

**KNCV**  
To eliminate TB



TUBERCULOSIS FOUNDATION



# OVERVIEW 2014

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## Colophon

De Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose ('KNCV' which uses the name KNCV Tuberculosis Foundation in English) is located at Benoordenhoutseweg 46 in The Hague, The Netherlands. This overview is derived from KNCV's complete annual report 2014, which includes all financial statements, specifications and a full auditors report and can be downloaded at [www.kncvtbc.org](http://www.kncvtbc.org).

CONTENT  
KNCV Tuberculosis Foundation

EDITING  
Schrijf-Schrijf, Utrecht

DESIGN  
Is vormgeving, Leiden

PHOTO COVER  
Martin Bushue

# DIRECTORS' REPORT

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

“We firmly believe that the only way to ultimately eliminate TB is to embed TB control into national health programs, involving all relevant parties.”

## Successes and contributions

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

Many of these successes were achieved thanks to KNCV's continued contributions. We advised National TB Programs

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

We did this work out of our central office in The Hague, Netherlands, and our Central Asia regional office in Almaty, Kazakhstan, with many activities implemented through our country offices. As in previous years, the majority of the activities were carried out as part of the U.S. Agency for International Development (USAID)-funded 5-year TB CARE I program, for which KNCV has been the prime contractor. Through this extensive program, the lives of 4 million people have been saved. Having achieved TB CARE I's targets one year ahead of schedule, we completed the



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program in 2014 and will close it formally in 2015. Subsequently, this year we were awarded the prime contract for the new USAID flagship TB program, Challenge TB. With a financial ceiling of US \$ 525 million, it is once again the largest multi-partner, multi-country TB program in the world, encompassing 18 countries in Africa, South and Central Asia and Eastern Europe by the end of 2014. We are very proud to have been selected for the fourth consecutive time to head this program as lead partner of an international coalition of nine organizations. We are also extremely pleased that the Dutch Ministry of Foreign Affairs (DGIS) has issued a five-year grant to KNCV to support our work under the Challenge TB umbrella, in particular for making the Global Fund money work to combat TB/HIV co-infection. Having been without DGIS funding for several years, we welcome the Netherlands Government's commitment to global TB-HIV control, as well as this clear sign of confidence in our abilities and vision.

## Step up on research

Although steps forward are being made, the challenges of fighting this disease of poverty remain: inadequate health ser-

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

vices, poor patients and generally poor tools for diagnosis, treatment and prevention. Since 2000 the global incidence of TB has fallen by about only 1.5% per year. In order to meet WHO's ambition of cutting the number of new TB cases by 90% by 2035, incremental improvements won't be enough - we must take unprecedented steps, develop new approaches to TB control and massively scale up those that promise to be successful.

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

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

We need better ways to prevent TB disease. With no effective vaccines on the horizon, prophylactic drug treatment, which is becoming more effective and less burdensome to the patient, is our most important weapon. However, this weapon can only be deployed in a feasible and affordable way if we are better able to identify those individuals infected with TB bacilli who have the highest risk of getting the disease. Again, this requires better diagnostics, and better understanding of the biological mechanisms that define people's risk of becoming ill once infected.

And finally, we need better approaches that maximize the yield of our efforts, improving access, strengthening the health service response, and engaging the private health sector in TB control. We need to try out creative solutions, learn from them as we go in a systematic manner, and scale up what works.

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

It also calls for a stepped up role for KNCV to advocate for and conduct research. In line with WHO's End-TB strategy, KNCV has therefore made research (generating a solid evidence base) one of the three pillars of its new Strategic Plan 2015-2020. Moreover, within the Challenge TB program, USAID explicitly

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

aims to support operational/implementation research to find local solutions to local problems and to invest in multi-year, multi-country studies to test new interventions for curbing TB transmission.

### Organizational internal developments

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

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

We also revised our internal organizational structure and modus operandi. Aiming to let people do what they do best, to optimally support high-quality technical output, and to maximize efficiencies, we replaced the geographically oriented units with a separation into an Operations and Technical Division operating alongside a Finance Division and supportive units. Central to this structure are crosscutting country teams, in which the different disciplines work closely together with the country office. The Project Management Unit for Challenge TB, which also oversees activities in countries that are led by our coalition partners, is fully embedded in this structure, with clear internal lines of reporting. KNCV's Technical Division has been divided into thematically

oriented teams that are meant to further enhance knowledge and develop new approaches. Also, we strengthened the Communications and Private Fundraising Unit to help raise awareness about TB among the general public and to sustain and strengthen the funding base for KNCV's activities in TB control. A small Resource Mobilization Unit was set up to focus on acquiring project grants to broaden and diversify our funding base. Following almost a year of preparations, the new structure became operational as of 1 January 2015.

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

Prof. dr. Frank Cobelens,  
Chief Scientific Officer

Dr. Kitty van Weezenbeek,  
Chief Executive Officer



# KNCV TUBERCULOSIS FOUNDATION IN KEY FIGURES

Income from third party activities € 1,075,270

95.7% Spent on mission related goals

Income from private fundraising € 1,593,139

209 Number of staff worldwide

25,436 Number of private donors

% of expenses to fundraising 24.6%

2.5% of expenses to administration and control

Income from government grants € 42,051,486

# COUNTRIES WHERE KNCV WORKED

## AND CORE COUNTRY HIGHLIGHTS IN 2014

**Africa**

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

**Asia**

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

**Europe**

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



○ Other countries where we worked

# ACTIVITIES AND RESULTS IN 2014



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

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

**Alies de With** tuberculosis nurse, The Netherlands

“The Dutch TB Handbook is an excellent reference book,”

## POLICY & GUIDELINES

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

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

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

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

### TB 2015 Handbook

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

up-to-date knowledge and experience regarding TB in the healthcare services.

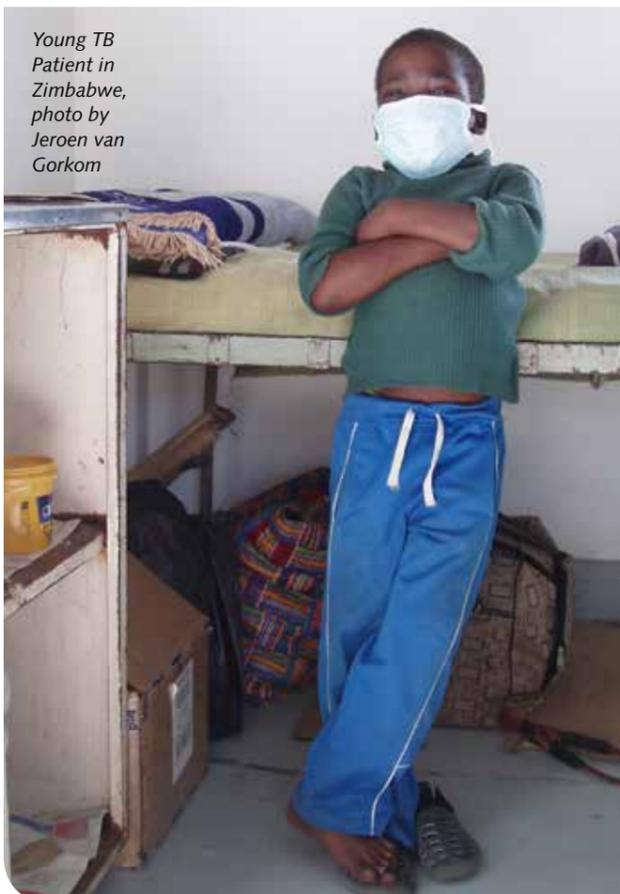
The new TB 2015 Handbook serves a wider readership than its predecessor, which was published in 2008. In addition to TB professionals in the Netherlands, the new Handbook is designed to inform students and healthcare staff in other fields. The Handbook is an essential reference: even seasoned practitioners like Alies de With still use it regularly. “TB control practice is always changing, and the guidelines are regularly amended”, she says. “Sometimes I need to refresh

my memory on what is currently recommended practice. I find the Handbook an excellent reference book: it is ideal for using online. It nicely brings together all that we need to know, and for more details there is a reference to the relevant guideline or regulation at the top of each paragraph. For instance, if we need to organize a contact investigation, we can easily refer to the Handbook for a reminder of the criteria for determining the first and second rings of contact. The Handbook is also convenient when we need to explain the contact investigation procedure.”

“TB control practice is always changing, and the guidelines are regularly amended.”

# 5 QUESTIONS ABOUT OUR INVOLVEMENT IN POLICY AND GUIDELINE DEVELOPMENT

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



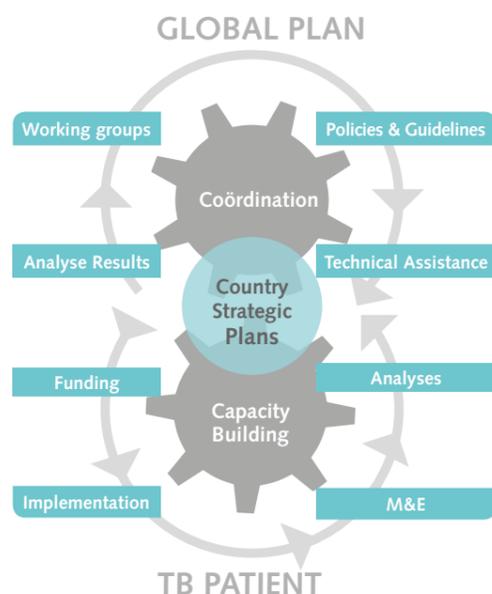
Young TB Patient in Zimbabwe, photo by Jeroen van Gorkom

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

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

## 2 Why does KNCV participate in these sort of bodies?

Because of our active involvement around the globe we use our insights and are at the forefront of international policy and guideline development. The combination of this involvement with our on-the-ground experience in TB control places us in a unique position. When working within the framework of countries' policies, we gain input that is valuable for developing WHO guidelines, for example. This in turn forms the basis for



### In 2014, KNCV was actively involved in:

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

- The Steering Committee of the Amsterdam Institute for Global Health and Development;
- Steering committee of the RESIST TB initiative;
- Steering committees of various research projects, as independent/external members;
- The Dutch Tuberculosis Steering Committee of the GGD (municipal health services);
- Virtually all other Dutch TB committees and working groups.

### KNCV staff are also on the editorial team of:

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

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

national policy adjustments and new regulations for better TB control. We help countries implement these adjustments and regulations, gaining new input for improvement – and so on.

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

Among other things, we contributed to:

- Almost 20 international TB guidelines, manuals and tools, including the majority of WHO TB and TB CARE I guidelines and tools;
  - TB CARE I publications, such as:
    - Compendium of Tools & Strategies – To achieve universal access to TB care for at risk and vulnerable groups;
    - Xpert MTB/RIF Training Package – Training course designed for health care workers, laboratory officers, clinicians and TB program staff;
    - Handbook for interpretation and use of TB data.
  - WHO guidelines and tools, including:
    - Guidelines on the management of latent tuberculosis infection;

- Framework towards tuberculosis elimination in low-incidence countries;
- WHO interim guidance on the use of delamanid in the treatment of MDR-TB.

- 35 scientific TB publications, to share and disseminate knowledge and lessons learned.
- In The Netherlands, we are responsible for all TB guidelines. In 2014 for example, we completed the Richtlijn bron- en contactonderzoek ("source and contact investigation guideline). In other countries, we help adapt and implement international guidelines to local countries' contexts.

## 4 What did that adaptation and implementation look like?

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

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

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

regimens. In 2013, KNCV therefore contributed – within the framework of the TB CARE I program – to the development of a protocol for the rational and safe introduction of bedaquiline, a new TB drug for MDR-TB treatment. In 2014, we supported Indonesia, Kazakhstan and Vietnam in the development of country-specific versions of this protocol. These countries are now implementing their plans



Laboratory Kampala, Uganda, photo by Tristan Bayly

## STRATEGIC LABORATORY PLANNING

Laboratories are essential for the diagnosis of TB and for monitoring TB treatment. In low- and middle-income countries, it is often a challenge for TB laboratories to provide the appropriate level of services. Laboratory work is also becoming progressively complex, with increasingly widespread use of quality-assured diagnostics in smear microscopy, culture and drug-susceptibility testing, as with the introduction of new laboratory tests (including line probe assays and the Xpert MTB/RIF test). TB laboratory plans are new to most countries. The countries need TB-specific laboratory strategic plans to help determine which laboratory interventions are required for the overall national

TB control strategy over a 5-year period. The TB CARE I Practical Handbook for National TB Laboratory Strategic Plan Development is a practical guide for conducting a TB-specific laboratory planning process. The second English edition of the handbook, published in February 2014, was produced under coordination by KNCV. The Practical Handbook has been endorsed by the Global Laboratory Initiative. It is found to be very useful and is being used in the supra-national reference laboratory in Uganda, for example. There is also an accompanying Participants' Manual and a Facilitators' Manual.

to systematically collect information on drug safety ("pharmacovigilance"), as well as on the feasibility and effectiveness of its implementation.

### Introducing a new WHO reporting framework and revised definitions

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

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

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

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

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

To effectively enhance the quality of TB care in private practices, KNCV in Indonesia worked with the Ministry of Health and professional societies to develop and legalize National Guidelines for Medical Practice Standards for TB care, based on the International Standards for Tuberculosis Care (ISTC). These standards are essential to ensure quality of TB care delivered by private providers. They are also impor-

## DATA DICTIONARY FOR SECOND-LINE TB DRUGS FORECASTING

With support from the Eli Lilly and Company Foundation, we developed a generic data dictionary as part of the E&M (online and mobile) Health project. The generic data dictionary describes the essential data needed for second line drugs forecasting. This is important because of the often limited supply, short shelf-lives and high sales prices for these drugs needed to treat MDR-TB.

Harmonization of data dictionaries for treatment of MDR-TB patients across countries allows for better prediction of the second line drugs needed, enabling countries and pharmaceutical companies to improve their planning. The dictionary is currently used in Kenya, Nepal and Tajikistan. It is a guide for IT developers in building drug management components into their electronic patient information systems. The data dictionary is freely available on the E&M Health web forum that is hosted and facilitated by KNCV and MSH. The project core team exists of staff from KNCV, MSH, IRD, PiH, Abt Associates WHO and PATH.

tant to establish a legal basis and foundation for certification by the Indonesian Medical Association. We then went on to assist 141 hospitals in ten provinces in developing their own Clinical Pathways and Clinical Practice Guidelines, based on the National Guidelines. The next step is to link those pathways and guidelines to the National Health Insurance System (JKN), thereby ensuring the necessary transparency and accountability for reimbursement of costs by health insurance providers. This will ultimately enable health care facilities to provide everyone in Indonesia with access to quality TB care.

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

To develop tools and approaches that work, it is of fundamental importance to combine policy-making and practical experience, while grounding our recommendations in operational research. This is the essence of the KNCV approach. A good example is the patient-centered approach (PCA) package, which was

## POLICY TOOLS IN THE NETHERLANDS AND LOW-INCIDENCE COUNTRIES

KNCV, and The Netherlands in general, have an outstanding international track record in effectively fighting TB. This reputation was upheld in the findings of the 'Evaluation of TB source and contact investigation in The Netherlands 2006-2010', published in 2014. In another landmark, in 2014 KNCV's unique online registry for TB and latent TB infection in the Netherlands [www.tbc-online.nl](http://www.tbc-online.nl) celebrated its 20th anniversary of operations.

We also participated in developing the WHO 'Framework towards TB elimination in low-incidence countries', which was also published in 2014. The Framework offers a coherent approach for eliminating TB in low-incidence countries. It is designed to guide national policy-makers and those responsible for technical aspects of the national effort to eliminate TB. Eliminating TB is possible, but there are huge challenges to be overcome. As the TB burden drops, it is increasingly difficult to keep TB on the public health agenda. Common challenges to the health system in low-incidence countries are diminishing political commitment, clinical and diagnostic expertise, and low general public awareness of TB.

developed within the TB CARE I project. The package, which focuses on stimulating countries and health workers to organize their care around the patient, consists of five different tools. The entire package was piloted and evaluated in five countries: Cambodia, Indonesia, Mozambique, Nigeria and Zambia. The PCA package tools fulfilled their promise: to provide practical suggestions for national programs and health facilities to take steps in improving patient-centered care and to empower patients to

To develop tools and approaches that work, it is of fundamental importance to combine policy-making and practical experience, while grounding our recommendations in operational research.



get organized and involved in TB care. In general, the tools were found to be easy to implement, with the exception of the Tool to Estimate Patients' Costs, which required more training and direction. This costing tool was then revised based on previous experiences. All five pilot countries reported plans to scale up their use of the PCA tools.

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

“Everybody felt a part of this”

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

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

“It was a Zambian project, but designed to be globally applicable”, Chanda continues. “Our survey team learned by doing. The World Health Organ-

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

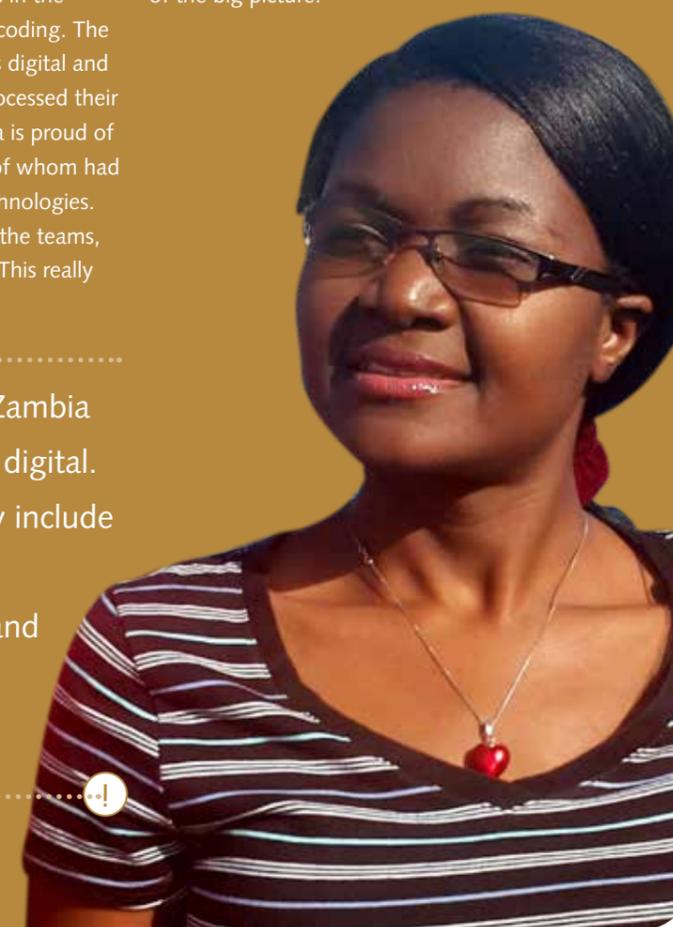
Also within the government system different expertise was brought in. “With such a large project, you can really optimize by working with what is already in the system” says Chanda. “We had a strong inter-ministerial cooperation, for instance the Ministry of Communication and Transport for courier of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

## RESEARCH

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

paid back in the commitment of people. We found that the fieldworkers started helping each other - when somebody was unable to do the work, another team member stepped in. Everybody felt part of the big picture.”

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

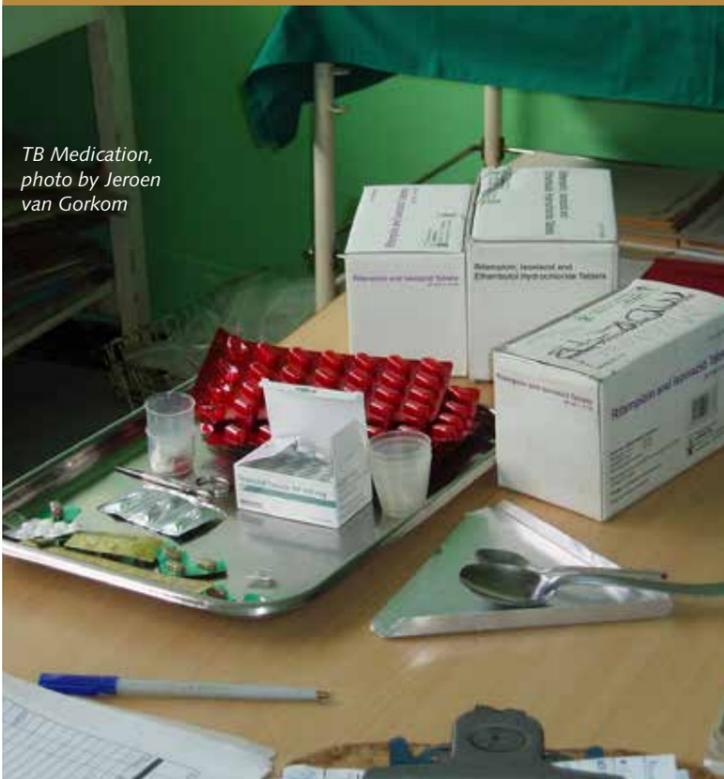


# 5 QUESTIONS ABOUT OUR RESEARCH IN 2014 KNCV

## INTRODUCING NEW DRUGS AND REGIMEN

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

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



TB Medication, photo by Jeroen van Gorkom

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

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

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

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



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

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

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

### 3 What results stood out in operational research in 2014?

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

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

These are a few of the many significant results:

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

regular provision of compensation, involvement in treatment support, tracing patients lost to follow-up treatment and explicit referral targets;

- In Indonesia, a study examined the possibilities of increasing the role of nurses in identifying people with presumptive TB. It turned out that engaging family public health nurses in the identification and referral of presumptive TB cases increased referrals by a factor of four compared to control areas;

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



*Indonesia, District Health Facility TB Control Supervisor*

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

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

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

#### **5** How did we build research capacity?

Capacity building, or the transferring and building of knowledge, is a key element of the KNCV approach. Besides coaching on the job, as we did in the development and implementation of operational research and population epidemiology, we also guided PhD students and supported the writing of research papers. In 2014, three PhD

### **ETHIOPIA OPERATIONAL RESEARCH CAPACITY BUILDING INITIATIVE**

Program-based operational research (OR) is instrumental for the enhancement of TB control. Ethiopia has a strong history of conducting operations research, but translating research results into policy or practice has been limited. In 2012, the Ethiopian Ministry of Health, together with USAID, KNCV and other partners, launched an initiative to develop sustainable capacity for operational research in Ethiopia. The results were published as a supplement to IUATLD's Public Health Action in December 2014. Teams representing regions in Ethiopia

conducted operational research, addressing national and regional priorities. To make use of local expertise and increase sustainability, a domestic mentor training program was included. Existing capacity was enhanced through a competitive grant scheme for TB researchers. The Ethiopian Tuberculosis Research Advisory Committee (TRAC) was also supported in its functions. Regional ethics review bodies were strengthened or established where they did not exist. Using a 'learning by doing' approach, KNCV and TRAC conducted intensive

modular training for regional OR teams of TB and TB/HIV program staff together with academia. Fifty-two people were trained and conducted 13 OR projects. In addition, eight protocols were supported through grants. Ethics review bodies were strengthened in all regions. The initiative trained participants from all regions and succeeded in the completion of all stages of the OR process. The success of the program can be attributed to the team approach, 'learning while doing', integrated mentorship program and strong national ownership.

### **LESSONS FROM PSYCHO-SOCIO-ECONOMIC SUPPORT FOR TB PATIENTS**

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

students graduated and eight more continued on in PhD programs. Research papers were written with our support in Kyrgyzstan (sixteen researchers, three papers), Tajikistan (eleven researchers, two papers), Kazakhstan (three papers, partly to be published in 2015) and Nigeria (two operational research papers under submission). In Indonesia, we supported a researcher in writing a paper on patient costs and an Indonesian student in writing a paper on the quality of sputum smear microscopy. The student's paper will be submitted in 2015. We also developed a highly successful research capacity building program in Ethiopia (see highlight).



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

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

“It helps to get support from other patients”

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

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

“I became ill with TB four months after my daughter Chacha was born. Chacha is now four years old.” says Ully Ulwiyah. “The Patients Support Group was established three years ago: it was my initiative, together with another patient who had the peer educator training from KNCV in Jakarta. Many people with MDR-TB have side effects and other problems. I want to help them. I don’t want other patients to experience the same problems and side effects that I had. The side effect I suffered from was depression.

## ACCESS TO QUALITY CARE

Even though I had a young child to care for, and a family, I felt loneliness. My experience at the hospital was traumatic. I was afraid to go to the hospital for treatment and I was also struggling with loneliness. It was traumatic to have to take the drugs every day. “

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

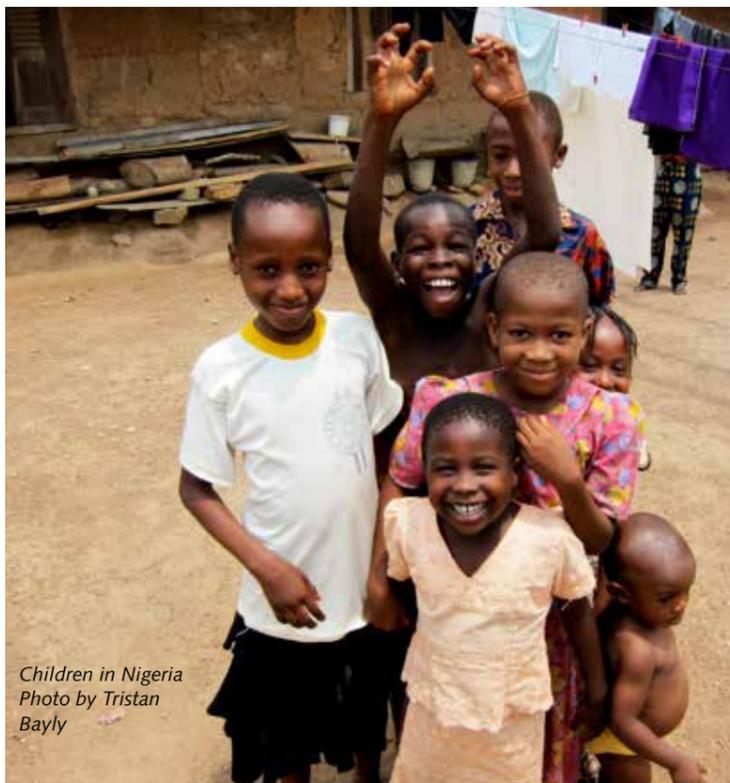
There are fifteen active members of the Patient Support Group; four men and eleven women. Ully Ulwiyah visits patients at the hospital on Mondays and Thursdays. “We educate and motivate new patients, and support them if they have bad side effects, like depression or hallucinations. I also visit patients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

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

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

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

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



Children in Nigeria  
Photo by Tristan Bayly

## SCALING UP MEASURES AGAINST CHILDHOOD TB

Childhood TB presents specific challenges, which should be addressed with appropriate measures, including screening, diagnostics and preventive therapy. In 2014, KNCV continued to invest in the quality diagnosis and treatment of TB in children in among others Ethiopia, Indonesia, Kazakhstan, Kyrgyzstan, Nigeria and Tajikistan.

In Vietnam, a new strategy on the management of TB in children was piloted and subsequently successfully scaled up. To improve access to diag-

nosis and treatment for children with TB, an isoniazid preventive therapy service package was introduced in four pilot provinces. KNCV was responsible for the review and supervision in 35 districts and 611 communes within the four provinces. Next we provided technical advice and assistance to the National TB Program in the roll-out of this strategy to 18 provinces. TB among children is now incorporated into annual plans and includes the production of educational materials and including childhood TB data in routine reporting

and reviews.

At the community level, KNCV is supporting community health workers who are following up children who are in close contact with an adult or adolescent with newly diagnosed pulmonary TB. An evaluation of the childhood TB program in Vietnam will be finalized in 2015.

In Nigeria, KNCV helped develop the national desk guide for the diagnosis and management of childhood TB. As a result, more than 2,000 children under the age of 5 were notified in 2014.

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

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

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

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

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

An important step forward in this is adapting a more patient-centered approach. In the Akmolra Region of Kazakhstan, KNCV demonstrated how standard hospital-based treatment can be replaced by outpatient care for adult and pediatric TB/MDR-TB patients

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

who are no longer infectious. This outpatient care led to an increase in treatment success rate for TB and MDR-TB patients combined from 66% in 2011 to 86% in 2013.

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



The Center of Excellence on PMDT Training, Kigali Rwanda

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

The introduction of the rapid diagnostic test Xpert MTB/RIF in Nigeria has led to a rise in the number of people diagnosed with and requiring treatment for MDR-TB. Consequently, patients who needed immediate treatment were kept waiting or even refused admission by treatment centers. Nigeria has only ten MDR-TB treatment facilities, with a limited patient intake capacity. To ensure better access to appropriate care for people with MDR-TB, Nigeria revised the national Programmatic Drug-resistant TB (PMDT) guidelines so that alternative models of care could be introduced. A pilot study was launched to introduce ambulatory care in eight selected states. Three different treatment models were studied: hospital admission during the initial 3 months of treatment; hospital admission during the initial 8 months; and treatment completely in the community. Community-based care involved training general healthcare workers to deliver ambulatory care services, including home visits to patients; delivery of daily medications; nutrition counseling and assistance; and ensuring that patients take effective infection control measures.

The pilot study showed that treatment of people with MDR-TB in the community is both effective and feasible. The ambulatory MDR-TB treatment at community level is being scaled up so that, increasingly, patients do not necessarily need to wait for admission to facilities. Important factors for success include capacity building of supporting staff; logistical support for patients' daily transport for directly observed treatment (DOT); quality supervision and patient monitoring; and timely transport of laboratory samples and results.



Family in Ethiopia, photo by Netty Kamp

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

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

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

## 2 How successful are the joint HIV/TB interventions?

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

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

That being said, there is quite a difference between regions and countries. As noted in the Directors' Report in Africa, 75% of TB patients know their HIV status, and in Central Asia the scale-up of HIV testing is generally going well. One of the KNCV-supported countries with the greatest improvements in HIV testing is Nigeria, where substantial investments in TB/HIV services were made and 88% of TB patients were tested for HIV by 2013. Indonesia, on the other hand, has a high TB incidence but limited HIV testing. Extra efforts are needed here in screening, reporting and treating latent TB infection among people with HIV by providing isoniazid preventive

## PATIENT CENTRED PALLIATIVE CARE

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

therapy (IPT). KNCV provided substantial support for the provision of IPT in Indonesia, as it did in Ethiopia. After successful pilot implementation in four hospitals in 2013, IPT has now been included in the national Indonesian TB policy. The National TB/HIV Forum supports an IPT scale-up in eight provinces, and in the second quarter of 2014, 94% of all the people known to live with HIV in these provinces were screened for TB. IPT provision is now introduced in seven provinces and implemented in 29 hospitals.



Giving information about TB, Ethiopia, photo by Netty Kamp

## 3 How did KNCV help to reach vulnerable patient groups?

Some population groups are more at risk of getting TB infected than others, or they (also) have more difficulties accessing regular health-care. Among them are, for example, persons using drugs, migrants, mineworkers and people in prisons/detention centers. KNCV continued to work on

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

improving the diagnosis, treatment and care of these groups, such as prisoners and prison staff in Ethiopia, Indonesia, Tajikistan, Kazakhstan, Mozambique and Nigeria.

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

TB patient in Nigeria  
Photo by Tristan Bayly



and 99% of inmates with HIV were screened for TB. A total of eight prisons/DCs successfully implemented cough surveillance to strengthen TB case finding.

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

This is a part of the FAST strategy - to detect early, separate, and effectively treat inmates with TB.

In Nigeria, KNCV worked to develop and scale-up TB screening, diagnosis and treatment systems for pris-

oners. These have now been taken up by the entire prison system and so far more than 6,341 inmates have been screened. In Tajikistan, we did a workshop for strategic planning for 20 prison administration staff members. Building on an assessment of the existing models for transitional care, implementation of activities will start in 2015.

**4 What progress has been made in infection control?**

Compared to only 50% in 2010, in 2014 all TB CARE I supported countries have developed national TB Infection Control (TB-IC) guidelines. In addition, all these countries have incorporated TB-IC in their overall national Infection Prevention and Control policy. And there are more country-specific achievements as well. In Ethiopia, for example,

KNCV provided assistance in developing design and engineering standards for building healthcare facilities that focus on the prevention of airborne infections like TB. Following those standards, and much aware of the importance to prevent these infections, the government has now adopted complementary regulations for the building design of healthcare facilities. After South-Africa, Ethiopia is only the second country in the Sub-Saharan African region to have implemented these important regulations.

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

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

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

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

- We helped develop a protocol for the introduction of bedaquiline, a new drug for MDR-TB treatment, and supported Indonesia, Kazakhstan and Vietnam in the development of country-specific versions of the protocol.
- Following the Expert Group meeting on delamanid in April 2014, we helped develop an interim guidance on the use of this new drug in the treatment of MDR-TB. This was approved by the World Health Organization (WHO) Guideline Review

Committee in September 2014.

- We have been heavily involved in the implementation and scale-up of testing the Xpert MTB/RIF diagnostic system in countries such as Indonesia, Nigeria and Vietnam, from shortly after WHO endorsed the test in 2010. As a result, the number of patients diagnosed with rifampicin resistance (and confirmed as MDR-TB) has rapidly increased, saving lives and preventing transmission by adequate MDR-TB treatment.
- In Nigeria, KNCV is supporting the introduction of two hundred Xpert MTB/RIF platforms, specifically for testing PLHIV. This support is made possible by an HIV grant from the Global Fund.
- In Nigeria and Vietnam, we also act as a technical service provider for the company that manufactures



GeneXpert training in Ghantsi Primary Hospital Botswana

the Xpert MTB/RIF platforms. We work on installation, calibration, training and troubleshooting.

- In Zimbabwe and Nigeria we are supporting a pilot project aimed at evaluating the utility of the Xpert MTB/RIF platform in HIV care settings. We also promote the use of this test to screen prisoners and health care workers.

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

“We now know the direction we have to take,”

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

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



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

The GeneXpert program is working very well: from initially four Xpert MTB/RIF machines there are now 24 machines for rapid diagnostic testing in the country. The NTP plans to place more Xpert machines close to the population. “Building on the good results we have achieved, we now know the direction we have to take. For further implementation we will be able to work very sustainably. A plan for

## SUSTAINABILITY

TB and MDR-TB control is being implemented now without external financial support. This is possible because the Kazakhstan government continues its comprehensive support to the TB control system.”

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

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

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

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

# 5 QUESTIONS ABOUT HOW WE WORKED TOWARDS SUSTAINABLE TB CONTROL

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

## 1 Why does KNCV engage the private health sector?

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

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



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

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

## 3 In what way did KNCV involve community organizations?

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

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

## ETHIOPIA: ENGAGING CIVIL SOCIETY

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



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



Respiratory Fit Test  
by KNCV Consultant  
Niesje Jansen



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

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

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

The principle of e-learning is to invite the learners to think through a topic or problem, ensure they receive immediate feedback on their answers, adding additional resources/information. The

modules were built as a story with a logical flow and a clear begin and end. Three model patients were created, using actors. All methods were tested with users. The course was developed in close collaboration with TB nurses in the field. The e-learning course is certified by the professional nursing body, which nurses can follow in their own time. The course is suitable both as a refresher for experienced TB nurses and for training new TB nurses, who both can follow the course in their own time.

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

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

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

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

## NIGERIA: ON THE ROAD TO EMBEDDING TB CONTROL

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

from insurance and corporate social responsibility financing. Sustainable financial strategies have to take this into account. In this respect, it is important for governments to improve cost-effectiveness and efficiency, so that results can be maximized with limited resources. To assist in this, we helped developing – within the framework of the TB CARE I program – a suite of four costing tools that donors and governments can use to model costs and ana-

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



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

## 5 What is the importance of costing tools?

We believe that countries need to replace dependency on donor funding with increased government budget allocations and revenue

lyze cost-effectiveness:

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

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

# ORGANIZATIONAL HIGHLIGHTS

## Getting ready for the future

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

In October 2014, it was announced that for the fourth time in a row, USAID has

selected KNCV to lead their flagship TB program, now called Challenge TB. With a ceiling of US\$ 525 million in five years

the fight against the deadly disease. The start of Challenge TB also marked the ending of TB CARE I, the former USAID

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

it is the largest TB program in the world, empowering us and our eight consortium partners to take great steps forward in

funded program, which we will formally close in 2015. We are proud to have contributed to saving more than 4 million lives through this extensive program, which ran for four years, and inspires us to continue the fight.

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

## Sharing knowledge

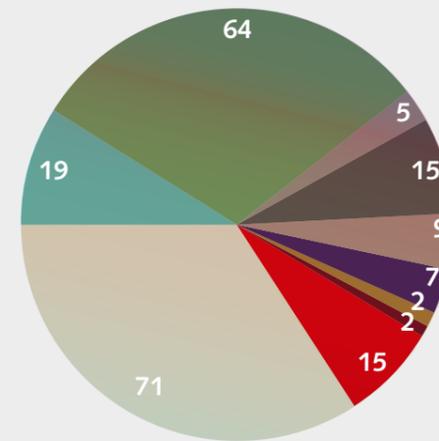
As an international center of TB expertise, KNCV sees sharing knowledge among colleagues as a crucial value. In 2014, we organized 24 lunch meetings to share and



## MAARTEN VAN CLEEFF AWARDED KAREL STYBLO PUBLIC HEALTH PRIZE

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

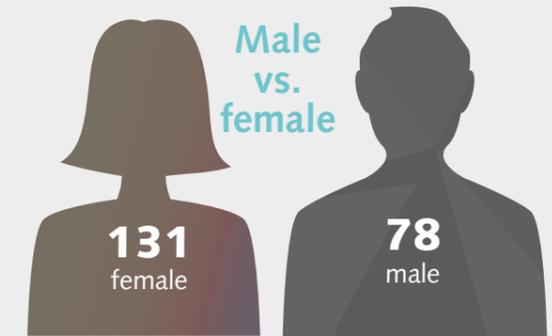
## SOCIAL REPORT



### Staffing per country as of 31.12.2014

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

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



## Inflow/outflow



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

## ANNUAL SYMPOSIUM INSPIRES TO WORK TOGETHER

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





Joep Lange

## SAD FAREWELL

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



Omer Ahmed Omer



Felix Salaniponi

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

### Next generation

To get more young professionals engaged in the fight against TB, we developed KNCV's Young Professional Program, supported by Dr. C. de Langen Stichting voor Mondiale Tbc-bestrijding (SMT) and the

's-Gravenhaagse Stichting tot Steun aan de bestrijding van Tuberculose. The idea is to link international KNCV TB professionals to a new generation, combining a world of experience with new knowledge, skills and working dynamics. An appealing selection procedure gave candidates the opportunity to present themselves through new media and case studies. The 81 applicants came from the Netherlands and abroad, with backgrounds in Medicine, Social Sciences and Economy. The selected candidate will start in January 2015. We aim to expand the Young Professionals Program in 2015.

### Diversifying the funding base

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

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

KNCV in 2014 also successfully attracted other institutional donors in 2014: TB REACH/Wave 4 (Tajikistan), Capital for Good, Fund Life Sciences for Health and Development (LSH4D), The Global Fund (GFATM), Cepheid and USAID Tajikistan (sub award through Project Hope). In total 7 new donors were attracted in 2014

which is a steady increase compared to the previous year. We were able to realize this positive result due to a more streamlined internal proposal development process. Systems and tools to screen, analyze and develop funding opportunities were put in to place and we strengthened the capacity of the institutional fundraising unit as well as the skills of technical staff to develop proposals for institutional donors.

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

### Campaigning and private fundraising in The Netherlands

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

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

TB is not seen as a major issue in The Netherlands and to make this happen creative campaigning is crucial. In 2014 we had a very successful campaign around World Stop Tuberculosis Day on March 24. More than 20 Dutch celebrities – actors, writers, TV presenters and even our national astronaut – helped us in raising publicity for the TB cause. Our new Face-

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

book page attracted more than 2,000 fans in less than two weeks. We will build on this success in 2015. Our websites had a growing audience in 2014, in some cases almost doubling the number of visits compared to 2013.

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

# FINANCIAL STATEMENTS 2014

This overview is derived from KNCV's complete annual report 2014, which includes all financial statements, specifications and a full auditors report and can be downloaded at [www.kncvtbc.org](http://www.kncvtbc.org).

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

Table 1: Financial monitoring data compared to standards



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

## BALANCE SHEET KNCV TUBERCULOSIS FOUNDATION PER 31 DECEMBER 2014

In Euro, after result appropriation

|  |    | 12/31/2014        | 12/31/2013        |
|--|----|-------------------|-------------------|
| <b>Assets</b>                                  |    |                   |                   |
| Immaterial fixed assets                        | B1 | -                 | -                 |
| Fixed Assets                                   | B2 | 240.624           | 370.422           |
| Accounts Receivable                            | B3 | 31.527.842        | 23.674.317        |
| Investments                                    |    |                   |                   |
| -Shares  | B4 | 1.729.494         | 1.755.664         |
| -Bonds   | B4 | 2.965.492         | 3.375.630         |
| -Alternatives                                  | B4 | 922.029           | 573.581           |
| Cash and Banks                                 | B5 | 13.497.523        | 8.786.733         |
| Current Assets                                 |    | 50.642.380        | 38.165.925        |
| <b>Total</b>                                   |    | <b>50.883.004</b> | <b>38.536.347</b> |
| <b>Liabilities</b>                             |    |                   |                   |
|  |    | 12/31/2014        | 12/31/2013        |
| Reserves and funds                             | B6 |                   |                   |
| - Reserves                                     |    |                   |                   |
| Continuity reserve                             |    | 7.180.533         | 6.423.985         |
| Decentralization reserve                       |    | 1.084.791         | 1.149.543         |
| Earmarked project reserves                     |    | 1.497.168         | 1.680.898         |
| Unrealized exchange differences on investments |    | 651.136           | 794.464           |
| Fixed Assets reserve                           |    | 240.624           | 370.422           |
|  |    | 10.654.252        | 10.419.311        |
| - Funds  |    |                   |                   |
| Earmarked by third parties                     |    | 476.515           | 463.281           |
|  |    | 476.515           | 463.281           |
| Various short term liabilities                 | B7 |                   |                   |
| -Taxes and social premiums                     |    | 318.587           | 886.805           |
| -Accounts payable                              |    | 552.270           | 357.921           |
| -Other liabilities and accrued expenses        |    | 38.881.380        | 26.409.028        |
|  |    | 39.752.237        | 27.653.754        |
| <b>Total</b>                                   |    | <b>50.883.004</b> | <b>38.536.347</b> |

**STATEMENT OF INCOME AND EXPENDITURE KNCV TUBERCULOSIS FOUNDATION 2014**

in euro

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

**EXPENSE ALLOCATION KNCV TUBERCULOSIS FOUNDATION 2014**
**Expenses**

|   | Budget 2015       | Budget 2014       | Actual 2014       | Actual 2013       |
|---|-------------------|-------------------|-------------------|-------------------|
| Grants and contributions                  | 28.000            | 28.000            | 21.975            | 42.155            |
| Purchases and acquisitions                | 15.832.600        | 11.776.200        | 12.210.704        | 15.981.346        |
| Outsourced activities                     | 30.000.000        | 32.500.000        | 23.134.198        | 28.492.071        |
| Publicity and communication               | 756.000           | 708.500           | 612.483           | 589.744           |
| Personnel                                 | 8.811.000         | 7.379.800         | 7.756.300         | 7.462.850         |
| Housing                                   | 447.500           | 544.000           | 486.646           | 473.310           |
| Office and general expenses <sup>1)</sup> | 649.200           | 650.300           | 537.194           | 547.087           |
| Depreciation and interest                 | 225.200           | 184.400           | 208.079           | 217.972           |
| <b>Total</b>                              | <b>56.749.500</b> | <b>53.771.200</b> | <b>44.967.580</b> | <b>53.806.536</b> |

1) Including incidental profits and losses

**Allocation to destination**

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

**Allocation to destination**

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

## Independent auditor's report

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

The accompanying summary financial statements, which comprise the summary balance sheet as at 31 December 2014, the summary statement of income and expenditure for the year then ended and related notes, are derived from the audited financial statements of Koninklijke Nederlandse Centrale Vereniging tot Bestrijding der Tuberculose (KNCV) (hereafter: KNCV Tuberculosefondsen) for the year 2014. We expressed an unqualified audit opinion on those financial statements in our report dated 20 May 2015. Those financial statements, and the summary financial statements, do not reflect the effects of events that occurred subsequent to the date of our report on those financial statements.

The summary financial statements do not contain all the disclosures required by the Guideline for annual reporting 650 'Charity organisations' of the Dutch Accounting Standards Board. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of KNCV Tuberculosefondsen.

### Board of directors' responsibility

The board of directors is responsible for the preparation of a summary of the audited financial statements in accordance with the general accounting policies as described in the extended version of the financial statements.

### Auditor's responsibility

Our responsibility is to express an opinion on the summary financial statements and the related explanatory notes based on our procedures, which we conducted in accordance with Dutch law, including the Dutch Standard 810 'Engagements to report on summary financial statements'.

### Opinion

In our opinion, the summary financial statements derived from the audited financial statements of KNCV Tuberculosefondsen for the year 2014 are consistent, in all material respects, with those financial statements.

Rotterdam, 8 July 2015  
PricewaterhouseCoopers Accountants N.V.

Original has been signed by: M. van Ginkel RA

Ref.: e0359935

PricewaterhouseCoopers Accountants N.V., Fascinatio Boulevard 350, 3065 WB Rotterdam, P.O. Box 8800, 3009 AV Rotterdam, The Netherlands  
T: +31 (0) 88 792 00 10, F: +31 (0) 88 792 95 33, [www.pwc.nl](http://www.pwc.nl)

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**KNCV**  
To eliminate TB



TUBERCULOSISFOUNDATION

PO Box 146  
2501 CC The Hague  
The Netherlands  
Phone: +31 (0)704167222

info@kncvtbc.org  
www.kncvtbc.org

 kncvtbc

 kncv-tuberculosis-foundation



VOOR  
GOEDE DOELEN



ANBI