberculosis Coalition for Technical Assistance

TB CARE I USAID-funded TB project 2010 – 2015 implemented by the TBCTA coalition

TBEC TB Europe Coalition

TRP Technical Review Panel

TSRU Tuberculosis Surveillance and Research Unit

UNION International Union Against Tuberculosis and Lung Disease

USAID United States Agency for International Development

USD US Dollar

US$ US Dollar

VFI Vereniging van Fondsenwervende Instellingen (Association of Fundraising Organizations): now Goede Doelen Nederland

V&VN/OGZ Verpleegkundigen Openbare GezondheidsZorg (Professional Association of Nurses)

VWS Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport)

WHO World Health Organization

WHO/Europe World Health Organization Regional Office for Europe

WPRO WHO TB Western Pacific Regional Office

Xpert MTB/Rif An automated diagnostic assay/test that can identify TB and resistance to rifampicin

XDR-TB Extensively Drug-Resistant Tuberculosis

ZonMW Zorgonderzoek Medische Wetenschappen (The Netherlands Organization for Health Research and Development)