KNCV
TUBERCULOSIS FOUNDATION

To eliminate TB

ANNUAL PLAN 2017

KNCV TUBERCULOSIS FOUNDATION

1 INTRODUCTION

The 2017 annual plan is based on the new KNCV strategy 2015-2020 "In transition to TB Elimination" and is characterized by strengthening of KNCV technical initiatives, capacity building of country offices and further diversification of funding.

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

Obviously, the operational plan 2017 builds on achievements and directions taken during the previous two years, but also proposes adjustments as considered necessary in a changing global and organizational environment.

Key developments

Several developments informed the annual plan 2017. The most important ones are summarized below.

Global need for evidence generation to support the global End TB Strategy

Since 2015, KNCV and partners have been implementing the global WHO "End TB" strategy, which combines highly ambitious targets with rational country specific priority setting. The latter requires general TB control expertise and programmatic experience, whereas the retooling that will be necessary to eliminate TB, requires highly specialized expert capacity. Hence, in order to serve patients and countries optimally, KNCV needs to bring both types of technical assistance. And KNCV is well positioned to do so as it hosts both programmatic and TB research experts under one roof.

Evidence generation will be more important than ever at a time that diagnosis, treatment and data handling all change at the same time.

Research and Development (R&D) is one of the three pillars of the End TB strategy. After years of stagnation, new tools now arrive at regular intervals and lead to significant programmatic changes. As a consequence, innovation and evidence generation has / should become the core of KNCV business. This is a slight, but necessary shift of focus and a different mindset in an organization that has traditionally focused on programmatic support. Research needs to be fully integrated in our programmatic assistance at country level. Evidence generation will be more important than ever at a time that diagnosis, treatment and data handling all change at the same time. The responsible and effective introduction of these new tools and interventions will require well-coordinated cross-cut-

ting initiatives across KNCV technical teams and active participation in (inter)national policy-fora.

In addition, KNCV will need to strengthen collaboration with Dutch technical partners, building on the White Paper that was jointly developed in 2015. This may include, but not be limited to joint ventures in the field of research and education.

A challenging "Challenge TB project" full of opportunities

On 30 September 2014, KNCV was awarded a five year USAID funded grant "Challenge TB" (CTB), with a ceiling funding level of a record 525 million USD. Implementing CTB has the highest priority within KNCV.

The ambitious CTB project is characterized by an explicit country focus and a related shift from international short term consultancies to local capacity-building. This comes with further decentralization at country level and intensified collaboration with local partners. It will require further strengthening of country offices to optimize outcomes, meet donor expectations and mitigate risks that come with decentralization and subcontracting. This process has started in 2016 and will need to be further accelerated in in 2017.

The developments listed above need to be balanced with the earlier mentioned need for retooling and the related needs for very specialized short term technical assistance missions. After all, one cannot expect country offices to stay on top of all the global developments in technical fields such as new diagnostics, new drugs, M&E health, data-management and pharmacovigilance. However, KNCV aims at quick and efficient transfer of new knowledge at the country level. This will be done through systematic and effective integration of education during short term consultancies and through the development and regular update of state of the art training modules.

KNCV aims at quick and efficient transfer of new knowledge at the country level.

KNCV will continue to be lead partner in Indonesia, Vietnam, Nigeria, Ethiopia, Botswana, Tanzania, Malawi, Kyrgyzstan, and Tajikistan, and Uzbekistan, whereas the regional technical hubs in Almaty, Kazakhstan and Kenia will support Challenge TB activities in Central Asia and East Africa respectively. KNCV will continue to work with its coalition partners as leads in Mozambique, Zimbabwe etc. In total 23 countries and 2 regional project are supported through CTB.

Supranational initiatives, such as the USAID funded Bedaquiline (new drug) programme and the Core Prevention project will be coordinated at KNCV central level.

The magnitude and scope of the CTB project require impeccable project management. In 2015, KNCV established a new Operations Division to manage the CTB project and smaller KNCV projects. In 2016, under the leadership of a new Division Director, the Operations Division has strengthened performance and broadened its scope of work. The division will continue to do so in 2017 in order to ensure optimal support to the CTB project and a growing number of other much smaller projects. In addition to the 'routine' of project management, the Operations Division will address important issues such as the registration status of KNCV offices in certain countries; the gradual shift of roles and responsibilities to country level; the functioning of the KNCV country teams; the development of new systems to monitor short term technical assistance (STTA); refinement of reporting processes and formats; and finally a review of the KNCV operations manual.

The Netherlands involvement in TB control

The Ministry of Foreign Affairs (DGIS) supports KNCV with a 5 year €7.5 million cost share contribution to the USAID's Challenge TB project. The related 'DGIS project' focuses on private sector involvement and interventions at country level ' to make the Global Fund work'. The KNCV DGIS project team has added Swaziland, Nepal and the Philippines under the umbrella of the DGIS project and will further expand related activities in 2017.

KNCV will also continue supporting the Dutch Government in its preparations for the organization of the 2018 World AIDS Conference in Amsterdam. KNCV is committed to use the upcoming 2017 Wolfheze conference in the Netherlands, which will bring together all European National TB programmes, to mobilize (scientific) interest in the 2018 AIDS Conference and ensure attendance and TB/HIV presentations from the Central and Eastern European Region. At field level, KNCV will continue to strengthen TB/HIV collaborative efforts, working together with local partners such as AFEW.

In 2017, KNCV will start mobilizing Dutch technical partners to prepare for a strong 'Dutch signature of excellence' in 2018.

The year 2017, will also mark the exciting start of preparations for the UNION 2018 World Conference on Lung Health, which is the global TB event of the year. After hosting this prestigious conference in 1932 and 1969, KNCV and the City of The Hague managed to get the conference back to the Netherlands. The explicit support of both VWS and DGIS was pivotal during the bidding process. Obviously, this global conference presents major opportunities to showcase Dutch TB expertise and experience. In 2017, KNCV will start

mobilizing Dutch technical partners to prepare for a strong 'Dutch signature of excellence' in 2018.

KNCV advocates a larger involvement of the Dutch Government in global health in general and positioning of the Dutch innovation and TB / HIV expertise internationally. KNCV advocacy efforts and intensified engagement in Global Fund governance bodies require separation of the Board Secretary and advocacy tasks, which thus far have been combined in one person. Following the successful implementation of the Capital for Good Advocacy project in 2015/6, KNCV has received funding through a follow-up grant which will run to the end of March 2017.

Responding to increasing demands for technical assistance

KNCV is confronted with an increasing demand for all types of specialized technical assistance, mostly, but not limited to, the context of the CTB project. On the contrary, new countries have approached KNCV independent of any project. In 2016 several technical staff were hired in areas of expertise such as epidemiology; drug-resistant TB; and data management. Obviously, KNCV cannot continue to recruit consultants and therefore needs to make strategic choices which technical areas to strengthen further and how and where to extend its external flexible layer of consultants. This priority setting needs to be explicitly linked to KNCV 'technical niche' development and results of 2016 resource mobilization. After all, the outcome of 2016 KNCV applications to for instance UNITAID might guide the decisions mentioned before.

KNCV will strengthen both resource mobilization as well as the tools and strategies to support these efforts.

Contributions to policy development at global level

GF resources continue to be the most important external funding source for resource limited countries. KNCV works with the Global Fund at both country and global level, with one KNCV staff member at GF Board level in the capacity of Vice Chair of the Audit and Finance Committee.

In 2017, the KNCV executive director will continue to represent the constituency of technical agencies at the Stop TB Coordinating Board, whereas several technical staff will be involved in various WHO technical guideline committees and regional meetings of NTP managers. KNCV presence in the fora mentioned above will be crucial to ensure translation of KNCV programme experience and evidence generation into global policies.

Strengthening resource mobilization in and beyond KNCV HQ

Execution of the KNCV mission requires country presence beyond the end of the CTB project. However, with all KNCV country offices depending on CTB funding, the sustainability of KNCV country presence beyond 2020 is at stake. Hence, in 2016, KNCV management took the decision to diversify and strengthen resource mobilization at both country and HQ level. The explicit choice to build resource mobilization capacity in selected KNCV country offices reflects a significant change as resource mobilization has been historically organized in KNCV HQ only.

KNCV will strengthen both resource mobilization itself, under the leadership of the newly recruited Head Resource Mobilization, as well as the tools and strategies to support these efforts. Obvious examples are further development of a KNCV technical profile (niche) and related strengthening of international communication, including KNCV storytelling to increase KNCV visibility. In order to maximize outcomes, the coordination between different KNCV disciplines such as advocacy, communication, resource mobilization and technical teams will be intensified.

In addition, we plan to expand our target for fundraising beyond the usual donors. We will do so with continued support of the Stichting Mondiale Tuberculosebestrijding (SMT).

KNCV Governance and internal organization

In 2015, KNCV introduced a new organizational structure, which was reviewed 18 months later. The results of this review have been discussed during the last quarter of 2016 and are expected to lead to some refinements of the KNCV governance structure and standard operating procedures in 2017.

KNCV has experienced a significant growth and geographic expansion over the last years. While the Technical Division represents the 'bread and butter' of the organization, the other two divisions (Finance and Operations) and supporting units, such as Human Resources and 'Facilities and IT', are key to success. No doubt, we need to continue close monitoring of the balance between technical outputs on one hand and the required administrative and utility support on the other hand. In 2017, we will address a variety of supporting functions such as improved connectivity within and between KNCV offices; revision of our document management system; and establishment of a system for electronic purchase invoice approval.

Important human resource decisions will be taken in the context of a mid-term HR strategy (to be developed in 2017), which provides a framework for decision-making but will be flexible enough to respond to opportunities such as winning large calls. The performance

appraisal system will be modernized to fit the needs of a technical organization and the revision of the salary house will be finalized.

All developments and plans listed above, and the related budget, will be shared in greater detail in the next paragraphs.

2 TECHNICAL AND PROGRAMMATIC AREAS

Wherever it engages, KNCV continues to deliver short- and long-term Technical Assistance (TA), conduct relevant research and provide input into the broader policy and development dialogue at national and international levels. Within that context, KNCV continues to broaden its scope of work in terms of both geographic and technical coverage. Concerning technical coverage, KNCV seeks to anticipate and strengthen new technical areas to be able to respond to evolving disease paradigms and health systems developments. We are therefore actively looking to develop strategic niche areas to better meet the growing demands of donors and countries (including, for example, digital health solutions, transmission and cost-effectiveness modeling, resource allocation tradeoff discussions, support to universal health coverage for tuberculosis). This means that KNCV will continue to strive to provide end-to-end technical assistance and leadership for issues ranging from global/national policy framework development, demonstration projects from sub-national level to scale-up programs at national level, and product introduction, adoption and access.

The broadened KNCV approach leads to various human resource and managerial consequences to be addressed simultaneously at headquarter (HQ) and country levels. Examples are the shift towards working at subnational levels, the need for robust health systems and patient-based data, improved data utilization to build quality programs and different approaches to risk mitigation.

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

Beyond CTB, the Technical Division supports programs funded by the Dutch Ministry of Foreign Affairs (DGIS), Global Fund (GF), Eli Lilly Foundation and industry. In a novel collaboration, KNCV is continuing its private-non-profit partnership with Cepheid, manufacturer of the GeneXpert rapid molecular test, to prevent disruption to key laboratory services by providing in-country service and maintenance support. In 2017, we aim to diversify our funding sources further to expand global adoption and delivery of several new products, including fixed-dose pediatric drug formulations as well as new drugs and regimens for TB prevention and treatment.

In line with KNCV's strategy 2015-2020, we continue to develop our programs according to the following Strategic Objectives:

1. Improve access to early TB prevention and care for patients with all forms of tuberculosis (and achieve better individual outcomes and public health impact).
2. Generate a solid evidence base for existing and new tools and interventions.
3. Bolster the governance and management capacity of the National TB Programs (to ensure robust, responsive and inclusive national TB Control systems).

Our ultimate aim is to develop, test, evaluate and scale-up country specific, patient and community centered strategies and interventions that save lives and have public health impact, including the appropriate incorporation of all new WHO-endorsed products. To reinforce this aim, we will continue our internal 'cultural'shift to incorporate evidence generation into all core work areas from the inception phase.

During 2015-16, KNCV adapted its organizational structure to strengthen technical capacity and policy development, aligned with our strategic objectives. We operate through five thematic technical teams: Access and Quality Care; Laboratory and Diagnostics; Evidence; Health Systems and Key Populations; Netherlands and Elimination. Based on completion of the first-ever KNCV Innovations Document in 2016, we have rapidly developed several crosscutting division-wide **initiatives**, one on New Drugs and Regimens and one on Digital Health.

Going forward into 2017, we will evaluate new opportunities, particularly technological and programmatic innovations for adoption into our work and look to strengthen the overall quality of our TA and associated deliverables. Another **initiative** just commenced will focus on strategic approaches to finding the missing TB cases (estimated globally by WHO as approximately one-third of all cases). This initiative is to be centered around case finding, but will be developed as part of a broader approach with associated tools for use at the country level and plans for evaluation. In parallel, we continue to expand our work in rolling-out new TB drugs and shorter regimen for the treatment of drug-resistant TB. A shorter regimen for DR-TB, just approved by WHO in mid-2016, has rapidly been harmonized into the relevant work streams. We also continue our efforts to coordinate and align TA regardless of funding source (CTB, Global Fund, DGIS, etc.) in CTB and non-CTB countries. Toward this purpose, a USAID financed Global Fund hub was initiated within the PMU during 2016. The DGIS contribution for TA will specifically be utilized to geographically expand and further strengthen and support the harmonization and optimization of any GF-supported interventions. As such, new efforts were very recently initiated in Nepal, Swaziland and the Philippines.

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

five years. Additionally, efforts to document and exchange Dutch TB knowledge will continue to intensify through new international research and policy development efforts.

Finally, capacity building throughout the KNCV structure remains an area of continued attention and development for the Technical Division to strengthen staff competencies wherever we work in countries, regions and at HQ. This is done using a variety of approaches: e-learning courses, development of a basic consultant package, creation of a core KNCV training niche, and new learning/research collaborations with other academic centers. While the Young Professional program brought our first two junior level consultants to HQ, HR at country level will also be reviewed in a few key countries to identify opportunities for expanding local professional development pathways. The institution of mandatory home-weeks for the Division (three yearly) will continue to provide a mechanism for greater cross-KNCV collaboration, knowledge sharing and initiatives generation. Balancing the longer with immediate term need to deepen the KNCV technical reach, we will explore options to expand the KNCV flexible consultants network – put into place during 2016 - to strengthen our capacity to deliver quality TA in a timely manner on a defined contract basis.

2.1 Focus Area 1: Access

Strategic Objective 1:

To improve access to quality prevention, early diagnosis and timely initiation of effective treatment, using a patient centered approach for all patients (including children and adolescents) with all forms of TB and within the framework of a comprehensive public health approach to achieve better individual outcomes and public health impact.

Approach

KNCV will deliver comprehensive country specific packages of interventions in the following 4 key areas:

1. Prevention of transmission of TB
2. Prevention of progression from latent TB infection to TB disease
3. Early diagnosis and effective treatment of TB disease
4. Overcoming barriers for special patients' groups (as defined in each country setting)

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

2.1.1 Key Result Area 1: Prevention of transmission of TB

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

In 2017, KNCV will therefore:

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

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

Prevention of progression from latent TB infection to disease remains a key strategy to limit transmission and prevent both incident cases and mortality. KNCV has a long history of detecting and treating persons with latent TB infection (LTBI) and knows the system requirements involved. We distinguish three target groups for LTBI: (1) recent exposure/ infection (contacts), (2) previously infected individuals with clinical or social risk factors; and (3) patients with untreated in-active TB disease, such as individuals with 'fibrotic' lesions. KNCV will follow a rational stepwise approach to improve, introduce and scale-up LTBI management, taking into account the country context and epidemiology.

In 2017, KNCV will pursue expanded opportunities to address LTBI management through existing (CTB) and new funding sources (UNITAID), specifically focusing on a new short regimen (3HP: 3months/12 weeks of once weekly isoniazid and Rifapentine. Following this logic, we will:

- Advocate and support scale up of preventive treatment for LTBI for all household contacts (regardless of age) and PLHIV and early ART initiation. KNCV will use country-specific epidemiological evidence as well as its expertise from The Netherlands to prioritize target groups for LTBI screening and to design patient centered treatment modalities.
- Support the introduction and scale-up of contact investigation in line with WHO guidelines on Contact Investigation (CI) and management of LTBI, with focus on household contacts and contacts of DR-TB patients.
- Develop and implement evidence based strategies for management of DR-TB contacts.

2.1.3 Key Result Area 3: Early diagnosis & effective treatment of TB disease (regardless of presence or absence of drug resistance) – right diagnosis/right treatment

Given recent prevalence surveys that continue to document higher national rates of active TB than previously estimated by WHO, countries must redouble their TB efforts to ensure universal access to early diagnosis of TB with provision of good quality, affordable and patient centered treatment and care. To this effect, KNCV will assist countries in two ways. First, we will assess country level delivery systems to better focus on and find 'the missing cases', addressing access barriers and scaling up successful approaches that engage providers across a broader range of key government sectors and in the private for profit and NGO sector. This effort will be driven by a new Division-wide **Initiative** focused on case finding. Second, KNCV will continue to develop its unique 'triage' approach to 'right diagnosis' followed by access to the 'right treatment', using all drugs available on the market: new, repurposed and old. New efforts will also take into account the recent WHO recommendations recommending a short regimen for DR-TB (previously known as the Bangladesh regimen).

In 2017, KNCV will focus on the following areas:

<u>Case Detection and Diagnosis</u>

- Promote the involvement of community members in early detection and referral of individuals with symptoms consistent with TB, as part of intensified case finding efforts.
- Support engagement of all care providers in case detection, diagnosis, notification and treatment of TB through strengthening public-public and public- private partnerships (PPP).
- Assist countries in defining and introducing optimal diagnostic algorithms for all forms of TB, including DR-TB, using the so-called 'Triage' approach.
- Support selected countries (Ghana, Malawi, Indonesia) to introduce automated reading software for digital radiography (CAD4TB).
- Continued strengthening of national laboratory networks with implementation of optimized diagnostic algorithms (and bacteriological follow-up of TB treatment), aligning with PMDT expansion and including laboratory quality management systems (LQMS).
    - Further introduction and roll-out of GeneXpert MTB/Rif testing in all KNCV supported countries for all eligible groups, with anticipated support for the roll-out of the next generation Xpert Ultra cartridge (delayed release from 2016).
    - Capacity building for first and second-line drug resistance testing, using both molecular and phenotypic methods, and identifying new paradigms that shift next generation molecular diagnostics to lower tiers of the health system (as will be done in Indonesia through development of Intermediate Reference Labs at district/sub-district level).

- Increase access to digital health technologies, including for example GXAlert, to link laboratory results to both providers and patients.
- Expand systems for sample referral, quality management (QMS), external quality assurance (EQA) and appropriate bio-safety measures.
- Expand programs for preventive laboratory maintenance, including calibration and repair of GeneXpert machines, based on experience from Nigeria and Vietnam, in collaboration with Cepheid.
- Support specialized trainings for processing of non-sputum specimens for Xpert examination, focusing on stool specimens from children.
- Continue supporting countries, dependent on their country-specific situations, with the WHO-recommended shift from using light microscopy to LED fluorescence microscopy.

Treatment

- Advocate early treatment initiation and patient centered care of drug susceptible TB as part of triage concept
- Provide technical assistance to scale-up Programmatic Management of drug resistant TB (PMDT) with particular attention to the quality of care provided.
- Provide technical assistance for the appropriate introduction and implementation of new and repurposed drugs and shorter treatment regimen for DR-TB to improve treatment outcomes and prevent/reduce management costs.
- Provide technical assistance on aDSM for safe and effective patient treatment and monitoring
- Provide technical assistance to ensure quarterly interim cohort assessments and clinical reviews take place to monitor and evaluate PMDT implementation, and identify and address problems early in MDR case management and support systems.
- Provide technical assistance on the uptake and roll-out of patient centered ambulatory DR-TB care under appropriate infection control conditions.
- Provide technical assistance to develop appropriate hospital admission capacity for those patients who cannot (yet) be managed on an ambulatory basis
- Provide technical assistance to develop country-specific patient social/psychological support packages (WHO 2016), which will contribute to minimizing treatment interruption.

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

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

In 2017, KNCV will:

- Address migration issues due to conflict and environmental factors and work to safeguard patients' interests and safety (for example through the East Africa cross border initiative and refugee interventions in the Netherlands)
- Provide technical assistance to countries to develop appropriate community engagement strategies and operational plans involving CSOs, private sector and relevant community partners. This will ensure access to quality and patient centered care.
- Promote country owned and community driven planning of community based interventions, together with community organizations, affected populations, government and other relevant stakeholders (private and industrial health sectors).
- Encourage NTPs to set-up formal partnerships with these groups and sectors to promote early case finding, management of TB and LTBI, use of TB-IC measures, and ensure access to TB services as near as possible to the affected population. In this context, innovative, setting specific communication methodologies will be tested to decrease stigma and increase general awareness on TB.
- Work with countries on the development of intensified and/or active case-finding (ICF/ACF) policies, strategies and standard operating procedures for the early diagnosis of TB in high risk groups. These setting specific strategies will be developed after careful assessment and prioritization of high-risk groups, (e.g. HIV populations). Specific groups that will be targeted for active case-finding are prisoners, injecting drug users, urban poor, difficult to reach populations, patients with diabetes and health care workers. All interventions should be carefully evaluated for future policy development. In several settings, case finding strategies will be evaluated at the health center level.

- Assist countries to scale up TB/HIV collaborative activities and fully integrated services for all patients with TB/HIV co-infection, especially IPT and ART uptake, and promote the use of new and shorter treatments for latent infection where possible.

- Improve prevention, case-detection, diagnosis and management of childhood TB, supporting the scale-up of contact investigation, awareness among health staff and parents to recognize symptoms of pulmonary and extra pulmonary childhood TB. KNCV supports piloting and evaluating full integration of TB diagnostic and treatment services into the existing Reproductive, Maternal, Neonatal and Child Health Care (RMNCH)/ Ante Natal Care (ANC) services, ensuring routine screening for TB and efficient referral systems. This approach is the focus of a new grant application to UNTAID as part of a coalition including Save the Children and UNICEF.

Digital Health initiative

Digital Health is the use of Information and Communication Technology (ICT) like computers, medical equipment and mobile phones to improve the accessibility, availability and exchange of information collected and stored in different sectors and places within the health system. Enabling easy access to such information empowers patients, health providers, managers and policy makers to take well-informed decisions. This can improve the quality of care for TB patients and strengthen diagnostic and treatment support. A holistic, patient-centered approach supported by digital health solutions contributes to more efficient, effective and high-quality health programs.

In 2016, KNCV developed a digital health strategy to align KNCV's view on digital health internally and augment digital health expertise and/or partnerships to support countries and programs. The strategy and associated tools were discussed with colleagues during a working session of the KNCV Home Week in June 2016 in The Hague.

By placing the TB patient at the center of our digital health strategy, KNCV seeks to improve the delivery of care and program decision-making. We will apply digital health to three areas of our work: (1) diagnosis and care; (2) awareness and education, and (3) surveillance and monitoring. Our aim is to support informed decision-making by patients, communities and health programs and build local capacity in: (a) information systems, (b) data quality & management, and (c) data utilization.

Several digital health mission packages have been planned until the end of 2016. In Swaziland and Indonesia, a digital health landscape assessment will be performed to determine the current digital health situation, identify programmatic gaps amenable to digital health solutions and develop a country digital health roadmap that is aligned with country ambition and available resources. In Malawi, KNCV will prepare the country for a nationwide roll-out of GxAlert, and in Mozambique, Tanzania and Ethiopia, we will expand our support for surveillance and data management.

2.2 Focus Area 2: Evidence

Strategic Objective 2:

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

Approach

KNCV will strive to remain among the leading TB research groups, as evidenced by impact on policy, research output and successful collaborations in four key Results Areas:

a. Implementation research: evidence for scale-up

b. Operational research: local solutions to local challenges

c. Population epidemiology: surveys and surveillance

d. Research capacity building: increase capacity in the above three research areas

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

2.2.1 Key Result Area 1: Implementation research, evidence for scale-up

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

In 2016 it was decided not to further pursue a planned multi-country, multi-year research project on transmission of TB within the scope of "Challenge TB". However, we will make considerable progress in 2017 in the following other multi-year implementation research projects:

- Prevention of TB. In a multi-country, multi-year pragmatic trial among HIV-infected persons led by the Aurum Institute with KNCV taking on the role of Sponsor, we will compare the effect of different treatment regimens on treatment completion and TB incidence. The main objectives are:

  1) to compare treatment completion of taking 12 weekly doses of rifapentine and isoniazid (3HP) to taking six months of daily isoniazid (6H) and
  2) to compare effectiveness of a single round of 3HP to two annual rounds of 3HP.

  The study is taking place in South Africa, Mozambique and Ethiopia. In South Africa enrollment was initiated in September 2016, and will initiate early 2017 in the other two countries. Participants receiving 6H will be followed for 12 months and participants receiving 3HP will be followed for 24 months for development of TB and other endpoints such as completion of preventive treatment, major side effects leading to prematurely stopping preventive treatment, and mortality. We will seek synergy with this project if awarded a recently submitted UNITAID proposal on the scale-up of 3HP.

- Testing novel packages of diagnostics for case finding. In 2016, we prepared for introduction of diagnostic screening and diagnostic algorithms using a combination of older and newer tools, including mobile digital chest X-ray with automated reading systems (CAD4TB), Xpert MTB/RIF and the second-line Hain test (GenoType MTBDRsl), and for evaluation of the efficacy and cost-effectiveness of these methods in relation to and in association with other approaches. The release of the portable GeneXpert system (OMNI) has been postponed from 2016 to 2017, hereby also delaying planned associated studies on its performance. In 2017, several projects will be running:

  - In Ghana, KNCV, in collaboration with Oldelft and AIGHD, will initiate studies to assess the impact of implementation of CAD4TB in district hospitals and evaluate where to best place CAD4TB in the diagnostic algorithm. Besides evaluating the impact and cost-effectiveness, different operational research questions around the implementation of digital X-ray will be answered.

- In several countries introducing shorter regimen and new drugs, we will evaluate how well different algorithms employed in these countries are performing in triaging patients to the right treatment.
- In Ogun and Nassarawa states of Nigeria, we will assess the yield in TB case finding, employing mobile testing vehicles targeting high-risk, male dominated industries, high volume health care settings, prisons and ART centers. The trucks are equipped with digital chest X-ray, automated chest X-ray reading software (CAD4TB), and 4-module Xpert machines.
- In Malawi, we will assess the impact of implementing CAD4TB as part of enhanced case finding activities (in outpatient departments and ART clinics) and ACF activities in the community. The project will include evaluations of impact and cost-effectiveness of various approaches using CAD4TB for ACF. Key operational research questions will also be addressed including, identifying the ideal placement of CAD4TB as a triage test in the diagnostic algorithm and identifying key risk groups who are most likely to benefit from screening with CAD4TB.
- In Indonesia, KNCV will assess intensified TB case finding strategies using novel algorithms among community health center attendants using a cluster randomized study design.
- In Nepal, we will test the cost-effectiveness of ACF in remote areas employing conventional sputum smear microscopy or Xpert MTB/RIF-based algorithms.
- In Ethiopia, as part of the childhood TB roadmap, the government plans to roll out integration of childhood TB care in Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and Integrated Community Case Management (ICCM). Its feasibility and effects are being evaluated through a stepped-wedge study during the first phase of its roll-out.

- Active drug safety monitoring and management (aDSM). Within the scope of the programmatic implementation of new drugs and shorter regimen for DR-TB treatment (ND/R Initiative), we have established aDSM including linkage with pharmacovigilance authorities. Indonesia, Vietnam, Kyrgyzstan, Tajikistan and Ukraine initiated patients on treatment with bedaquiline and all countries, except Indonesia, also initiated shorter regimen in 2016. In 2017, the quarterly cohort analyses on safety and efficacy will be established in all countries.
- If awarded one or both of the UNITAID grants recently applied for, we will prepare for generating evidence in several African and Asian countries related to implementation of pediatric FDCs and 3HP (short-course treatment for LTBI) for household contacts and PLHIV.

2.2.2 Key Result Area 2: Operational research, local solutions to local challenges

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

In 2017, KNCV will continue to assist countries to generate more evidence on how to prevent, diagnose and treat TB, addressing local conditions, and further, to evaluate the role of stigma, gender, and structural barriers to access and utilization. Ongoing OR projects prepared and/or initiated in 2016 include:

- Assessing under-notification. In Lagos State in Nigeria, an inventory study is being conducted to measure the scope and magnitude of under-notification of TB cases. KNCV is expected to support WHO with similar studies in other countries.
- Measuring DR-TB stigma among HCWs in Nigeria. In a collaboration with IHVN, we will develop and validate a new measure of DR-TB stigma among HCWs in 13 facilities. This measure will be used as part of a broader Quality of MDR Care Assessment that may develop into an intervention study, if baseline levels of quality are low.
- Bangladesh, Zimbabwe, and Tajikistan are all incorporating TB stigma baseline measures into CTB year 3 work plans and evidence team members will support them to follow the new measurement manual guidelines developed as part of the CTB stigma core project.
- Determining more sensitive and specific screening and diagnostic algorithms for finding all TB cases, including drug-resistant, HIV-infected, and pediatric cases. Concerning DR-TB, for example in Ethiopia, KNCV will support the evaluation of an alternative strategy to enhance DR-TB case detection whereby Xpert MTB/RIF testing will be done for all presumptive TB cases in the urban regions (Addis, Dire Dawa and Harari).

- Evaluation of the cost and cost-effectiveness of different models of care for DR-TB patients. In Nigeria 3 different models of care are utilized, with different modes of hospitalization (8 months, 4 months or no hospitalization). In 2016 data was collected on the cost and effectiveness of each of these models, which will be analyzed and published in 2017.

Newly planned OR studies for 2017 include:

- Assessment of the cost-effectiveness of contact investigation and semi-active case finding targeting the elderly at Pagodas in Cambodia;
- Modelling the reduction of TB case notifications in Cambodian prisons using existing data;
- Evaluation of cost-effectiveness of interventions using paid health workers and community volunteers in case finding and holding in Vietnam;
- Assessing the additional yield in good-quality sputum specimens among prisoners in Indonesia when using a short instructional movie on sputum production;
- Identifying barriers to timely definitive diagnosis and treatment initiation after DR-TB suspicion in Tanzania with the aim to increase the proportion of diagnosed DR-TB patients that timely start treatment and reducing the delay of DR-TB treatment initiation after diagnosis;
- Assessment of the feasibility of hospitalized versus ambulatory DR-TB treatment care in Tanzania, what are challenges for each model according to patients and health care workers' perspectives. KNCV is working with graduate level medical and public health students to complete these 2 projects in Tanzania while also building in-country research capacity.

2.2.3 Key Result Area 3: Population epidemiology, surveys and surveillance

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

In 2017 KNCV will:

- Continue assisting countries in gathering and analyzing epidemiologic data at national and sub-national levels, and to translate findings into policy and practice (epidemiological assessments & surveillance system reviews).
- Continue to support Mozambique, Swaziland, Vietnam, and Botswana (the latter two only if funding is secured) with planned prevalence surveys that will also test new screening and diagnostic approaches including mobile technologies. Botswana will be the first country to conduct a combined national TB and HIV survey. Mozambique will be the first country to use mobile Xpert and CAD4TB as part of the screening algorithm.
- We expect to support four drug resistance surveys. We will assist Zimbabwe with analysis of the drug resistance survey after finalization of data collection end of 2016, and expect to support surveys with data collection in 2017, in Ethiopia, Indonesia, and Malawi.
- A review and assessment of the wide range of ACF activities conducted in Myanmar to establish an evidence base of ACF activities and assess which approaches had the most impact.
- Continue collaboration with the LSHTM to improve the TIME Model and gathering data to populate the TIME model for country specific use after regional workshops in Ethiopia and Indonesia, and a country workshop in Nigeria in 2016. This collaboration will be expanded in 2016-17 to further develop our in-house modeling and training capacities through joint investments in KNCV staff development to support future country-based model development.

2.2.4 Key Result Area 4: Research capacity building

In 2017, KNCV will continue to invest in expertise and build scientific collaborations. Not a research institute as such, KNCV takes a pragmatic view to balance in-house expertise against involving outside expertise through collaborations that maximize efficiencies of each respective partner. This year, KNCV aims to:

- Build capacity. Train NTP staff, staff of collaborating organizations and local academic groups in research methods, data collection and analysis, and manuscript writing in several countries.
- Support national OR bodies and related research agendas. In Ethiopia, KNCV will continue to support the Tuberculosis Research Advisory Committee (TRAC) to enhance OR capacity in the country. Technical and financial support will also be provided to the annual TRAC conference where young researchers are encouraged to present their OR studies. In 2016 KNCV/CTB continued its OR capacity building activities in Ethiopia by overseeing the implementation of different operational research studies conducted by earlier trained teams, this ranges from evaluation of the postal service for sputum transportation to assessing the quality of TB services.
- Share TB knowledge and experiences. This work will continue on several levels through 'KNCV lunch meetings', publications and presentations at international fora.

2.3 Focus Area 3: Health Systems and Key Populations

Strategic Objective 3:

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

Approach:

Effective TB control at country level requires strong technical and managerial leadership to ensure sound strategies, responsible resource management, adequate response to opportunities and capacity to overcome challenges. We promote a holistic, joint approach involving all public and private stakeholders, ensuring optimal use of resources with each constituency contributing to a unified, comprehensive national TB control strategy and plan. Working across teams, KNCV will reach the above strategic objective 3 through delivering comprehensive country specific technical assistance packages in the following 5 key areas:

1. Strategic governance, policy development and operational planning
2. Sustainable finance and affordable services for all
3. Enhanced performance across sectors and leveraging health resources of countries, including community systems strengthening and engagement and private sector engagement
4. Interoperable surveillance & monitoring systems
5. Optimizing TB care to groups under-served by current systems2

2.3.1 Key Result Area 1: Strategic governance, policy development, and operational planning,

During 2014-16, most countries either revised or developed new National TB Strategic Plans (NSPs). The impetus was largely to prepare for the Global Fund's New Funding Model (NFM). Most countries are now implementing their NSPs with the support of the 2-year NFM cycle. It is anticipated that early in 2017, KNCV's technical staff will again be called upon to support many countries in a 2nd cycle. KNCV will continue to support NTPs in the development and implementation of their NSPs based on a thorough gap and situation analysis and through prioritized and costed action plans. KNCV will also strive to improve the planning processes by developing and fine tuning existing planning and assessment tools with a focus on improved priority setting, alignment of NSPs with the Global EndTB strategy, and by providing training and mentoring to key NTP and local partners.

Strategic and operational planning occurs at global and national levels. In 2017 at the global level, KNCV will:

- Continue to advise the GF secretariat and participate in the policy dialogue through the NGO Northern Constituency where KNCV is represented by the Executive Office
- Participate and contribute to other relevant global fora (WHO, STP, TB Situation Room, STAG). At the international level, KNCV will strengthen its role as TB advocate through intensified advocacy, communication of compelling data/results and active participation in relevant global TB and non-TB fora
- Continue to participate in global policy and guideline development working groups – highlighting the need patient centered approaches, involvement of affected key populations, ethics and human rights issues.

At national level, KNCV will:

- Ensure that planning through all KNCV programs and projects are aligned and complimentary with the countries' NSPs and the global EndTB strategy
- Assist countries to fulfill basic NFM requirements such as national program reviews, situation & gap analyses and NSP development, etc. before developing a Global Fund Concept Note (CN)
- Support all KNCV - countries in development and adjustment of national screening policies and regulations, based upon data-driven risk group prioritization and rational algorithm selection.
- Assist countries to enhance national management and service delivery capacities. This will include support to HRD planning and implementation through review and revision of human resource capacity and organizational structures, (in-service) training curricula and the organization and provision of training in collaboration with local/regional training centers. Furthermore, we will assist in curriculum development for pre-service training, collaborating with professional associations to update continuing medical education programs (CME) and advise HR departments of Ministries of Health on TB related accreditation and training certification schemes. These approaches are especially relevant as countries move toward better integration of TB/HIV service provision.

- Develop and test related e-health and m-health solutions in target countries that address communication and information feedback gaps. Improved transfer of data/information should result in more rapid diagnostic test results and treatment initiation/ adaption. These platforms can also be used to facilitate information flow from facilities to communities and back.

At subnational level, KNCV will:

- Assist in participatory provincial, zonal, regional, district work planning
- Provide support to further integration of TB services at facility levels
- Improved quality of TB services
- Strengthen general systems such as supportive supervision and regular reviews
- Enhance the quality of data collection and analysis and use of routine program data
- Enhance local ownership, governance and resource provision (inclusion of TB into local government budgets)

2.3.2 Key Results Area 2: Sustainable finance and affordable services

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

In 2017, KNCV will:

- Evaluate the cost-effectiveness of different models of DR-TB care in Nigeria to inform national DR-TB policy
- Evaluate the cost effectiveness of different models of case finding in Burma and Indonesia to inform the national strategic planning process and GF concept note development.
- Assist countries to assess the comparative return on investment from GeneXpert Ultra, digital chest X-ray (CXR), CAD4TB and other mobile services versus business as usual in Mozambique, Nigeria, Malawi. In collaboration with the LSHTM, explore the feasibility to develop long-term (20-25 years) costing and financing models that include phasing out scenarios of external funding (Indonesia & Vietnam).
- Explore approaches that combine national push (regulatory) and pull (financing) mechanisms to improve access/care. Expanding health systems financing opportunities (such as Universal Health Care, national insurance schemes, performance based financing) linked to facility accreditation and GP certification are opening novel avenues for engaging hospitals and the private sector in a growing number of countries. Indonesia, for example, represents a unique opportunity given the expanding reach of its national health scheme (JKN) for public health facilities and GPs. In the Philippines, the DGIS project will support KNCV/HIVOS/NTP partnership to implement an innovative program, which aims to increase private sector provider engagement in TB control activities in high endemic urban areas through the national insurance programs reimbursement initiative.

2.3.3 Key results Area 3: Enhanced performance across sectors and leveraging health resources of countries, including community systems strengthening /engagement and public-private partnerships

Many countries, including those with originally strong public TB services, are confronted by a service delivery shift from public to private sector throughout all levels of society, including the poor. KNCV recognizes this reality as an opportunity and will continue to support processes that strengthen referral and quality assurance mechanisms for private sector providers. Simultaneously, KNCV will initiate and guide National TB Control Programs to operate more outside the usual boundaries of the Ministry of Health by supporting them to strengthen their advocacy capacity within the MoH and towards other government sectors. NTPs are encouraged to establish formal partnerships with prisons and mining companies to promote early case-finding, infection control measures and LTBI treatment, and establish TB services as near as possible to the affected population. KNCV will continue to spark these collaborations. This multi-sectorial approach is crucial for reaching vulnerable groups, the uptake of new tools, ensuring sufficient staffing levels and facilitating public-public and public-private collaboration.

In 2017, KNCV will:

- Continue to catalyze transparent and formal collaboration among various government Ministries to ensure that TB services reach those at-risk and in-need.
- With DGIS funding in Nigeria, Kazakhstan and the Philippines, KNCV will use existing frameworks of patient centered care to expand service delivery models to private providers. The aim is to increase affordable access to quality TB screening, diagnosis and care by incentivizing adherence to national (and professional) standards established by domestic programs. Linkages with civil society organizations will serve to push demand for access/care by increasing awareness of TB, promoting early health seeking behavior and providing support to patients and families once diagnosed and treatment is initiated. These efforts will be complementary to other private sector engagement efforts already established under CTB.

2.3.4 Key Results Area 4: Interoperable Monitoring and Surveillance Systems

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

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

In 2017, KNCV will:

- Initiate support to new countries (e.g. Burma, Malawi, Botswana and Swaziland) and continue surveillance support in others (e.g. Vietnam).
- Provide technical assistance to countries seeking to move from a paper based system to interoperable case-based and/or electronic systems (e.g. Mozambique, Indonesia, Malawi, Swaziland). Ensure higher quality data collection aligned with appropriate M&E systems through design, introduction, monitoring, supervision and better integration of these systems (e.g. Vietnam, Malawi, Indonesia, Swaziland)
- Continue support for strengthening of comprehensive R&R systems that link laboratory, drug stores and treatment sites
- Continue support for the development and integration of appropriate recording and reporting systems for LTBI interventions, especially for children and PLHIV
- Ensure integration into and/or exchange with other national disease M&E systems, specifically opportunities to link TB and HIV reporting systems for better patient and program management
- Under the Digital Health Initiative, promote comprehensive digital systems & data management/utilization assessments using tools developed in 2016 and assist countries in developing adequate surveillance and data management strategies and capacities for TB control.

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

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

In 2017, KNCV will explore and support efforts in:

- Occupational health systems approaches: KNCV will work with SADC countries on improving screening, diagnosis and treatment in the mining/extractive industries.

- Ecosystems approaches: With continued large population migration to cities and TB prevalence surveys that confirm high rates of TB in these settings, it is essential to evolve our approaches to TB control. KNCV will continue its work with partners in Nigeria, Malawi and Ethiopia to develop and implement a framework for URBAN TB control in selected cities to focus on improving access in particular for men and other at–risk populations that comprise the urban poor.

- National self-assessment approaches. Using the KNCV Childhood TB benchmarking tool, KNCV will continue broad based work to expand national self-assessments linked to action plan development, as was tested in 2016 in Vietnam, Bangladesh and Malawi.

- KNCV will further integrate TB screening, diagnosis and care activities targeting vulnerable populations such as children, together with partners such as UNICEF and the TB Alliance. This is the focus of a UNITAID grant proposal submitted in 2016.

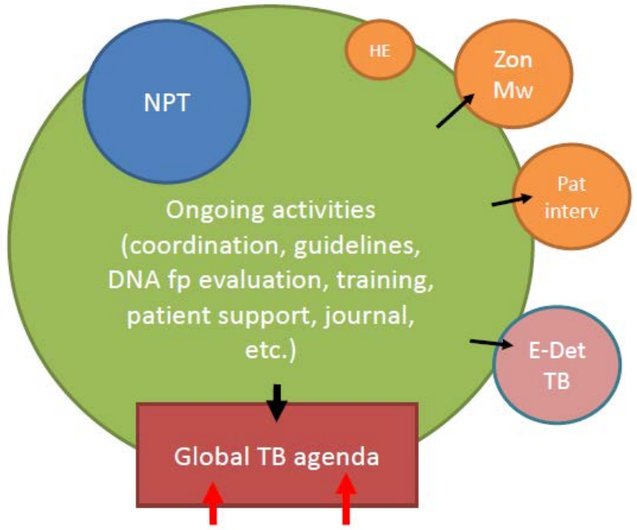
- Using the 2016 KNCV Key Populations white paper and through the recently formed Case Finding **Initiative** (co-led with the Evidence Team), we will assist select countries to address the needs of relevant key populations by assessing their situation, adapting and adopting tools to promote access and affordability of TB services and to identify social protection, stigma and legal barriers. This work will mandate further engagement with community-based partners and affected communities to develop effective strategies, tailor the service delivery model, design acceptable interventions and create a monitoring & evaluation framework that builds the evidence base for reaching such populations. The comprehensive Case Finding Initiative will be closely aligned with similar efforts of the WHO, STP and GF that prioritize the finding of the missing TB cases.

1.1 The Netherlands & Elimination

The Netherlands & Elimination program team remains focused on TB activities in the Netherlands to implement the new national strategic plan and be central to the government response to changing numbers of asylum seekers. In parallel, the program is increasing its efforts to document and use Dutch TB knowledge to benefit TB programs throughout the EU and elsewhere. Such efforts include new research and training programs and leadership on WHO-sponsored task forces relevant to TB elimination.

Figure 1. Activities of The Netherlands & Elimination program

2.4.1 Focus Area 1: Support access to quality health and TB care in the Nether lands



a. Policy and guideline development

KNCV supports evidence-based policy and guideline development in the Netherlands by organizing the Committee for Practical TB Control (CPT). The CPT is a multidisciplinary meeting of professionals involved in Dutch TB Control and consists among others of representatives of the 7 TB regions, the pulmonologists and microbiologists' associations and KNCV Tuberculosis Foundation. The CPT aims to contribute to a comprehensive and consistent policy of TB control in the Netherlands. The Manual on TB control (*'Handboek Tuberculose'*) provides an overview of all TB control activities and is updated each year.

In 2017, KNCV will:

- Organize quarterly CPT meetings to discuss and decide on new guidelines and TB control policies.

- Organize a joined meeting with LOI (Landelijk Overleg Infectieziekten), the organizing body of general infectious disease guidelines, and the Dutch TB Doctors Associations (VvAwT) will be held on a specific topic.

- Organise, support and participate in the CPT working groups (often KNCV fulfils the secretariat function), and participate in other TB-related working groups of professional organizations (e.g. TB nurses (V&VN/Vakgroep Tuberculose, pulmonologists (NVALT), medical microbiologists (NVMM)).

- Update the Regulations on Practical TB control (‘Regelgeving Praktische Tuberculosebestrijding’; RPT), which is a web-based application of guidelines, protocols and work instructions.
- Participate as national representative in World Health Organization (WHO), WHO European Region (WHO Euro) or European Centre for Disease Prevention and Control (ECDC) technical meetings, such as WHO Euro National TB Managers meeting (2017 in The Hague) and, depending on requests during the year.

b. Wolfheze Workshops 2017

Since the 1990s, the WHO Euro and KNCV Tuberculosis Foundation have been organizing every two years a European meeting on TB control (alternating with the 2-yearly Union Europe Region conference). For the last decade, KNCV and WHO Euro organize the Wolfheze Workshops together with ECDC. The Wolfheze Workshops aim to strengthen TB control in the WHO European Region. The emphasis of the meeting is on sharing experiences, monitoring progress of plans in the Region and developing region-specific guidance documents based on a consensus-building approach.

In 2017, KNCV will:

- Co-organize with partners the Wolfheze Workshops 2017 in The Netherlands
- Participate (as secretariat and member) in the Working Group on TB/HIV collaborative activities
- Participate (other KNCV staff then from the Team The Netherlands & Elimination) in the Working Group on New TB drugs and regimens introduction & anti-TB drug-safety monitoring

c. E-Detect TB

KNCV and partners (University College of London (UCL) is lead partner) were awarded a project with the European Commission (EC) for the early detection and integrated management of tuberculosis in Europe. The project will run from May 2016 – May 2019. E-Detect TB will prioritise migrants, homeless persons, prisoners, problem drug users and those with multi-drug resistant tuberculosis. The project has 4 main work packages (WP):

WP 4. Outreach for early diagnosis: Using a mobile x ray unit equipped with computer-aided diagnostics (CAD4TB) and molecular test to detect tuberculosis in Romania and Bulgaria, and ensure appropriate support to complete treatment.

WP 5. Migrant TB detection, prevention and treatment in Italy, screening new and settled migrants for active and latent TB and generating the evidence to support future European policy.

WP 6. Establishing a database of latent and active TB in Europe starting with Italy, Sweden, the Netherlands and the UK to inform epidemiological analysis and future interventions to control TB.

WP 7. Supporting national TB programmes to develop action plans and national TB control strategies by establishing an action framework.

KNCV is leading work package 4 and contributing to work packages 6 and 7. Furthermore, KNCV will contribute to the evaluation (WP 3) and dissemination (WP 2) of the results.

In 2017, KNCV will:

- WP 4: Mobile x-ray unit ready by 1 March 2017 and start screening in Romania. Furthermore, we will contribute to other activities such as training, supervision, quality control, research, etc. all in line with the project.
- WP 6: Submit the Dutch TB/LTBI databases of screening migrants/asylum seekers and contribute to the epidemiological analysis.
- WP 7: Survey of national TB strategies and action plans and policy review

d. Public information, Tegen de Tuberculose, Fund serving Special Needs, Equitable Access, Patient Platform

KNCV supports the Dutch TB programme by providing patients, TB departments of Municipal Public Health Services (GGDs) and other organizations involved in TB control with context and language-specific information materials. In the latter part of 2016, health education materials on latent TB infection (LTBI) will be available for Eritrean asylum seekers.

KNCV also produces the Dutch journal ‘*Tegen de Tuberculose’*, which aims to provide information and education (e.g. clinical lessons; articles on new guidelines; advocacy; surveillance; international TB control) to professionals and policy makers in the Netherlands. The journal was restyled in 2016.

TB mostly affects people who have a poor socioeconomic background in the Netherlands. KNCV provides support through the ‘Fonds Bijzondere Noden’ (FBN) (enablers and especially incentives) for patients and their families in need, to help them to complete treatment. This support varies and includes financial support for patients without any income, food support, material support (e.g. a bicycle), etc.

In 2015, for the first time, a patient platform was created. Currently, 6-8 former patients are actively contributing to e.g. peer support (lotgenoten groep), research (one partic-

ipates in the 'improving patient support interventions' project), training, advocacy (one patient addressed the WHO Euro/ECDC meeting in Bratislava). In 2017, we aim to build on these activities involving patients.

In 2017, KNCV will:

- Produce and distribute TB health education materials in different languages on selected topics to organizations involved in TB control.
- Expand the production of LTBI health education to other target groups.
- Produce 3 editions of '*Tegen de Tuberculose'*
- Continue to provide enablers and incentives for patients and their families in need to help them complete treatment through the Fund for Special Needs.
- Liaise with national organizations involved in care for TB risk groups (e.g. Lampion) and improve access to health services of persons at risk.
- Organize meetings with (former) TB patients and identify the needs, wishes and ways these (former) patients want to contribute. Involve non-Dutch and non-Dutch-speaking (former) TB patients in these activities.

2.4.2 Focus Area 2: Generate solid evidence base in the Netherlands

a. Research

KNCV together with other partners formulated in 2015 the 'Dutch TB Research Agenda for 2016-2020'. KNCV collaborates with academia, GGDs and other organizations in on-going research projects related to the national research agenda and initiates new research projects as funding opportunities arise. In 2016, a 'Dutch TB knowledge exchange project' (3. NL.007.6) was formulated to frame TB knowledge and experience from the Netherlands in several ways to contribute to international TB policy development; share knowledge/ experience in conferences and courses, publish in peer-reviewed journals; participate in national (ENDTB Point, iPSI) and international projects (Challenge TB, E-Detect TB); host exchange visits; and contribute to a basic package for KNCV consultants.

In 2017, KNCV will:

- Organise a national research meeting once a year
- Support researchers in the Netherlands (e.g. GGDs, students) in research in various ways.
- Share Dutch TB knowledge and experience in 'KNCV lunch meetings'
- Continue the Dutch TB knowledge exchange project, including the topics described above.

b. ZonMw TB ENDPoint

We continue the comprehensive pilot study program supported by the Dutch government (ZonMw) to develop an optimized screening and treatment program for LTBI in three different groups: immigrants, asylum seekers, and refugees. In 2016, the pilot among immigrants was successfully implemented and results will be available early 2017.

In 2017, KNCV will:

- Implement the pilot among asylum seekers. Qualitative results and lessons learned in the first asylum seekers center will be used to improve the pilot in the other centers and in the community approach around refugees.

c. Improving Patient Support Interventions (iPSI)

The primary objective of this project is to develop a guideline/standard on nursing support interventions for TB/LTBI patients in the Netherlands. The secondary objective is to build research capacity among TB nurses in the Netherlands. Overarching in the project is inclusion of the patients' perspective. In 2016 a literature review and European survey on nursing support interventions for TB/LTBI patients in low-incidence countries was completed. In 2016/2017 the practice of the current nursing/patient support in the Netherlands (WP2) will be described and a case-control study (WP3) will be done to assess differences in nursing support interventions and patient characteristics in TB patients with low (cases) versus high (controls) treatment adherence. A WP 4 is anticipated, i.e. an intervention study comparing the conventional approach against a package based on findings from WP 1-3.

In 2017, KNCV will:

- Implement WP 2 and WP 3 activities, including publication of results
- Provide a full report of iPSI-project to the Executive Committee of KNCV for advise whether to proceed with the final work package.

2.4.3 Focus Area 3: Support health systems in the Netherlands

a. Coordination and Technical Advice

KNCV's Team the Netherlands & Elimination and the RIVM-CIb (Centre for Infectious Disease Control) work closely together to coordinate and support TB control activities in the Netherlands. A National TB Control Plan (NTCP) 2016-2020 was developed in 2015 and is being implemented. KNCV is responsible for a number of specific activities and together with RIVM-CIb involved in implementation of most other activities and objectives. Three KNCV staff members are part-time seconded to RIVM-CIb.

In 2017, KNCV will:

- Implement (parts of) the NTCP 2016-2020, including a (possible) gradual change directing TB control in the Netherlands towards targeted diagnosis and treatment of latent TB infection (LTBI) in certain high risk groups, e.g. child-migrants and high-risk populations
- Monitor the implementation of the NTCP 2016-2020
- Support and actively contribute to a system where stakeholders in TB control (RIVM-CIb, GGD GHOR Nederland, GGDs, KNCV, and professional associations) discuss planning TB control activities, resources (e.g. human resources), results and efficiency.
- Strengthen TB/HIV collaboration by organizing a TB/HIV club, involving disciplines from both fields.
- Collaborate with RIVM-CIb in support of a program of regional TB consultants/coordinators ('Regionale Tuberculose Consulenten'; RTCs). Implementation of guidelines and TB control issues are high on the agenda of the RTCs, as well as making uniform protocols across regions. They play a role in setting up the Regional TB Expert Centres (RECs).
- Collaborate with GGD GHOR Nederland and other organizations on national TB control issues, such as the screening programs of immigrants, asylum seekers and prisoners.
- Monitor TB transmission clusters in close collaboration with the national reference laboratory and with the GGDs.
- Evaluate cases that share a DNA fingerprint (clustered cases) and have a known epidemiological link to an index patient in the Netherlands, but who were not detected by source and contact investigation.
- Provide advice to professionals and organizations.
- Provide technical support to RIVM-CIb (the EPI department and to individual staff members) for TB disease surveillance, including support to enhanced surveillance of relevant indicators for timely action.

b. Quality policy (regional reviews; monitoring and evaluation of screening risk groups)

KNCV supports Dutch TB control by organizing the secretariat of the plenary review committee ('plenaire visitatiecommissie'). KNCV also monitors and periodically evaluates the screening policy of risk groups in the Netherlands. As outlined in the NTCP 2016-2020, the focus is on continuing programme monitoring with publication of year-results of screening in the TB surveillance report and evaluation of screening risk groups 2011-2015. KNCV further provides technical (epidemiological) support to GGD GHOR Nederland to evaluate annually the screening of asylum seekers and prisoners.

In 2017, KNCV will:

- Conduct one regional (REC) visitation/review
- Organise follow-up of recommendations of last year(s) visitation(s)/review(s)
- Assess and report screening results of immigrants, asylum seekers and prisoners (in close collaboration with GGDs and with GGD GHOR Nederland) and contact investigation yield, both for the year 2016
- Evaluate screening immigrants and asylum seekers for the years 2011-2015, including the persons screened (e.g. age, country of origin) and TB cases identified, according to the previous methods in the evaluation process of screening immigrants.

c. Training

Professionals in the field of TB need adequate knowledge and skills in TB prevention, diagnosis, treatment and care. Depending on their work, they need regular updates and continuous education. KNCV supports professional associations to develop curricula and provide continuous education. KNCV also offers specific TB training courses, e.g. the E-learning course for TB Public Health Nurses, contact investigation and the basic training for Medical Technical Assistants (MTM'ers). Further, KNCV participates in TB courses organized by others (e.g. Nederlandstalige Tuberculose Diagnostiek Dagen; NTDD) and is co-organizer of the European Advanced Course on Clinical Tuberculosis for 2017.

In 2017, KNCV will:

- Participate in educational committees of the Association of Pulmonologists (NVALT), the Association of TB Physicians (VvAwT), Association of TB Public Health Nurses (V&VN/ Commissie Tuberculose) and the Association of Medical Technical Assistants (MTM-BeVe).
- Participate in the 'Studiedagen' VvAwT, V&VN/Vakgroep Tuberculose, and NTDD.
- Co-organize the 'Studiedag MTM'ers'
- Co-organize the 5th European Advanced Course in Clinical Tuberculosis in Stockholm, Sweden.
- Give ad hoc lectures and presentations at universities and other educational institutions.

3 ORGANIZATONAL DEVELOPMENTS

In 2015, KNCV has introduced a new organizational structure that makes the organization 'fit for the future'. After some changes to that new structure at the end of 2015 an external evaluation was held in 2016. The outcomes of that evaluation focus on:

- Workload
- Governance structure
- Position of the Challenge TB Project Management Unit (PMU)
- Functional split between the Technical Division and the Operations Division
- Executive Board composition (one-headed Executive Board)

Refinement of the governance structure and the standard operating procedures will be implemented in 2017.

3.1 Operations division

In 2017, the priority areas of the Operations Division will be project management, optimize country support, country office strengthening, project development and organizational management

A. **Project Management**

1. **Ensuring the successful management of Challenge TB projects**; to continue developing plans and budgets for all KNCV Challenge TB projects, implement and ensure timely and quality technical and financial reporting. Main focus will be to manage the KNCV led countries which all have a KNCV country office. These are Botswana, CAR-Tajikistan, CAR-Kyrgyzstan, East Africa Region, Ethiopia, Indonesia, Malawi, Namibia, Nigeria, Tanzania and Vietnam. For non KNCV led countries all KNCV activities will also continue to be supported by the Operation Division.

2. **Successful management of the DGIS project;** For 2017 the DGIS funded project 'Making Global Fund money work' will focus on the further implementation and scaling up of its activities for the three pillars of the project:

I. Improve TB and TB/HIV case finding and treatment success by strengthening engagement of the non-public sector, together with our partners HIVOS (for the Philippines), PharmAccess (for Nigeria) and AFEW (for Kazakhstan). In the Philippines we will work on TB training for diagnosis (microscopy and Xpert testing) and training on treatment on Basic DOTS for the staff of the HIV clinic; HIV testing and clinical management with ARVs for the PPMDs (Public Private Mix DOTS); and patient support for the CBOs. In Nigeria we will optimize TB screening through application of an assessment of baseline activities undertaken in participating private health care facilities that include quality parameters (SafeCare), as well as the ISTC standards of care to TB and TB/HIV screening of all clients who visit the facility.
In Kazakhstan, in order to develop a successful TB/HIV Public Private Mix model, the project will provide technical support in revision of local regulations related to involvement of non-public organizations in TB and HIV care. To support improved quality of TB/HIV ART and treatment support services there will be interventions to improve knowledge and skills of TB and HIV specialists on management of TB/HIV co-infection and patient counseling; to improve level of patients' knowledge about TB and HIV.

II. Improve Global Fund implementation through quality long term technical assistance (LTTA) in Nepal and Swaziland. In both countries a senior Global Fund technical advisor has been put in place in 2016. Throughout 2017 they will support the respective National Tuberculosis Programs (NTPs) in selecting suitable staff for additional training in performance based grant management and performance based M&E and the advisors will act as a conduit and coordination hub for relevant key stakeholders in the Global Fund grant implementation, ensuring that grant implementation concerns are adequately communicated and addressed by assisting the respective NTPs and Primary Recipients (PRs). They will mentor key staff to adequately monitor grant and program performance and develop and implement necessary Technical Assistance plans to address challenges and bottlenecks. Under this pillar we will also support Global Fund implementation in Indonesia by improving the interpersonal communication skills and provision of patient support of health workers in MDR TB treatment sites and their patient support groups. We will do this by training 20 master trainers in 10 priority provinces and enable them to train multidisciplinary PMDT teams and patient support groups in 40 PMDT sites in their provinces.

III. KNCV will contribute TB and TB/HIV perspectives to the operational and strategic policy making in the Global Fund Board processes. The TB and TB/HIV perspectives remain underrepresented in Geneva and at country level. KNCV will serve as Vice Chair of the Audit and Finance Committee of the Global Fund and will serve in the NGO developed country delegation of the Global Fund; to facilitate a 2-way knowledge exchange between the NGO Developed Country Delegation and KNCV, Dutch and international Civil Society (i.e. CSPRN – the CS Primary Recipient Network). This in order to represent the interests of our TB implementers and partners from civil society, in the Netherlands and in-country. Thus seeking to integrate and link the KNCV and Dutch policy advocacy agendas to relevant policy work at the Global Fund.

3. **Successful management of the Global Portfolio (non-Challenge TB projects);** In 2016 we started up a project balanced score card and a project tracking system for the projects in the Global Portfolio. We will continue to invest in development and maintenance of up to standard project management tools. We will ensure adequate internal monitoring of progress and follow up and timely quality reporting in line with donor requirements.

4. **Review the KNCV Field Office manual** to further develop and document standard procedures and related to that develop a KNCV toolkit with all relevant templates for both CTB as well as non-CTB projects to facilitate project management in a multi donor environment.

B. **Optimize country support & Country office strengthening**

- Optimize functioning of multidisciplinary country teams, looking for the required balance between technical and administrative issues in collaboration with the Technical division. Country teams are to oversee all active projects in country and define overall KNCV Country strategy within the country (project overarching)
- Optimize collaboration with the Challenge TB PMU to ensure clear communication lines towards the countries and align reporting requests.
- Effective and efficient division of tasks between HQ and Country offices, taking into account differences between the countries based on inventory of responsibilities and tasks, required capacity and decision of what needs to be done on what level and built capacity to realize this. Link to both finance and technical division (basic package under development/developed)
- Support relevant country offices in further development of local resource mobilization in collaboration with the Resource mobilization unit

C. **Project Development:**

As funding diversification is essential for KNCV we will be actively engaged in developing new proposals, expanding knowledge on rules and regulations of different funders, smart budgeting and further development of standard KNCV formats according to the needs, and ensure that existing tools and formats are well known within the organization

D. **Organizational Management – organization level**

In order to ensure that management information is available not only on project level, but also on unit and organizational level we want to work on:

- A system to monitor STTA and workplans, based on an initial analysis done in 2016. (collaboration between Operations/Finance/Technical)
- Further improvement of Quarterly reporting process and formats
- Information management; good filing system for the operations division, accessible to all relevant actors (to prevent parallel systems)

In collaboration with the HR department we will we will further implement the security framework.

3.2 IT and facility management

3.2.1 IT

The focus for IT & Facilities is to ensure there is an up to date, reliable and flexible IT system in the office in The Hague, with good communication links to the country offices.

We will evaluate the performance of IT provider OGD and scan other IT partners besides OGD with regard to outsourcing our IT environment.

Focus in 2017 will be on solving connectivity issues with Skype for Business by investing in a traditional telephone system, working on a CRM database, improvement of the e-portal, possibly through a SharePoint solution and migrating to Windows 10.

We will develop and implement a policy on Choose Your Own Device to enable employees more flexibility in the choice of a device or the possibility to use personal devices.

Together with CYOD, MDM will be implemented to control unmanaged devices accessing KNCV IT resources. This also includes rights management on documents and/or Sharepoint sites, enabling KNCV to share information or to collaborate with stakeholders or beneficiaries by managing control of this information.

3.2.2 Facility management

The reception function will be improved, possibly by adjusting the physical location and/or by expanding staff (e.g. by hiring a trainee).

3.3 Resource Mobilization and fundraising

The plan for 2016 to make a sharp shift towards strategic fundraising has been delayed due to the fact that it took time to fill the vacancy for Head of Resource Mobilization. Now that this vacancy has been filled the focus on strategic fundraising can be implemented.

The year 2017 will mark the change to intensified resource mobilization efforts in general, and the introduction of country level resource mobilization in particular. The latter is a strategic choice related to KNCV's ambition to ensure the sustainability of selected country offices in key countries, beyond the Challenge TB (CTB) project. Obviously, our current CTB country presence offers opportunities to position ourselves for local fundraising. However, this will require investments to build local fundraising capacity and ensure adequate support from headquarter level. Local resource mobilization pilots are foreseen in Nigeria and Ethiopia.

In addition, KNCV will strengthen the coordination and collaboration between Communications and private fundraising, Institutional Fundraising, advocacy and the Technical Division in order to ensure optimal planning of focus, timelines and messaging and increase visibility and recognition of its expertise in the Netherlands and internationally

Focus on strategic fundraising and sustainability

In line with KNCV's organization strategy, the unit Resource mobilization will focus on strategic fundraising in 2017 in order to achieve its target, which is to increase the number of multiannual (>2 years) by 25% in 2020. This target can only be achieved if it is fully aligned with the priorities of the technical, operations, finance, communication, public affairs and vice versa.

A consequence of the above mentioned focus is that there will be less emphasis on applying for short-term projects (<2 years) and short term TA (STTA). We will need to be selective to which short-term and STTA opportunities KNCV responds and the PADT is instrumental in this.

Instead we will focus on strategic opportunities that will contribute to the diversification and sustainability of KNCV's funding base provided that they are also in line with the technical priorities and strategic interventions of KNCV. The aim is to have a variety of donors that can support KNCV with multiyear contracts. Also, KNCVO will explore options for increasing the core funding base and engagement with major donors and private foundations.

This will require some reverse thinking on KNCV's part: "Where do we want to be and how do we get there?" becomes leading. This will enable the RM unit to efficiently direct the available resources to develop/raise the funds needed as we can then define:

- Which donors with potential multiyear potential will we approach?
- How to connect our own strategic priorities to these funders.
- The type of partners we may need to position for successful funding bids.
- Which regions/countries we will focus on?
- What resources and skills are needed to ensure successful fundraising?

Retain, Revive and Develop

To achieve our resource mobilization target mentioned above, the approach will be to retain, revive and develop relations with donors and partners that can provide access to multiyear funding.

- **Retain**: Achieve the goals in existing multiyear contracts provide the basis to retain the donors concerned and to apply for a renewal of their support. Timely identification of the potential for renewal and a joint approach with the operations and technical divisions is crucial.
- **Revive:** Research the potential to revive former donor relations. These are donors that supported KNCV in the past. Why did the support stop and how can KNCV reconnect to their current policies and funding opportunities for TB?
- **Develop:** Proactively scan and develop new donors with the potential to support KNCV with multiannual contracts or frameworks. This could be achieved in various way for instance:
    - through an initial pilot or short term contract so as to build up a basis for follow-up funding.
    - by partnering with strategic partners that can create access for KNCV to build up a track-record with new donors.
        - ⇨ by exploring new roles that KNCV could take and that create value for both the donor as well as KNCV. For instance, through sub-granting to local partners in selected countries or taking the role of incubator bringing together different players and linking 'unusual' suspects (thought leader)

⇨ In all three approaches it should be clear that cost-recovery (coverage of indirect costs) is a minimum principle in all new funding opportunities.

Increase country-based funding

Almost all proposals developed over the course of 2016 are developed at central office level, with input from country offices. We will step up efforts to identify country-based funding schemes in order to achieve our target for 2020. But a pre-condition for tapping into country-based funding is that there should be sufficient capacity to do so. At present, this is challenging as all country offices of KNCV devote all their time to implement Challenge TB and other projects. In 2017, KNCV will make a strategic decision to invest in country capacity in two pilot countries to raise funds and develop donor and partnership relations on the ground. Strong support and involvement from the management at country and central office level is needed to ensure that the fundraising efforts are going to be successful.

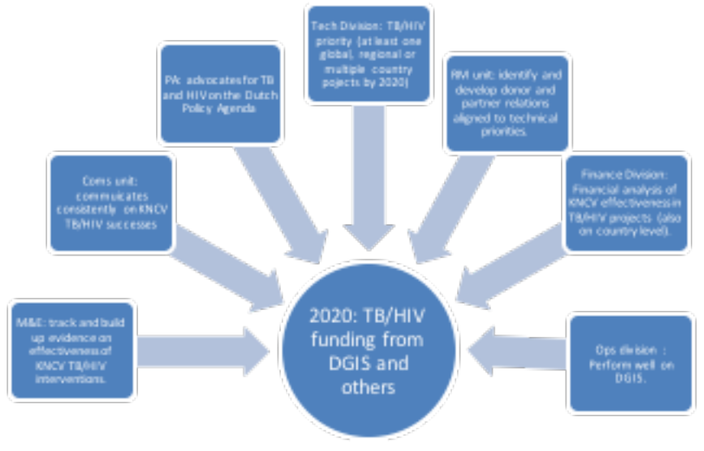
Evidence based interventions (approaches)

In 2017, KNCV will strengthen efforts to systematically build and collect evidence to demonstrate the effectiveness of its strategies and interventions across projects. Donors increasingly demand for an evidence based 'track record' and KNCV needs to invest in a system to generate evidence-based materials which can serve resource mobilization purposes.

Integrated program pilot

In order to accelerate efforts to diversify our funding base, the organization as whole has to collaborate to position the organization around a number of strategic priorities, such as TB/HIV. The Unit Resource Mobilization will coordinate these efforts. The Figure below shows how different KNCV teams will contribute to one strategic resource mobilization effort.

Figure 2: Teams contributing



3.4 Communication and private fundraising

In 2017 we will step up our efforts in communications and private fundraising, building on gained knowledge and guided by KNCVs Strategic Plan. In the last year we have been building the required infrastructure to do so. Our new website has the technical requirements to attract more visitors looking for added value content about TB and how to fight it. We created more dialogue through social media and welcomed 75% more newsletter subscribers. We revised our logo to enhance recognition and made a transition to a new database to be able to reach out to donors in a more personalized way.

Share more to raise visibility

An important focus for 2017 is to better share our knowledge and experience, most notably on specific themes or niches, as identified by the Technical Division. We will share more through our website, as well as bring this to the attention of interested parties through online and social media, including the KNCV Update newsletter. Also our many attributions to events and expert meetings on TB will be shared more widely, as will our many partnerships around the world. Important meetings will be the Wolfheze conference in The Hague, the TSRU meeting and of course the Union Conference. We will strive to further enhance the transparency of our work, by communicating, through storytelling, the measured results of our projects, showing both impact as well as challenges.

In the Netherlands TB is not recognized as a major problem anymore. We will work to raise awareness for the disease as a global health issue, working closely together with KNCVs advocacy team as well as our colleagues from the Technical Division. Also in this respect, creating and sharing the appropriate content is crucial. The Netherlands being a guiding country in worldwide TB control will be a major theme in this. The fact that the World Conference of TB will be held in the Hague in 2018 presents a major opportunity to get TB on the agenda again. In 2017 we will work to maximize that impact.

Engage younger donors

In our private fundraising we will continue the successful approach to attract younger donors through face-to-face and online media. We will also build on the loyalty program that we started in 2016, adapting a more personalized approach that is made possible by the new database. Thirdly, we will further expand our legacy program.

Scale up successful pilots

Private fundraising, including the cooperation with Lotto and the Vriendenloterij, is crucial for KNCV to work on new and innovative approaches and enable participation in other projects. In 2017 we will invest in a scale up of some of the fundraising methods that we have piloted in 2016. This also includes exploring possibilities for cooperation with major donors, corporates and foundations, for which we work in close cooperation with the unit Resource Mobilization.

3.5 Governance and Public Affairs

3.5.1 Governance

A new Board Secretary (1 fte) is expected to be on-board late 2016. In a revised secretariat structure and job profile, the Board Secretary will assume a supervising and a hands-on role in accurate and 'on-top of the calendar' deadline monitoring so as to strengthen the executive secretariat and front office functions in addition to the responsibilities as carried out by the incumbent through September 2016.

After the changes in leadership of the Board of Trustees in 2016 and a revision of the internal governance structure to be agreed in November 2016 (following the external evaluation) the Board Secretary will in 2017 focus on a smooth transition as well as support in the recruitment and on-boarding of a new Board of Trustees member and online availability of all Board of Trustees documents.

Revisions to the governance framework, initiated in 2016, will be finalized in Q1 (to include further changes in the internal decision-making structures. Focus remains on supporting informed decision-making, timely and concise reporting.

3.5.2 Advocacy

KNCV's overarching institutional objective is to position KNCV for post CTB/2019 through:

- Global visibility of Dutch/KNCV expertise
- Positioning for DGIS funding
    - Extending the TB and HIV policy advocacy
    - Global Fund engagement
    - Explicit building of KNCV advocacy track record through connecting KNCV technical work to political advocacy for health/TB in-country.

In view of the priority assigned to KNCV positioning, and in order to deliver on funded advocacy commitments (continued funding by CfG, expansion of Pillar 3 in DGIS), the Union Conference preparations and to deliver on the responsibilities as Vice Chair of the Audit and Finance Committee, advocacy function has been expanded to 1.0 fte. Additional capacity has been contracted (0.3 fte) for the duration of CfG2.

Advocacy work is done at 3 levels: The Netherlands, in-country and at a global level. The activities are summarized below.

3.5.3 Netherlands Advocacy

Following the successful implementation of the Capital for Good (CfG) Advocacy project in 2015/6, KNCV has been invited for a second grant which will run to the end of March 2017. Following this we will seek continued financing of our advocacy engagement in the Netherlands. A structured approach to stakeholder engagement is aimed at creating a strengthened, broadly-based and unified voice in advocacy by both advocates and experts. With funded NL advocacy through CfG2 grant (to3/2017) we work towards

- maintaining Dutch policy engagement in global health, and Global Fund
- profiling the role of Dutch (TB and HIV) expertise

3.5.4 Global advocacy and policy engagement

With DGIS funded advocacy and governance work (Pillar 3) to 'make the GF money work' KNCV is well positioned for a growing role in TB and TB/HIV advocacy at the GF (global

and in-country), as well as oversight on strengthening operational excellence and risk mitigation in country operations.

- With a 0.15 fte higher level of effort (as recently approved by the donor) the internal consultation processes and information flows will be strengthened to seek optimal alignment and information exchange between operationally gained insights and board governance processes.
- By serving in the NGO developed country delegation: with the increased level of effort we will facilitate knowledge exchange between the NGO Developed Country Delegation and KNCV, Dutch NGOs and TB implementers in-country.
- The M&E framework in the DGIS project has been revised to capture both aims.

3.5.5 In-country advocacy

As part of the overall agenda to strengthen KNCV country offices and build local ownership in-country advocacy role will be stepped up building on CTB defined priorities for TB control agenda setting in selected CTB countries. Country directors embraced the approach during the country directors meeting week; it will be rolled out and supported by central office advocacy officer upon request by CTB country directors /PMs.

3.5.6 Global fund governance

In *governance* the aim is to assure expedient and balanced AFC agenda setting and decision processes. In 2017 the the AFC focus is on strengthening country operations and delivery of impact, striking a healthy balance between fiducary and mission risk mitigation; there is need to reduce duplication and complexity of operational processes.

3.6 Finance Division

Focus in 2017 will be on the diversification of funding sources, accelerated implementation Challenge TB and DGIS, strengthening country offices and hopefully some new larger grants (UNITAID).

The strengthening of country offices requires an analysis of responsibilities that can potentially be moved to country offices, assessment of local partners and capacity building on finance related issues.

In 2017 we will continue our efforts to implement a system for electronic purchase invoice approval. This will make it possible for staff members to approve invoices online and to create an online archive, including pipeline overview.

Both at HQ and in countries we will make ourselves more geared to dealing with a multi-donor environment. This includes gathering, sharing and filling knowledge on donor guidelines and budgetary restrictions as well as setting up local accounting and time writing systems that are able to handle more than one donor/ project.

Effort will be put into creating more financial awareness and cost awareness within the whole organization (non-finance staff), in an effort to reduce indirect costs.

In 2017 a new auditor will be selected for the USAID project audit (2015 audit). The request for a NICRA change will be followed up and if approved, implemented.

Internal audit missions (both country offices and CTB partner offices) will be performed according to the internal audit plan and quality consulting guidelines and outcomes registered based on the registration tool.

3.7 Human Resource Management

In 2016 KNCV has further grown in its (global) operations which brings on a set of HRM challenges that will require further attention in 2017. The HRM unit has indicated the following priorities that will be dealt with in the new year:

The revision of the salary house that was initiated in 2016 will be finalized.

Following up on what has been put into motion in 2016, the HRM unit will further strengthen the performance management system with a focus on personal development based on the organizational strategy and smart objectives.

The country offices will require more capacity building on HRM related topics to strengthen their knowledge, competences and skills within this specific field of expertise.

In 2016, KNCV has conducted an initial analysis of the increasing and changing workload within the organization that is felt by a lot of our employees. Following up on the outcomes of this analysis an action plan will be drafted that will provide interventions to manage an increasing workload on an organizational, team and individual level. Among the interventions will be a leadership training for the supervisors and courses for our employees with the focus on creating a healthy work-life balance. To ensure the workforce's effectiveness in supporting KNCV's mission, proper HRM reporting (FTE planning, mobility, sick leave statistics etc.) will be one of the priorities in 2017.

The growing number of expats at Central Office requires a different HRM support. To ensure the retention of expat staff a tailor made service will be put in place to accommodate to the specific needs of the expat. This means, next to the regular HRM services we provide to all staff, expats will also receive extra support in settling into Dutch life.

The succession planning will remain an ongoing topic in 2017. As the average age and length of service within KNCV is increasing, it is important to invest in succession planning, specifically for key positions in the organization. Besides the identification and development of staff for these key positions, a priority is the further development of a new generation of TB specialists (including the Young Professionals Program).

Following up on the implementation of the safety and security policy in 2016, we will further implement the security framework in close cooperation with the Operations Division in 2017.

HRM will do an initial analysis of possible competitive pension funds or plans that's more fitting to our current (international) staff composition.

In 2017 we will explore whether a revision of the employment conditions scheme is needed.

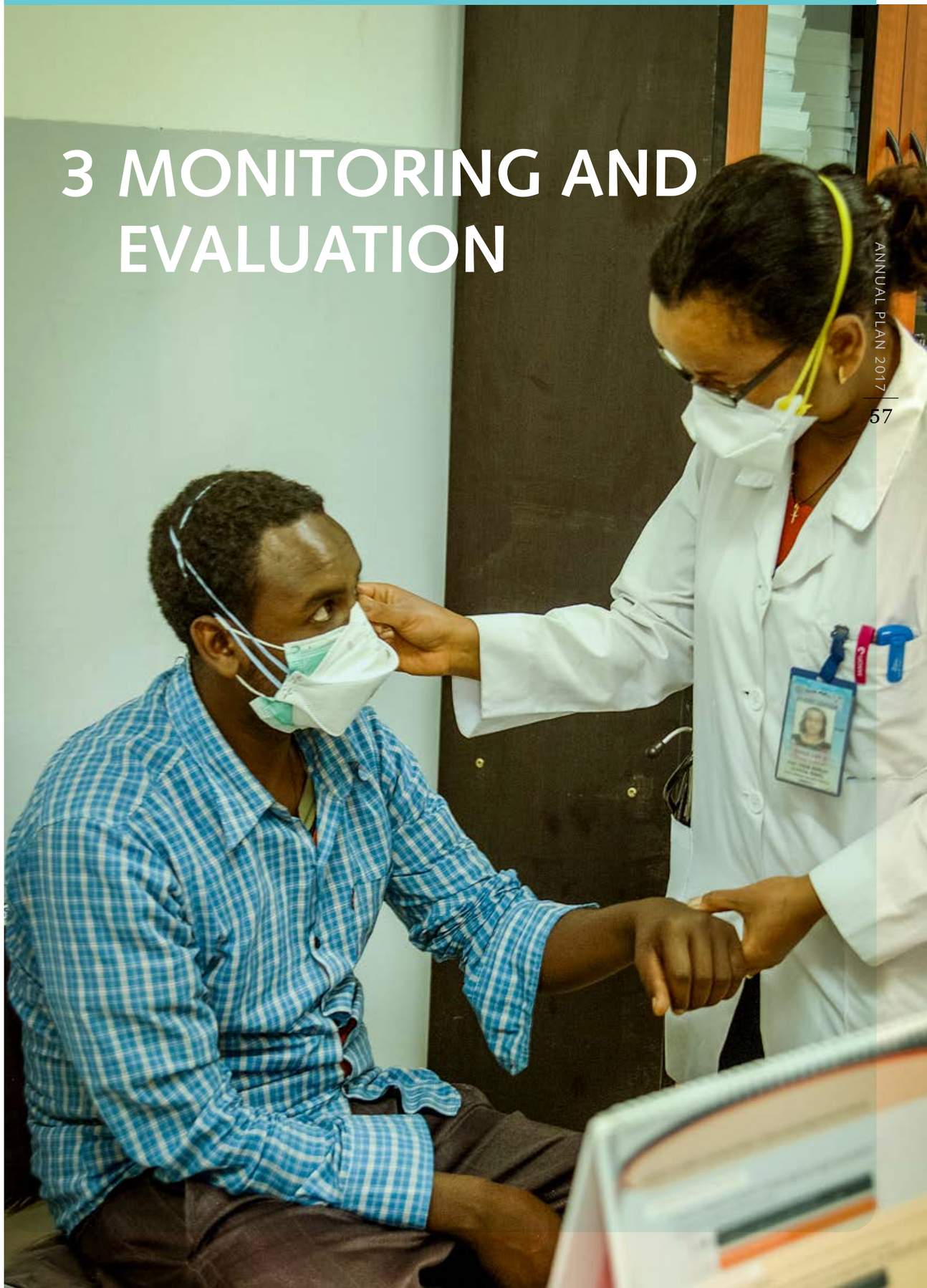
Besides these priorities the HRM unit will continuously work on the improvement and the process of advancing professionalization of our services. This includes but will not be limited to; HR and payroll administration, HRM advice to managers and employees, sick leave management and recruitment.

Workload management

In 2016, KNCV has conducted an initial analysis of the increasing and changing workload within the organization that is felt by a lot of our employees. Also the Works Council conducted in close consultation with HRM an Employee Satisfaction Survey. After filling out this survey, employees received a personal feedback with suggestions. On organizational level analysis will be made from the Employee Satisfaction Survey to develop tailor made interventions for the organization.

Following up on the outcomes of this analysis and the outcome of Employee Satisfaction Survey an action plan will be drafted that will provide interventions to manage an increasing workload on an organizational, team and individual level. Among the interventions will be a leadership training for the supervisors and courses for our employees with the focus on creating a healthy work-life balance.

3 MONITORING AND EVALUATION



As part of the Strategic Plan 2015 – 2020 KNCV has defined the following seven KPIs (key performance indicators) in an attempt to better measure the outcomes and impact of KNCV's work. They will be formulated in lay mans' language ("by 2020 we will…"), and the description gives the actual technical wording. These indicators are collected annually in December and provide the monitoring framework for measuring progress in relation to our mission objectives.

Underlying the KPIs are a set of 12 strategic indicators (found in Table 1) reflecting the KNCV focus areas: Access, Evidence, and Supportive Systems shown in the KNCV Strategic Map, which track processes and progress more closely from an operational and KNCV attribution angle. These will be measured and reported at an operational level.

A new M&E officer started working at KNCV in Q4 2016 and will Strengthen KNCV institutional and strategic M&E and continue to further develop the KNCV M&E performance

Furthermore, institutional indicators have been defined owned by relevant manager / unit head to measure progress in relation to operational efficiency and staying fit-for-future, found in Table 2. These indicators are included in the quarterly management reporting cycle.

Key Performance Indicators

1. **Find 2% more TB cases every year, cumulating to a 10% increase in bacteriologically confirmed cases notified to NTPs in 2020**.

Description: Substantial increase (number and %) in case notification of bacteriologically confirmed cases[1][1] in target countries:

   a. for total population
   b. for population served by KNCV, if this can be disaggregated
   c. key populations (where data is collected by countries)

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

1 [1] In the strategic indicators we included an indicator (1.3) on the proportion of cases that is bacteriologically confirmed.

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

Baseline: 49% of all forms notifications are SS+/Bac+ (n = 9)

Target: 10% overall increase in SS+/Bac+ notifications for final proportion of 60% SS+/Bac+ among all forms notifications. (n = 11)

Reduce TB mortality among notified cases by 35%.

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

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

Baseline: 13% mortality among TB cohort diagnosed in 2013 (n = 8)

Target: 8% mortality among TB cohort diagnosed in 2018. This would be a 35% reduction of the 13% mortality rate baseline. (n = 11)

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

2. **Complete treatment for 90% of all detected drug-sensitive TB cases.**

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

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

Baseline: 86% (2013 cohort) (n = 8) Target: 90% (n = 11)

3. Initiate treatment for all identified drug-resistant patients.

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

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

Baseline: 80% (n = 8) Target: 100% (n = 11)

4. Test all TB patients for HIV.

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

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

Baseline: 82% (n = 7) Target: 100% (n = 11)

5. Start all TB/HIV co-infected patients on anti-retroviral therapy.

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

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

Baseline: 81% (n = 6)
Target: 100% of TB HIV co-infected patients should be on ART by 2020. (n = 11)

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

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

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

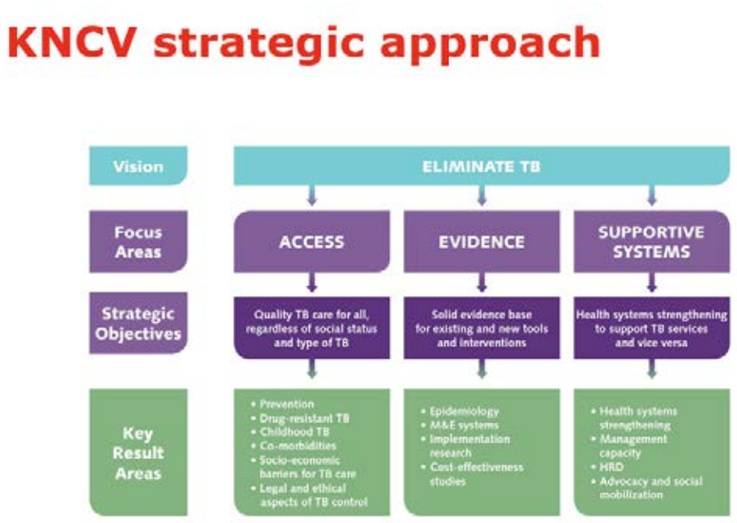
- Baseline: 0%

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

Strategic indicators

The strategic indicators are linked to KNCV's Strategic map.

Figure 3: KNCV Strategic map



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

Table 1 : Strategic Indicators

Focus Area: ACCESS		
Strategic objective: Improve access to early TB prevention and care for patients with all forms of tuberculosis and achieve better individual outcomes and public health impact		
Key Result Area	Strategic Indicators	Indicator specifications
1.1: Prevention of transmission	1.1: Proportion of target countries that have developed, implemented and monitored country specific TB-IC and laboratory biosafety strategies effectively by 2020	**Baseline (2014):** 36% (4/11 countries) **Target (2020)**: All target countries have developed, implemented and monitored country specific TB-IC and lab biosafety strategies effectively.
1.2: Prevention of progression from infection to disease	1.2: Proportion of target countries that have developed, implemented and monitored contact investigation and screening policies and strategies by 2020	**Baseline (2014):** 27% (3/11 countries) **Target (2020)**: All target countries have developed, implemented and monitored CI and screening policies and strategies.
1.3: Early diagnosis and effective treatment	1.3: Annual percent increase in proportion of notified cases that are bacteriologically confirmed in target countries	**Baseline (2014):** 0.3% increase (50.6% in 2013 to 50.9% in 2014) **Target (2020)**: Among all target countries, 60% of all forms notifications are bacteriologically confirmed.
1.4: Overcoming barriers and ensuring equitable access for special patient groups	1.4: Proportion of target countries that have developed, implemented and monitored country specific strategies to address barriers and ensure equitable access for special patient groups by 2020	**Baseline (2014):** 18% (2/11 countries) **Target (2020)**: All target countries have developed, implemented and monitored country specific strategies to address barriers and ensure equitable access for special patient groups.
Focus Area: EVIDENCE		
Strategic objective: Generate solid evidence base for existing and new tools and interventions		
Key Result Area	Strategic Indicators	Indicator specifications
2.1: Implementation research: evidence for scale up	2.1: Proportion of KNCV supported intervention studies/ demonstration projects resulting in a publication with contribution of KNCV staff as co-author	**Baseline value (2014)**: 17/17 [1] (from 2011 – 2014) **Target (2020)**: 80% within 3 years of project completion
2.2: Operational research	2.2: Number of research publications/reports that have contributed to international or local country guidelines/policies	**Baseline value (2014)**: 7 **Target (2020)**: At least 10 in total
2.3: Population epidemiology	2.3: Number of successfully completed population epidemiology relevant studies (e.g. prevalence and/or drug resistance survey) w/ substantial support of KNCV	**Baseline value (2014)**: 1 **Target (2020)**: At least 1 per year (i.e. at least 5 in total)
2.4: Research capacity building	2.4: Number of publications resulting from KNCV led research capacity building activities	**Baseline value (2014)**: 14 **Target (2020)**: 4 per year
Focus Area: Supportive Systems SUPPORTIVE SYSTEMS		
Strategic objective: Bolster sustainable governance and management capacity of National TB Programs		
Key Result Area	Strategic Indicators	Indicator specifications
3.1: Strategic and operational planning	3.1: Proportion of target countries that have a valid, evidence-based, prioritized, costed, and endorsed national strategic plan, used for annual planning [2]	**Baseline value (2014)**: 8/11 (73%) **Target (2020)**: All KNCV-supported countries have an up-to-date NSP throughout up to and including 2020.
3.2: Engagement and coordination of other sectors and partners	3.2: Proportion of private providers and facilities notifying TB cases to NTP	**Baseline value (2014):** TBD [3] **Target (2020):** 50% of private providers/facilities in 8/11 countries
3.3: Monitoring and evaluation	3.3: Proportion of target countries that have a countrywide implementation of a patient based electronic recording and reporting system	**Baseline value (2014)**: 3/11 (27%) **Target (2020)**: 6 of 11 target countries w/ countrywide implementation
3.4: Measurement of catastrophic costs incurred by TB patients and their families	3.4: Proportion of target countries that have collected routine data on individuals expe-riencing catastrophic costs at least once	**Baseline value (2014):** 0% **Target (2020):** 11 of 11 target countries

5 THE BUDGET FOR 2017

ABBREVIATED VERSION

5.1 Budget according to the CBF reporting format

In table 2 the budget for 2017 is depicted in compliance with the regulations set by the Central Bureau for Fundraising (CBF).

Table 2: Budget 2017 in compliance with CBF regulations

	Actual 2015	Budget 2016	Prognosis 2016	Budget 2017
Income:				
- Income from own fundraising	2,189,882	1,609,100	1,688,600	1,683,900
Activities Fundraising	1,013,319	1,095,500	1,085,500	1,182,400
SMT and other endowment funds	445,000	385,800	415,800	452,000
Non-gouvernmental project subsidies	731,563	127,800	187,300	49,500
- Income from joint fundraising activities				
- Income from activities third parties	1,066,763	1,092,500	1,182,500	1,070,000
- (Government) subsidies	45,961,623	73,326,900	73,380,600	92,340,100
- Income from investments	369,716	135,700	171,700	128,000
- Other income	17,717	16,400	15,900	16,400
Total income	49,605,702	76,180,600	76,439,300	95,238,400
Expenses:				
Expenses to KNCV Tuberculosisfoundation's mission				
- TB control in low prevalence countries	805,955	820,200	969,900	960,800
- TB control in high prevalence countries	43,807,623	71,243,200	71,052,300	90,503,600
- Research	1,243,902	1,475,300	1,280,400	1,362,500
- Communication and advocacy	812,487	869,900	920,100	1,152,800
Expenses to acquisition of funds				
- Costs for own fundraising activities	275,412	365,900	353,800	416,600
- Costs for joint fundraising activities	-	-	-	-
- Costs for activities by third parties	49,608	51,500	53,000	40,100
- Costs to acquire subsidies	352,867	622,700	544,100	524,300
- Costs for investments	50,103	42,800	44,400	40,100
Management and control				
- Costs for management and control	1,253,448	1,310,200	1,166,200	1,139,000
Total expenses	48,651,403	76,801,700	76,384,200	96,139,800
Nett result	**954,298**	**621,100-**	**55,100**	**901,400-**

The deficit of € 0,9 million is covered by the use of earmarked reserves (€ 0,9 million). The total income is budgeted on a consolidated level of € 95,2 million. Of that, € 51,9 million is compensation for activities implemented by the coalition partners of Challenge TB. Total income budgeted for 2017 is € 19,1 million higher than budgeted for 2016. This substantial increase is fully justified by a greater amount for activities in countries for the Challenge TB project and the DGIS project, both for KNCV and for coalition partners. Income from (government subsidies) is planned for a total of € 92,3 million, while income from other sources is € 2,9 million. The latter mainly consists of private fundraising and lottery income. In the private fundraising category project funding from nongovernmental sources is also included. The amount of € 92,3 million from government subsidies is dominated by the income from USAID. A breakdown of the total amount is shown in table 3.

Table 3: Breakdown of Subsidies 2017

Category	Budget 2016		Budget 2017	
	In € 1 mln	*In %*	*In € 1 mln*	*In %*
CIb for activities Netherlands	0.51	1%	0.50	1%
DGIS	0.76	1%	3.20	3%
USAID:				
- Project management Challenge TB/ TB CARE I	2.36	3%	2.70	3%
- KNCV activities fees related to technical assistance	5.08	7%	6.30	7%
- KNCV material costs and country expenses	21.80	30%	17.90	19%
- Activities implemented by coalition partners	41.40	56%	51.90	56%
Subtotal USAID	70.64	96%	78.80	85%
Other (government) subsidies	1.42	2%	9.84	11%
Total	**73.33**	**100%**	**92.34**	**100%**

The total level of consolidated expenditures amounts to € 96,1 million, which is € 19,3 million higher than budgeted for 2016. This is also explained by higher budgeted costs in countries for Challenge TB projects. These costs are based on submitted year 3 work-plans. TBCTA Partner expenses amount to € 51,9 million in 2017 compared to

€ 41,4 million in the budget for 2016.

Table 4 shows a breakdown in percentages for the various expenditure categories. The largest part of the expenses goes to activities for TB control in high prevalence countries.

Table 4: Division of expenditures 2015-2017

Relative division of expenditures	Actual 2015	Budget 2016	Prognosis 2016	Budget 2017
Expenses to KNCV Tuberculosis Foundation's mission				
- TB control in low prevalence countries	1.7%	1.1%	1.3%	1.0%
- TB control in high prevalence countries	90.0%	92.8%	93.0%	94.1%
- Research	2.6%	1.9%	1.7%	1.4%
- Communication and advocacy	1.7%	1.1%	1.2%	1.2%
Subtotal	95.9%	96.9%	97.2%	97.8%
Expenses to acquisition of funds	1.5%	1.4%	1.3%	1.1%
Management and control	2.6%	1.7%	1.5%	1.2%
Total	100.0%	100.0%	100.0%	100.0%

5.2 The net result

The net result presented for 2017 is a surplus of € 47,800. This amount is budgeted to be added to the continuity reserve. This contributes to the higher amount needed to cover the risk of redundancy payment for a higher number of staff. The required size of the continuity reserve will be analyzed again on its risk level before the end of year closing of 2017.

Table 5: Coverage of the deficit 2017

Use of reserves	Movements			
	Actual 2015	Budget 2016	Prognosis 2016 Q3	Budget 2017
Continuity reserve	513,663	86,800	429,700	47,800
Decentralization reserve	-21,654	-171,100	-18,800	-150,000
Reserve investment revaluation	6,039	P.M.	P.M.	P.M.
Fixed asset reserve	348,790	P.M.	P.M.	-49,900
Earmarked project reserves				
Fund innovation	-45,384	-165,250	-118,400	-121,500
Fund e-learning (SVOP)	-10,223	-	-	-
Fund new developments Netherlands	-17,356	-	-40,300	-62,100
Fund new developments Africa, Asia, Europe, Latin America	-	-95,800	-	-180,900
Fund new developments policy development and research	-16,682	-50,000	-59,100	-65,100
Fund capacity building decentralization strategy	-63,443	-225,750	-114,350	-207,000
Fund special needs (allocation decided by the boards)	-	-	-	-
Fund monitoring tools	150,000	-	-	-50,000
Fund advocacy	150,000	-	-	-62,800
Earmarked project funds				
Fund TSRU	-1,175	-	-	-
Fund Van Geuns	-7,875	-	-	-
Fund special needs (allocation decided by third parties)	-838	-	-	-
Fund projects allocated by endowment funds	-29,563	-	-23,600	-
Total reserves	**954,299**	**-621,100**	**55,150**	**-901,500**

5.3 Ratios

The CBF requires fundraising organizations to publish three ratios, which indicate the cost effectiveness and efficiency. These ratios are shown in table 6. The ratio for fundraising costs has to stay under a maximum of 25%, calculated as an average over three years. The projected average for KNCV, based on the actual for 2015 and the budgeted ratios for 2016 and 2017 is 20,0%. If the forecast for 2016 is taken as a base, this is 20.0%. The percentage for 2017 alone is 24.7%, related to an investment in private fundraising campaigns with the aim of rejuvenating the donor base.

For expenses on management and control, KNCV has set a minimum and a maximum ratio of 2.5-5%. Due to the increase in in country and coalition partner expenses the percentage budgeted for 2017 is 1.2%.

Table 6: Ratios required by CBF

	Actual 2015	Budget 2016	Prognosis 2016	Budget 2017
Ratio expenses on mission versus total expenses	95.9%	96.9%	97.2%	97.8%
Ratio expenses to the mission versus total income	94.1%	97.7%	97.1%	98.7%
Ratio expenses for own fundraising versus income from own fundraising	12.6%	22.7%	21.0%	24.7%
Ratio expenses management and control versus total expenses	2.6%	1.7%	1.5%	1.2%

Apart from the CBF ratios KNCV also monitors the calculated percentage for indirect costs using two methods:

- An internal method used for charging personnel and overhead costs to projects.
- The USAID method to calculate the indirect costs which we are allowed to declare for the Challenge TB project.

Both percentages are shown in table 7, together with the number of (in)direct days and the average cost price per direct (project) day.

Table 7: Key ratios 2017

Key ratios	Actual 2015	Budget 2016	Prognosis 2016 Q3	Budget 2017
Total days direct	12,801	15,784	15,220	15,407
Total days indirect	4,667	6,921	7,654	9,303
Total days	17,468	22,705	22,875	24,711
% Direct	73%	70%	67%	62%
Number of fte	82.00	105.76	106.65	115.81
Average costprice excluding indirect costs per project day in €	430	445	448	461
% indirect costs	80.93%	66.15%	71.52%	82.80%
% ICR USAID	69.19%	52.81%	56.89%	64.71%
Ratio expenses - income own fundraising	12.6%	22.7%	21.0%	24.7%

The number of direct days decreases from 15,784 in 2016 to 15,407 in 2017. This is mainly caused by additional indirect days for technical staff. The average cost price per direct day increases from € 445 to € 461 (excluding indirect costs), due to salary raises (inflation and merit increases).

6 ABREVIATIONS

3HP	3 months weekly rifapentine plus isoniazid
6H	6 months of daily isoniazid
ACF	Active Case Finding
aDSM	Active drug safety monitoring and management
AFEW	AIDS Foundation East-West
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
Bac+	Bacteriologically confirmed cases
CAD4TB	Computer-aided detection of TB
CBF	Centraal Bureau Fondsenwerving (Central Bureau for Fundraising)
CBO	Community-Based Organization
CfG	Capital for Good
CI	Contact Investigation
CIb	Centrum Infectieziektenbestrijding (Center for Infectious Disease Control in the Netherlands)
CME	Continued Medical Education
CN	Concept Note
CPT	Commissie voor Praktische Tuberculosebestrijding (Committee for TB Control Policy Development)
CRM	Customer Relationship Management
CSO	Civil Society Organizations
CSPRN	Civil Society Primary Recipient Network
CTB	Challenge TB
CXR	Chest X-Ray
CYOD	Choose Your Own Device
DGIS	Directorate-General for International Cooperation in The Netherlands
DNA	Deoxyribonucleic acid
DOTS	Direct Observed Therapy Short-course
DR-TB	Drug-Resistant TB
DS-TB	Drug-Sensitive TB
ECDC	European Center for Disease Prevention and Control
EQA	External Quality Assurance
FAST	Finding TB cases Actively, Separating safely, and Treating effectively
FDC	Fixed dose combinations
FTE	Full Time Equivalent
GeneXpert® MTB/RIF	Rapid diagnostic test for diagnosing Mycobacterium Tuberculosis and rifampicin-resistance
GenoType MTBDRsl	Hain Lifesciences test: assay for the detection of resistance to second-line anti-TB agents
GF(ATM)	Global Fund (to fight AIDS, Tuberculosis and Malaria)
GGD	Gemeentelijke of Gemeenschappelijke Gezondheidsdienst (Municipal Health Services in the Netherlands)
GHOR	GGD GHOR Nederland
GxAlert	Digital health technology: system for data management
HCW	Health Care Worker(s)
HIV	Human Immunodeficiency Virus
HQ	Headquarters (KNCV The Hague)
IC(P)	Infection Control (& Prevention)
ICF	Intensified Case Finding
ICT	Information and Communication Technologies
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
iPSI	Improving Patient Support Interventions
IPT	Isoniazid Preventive Treatment
IT	Information Technology
JKN	Jaminan Kesehatan Nasional (Indonesia universal health care scheme)
KNCV	KNCV Tuberculosis Foundation
KPI	Key Performance Indicator
LED	Light-Emitting Diode
LOI	Landelijk Overleg Infectieziekten
LSHTM	London School of Hygiene and Tropical Medicine
LTBI	Latent TB Infection
LTTA	Long term technical assistance
M&E	Monitoring & Evaluation
MDM	Mobile Device Management
MDR-TB	Multidrug-resistant Tuberculosis
MoH	Ministry of Health
MTM	Medical Technical Assistants
MTMBeVE	Association of Medical Technical Assistants
ND/R	Initiative programmatic implementation of new drugs and shorter regimen for DR-TB treatment
NFM	New Funding Model
NGO	Non-Governmental Organization
NICRA	Negotiated Indirect Cost Rate Agreement
NSP	National Strategic Plan
NTCP	National TB Control Plan
NTDD	Nederlandstalige Tuberculose Diagnostiek Dagen; TB course
NTP	National TB Control Program
NVALT	Association of Pulmonologists
OGD	Operator Group Delft
OMNI	portable GeneXpert system
OR	Operational Research
PADT	Proposal Assessment Development Team
PEPFAR	U.S. President’s Emergency Plan For Aids Relief
PLHIV	People Living With HIV
PMDT	Programmatic Management of Drug resistant Tuberculosis
PMU	Project Management Unit
PPM/P	Public Private Mix/Partnership
PPMD	Public Private Mix DOTS
PR	Prime Recipient
PWUD/PWID	People who use drugs/people who inject drugs
QMS	Quality Management System
R&D	Research & Development

REC	Regional TB Expert Centers
RMNCH	Reproductive, Maternal, Neonatal and Child Health Care
RPT	Regulations on Practical TB control ('Regelgeving Praktische Tuberculosebestrijding'
RTC	regional TB consultants/coordinators ('Regionale Tuberculose Consulenten')
SMT	Dr C. de Langen Stichting voor Mondiale Tuberculosebestrijding
SS+	Sputum-smear positive
STAG (TB)	Strategic and Technical Advisory Group (for Tuberculosis)
STP	STOP TB Partnership
STTA	Short term technical assistance
TA	Technical Assistance
TB	Tuberculosis
TB/HIV	Tuberculosis/Human Immunodeficiency Virus
TBCTA	Tuberculosis Coalition for Technical Assistance
TB-IC TB	Infection Control
TIME TB	Impact Model and Estimates
TRAC	Tuberculosis Research Advisory Committee
UCL	University College of London
UNION	International Union against tuberculosis and lung diseases
UNITAID	Global organization founded in 2006 by Brazil, Chile, France, Norway and the UK to invest in new ways to prevent, diagnose and treat HIV/AIDS, tuberculosis and malaria
USAID	United States Agency for International Development
V&VN	Association of Public Health Nurses
VvAWT	Association of TB Physicians
VWS	Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health Netherlands)
WHO	World Health Organization
WP	Work Package
Xpert	See GeneXpert
Xpert MTB/RIF	See GeneXpert

Together
WE FIGHT TB

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