ANNUAL REPORT 2012

KNCV
To eliminate TB

TUBERCULOSISFOUNDATION

KNCV Tuberculosis Foundation would like to thank all partners for their collaboration and support in 2012

In the Netherlands

Academic Medical Centre Amsterdam	GGD Nederland, vereniging voor GGD'en	Our private donors
Aids Foundation East West	's-Gravenhaagse Stichting tot Steun aan de Bestrijding der Tuberculose	Radboud University Nijmegen
Aids Fund	ING Bank	Royal Dutch Airlines – KLM Flying Blue program
Amsterdam Institute for Global Health & Development (AIGHD)	Leids Universitair Medisch Centrum	Royal Tropical Institute
Center for Infectious Disease Control Netherlands/RIVM	De Lotto	Stichting Loterijacties Volksgezondheid
Central Bureau for Fundraising	Madurodam	Stichting Suppletiefonds Sonnevanck
Committee for Practical TB Control Netherlands	Medical Committee Netherlands-Vietnam	Stop Aids Now!
Dr. C. de Langen Stichting voor Mondiale Tbc-bestrijding	Ministry of Health in The Netherlands and other countries	Tuberculosis Vaccine Initiative (TBVI)
Dutch Ministry for Foreign Affairs / Development Aid	Ministry of Justice in The Netherlands and other countries	Vereniging van Artsen werkzaam in de Tbc-bestrijding
Dutch Ministry of Health, Welfare and Sports	Municipal health services in The Netherlands	Verpleegkundigen & Verzorgenden Nederland, Platform Verpleegkundigen Openbare Gezondheidszorg
Dutch TB Laboratory partnership	Nederlandse Vereniging van Artsen voor Longziekten en Tuberculose	VriendenLoterij
Erasmus University Rotterdam	Nederlandse Vereniging voor Medische Microbiologie	Mr. Willem Bakhuys Roozeboomstichting
ETC Crystal		ZonMW
And many others…		

In other countries and globally

ABT/ZdravPlus program, Kazakhstan	Hain Life Sciences, Germany	NWO-WOTRO
Advanced Community Health Care Services Namibia (CoHeNa)	Hasan Sadikin Hospital, Indonesia	Office of the US Global AIDS Coordinator
AERAS, USA	Harvard Medical School, USA	Partners in Health (PiH), USA
American Thoracic Society, USA	HEAD, Cambodia	Persahabatan Hospital, Indonesia
Armauer Hansen Research Institute (AHRI), Ethiopia	Indonesian Association Against Tuberculosis (PPTI)	Population Services International (PSI), USA
Aurum Institute, South Africa	International Centre for Diarrhoeal Disease Research, Bangladesh	Project Hope, Kazakhstan
Cambodian Health Committee	Japan Anti-Tuberculosis Association	RHAC, Cambodia
CENAT, Cambodia	Kazak Tuberculosis Research Institute	Stellenbosch University, South Africa
Centers for Disease Control and Prevention, USA	Kenya Medical Research Institute (KEMRI)	Stop TB Partnership
Cipto Mangunkusumo Hospital, Indonesia	Kenya AIDS NGO's Consortium (KANCO)	TB Alliance, USA
CISM, Mozambique	Kenya Association for the Prevention of Tuberculosis and Lung Diseases	
Diponegoro University, Indonesia	Leprosy Mission International	UNICEF -University Clinical Centre
Eli Lilly MDR-TB Partnership	Leprosy Mission, Nigeria	University of Indonesia
European Centers for Disease Prevention and Control	Makerere University, Uganda	The Union
European and Developing Countries Clinical Trials Partnership	Management Sciences for Health, USA	United Nations Development Program
Family Health International, USA	McGill University, Canada	United States Agency for International Development
Foundation for Innovative New Diagnostics (FIND), Switzerland	National TB Control Programs in the countries	University of Cape Town- SATVI, South Africa
Global AIDS Alliance	National TB Reference Laboratories in the countries	University of Gadjah Mada Indonesia
Global Fund to Fight Aids, Tuberculosis and Malaria	Netherlands-African partnership for capacity development and clinical interventions against poverty-related diseases (NACCAP)	World Health Organization (Headquarters and Regions)
GSK Biomedicals, Belgium		
And many others…		

Table of Contents

1. Introduction 9
2. Director's report 10
3. Board of Trustees report 17
4. TB Epidemiology and global developments 19
5. KNCV Tuberculosis Foundation's strategy and results for 2012 22
6. Social report 45
7. Governance report 48
8. Financial indicators and monitoring data 57
9. Notes to the Financial Statements 61

Financial Statements 2012 67
Independent auditor's report
Annex 1: List of publications 91

List of Abbreviations

ACSM	Advocacy, Communication and Social mobilization
AIDS	Acquired Immune Deficiency Syndrome
AMC	Academic Medical Centre Amsterdam
ATS	American Thoracic Society
CDC	Centers for Disease Control and Prevention (USA)
CIb	Centrum Infectieziektenbestrijding (Center for Infectious Disease Control in the Netherlands)
CPT	Commissie Praktische Tuberculosebestrijding (Committee for TB Control Policy Development)
DGIS	Directorate-General for International Cooperation in The Netherlands
DOTS	Direct Observed Therapy Short-course
ECDC	European Centers for Disease Control and Prevention
FHI	Family Health International
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GGD	Gemeentelijke of Gemeenschappelijke Gezondheidsdienst (Municipal Health Services in the Netherlands)
HIV	Human Immunodeficiency Virus
HRD	Human Resource Development
HRM	Human Resource Management
HSS	Health Systems Strengthening
IPT	Isoniazid Preventive Therapy
JATA	Japan Anti-Tuberculosis Association
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute)
MDG	Millennium Development Goal(s)
MDR	Multidrug-resistant (Tuberculosis)
M&E	Monitoring and Evaluation
MPH	Master in Public Health
MSH	Management Science in Health
NGO	Non Governmental Organization
NTP	National TB Control Program
PEPFAR	U.S. President's Emergency Plan For Aids Relief
PMDT	Programmatic Management of Drug resistant Tuberculosis
PPM/P	Public Private Mix/Partnership
QQ	Qualitate Qua
RIVM	Rijksinstituut voor Volksgezondheid en Milieu
STAG (TB)	Strategic and Technical Advisory Group (for Tuberculosis)
TB	Tuberculosis
TBCTA	Tuberculosis Coalition for Technical Assistance
TB CARE I	Tuberculosis Control project 2010-2014 agreement I, funded by USAID
USAID	United States Agency for International Development
VFI	Vereniging Fondsenwervende Instellingen
VWS	Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health Netherlands)
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant TB

1. Introduction

Who we are

KNCV Tuberculosis Foundation is an international non-profit organization, committed to fighting tuberculosis (TB) worldwide and to strengthening health systems against TB. The organization consists of dedicated professionals – epidemiologists, doctors, nurses, researchers, and trainers. Our central office is in The Hague, Netherlands. In addition, our decentralized network comprises of three regional and 12 country offices. In 2012, KNCV professionals worked in over 30 countries.

Our vision is:

A world free of tuberculosis

Our mission is:

The global elimination of TB through the development and implementation of effective, efficient and sustainable TB control strategies

What we do

KNCV has identified three key program areas to focus on: TB/HIV, MDR-TB and laboratory strengthening. We pride ourselves in providing quality technical assistance to national TB programs, civil society and international organizations. Our growing network of qualified and experienced consultants and researchers provides advice on drug management, strategic planning, monitoring and evaluation, operational research, human resource development, development of tools and guidelines and laboratory strengthening. We also assist countries with the implementation of projects funded by third parties, and help with fundraising, particularly from the Global Fund to fight AIDS, TB and Malaria. As co-founders of the Stop TB Partnership, a worldwide coalition of TB control organizations and as active members of the Tuberculosis Coalition for Technical Assistance (TBCTA), KNCV plays a pivotal and influential role in international policy development and advocacy. Our general approach is depicted in figure 1.

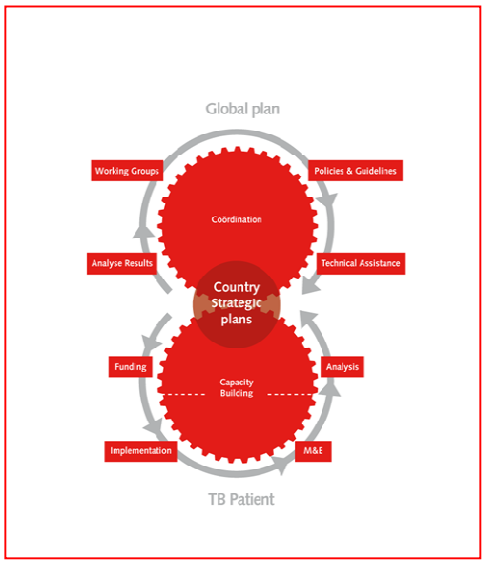

Figure 1: KNCV's role and approach

2. Director's report

Foreword

National TB Programs and the global TB control community face numerous challenges: the worsening situation around drug resistance, an increasingly complex partner environment, the need for multifaceted approaches, changing donor priorities and reduced global funding for TB programming. The world is moving alarmingly slow to address the threat of drug-resistant TB (Multi Drug Resistant TB [MDR-TB] and Extreme Drug Resistant-TB [XDR-TB]), although progress is being made on some fronts. In some countries about 50% of new TB cases are MDR-TB. Programs need to increase their focus on equitable access, on ensuring consistent quality of care by all providers, safeguarding sustainable financing, and securing human resources.

The world is on track to achieve the 2015 Millennium Development Goal (MDG) targets in the reduction in incidence and mortality of TB, except in Africa and Europe, which are not on track to meet the target of 50% reduction of mortality. In the period 1995-2011, 51 million patients were cured from TB, saving 20 million lives.

Treatment of MDR-TB is more complicated, of a longer duration and is more expensive than the treatment of drug-sensitive TB. During 2011, only 19% of the estimated 310,000 patients who developed MDR-TB were diagnosed, which is still too low. Almost 60% of these patients lived in China, India and the Russian Federation.

In order to control the co-epidemic of TB and HIV, it is vital to improve the screening of TB patients for HIV and the other way around. The proportion of TB patients tested for HIV has increased to 40% globally but needs more efforts. We have to consolidate and sustain our achievements and impact but also innovate to reach the unreached and urgently address the Multi-Drug Resistant TB (MDR-TB) crisis.

In this mixed picture of hope and threats we have to make use of the opportunities, such as stepping up TB/HIV collaboration and scaling up of new diagnostics like the Xpert MTB/RIF tests. Despite decreasing budgets, the donor community is still willing to invest in innovative solutions, and that is where our opportunities lie. KNCV Tuberculosis Foundation has chosen Programmatic Management of Drug Resistant TB, TB/HIV and laboratory strengthening including new diagnostics as its priorities, building on our good track record in these areas, especially within the context of our TBCARE I activities. Additionally, and as an overarching approach, we will strengthen health system linkages in all our intervention areas in line with the global Stop TB strategy. Our focus will be on system aspects such as equitable access, sustainable resource allocation and quality TB service provision throughout the health sector. Our collaboration has expanded from national TB control programs towards research institutes and the greater involvement of civil society organizations.

Strategy and Results

The year 2012 was the second year of implementing our Strategy for 2011-2015: *Towards Equitable Access and Sustainable TB Control*. Since the development of this strategy the world of TB control has changed significantly, as described above. The changed funding environment in particular, has impacted on national TB programs and on knowledge and research expert centers like KNCV Tuberculosis Foundation. We have to continuously adjust our activities and processes, without losing focus of our longer term strategic goals and targets. This is not easy, especially in the area of global policy development and strengthening of health systems, mostly for reasons of limited funding.

During 2012, we worked in more than 30 countries, including the Netherlands, operating from a central office in The Hague, three regional offices and twelve country offices. Many of the activities were carried out within the context of the TB CARE I program, funded by the US Agency for International Development (USAID). This is one of the main global mechanisms for implementing USAID's TB strategy as well as contributing to TB/HIV activities under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Being the prime contractor for this program, KNCV Tuberculosis Foundation implements TB CARE I in partnership with six other organizations.
The results per strategic goal are satisfying and at the same time, there are a number of challenges that lay ahead.

- Within our strategic goal of catalyzing evidence-based TB control policies and guideline development, we have contributed to 16 out of 20 international guidelines, policy documents and tools that were produced by our partners WHO and ECDC and within the TB CARE program (80%). The goal of 50% for 2015 has been more than achieved.
  With limited funds available, KNCV intends to reduce its participation in policy fora in the Netherlands and Europe. At the same time we plan to increase our participation in global groups related to MDR-TB, such as global GLC (formerly known as Green Light Committee) and the MDR research group.
  In 2012, 15 out of 21 (71%) guidelines that our staff contributed to in the previous year were being implemented in at least one country and usually in more countries. The goal for 2015 is 75%.
- In relation to our second strategic goal of generating evidence through epidemiological and operational research, we have contributed to 38% of the international TB research agendas of the previous 5 years. The target for 2015 is 75%. KNCV will have to reach this ambitious goal with a decreasing number of epidemiologists.
  Our research staff supervised 15 PhD students, of whom two finished their PhD during 2012. The aim was to supervise at least five finished PhD students in core countries between 2011 and 2015. At the end of 2012, three had finished in total; so this goal is well on track.
  Although the number of epidemiologists has decreased in the last two years, the number of publications remains high, at 40 per year.
- In contributing to equitable access to comprehensive quality TB services, our next goal, we have supported countries to develop strategic approaches for high-risk groups. In 2012, nine out of

17 (53%) of KNCV core countries developed such approaches with the assistance of our consultants. Now that KNCV has exceeded the goal for 2015, we will focus on the implementation and effect of these developed approaches.
We aim to support our core countries to achieve the goal of at least 90% of TB patients knowing their HIV status. In 18% of the core countries, at least 90% of TB patients were tested for HIV (data from 2011). A lot of countries however achieved 80-90%. A remaining challenge is to continue to integrate TB and HIV services, which will also have an effect on the number of HIV patients screened for TB and treated appropriately.

- As stated above, the most challenging strategic goal is strengthening health systems, which enables the delivery of comprehensive TB services. Since 2010, five countries performed a health systems analysis using KNCV methodology. The goal for 2015 is 12 countries. To achieve this, KNCV needs to increase the number of countries that collaborate on undertaking this analysis. We will conduct health system capacity assessment workshops at national and regional levels.
  Although we do not have a direct influence on countries' domestic contribution to TB control, it remains an important indicator during this time of decreased external funding for TB control. We will continue to address the issue of sustainability and try to convince governments to take up the responsibility and guarantee continued support of key activities such as drug supply, laboratory commodities, and supervision.

These four strategic goals cannot be reached without a strong enabling environment and well functioning knowledge exchange mechanisms. In those managerial areas, we have started to implement a regionalization strategy and we have built new supporting web based systems. The strategic plans for all three regional offices and for the central Knowledge, Research and Policy unit are almost ready and major steps have been taken towards building the managerial capacities of regional office staff in fundraising, HRM and financial management. In knowledge management, the introduction of an E-portal environment created new possibilities for group discussions, sharing of view points and facilitating access to a diversity of documents. There are now six thematic working groups, which are the spiders in the web that facilitate knowledge sharing and policy development around a specific technical area. The technical groups for Programmatic Management of Drug Resistant TB, TB/HIV and laboratory strengthening play a pivotal role in creating and maintaining the knowledge base needed to address our priorities for the coming years.

Key figures

In financial terms, we have closed the year with a surplus of €0.6 million, while a deficit of €0.8 million was budgeted. The main reasons for the difference with the budgeted figures is an unrealized profit on investments of €0.3 million, lower expenses for administration and control (€0.5 million) and the fact that reorganization expenses for staff made redundant at the end of 2011 was taken as an expense in 2011, but was budgeted in 2012 (€0.25 million).
The result appropriation is a balance of withdrawals from earmarked (project) reserves and funds, totaling €0.4 million, and contributions to (new) earmarked reserves and the continuity reserve for is a total of €1.0 million.

The total income, consolidated with activities implemented by coalition partners, has reached a level of €49.7 (2011: €39.7). Total expenditures amount to €49.1 (2011: €40.7). The consolidation of partners' activities concerns is €23.8 million, both in income and expenditures. Sources of income and allocation to expense categories for 2012 compared with the actuals for 2011 and the budget for 2013 are shown in figures 2 and 3.

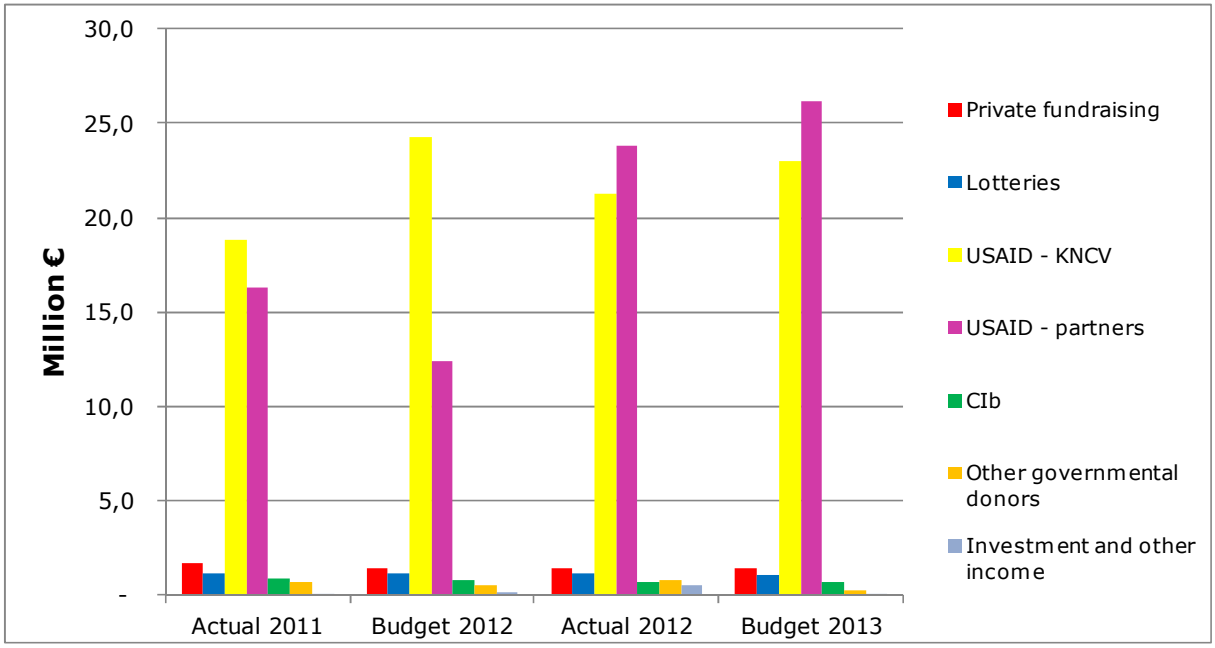

Figure 2: Income sources 2011-2013

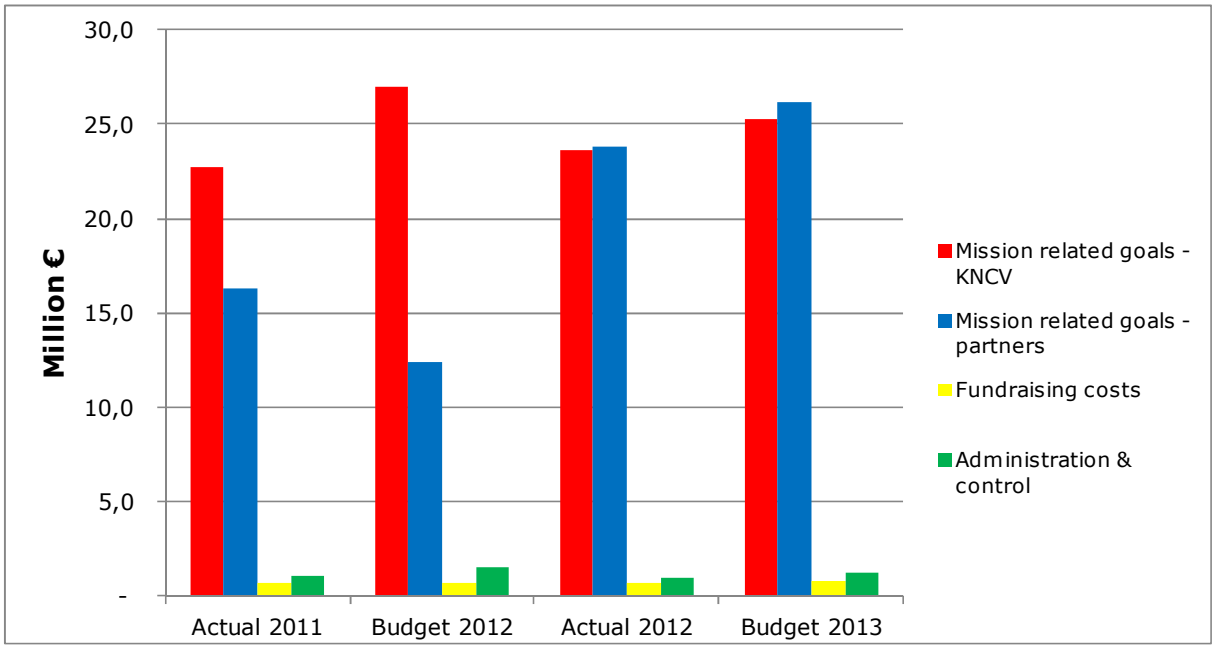

Figure 3: Expenditure categories 2011-2013

The year ahead – some highlights

Despite the numerous positive results achieved in 2012, numerous challenges still lay ahead of us. Based on the lessons learned and the most recent external developments, we have defined our activities and targets for 2013 in a new Annual Plan.

For policy development at the global level, we will focus on participating in policy fora in the priority areas PMDT, TB-HIV/Infection Control and diagnostics/laboratory strengthening. KNCV will chair the ACSM sub-working group and as a core member of the DOTS Expansion Working Group, participate in the Public Private Mix group and seek membership of the Multi Drug Resistance working group and Childhood TB. We will also participate in STAG-TB, the Global Laboratory Initiative, the Poverty working group, TB/HIV and TB Alliance.

Together with the WHO Europe Office and the European Centers for Disease Control, we will organize the Wolfheze Workshop, which will focus on the progress made since the Berlin Declaration of 2007 to prevent and combat multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB) in the European Region.

Through the TBCARE I program, we expect to support 19 countries[1] in 2013, in which KNCV is the lead partner and seven countries in which coalition partners take the lead. Key areas that will receive full attention at country level are: DOTS expansion, TB/HIV, PMDT, IC, laboratory services including the introduction of new techniques such as Xpert® MTB/RIF, X-ray diagnosis, Childhood TB, ACSM, TB/HSS, TB in prisons, PPM, M&E, data quality and Operational Research capacity building.

In research, capacity building of the regional teams will remain a priority, in the areas of epidemiology, surveillance and data management (SDM). We will start with building SDM expertise by training a junior officer who can capacitate the regional team in Africa after a one-year training period in The Hague. Also, in 2013, TBCARE M&E officers will be trained in SDM, and those considered excellent will be selected for further capacity building opportunities.

We will continue to finalize and implement Advocacy, Communication and Social Mobilization (ACSM) strategic approaches, aimed to secure sustainable government support for TB control. We will also continue implementing tools that focus on equitable access, including involving civil society and implementing patient centered approaches. Engaging all health providers, including pharmacists, through Public Private Mix interventions will enhance universal access to TB control. Scaling up PMDT is another aspect of ensuring equitable access to drug resistant TB control.

To increase our achievements in strengthening health systems we will develop exit strategies in combination with securing sustainable financing at country level. We seek to improve the supportive systems by strengthening monitoring and evaluation of National TB programs through

[1] In Africa: Botswana, Ethiopia, Ghana, Kenya, Namibia, Nigeria, Mozambique, South-Sudan, Uganda, Zambia, Zimbabwe.
In Asia: Indonesia, Vietnam, Pakistan.
In Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, Uzbekistan.
In Latin-America: Dominican Republic

more data management training, surveillance checklists, data quality handbooks, and developing a manual on the analysis of TB surveillance data. KNCV will strengthen cross-linkages between different specialties, especially in relation to childhood TB and laboratories.

The budget for 2013 shows a total income of €52.8. Of that amount, €26.2 million is compensation for implemented activities by the coalition partners for TBCARE I. Therefore, excluding consolidation, the total income is budgeted at €26.6 million, which is €0.7 million more than the actual for 2012. Income from government grants is budgeted to increase, related to the plans for activities under TBCARE I in 2013. Income from our share in third parties activities (e.g. lottery income) is budgeted to decrease compared to 2012, as well as our income from investments. The total level of consolidated expenditures amounts to €53.6 million. Once partners' activities are excluded, a total budgeted cost level of €27.4 million is reached, which is €2.1 million higher than the actual for 2012. The financial input to TB control in high prevalence countries is increasing compared to 2012, related to the pace of activities in the third full year of the TBCARE I program. Due to increased competition and decreased funding available for TB control globally, KNCV had limited success in attracting new funding in 2012. In 2013, we plan to continue positioning KNCV strategically in order to secure our financial position up to 2015 and beyond. For this, also our involvement in the development of a new global strategy under the guidance of WHO, will be crucial.
Our Human Resources contracted by the central office, with 81.1 FTE, will stay around the same level for 2013, while we aim for a further shift from the central level to the regional offices. Of the total, 19.9 FTE are located as managerial positions in the regional offices in Kenya and Kazakhstan and in country offices. In these de-central offices, a further 150 staff members will be hired on local contracts.

All in all, 2013 will again be a challenging year. We are confident that we will be able to make further progress in achieving the strategic targets, set for 2015.

The Executive Board,

The Executive Board,

Executive Director
Peter Gondrie

Director of Finance and Organization
Gerdy Schippers

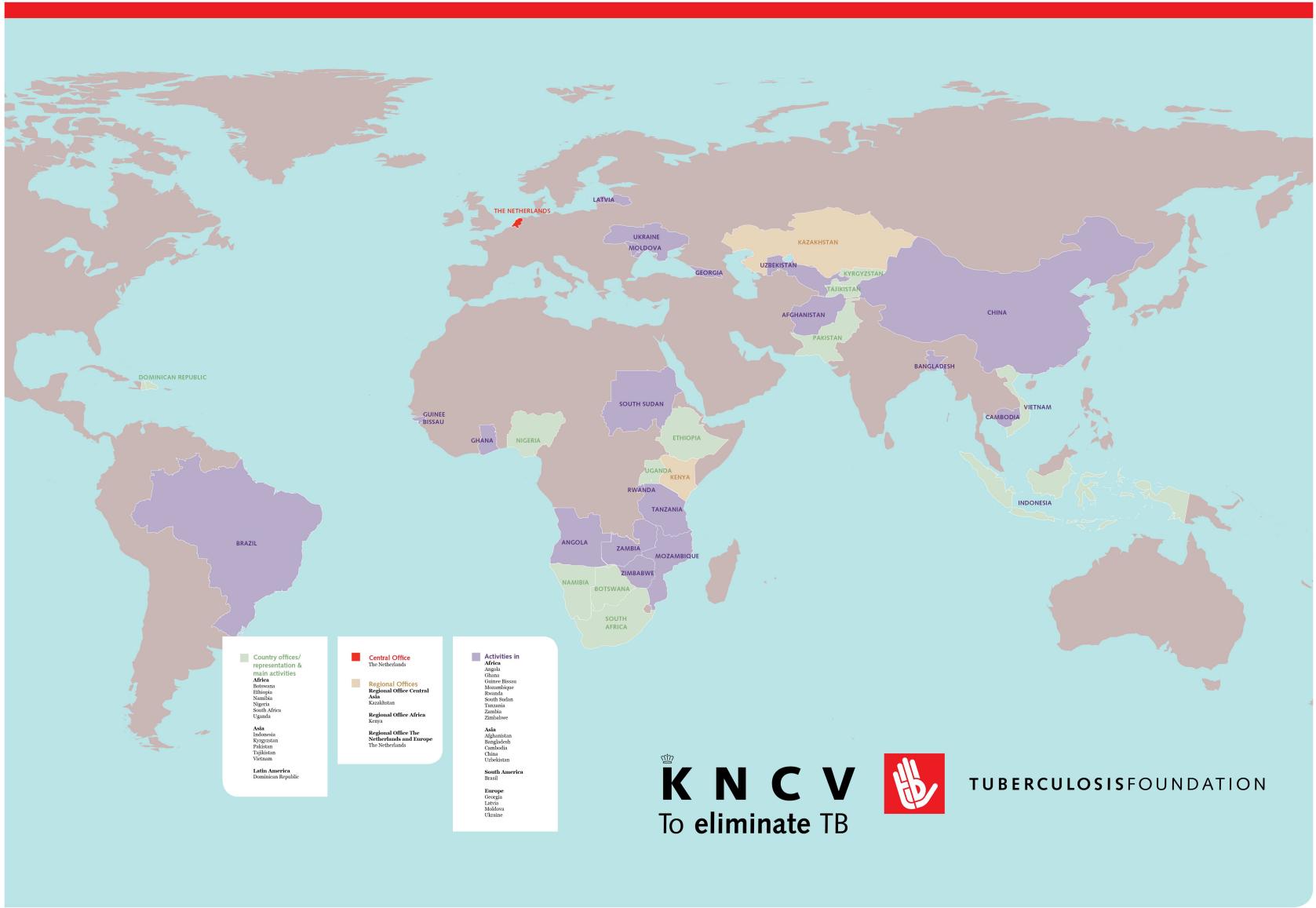

Figure 4: Countries where KNCV Tuberculosis Foundation worked in 2012

3. Board of Trustees report

Supervisory governance in 2012

The KNCV Board of Trustees is made up of seven members, with expertise in public health, research, financial management, international development, organizational development and fundraising. In 2012, there was one change to the Board. Vice Chair Nanno Kleiterp completed his last term, a position taken over by Sjaak de Gouw. Dirk Dotinga was appointed as a new Trustee. Dotinga has a background in internal auditing, risk management and financial management. He will also serve as chair of the Audit Committee.

In 2012, the Board of Trustees held four regular meetings and the Audit Committee met twice to prepare the endorsement of the financial report and budget. One of the plenary meetings took place in the office of the Vriendenloterij, which gave us an opportunity to get more acquainted with the work of this lottery and foster the special relationship it has with KNCV Tuberculosis Foundation. The appraisal and remuneration committee evaluated performances of the Executive Board members and reported their findings to other members. Six Board members attended the annual meeting of the International Advisory Council and one member was present during a Works Council meeting. In view of the planned retirement of Peter Gondrie as Executive Director in 2013, a recruitment and selection committee has been established to identify his successor. In view of current challenges faced by the organization – reduced funding and the dependency on one major institutional donor, decentralization and reorganization - the Executive Board agreed, for the next 3-5 years it is important and necessary to have two Directors. This will enable KNCV to continue refining its position to the external world and further define its role as a highly specialized knowledge and research center, while finalizing the regionalization process and building managerial capacity at the regional and country levels. The recruitment process for a new director will be concluded by May 2013.

Key areas governed

We continued to monitor the organization's progress in achieving its strategic goals and targets - 2011-2015. In particular:

- The implementation of the TBCARE I program funded by USAID including donor satisfaction;
- Measuring the progress of the decentralization process;
- Establishing and strengthening the regional offices, including setting up relevant governance structures;
- Defining the role of the Knowledge, Research and Policy Unit as a specialized center of expertise;
- Monitoring the acquisition strategies for new and diversified financial resources;
- The Executive Board's approach and decisions around suspected fraudulent activities in Kenya;
- Managing the containment of costs and financial competitiveness.

Due to increased competition and decreased funding available for TB control globally, KNCV had limited success in attracting new funding in 2012. As an outlook to 2013, we plan to continue positioning KNCV strategically in order to secure our financial position up to 2015 and beyond. We strongly support the choices made to prioritize KNCV's program in the areas of TB/HIV, MDR-TB and laboratory strengthening and are confident that these will enable the organization to continue providing technical services of excellence.

The Board of Trustees,

Chair
Dina Boonstra

Vice Chair
Sjaak de Gouw

4. TB Epidemiology and global developments

Worldwide, TB continues to be an important public health issue. Although the absolute numbers of TB patients have been declining since 2006, in 2011, according to the latest available data there were approximately 8.7 million persons diagnosed with TB. Of these, 1.1 million (13%) were co-infected with HIV, and 0.5 million were children. Roughly 1.4 million persons died from TB, of which 0.4 million was from HIV-associated TB. Tuberculosis remains one of the top killers of women with 0.5 million deaths in 2011. An estimated 64,000 children died from TB in 2011. Globally, 5.8 million new and recurrent patients with TB were notified. This is equivalent to 66% of the estimated number of patients falling ill with TB. The treatment success rate among newly confirmed patients was 87% at the global level. In the period 1995-2011, 51 million patients were cured from TB, saving 20 million lives.

The world is on track to achieve the 2015 Millennium Development Goal (MDG) targets for the reduction in incidence and mortality. Exceptions are the regions of Africa and Europe, which are not on track to meet the target of 50% reduction of mortality. Table 1 below and Figure 5 on the next page give insight into the most recent epidemiologic data.

Table 1: Estimated Global Burden of TB 1990- 2011 (source: WHO global TB control annual reports)

Indicator	**1990 Rate/100.000**	**2000 Rate/100.000**	**2011 Rate/100.000**	**2011 Cases**
Prevalence[2]	190	225	170	12.0 million
Incidence[3]	126	137	125	8.7 million
Among which HIV+	-	-	-	1.1 million
Prevalence multidrug-resistant TB (MDR-TB)	-	-	-	0.64 million
Deaths	24	27	14	1.42 million
Among which HIV+	-	-	-	0.43 million

MDR TB

MDR-TB continues to be a major concern although progress has been made on some fronts. Treatment of MDR-TB is more complicated, of a longer duration and is more expensive than the treatment of drug-sensitive TB. During 2011, only 19% of the estimated 310,000 patients who developed MDR-TB were diagnosed, which is still too low. Almost 60% of these patients lived in China, India and the Russian Federation. Extensively drug resistant TB (XDR-TB) has now been identified in 84 countries; the average proportion of XDR-TB among all MDR-TB patients is 9%. The target of 75% treatment success was only reached in 30 out of 107 countries recording this

[2] The prevalence of a disease in a population is defined as the total number of cases of the disease in the population at a given time, or the total number of cases in the population, divided by the number of individuals in the population. It is used as an estimate of how common a condition is within a population over a certain period of time (source: Wikipedia).

[3] The incidence rate is the number of new cases per population in a given time period (source: Wikipedia). For tuberculosis, the incidence rate peaked at 143/100.000 population in 2004.

information. Much more work still needs to be done to reach the missing 81% and increase the treatment outcomes. The rollout of the Xpert MTB/RIF rapid molecular test continued and by mid 2012, it was introduced in 67 out of 145 countries eligible to buy the machine and cartridges at concessional prices. This rapid test allows for results to be available within two hours and has the potential to increase the diagnosis of TB and MDR-TB at an earlier stage. The test however is still too complicated to be considered as a point-of-care test, requiring a strong laboratory system with reliable electricity, and quality culture. Drug sensitivity testing is still required for the good management of drug-resistant tuberculosis, although many countries do not have these services.

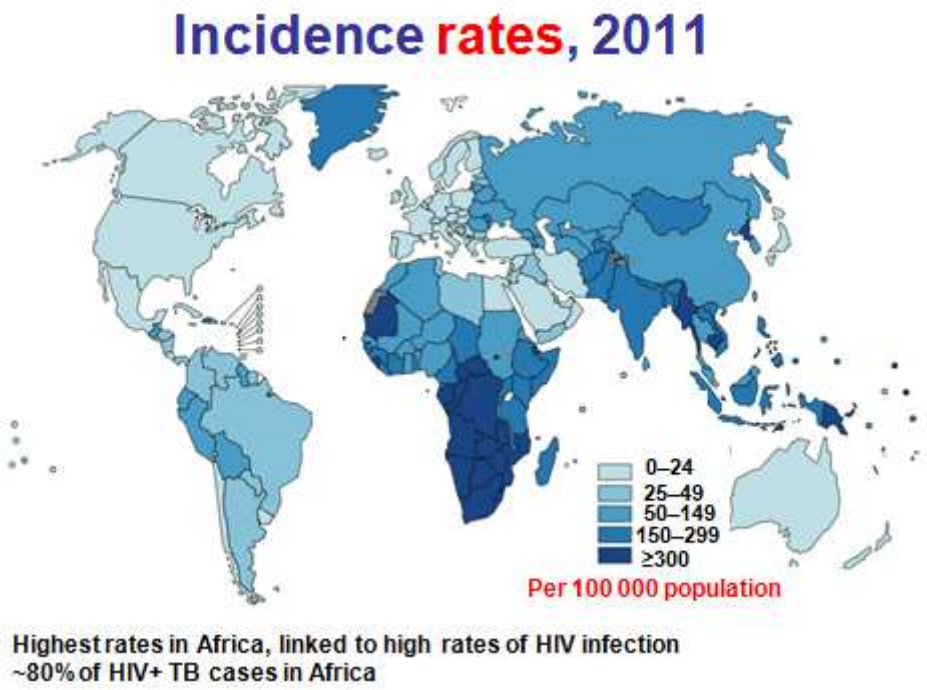

Figure 5: Estimated TB incidence rates 2011, source WHO global TB report, 2012

TB/HIV

In order to control the co-epidemic of TB and HIV, it is vital to improve the screening of TB patients for HIV and the other way around. The proportion of TB patients tested for HIV has increased to 40% globally but needs more efforts. Progress in many African countries was significant: 69% of TB patients knew their HIV status, up from 59% in 2010. There was a large increase in screening for TB among people living with HIV, including the provision of Isoniazid Preventive Therapy (IPT) for those without active TB disease. Globally, 79% of HIV-positive TB patients were receiving Cotrimoxozole Preventative Therapy and 48% were receiving Antiretroviral Therapy (ART) – a small increase from 46% on ART in 2010. Efforts need to be sustained and expanded in order to reach the global targets of every TB patient being tested for HIV and for every co-infected patient to receive CPT and ARV.

National TB control program challenges

National TB Programs face numerous challenges: the worsening situation around drug resistance[4], an increasingly complex partner environment, the need for multifaceted approaches, changing donor priorities and reduced global funding for TB programming. There are also opportunities, such as stepping up TB/HIV collaboration. Those working exclusively on HIV and AIDS acknowledge the dangers of drug-resistant TB, especially for those whose immunity is severely comprised. The prevention of TB for those living with HIV is essential, as is the early start of ART. All these developments demand new approaches, higher levels of technical specialization (e.g. Programmatic Management of Drug-resistant TB [PMDT]) and tailor-made context specific interventions. At the same time, health system limitations and weak linkages between TB programs and broader health systems remain priorities for innovative action. Programs need to increase their focus on equitable access, on ensuring consistent quality of care by all providers, safeguarding sustainable financing, and securing human resources. We will consolidate and sustain our achievements and impact but also innovate to reach the unreached and urgently address the Multi-Drug Resistant TB (MDR-TB) crisis.

KNCV Tuberculosis Foundations' response to the external developments

Midway into the 2011-2015 Strategic Plan, there is increased recognition of the role KNCV needs to play globally in knowledge management and being adept to the changing epidemiological and technological environment. KNCV's primary process remains: *'To facilitate the exchange of knowledge and experience with countries and partner organizations'* by developing TB knowledge and building the capacity for effective and efficient TB control strategies. For the remaining years of the strategic 5-year plan, in terms of technical specialization, we will extend our knowledge sharing and assistance in the areas of PMDT, TB/HIV management, infection control, development of new diagnostics and strengthening laboratory capacities. These priorities represent the major challenges existing in international TB control and reflect the present thinking of the donor community regarding their investments. The choice to intensify our activities in PMDT is clear: the world is moving alarmingly slow to address the threat of drug-resistant TB. In some countries about 50% of new TB cases are MDR-TB. KNCV has, over the past years established a good track record in these areas, especially within the context of our TB CARE activities. Additionally, and as an overarching approach, we need to strengthen health system linkages in all our intervention areas in line with the global Stop TB strategy. Our focus will be on system aspects such as equitable access, sustainable resource allocation and quality TB service provision throughout the health sector. Our collaboration has expanded from national TB control programs towards research institutes and the greater involvement of civil society organizations.

[4] T. Dalton et al, *Prevalence of and risk factors for resistance to second-line drugs in people with multidrug-resistant tuberculosis in eight countries: a prospective cohort study,* The Lancet, August 2012

5. KNCV Tuberculosis Foundation's strategy and results for 2012

In this chapter, we highlight the key results for 2012 in relation to our strategic goals up to 2015. For some of the strategic goals, these are described per priority area (programmatic management of drug resistant TB, TB/HIV and laboratory strengthening). We also give insight in into lessons learned and the plans for 2013. Overall results per strategic goal are shown using the progress indicators. For these we also show our expectations in how far we will reach the targets by 2015 (**green** = on track; **orange** = needs extra input and focus; **red** = probably too ambitious). A large number of the activities described are implemented under the umbrella of the USAID funded TB CARE I program, which is one of the main global mechanisms for implementing USAID's TB strategy as well as contributing to TB/HIV activities under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The overall results of the TB CARE I program, including the results of activities implemented by coalition partners, are reported in separate annual reports, which can be found on www.tbcare1.org.

Strategic goal 2011 - 2015:

Evidence-based policy and guideline development

In 2015, KNCV has catalyzed evidence-based TB control policy and guideline development.

At global level

In 2015 KNCV has proactively contributed to comprehensive evidence-based TB control policies and guidelines.

At country level

In 2015 KNCV in countries has facilitated the adaptation of TB control policy and guidelines to local contexts.

Programmatic Management of Drug-resistant TB – some highlights

Within Africa, we were involved in the development of PMDT strategic plans in Botswana, Ethiopia, Kenya, Mozambique, Namibia Nigeria, Southern Sudan and Zambia. An important contribution made to policy development was the facilitation of a planning workshop with country program managers from nine Eastern Central and Southern Africa Health Community (ECSA) member states. The workshop focused on several new WHO guidelines, including: PMDT, management of drug susceptible TB, Infection control, TB-HIV and Childhood TB.

In Central Asia, KNCV continued to assist countries with building their human resource capacity for TB infection control, both in civilian and prison settings. By supporting the design of locally funded systems that provide patient centered social support in Kazakhstan and Kyrgyzstan, KNCV contributed to the treatment success of MDR TB patients. According to TB CARE I estimates, there are 8,374 MDR TB patients annually in Kazakhstan; of these, 6,464 patients enrolled for treatment in 2012. In 2012, TB CARE I estimated there to be 1,300 MDR patients in Kyrgyzstan, with a shortage of US$ 2.6 million for second line drugs.

In the Netherlands, KNCV organized a workshop for all health professionals involved in MDR TB control. The outcome was the development of concise guidelines on MDR TB Prevention, Diagnosis,

Treatment and Care in the Netherlands. The MDR workshop will be repeated annually; in 2013, the focus will be on developing a MDR TB training program for TB public health doctors and nurses.

TB/HIV activities – some highlights

KNCV Uganda reactivated the National TB/HIV steering committee, and provided guidance to all PEPFAR funded AIDS organizations on the implementation of TB/HIV. KNCV also facilitated the finalization of the national policy and guidelines for Isoniazid Preventive Therapy (IPT), amended the ART treatment guidelines to improve access to ART, revised the TB/HIV training guidelines and policy and facilitated the implementation of the TB Infection Control Strategy. Local AIDS partners involved in TB/HIV collaborative activities were visited and assisted in using the amended guidelines to establish a more uniform approach to TB/HIV.

In Zambia, KNCV and FHI 360 introduced TB Infection Control (TB-IC) policies and practices in a district demonstration project in collaboration with the Ministry of Health. The approach, tools and lessons learned from the district implementation model are now being used to scale-up TB-IC. Screening for TB and HIV among health workers is part of this policy, for which a protocol has been developed that has already been granted ethical approval.

Laboratory strengthening and new diagnostics – some highlights

Making new tools available to rapidly & accurately diagnose TB

KNCV played a leading role in the introduction and expansion of Xpert MTB/RIF diagnostic tests in Ethiopia, Kenya and Nigeria. Progress made at country level was reviewed during a regional Xpert MTB/RIF workshop with the objective of expanding implementation and routine use at country level. An African workshop for early implementers was held in Kenya with 50 participants from Botswana, Djibouti, Ethiopia, Kenya, Mozambique, Zambia and Zimbabwe during which national Xpert MTB/RIF implementation plans were drafted. The Xpert MTB/RIF implementation projects have led to the development of comprehensive training materials, to be reviewed by the Global Laboratory Initiative of WHO and will be further developed into a globally standardized version.

In Kazakhstan, the Xpert MTB/RIF strategy was initiated; KNCV developed guidelines and protocols for its implementation, including an M&E plan to aid developing the final policy. In Indonesia, a strategy for Xpert MTB/RIF introduction is being formulated. Training has been organized and the sites are being equipped to use these machines. In Vietnam, after the diagnosis of MDR TB among MDR risk groups, Xpert MTB/RIF is also being used for the diagnosis of TB in children.

Other results for this strategic goal

KNCV, in collaboration with TBCARE partners also developed the following during 2012:

- Guidelines to Measure the Prevalence of Active TB Disease Among Health Care Workers;
- A Strategic Guide for Building Public Private Mix Partnerships to Support TB Control;
- Refresher (Advanced) Training Course and Workshop on TB-IC for Consultants;

- Acceptability of Household and Community-based TB Screening in high burden countries – a systematic literature review;
- Lessons from Loss – a guide to conducting TB mortality audits using a patient- centered approach;
- Building the Capacity of Civil Society Organizations in TB Control - An Approach;
- A Practical Handbook for National TB Laboratory Strategic Plan Development.

The CPT commemorates 60 years

The Committee for Practical TB (CPT) control is an independent body made up of health professionals involved in the fight against TB in the Netherlands. Started by KNCV in 1953, this body of approximately 20 members consists of regional representatives from the Municipal Public Health Services, clinical specialists, TB-doctors and nurses, consultants and three members from KNCV. Maurits Verhagen, the current Chair has been involved in the CPT since 1994. The CPT provides a platform for sharing information about TB issues between field workers, consultants and policy makers. It's responsible for developing and approving guidelines and endorses policy documents. The international guidelines are the starting point. "In The Netherlands, we fine tune them to our local context, as a low prevalence country."

In 2012, one significant outcome was the CPT's recommendation to adjust the existing law on TB screening for immigrants entering the Netherlands. Based on current evidence, the CPT is advising the national body to abolish mandatory TB screening for immigrants from certain low incidence countries. (The EU, European Economic Area, North America, Australia, Surinam and Japan are currently exempt). "The evidence shows, for example that Turkey has less than 50 cases of new TB in 100,000 inhabitants, making it a low incidence country. It is likely that it may take at least a year before the law is changed." If adopted, the number of immigrants that need screening will reduce significantly.

One of the main challenges of the CPT is the volunteer nature of the Municipal Health Service-members, who represent a region, and play a pivotal role on the committee. They are the lynchpin between CPT and the Public Health field but their position is not officially recognized. *"We need to start a conversation with the Municipal Health Services to institutionalize these positions; make it part and parcel of their responsibility. This would professionalize their role but also enhance their status. "Looking to the next 60 years, this would also guarantee that younger people enter the CPT and stay into the system thereby guarding it from shocks"*, Maurits highlights.

Some lessons learned

1. With limited funding available, KNCV struggles to sustain its position on all international policy discussions. In view of our traditionally strong role in global policy development, international partners are concerned about KNCV's reduced presence and participation in critical international forums. Using our limited funds as effectively as possible, we will focus

on MDR-TB, TB HIV, and provide assistance to the Global Laboratory Initiative and TBTEAM[5]. An area that will demand increased attention in 2013 is our participation in the discussions for the development of the new global strategy 2016-2025.

Progress towards the 2015 targets			
Indicator	**Baseline 2010**	**Result 2012**	**Target 2015**
Number and type of KNCV representation at most relevant national and international policy making bodies	71	56	**50**
Proportion of international partner guidelines/policy documents/tools produced with KNCV contribution	64%	80%	**50%**
Proportion of relevant guidelines and tools distributed in core countries of which implementation has started within one year	Not available	71%	**75%**

With limited funds available, KNCV intends to further reduce participation in groups to focus more on priority areas. This especially concerns the Netherlands and Europe. At the same time KNCV plans to increase participation in global groups related to MDR-TB, such as global GLC (formerly known as Green Light Committee) and the MDR research group. Three working groups were added in 2012 with staff from decentralized offices.

In 2012, KNCV contributed to 16 international guidelines, policy documents and tools out of 20 that were produced by our partners WHO, TBCARE and ECDC (80%). The goal of 50% for 2015 has been more than achieved. KNCV will assess whether participation in guidelines needs to be expanded.

KNCV continued it support to countries with implementing international guidelines. In 2012, 15 out of 21 (71%) guidelines that KNCV staff had contributed to were being implemented in at least one country and usually in more countries. The goal for 2015 is 75%.

Plans for 2013

KNCV will continue to take an active part in global policy fora, develop tools and guidelines for TB control; partly by implementing TBCARE I core projects, including:

- Collect evidence on how to do TB infection control, how to screen health care workers for TB, assess costs of MDR-TB patients;
- Develop guidelines/tools/manuals on the standard implementation and training materials on Xpert MTB/RIF, updating laboratory tools and Standard Operating Procedures, manual for TB laboratory consultants, and guidelines for making the financing of TB services more sustainable;
- Organize international workshops/fora on Xpert MTB/RIF to build capacities for implementation and quality ensured usage and on analyzing TB surveillance data;
- Build the capacity of international consultants on three new TBCARE I laboratory tools.

[5] TBTEAM is a coordinating mechanism for technical assistance in TB control, managed by the secretariat of the STOP TB Partnership.

Strategic goal 2011-2015:
Generating evidence through epidemiological and operational research

In 2015 KNCV has catalyzed production of evidence to improve TB control.

Research agendas

In 2015 KNCV has substantively contributed to the establishment of research agendas at country and global level.

Research capacity

In 2015 KNCV has developed research capacity in KNCV core countries.

Research characteristics

In 2015 KNCV ensures that research with partners is compliant with international quality standards and applied.

Highlights in the results for this goal

In Ethiopia, KNCV obtained funding to lead a 3-year operational research capacity building project in collaboration with The Union. This project is guided by a jointly developed training curriculum that will mentor participants from proposal development, data collection and analysis to final publication of results. This ambitious project should lead to the publication of at least ten articles over the next three years.

We continued to lead on a diversity of research projects that are implementing the Xpert MTB/RIF. Operational research in Brazil, Indonesia, Kazakhstan and Nigeria focuses on gathering evidence for the scale up of Xpert MTB/RIF. In Zimbabwe, the investigation assesses how the test combined with enhanced case-management and early anti-retroviral therapy can improve treatment and clinical outcomes among HIV-infected TB suspects. In China, we are a collaborator on a large project that compares four different diagnostic algorithms, one of which is Xpert MTB/RIF.

KNCV remains a key partner in supporting countries in the preparation, implementation and analysis of national TB prevalence surveys. The fieldwork for the Ethiopia prevalence survey was completed with the support of TB CARE I. The prevalence of smear positive TB among the Ethiopian population was estimated to be 61/100,000 (95% CI: 44-81), which is three times lower than the 2008 indirect estimate (284/100,000). The field work for the Pakistan prevalence survey was completed, and showed the prevalence of bacteriological confirmed TB cases of 295/100,000 population; lower than estimated by WHO but within the 95% confidence interval.

KNCV finalized reporting on four TB incidence studies among children in Kenya and Uganda. These were carried out to build the capacity for undertaking trials of new TB vaccines as well as identifying hotspots for new vaccine trials.

In Kenya, we facilitated the NTP to implement a new Information, Communication and Technology (ICT) system to improve program management within the NTP. The innovative ICT solution (also known as the "Safaricom Project") is a two-pronged approach using real time reporting to enable managers to access data for decision-making at all levels. The first component strengthens recording and reporting with real time data - from the facility level up to the central unit and then feedback to lower levels. The second component aims to improve governance and accountability using M-pesa (a mobile-phone money transfer and micro-financing service) - to make payments for supervision and MDR-TB patient support. The roll-out has just begun; thus far, the approach and potential results look promising.

In the Netherlands, we completed a major evaluation of 6-years immigrant screening (2005-2010). The findings of this evaluation has led the CPT to advise the Ministry of Health to adjust the number of countries that require TB screening after immigration.

From survey to policies and strategies

KNCV has been providing technical support to the Vietnam National TB Control Program (NTP) for more than 20 years and is considered a world leader on TB management with a strong research component. One of the six objectives of the NTP is Research and Surveillance. Hoa Binh, Head of the Planning and Financing group of NTP, has been associated with University of Amsterdam and KNCV as part of his PhD program, *Tuberculosis burden in Vietnam: What have we gained from the first national prevalence survey*. "My promoter at KNCV has helped me every step of the way – from developing the protocol for the survey, collecting and managing a large data set (nearly 100,000 records), doing data entry, data validating, data analysis and writing the report." From the data analysis, Hoa has written six papers on a diversity of topics: *National survey of tuberculosis prevalence in Vietnam; Household expenditure and TB prevalence; Proportion of TB Cases Diagnosed and Treated in the Private Sector; Health seeking behaviors among adults with prolonged coughs*; *Yield of interview screening and chest X-ray abnormalities in a TB prevalence survey; First national tuberculin survey in Vietnam: characteristics and association with tuberculosis prevalence* to fulfill the requirements of the PhD, which he completes in March 2013. Prior to the national survey, in 2006, WHO estimated that Vietnam ranked 12th among the tuberculosis high-burden countries, with a prevalence of smear-positive tuberculosis of 89/100,000 population, a prevalence of TB all cases of 225/100,000 and an estimated case detection rate of 85%. The results of this first national prevalence survey showed a prevalence rate of smear-positive tuberculosis in Vietnam to be 145/100,000. This number is 1.6 times higher than previously estimated, in 2006 (89/100,000). From the results of the survey, WHO has adjusted and revised the estimate of the prevalence of TB cases in Vietnam to be 333/100,000, with a case detection rate 54%. "From the survey, we realized that case finding is most important and that we also need to improve the collaboration with the private sector." Ultimately, the results of the survey have helped to determine the design of programs, in terms of improving its effectiveness.

The evidence is clear. By building the capacity of key personnel over a sustained period, improvement of policies and practices can be realized. In the case of Vietnam, Hoa's PhD has helped to improve the quality of the survey data and consequently informed better policies and strategies thereby contributing to the decrease of TB incidence and burden in Vietnam.

Some lessons learned

2. From the various resistance and prevalence surveys undertaken, a key lesson emerging is the importance of technical capacity, especially laboratory skills for processing a large number of samples. Also, based on experiences in Pakistan, field visits and checks on data quality are crucial for guaranteeing the quality of survey results. If field visits to check this are not possible for whatever reason, the quality cannot be assured.
3. Furthermore, the operational research component of the Xpert MTB/RIF implementation projects were challenged by the fact that not all baseline data was available from routine national recording, leaving some research questions unanswered. Future projects should include more time and resources to collect baseline data prospectively.

Progress towards the 2015 targets

Indicator	Baseline 2010	Result 2012	Target 2015
Proportion of KNCV core countries* with a) TB research agenda and/or b) TB research capacity building plan available, to which KNCV has contributed	29%	41%	**75%**
% of relevant international WHO TB research agendas to which KNCV has contributed in the last 5 years	17%	38%	**75%**
TB research capacity developed to which KNCV contributed through a) Funding or b) Guidance	8 ongoing PhD students	3 finished, 7 ongoing PhD students	**≥5 finished PhD students**
% of KNCV core countries* with at least one completed research project supported by KNCV through mentoring or support in which the local principal investigator contributed significantly to 12 out of 16 predefined steps of the research project.	Not available	45%	**75%**
% of research reports in KNCV core countries* of which the recommendations were taken up within three years	Not available	17%	**50%**

*(N=17)

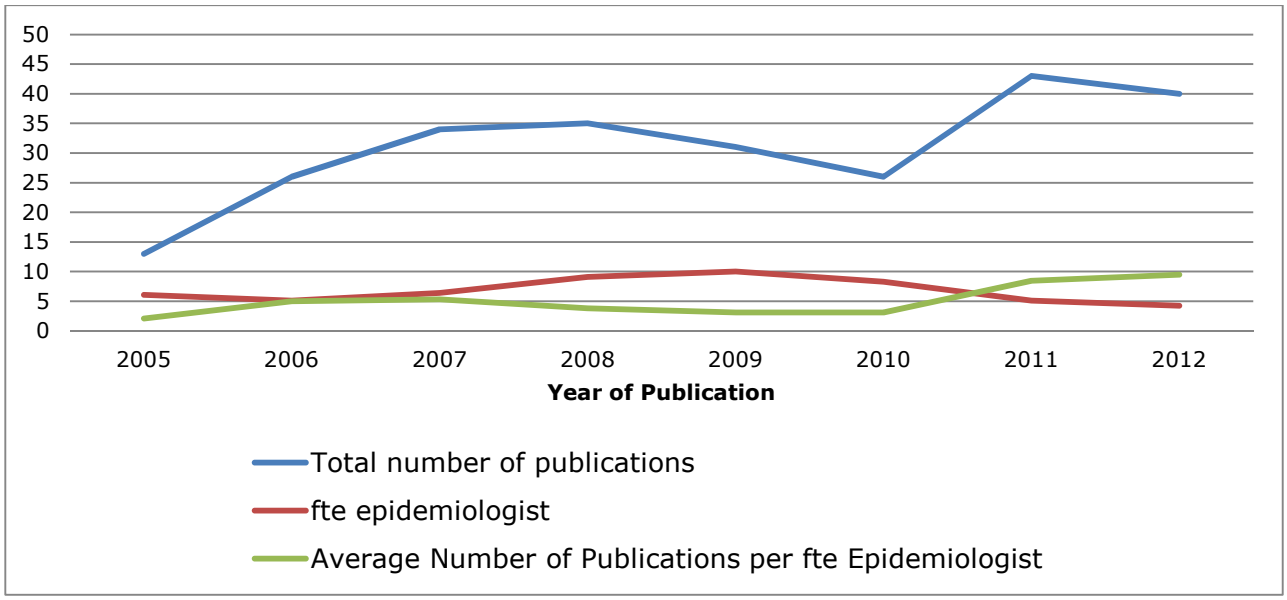

Figure 6: Number of Publications of KNCV Tuberculosis Foundation 2005-2012

The number of countries where KNCV contributed to research agenda and/or research capacity building plan has increased, but remains slow. KNCV will strengthen efforts to work with countries to encourage them to develop a research agenda, and assist them with find funding for these activities. KNCV acknowledges that the attention to operations research depends on competing priorities and will focus on developing research capacity to publish quality publications in those countries that have resources for it.

KNCV contributed to 38% of all international TB research agendas over the previous five years. The target for 2015 is 75%. KNCV will have to reach this ambitious goal with a decreasing number of epidemiologists.

In 2012, KNCV staff supervised 15 PhD students in all countries (core and non-core), of whom two finished their PhDs during that year. KNCV aims to supervise at least five finished PhD students in core countries between 2011 and 2015. At the end of 2012, three had finished in total; so this goal is well on track. This is also shown by the next indicator on contribution to research steps.

Plans for 2013

In 2013, KNCV will continue monitoring the implementation of research including contributing to the development of new global research agendas. We seek to form new partnerships and strengthen our collaboration with international universities and research institutes, especially in connection with PhD students. Furthermore, we will continue to assist countries with setting their research agendas and will run at least four operational research courses. Our work of supporting nationwide prevalence surveys and drug resistance surveys will continue, particularly in Zambia and Zimbabwe. We seek to improve supportive systems by strengthening monitoring and evaluation of National TB programs through more data management training, surveillance checklists, data quality handbooks, and developing a manual on the analysis of TB surveillance data.

Strategic goal 2011-2015:
Equitable access to TB services

In 2015 KNCV has contributed to equitable access to comprehensive quality TB services.

Demand side

In 2015 KNCV in countries has contributed to increase demand for quality TB services by general- and by high-risk populations, including the poor.

Supply side

In 2015 KNCV in countries has contributed to provide quality TB services that are sufficiently accessible to the general- and high-risk populations.

Programmatic Management of Drug-resistant TB – some highlights

In East Asia, with KCNV support, Vietnam made important steps in the scale-up of PMDT through the controlled decentralization of MDR diagnosis and treatment in nine treatment centers and 26 satellite provinces.

In Central Asia, KNCV contributed to the scale-up of PMDT by promoting and piloting shorter hospitalization, up to date TB infection control and developing home based care with adequate patient support. In Kyrgyzstan, a joint plan for TB control in prisons was developed by the technical working groups, under the leadership of KNCV/TB CARE. The aim is to improve the collaboration between general and TB prison services and in 2013, an outpatient model of care will be piloted in the city of Bishkek. Tajikistan is expanding its MDR TB program nationwide and the MoH and NTP welcome initiatives that support this expansion. Two districts in the Khatlon oblast were recommended for piloting the MDR TB program. Following visits to both districts, training on MDR TB management was conducted for TB and PHC managers and nurses, TB clinicians and family doctors.

TB/HIV activities – some highlights

The Namibia office obtained additional funding to implement a three-year PEPFAR funded project to strengthen the "3i's" (Intensified case finding, Infection control and Isoniazid preventive treatment) within the TB/HIV services.

In the Ukraine, we were subcontracted by AFEW to provide technical assistance on integrated TB/HIV care for vulnerable groups, in particular young drug users at two sites. The main findings of the assessment showed the need and importance of integrating TB diagnostics, care and treatment into all HIV services. For this to happen adequately, KNCV will be involved in strengthening the technical capacities of local NGOs, regional TB service providers and other non-medical service providers.

Other results for this strategic goal

- In 2012, KNCV made progress in engaging civil society through the project, *Building the Capacity of Civil Society Organizations in TB Control*. This seeks to build the capacity of civil society organizations (CSOs) in Nigeria (4), Indonesia (4) and Ethiopia (3), whereby CSOs are trained to refer TB suspects to health facilities, capacitate their own staff and engage other CSOs into the TB network.
- 12 facilities in Ethiopia and Nigeria are in the process of measuring patient cost at the facility level using a *Tool to Estimate Patients' Cost*, developed by KNCV consultants [Mauch 2011 & 2013[6]]. In Ethiopia, TB patients spent on average 26% of their median individual annual income ($272.20) on direct and indirect costs related to their care. Also, after having TB, the median individual monthly income decreased by 33.3% and that of the total household income decreased by 72%.
- In the Netherlands, KNCV co-organized World Stop TB Day together with the Municipal Public Health Service of Rotterdam on the theme of Urban TB Control. The Director of the European Center for Disease Control (ECDC) addressed his speech to about 100 participants. In 2013, we plan to collaborate with other EU countries on a project that assures continuity of treatment for patients who voluntarily or involuntarily leave the Netherlands to another EU state.

[6] Source: Mauch V et al, BMC Public Health 211 and Int J Tuberc Lung Dis 2013

A patient and community-centered approach yields positive results in the Dominican Republic

Since the end of 2009, KNCV has been providing technical support to the Dominican Republic. "In collaboration with the National TB program, we started many innovative, bottom-up and patient centered interventions", says Netty Kamp, a KNCV Consultant/Advisor. 2012 was the last year of this project and a time when most of the planned activities have come to fruition.

The focus of the project was to fully implement the stop TB strategy with all its components. This has involved training and skilling front-line staff including health workers to 'think out of the box' when it comes to quality TB services. The project covered the most affected 12 provinces and the city of Santo Domingo. It emphasized the importance of working directly with most affected communities, involving them to find their own solutions and empowering them to take action through the formation of the Stop TB Committees. Local stakeholders from civil society, local authorities, schools and health workers elaborated their plans and currently 71 committees are active, including one composed of inmates in a prison.

Another approach was using the creative arts to involve TB patients to raise awareness. The idea of **Photo Voices**, was adapted to suit the needs and setting of the Dominican Republic. Working with a group of 12 patients and two TB health workers over a period of six sessions, the 'coach' got them to share their feelings and emotions about the disease and while on treatment and also taught them how to use the camera. "In the beginning, they were reluctant but then the talking really helped to break the silence and stigma surrounding the disease". At the end, the photos were part of a travelling exhibition – to hospitals, prisons, municipalities, receiving a lot of media and high-level political attention. In addition, based on these testimonies video clips were made that will be shown in the media and waiting rooms of health facilities. "*It has been used to raise awareness of the 'sleeping killer' disease and as an advocacy tool, it has helped to take away the existing stigma and fear around the disease",* says Netty.

Some lessons learned

4. The implementation of Xpert MTB/RIF test machines often takes more time than expected. In Indonesia, we planned to install 17 machines. Initial implementation was delayed due to the revised approach by the USAID mission, which requires the availability of a well-functioning operational PMDT program prior to Xpert MTB/RIF installation. Once five sites started operations in March/April 2012, further rollout of 12 machines was delayed due to insufficient Xpert MTB/RIF tests and hand-over to a new KNCV GeneXpert focal person. Fortunately, at the end of 2012, four additional machines became operational. The rest will follow.

Progress towards the 2015 targets			
Indicator	**Baseline 2010**	**Result 2012**	**Target 2015**
Proportion of KNCV core countries* with specific high risk group strategic approaches developed, with assistance from KNCV consultants	0%	53%	**25%**
Proportion of KNCV core countries* with an operational ACSM plan as part of the national TB strategic and operational plans	Not available	18%	**25%**
Number of ACSM initiatives KNCV collaborates on to raise demand for services in all countries supported	Not available	8	**20**
Proportion of KNCV core countries* that have reached the WHO norm of one smear diagnostic centre per 100,000 population	59%	17%	**75%**
Proportion of KNCV core countries* in which at least 90% of TB patients were tested for HIV	13%	18%	**50%**

*(N=17)

KNCV supports core countries to develop strategic approaches for high-risk groups. In 2012, nine out of 17 (53%) of KNCV core countries developed such approaches with assistance from KNCV consultants. Now that KNCV has exceeded the goal for 2015, we will focus on the implementation and effect of the developed approaches.

KNCV collaborated on six initiatives in advocacy, communication and social mobilization to raise the demand for TB services by civil society. In 2011, there were 12 such initiatives counted, some of them were canceled with the departure of the responsible staff member. To reach the target of 20 supported initiatives in 2015, KNCV needs to ensure trained staff is available for such projects.

In 2012, 76% of KNCV core countries had reached the WHO norm of one diagnostic centre per 100,000 population compared to 59% in 2010.

KNCV aims to support core countries to achieve the goal of at least 90% of TB patients knowing their HIV status. In 18% of the core countries, at least 90% of TB patients were tested for HIV (data from 2011). A lot of countries however have achieved between 80-90%. A remaining challenge is to continue to integrate TB and HIV services, which will also have an effect on the number of HIV patients screened for TB and treated appropriately.

Plans for 2013

We plan to develop guidelines for engaging and implementing PMDT in the private sector. Technical officers will support the development and dissemination of the existing patient centered tool kit. Countries will be supported to scale-up patient centered approaches and other strategies for improving universal access. Through the intensified case finding mechanisms, community-based services and other approaches will be supported to increase case detection and TB care with extra focus on vulnerable groups such as miners, women, children and prisoners.

KNCV staff will also assist in the development of a TB advocacy plan at national level, design "quick-chats" to identify TB suspects using visuals and photo-voices. ACSM capacity in the regional

offices will be developed and expanded, including M&E systems that show the impact of the ACSM interventions.

Strategic goal 2011-2015:
Enable comprehensive service provision

In 2015 KNCV has contributed to the strengthening of systems that enable comprehensive TB service delivery.

Supportive Systems

In 2015 KNCV has contributed to the strengthening of the health systems that support TB service delivery, in compliance with the Stop TB strategy.

Integration

In 2015 KNCV has built capacity for appropriate integration of national Stop TB strategies into the general health systems, without compromising on the quality of TB care.

Sustainable financing

In 2015 KNCV has contributed to ensuring sustainable financing mechanisms at country level.

Highlights in the results for this goal

In East Africa, KNCV with the support of TBCARE I continued to provide technical guidance to the Regional Center of Excellence (CoE) in Kigali, Rwanda. In 2012, the CoE organized trainings on PMDT, Infection Control and laboratory strengthening. Over time, more and more participants are being sponsored by their own Ministries of Health to attend, thereby reducing its dependency on external donor funding. The center is set to become fully self reliant by 2015.

In Indonesia, we provided extensive technical assistance with supervision, mentoring and on-the-job training to improve the public accessibility of quality TB services. During the past year, the number of hospitals implementing DOTS increased from 325 to 397. However, the provision of good/moderate quality DOTS was observed only in 189 hospitals.

A tool to identify health system barriers that hinders the provision of quality TB services was developed and applied in Turkmenistan and Ethiopia. In both countries action plans were made that aim to address identified obstacles. With regard to sustainable financing, we have started developing a methodology to assess the sustainability of financing of TB services in five African countries.

KNCV was successful in improving on reported TB treatment outcomes and patients' attitudes towards TB care by tracking missing patients using mobile phone technologies. An extensive assessment of health facilities in Kampala, Uganda revealed that 27% of patients' treatment outcomes were unknown. Besides intensified supervision, an important intervention to address this problem was the provision of pre-paid phone credit and patient diaries. This enabled the TB Unit focal persons in 23 TB clinics to call patients that had missed their appointments. In a period of three months, a total of 309 patients with unclear treatment outcomes had been contacted; and of these, 204 had completed their TB treatment at other health facilities, 59 patients were confirmed

dead, 24 were verified as defaulters and seven had treatment failures or were diagnosed with MDR-TB. Reports on treatment success in some clinics improved by more than 25%.

The importance of infection control

Since 2009, more than 1,000 health professionals have been trained in TB-IC. In 2012, of those trained, 34 health care workers from 13 facilities in the region, Addis Ababa City Administration Health Bureau were supported through mentorship visits scheduled three months after the training. The follow-up visits found that nine of the thirteen health facilities (70%) had established a coordination body to address both, infection prevention in general and, specifically Infection Control and TB-IC. Infection prevention and control coordinating bodies had already existed in four other facilities and their functioning was strengthened to implement infection prevention interventions in the context of TB control. In addition to changing certain managerial and administrative procedures, some of the health facilities mobilized their own resources to implement both major and minor renovations. Akaki Health Center is one of such facility. Following the TB IC training, Akaki Health Center undertook renovations based on the training staff received, Ato Desalegn Merja, head of Akaki Health Center, said: *"We have taken lessons on what to improve and how to intervene in our facilities by visiting Geda Health Center during the training. We were able to renovate the general outpatient department waiting area, walkway, card rooms, triage rooms, and the TB room by allocating a budget from our own resources. We believe that the renovated [areas] will be attractive and safer places for staff and clients, which will undoubtedly bring a decline in TB transmission in health facilities."*

During 2012, KNCV handed over, as planned, the Netherlands Tuberculosis Register (NTR) to the RIVM. This process was guided by a working group with members from the Municipal Health Services, CPT, KNCV and RIVM and occurred without any major hiccups. All Health Services signed new agreements with RIVM (for NTR) and with KNCV (for other activities).

Some lessons learned

6. For many TB specialists, the mindset of using a wider health system strengthening approach is a challenge. A simplified quick assessment on HSS in a workshop set-up was found to be appropriate; this can be used for an action plan for a number of obvious health system barriers. For a more systematic assessment of the health system barriers, a more detailed assessment is needed. Integrating TB and HIV services also remains a challenge and countries will receive extra attention in that regard.

Progress towards the 2015 targets

Indicator	Baseline 2010	Result 2012	Target 2015
Number of countries that performed an Health Systems Strengthening analysis in conformity to KNCV developed methodology	1 country	5 countries	**12 countries**
Number of countries that identified specific health systems obstacles and have addressed these through the implementation of targeted interventions	0 countries	1 country	**12 countries**
Number of countries with a national health plan that prominently reflects the national TB strategy, to which KNCV contributed.	0 countries	6 countries	**12 countries**
Number of countries where staff has been trained in the KNCV TB health systems strengthening approach.	0 countries	5 countries	**12 countries**
Proportion of KNCV core countries* with increasing domestic per capita contribution to TB control	Increasing as of 2011	41%	**75%**

*(N=17)

Since 2010, five countries have performed a health systems analysis according to KNCV's methodology. The goal for 2015 is a total of 12 countries. To achieve this, KNCV needs to increase the number of countries that collaborate on undertaking this analysis. We will continue conducting health system capacity assessment workshops at national and regional levels.

In six of 17 core countries TB control is prominently included in the overall health system strategy with support of KNCV; while the target 2015 is 12. KNCV will work on a strategy to embed TB into more national health plans.

KNCV encourages core countries to increase their domestic contribution to TB control. In 2012, seven out of 17 countries raised their financial contributions for TB control, the same number as in 2011. However, the data available remains unreliable with seven countries failing to report their financial contribution to WHO in both years, making it difficult to make a comparison.Three countries did not raise their contributions.

Although we do not have a direct influence on countries' domestic contribution to TB control, it remains an important indicator in this time of decreased external funding for TB control. KCNV will continue to address the issue of sustainability and try to convince governments to take up greater responsibility and guarantee continued support of key activities such as drug supply, laboratory commodities, and supervision.

Plans for 2013

In Namibia, KNCV will support the implementation of a 3I's project, scaling up TB interventions for people living with HIV. This means that all persons in HIV care are routinely screened for TB and have access to Isoniazide Preventive; all TB patients have access to early ART; and TB-Infection Control and Health Care Worker TB surveillance is fully integrated in all work practices.
KNCV will support the continued implementation of the TB HSS assessment scan, for example, in Ethiopia. The focus will be on embedding TB services into the general health system. Countries will be guided to develop more sustainable TB services by 2015. This will help them to withstand the impact of reduced international funding for core components such as drug and laboratory supplies, human resources, monitoring and evaluation etc. We will assess the sustainability of financing TB services in five African countries using KNCV-designed workshops with staff from the national TB control programs, Ministries of Health, Finance and other relevant government agencies.
Although within HSS, the focus is on sustainable financing, we will also continue supporting the development and implementation of the wider Health System Strengthening strategy, including: i) Increased political commitment ii) Human Resources for Health iii) Information & Surveillance systems, iv) Integrated Infection Control and v) Engaging all providers.

Strategic goal 2011-2015: Organizational learning, knowledge management and supporting culture

In 2015, KNCV will have a well-established organizational learning and knowledge management culture and supporting processes on all organizational levels, underpinning our primary processes of policy development and capacity building and resulting in overall operational excellence.

Highlights in the results for this goal

In 2012 we launched the E-portal: a social intranet for internal and external collaboration and knowledge sharing. All staff members are able to access the E-portal from all over the world. In addition, more than 500 external partners have an E-portal account and participate in one or more of the 60 existing groups. The first E-learning course, on TB data management is ready and provides an excellent opportunity for distance learning. The E-portal has boosted information sharing, learning within KNCV Tuberculosis Foundation globally and strengthens our "identity" as a center of knowledge and expertise.
We organized a diversity of internal learning events, for sharing experiences, learning and building staff capacity. We hosted lunch presentations, research fora and journal clubs. With the exception of the International Meeting Week, all events were open to external partners. We hosted 19 lunch presentations, attended by 306 participants. These continued to provide an excellent opportunity for sharing and discussing new developments in TB control, policies, guidelines, tools as well as the actual experiences of implementation.
The International Meeting Week, held in January and June is an excellent forum where consultants and directors from all over the world, meet to discuss, share information and take practical and strategic decisions. The Meeting Weeks are critical during the process of decentralization, as it

creates a common organizational and technical understanding and facilitates learning and builds a stronger and a more unified KNCV team.

KNCV has the following thematic groups on the main TB specializations: Programmatic Management of Drug resistant TB, laboratory strengthening and new diagnostics, TB/HIV and infection control, Childhood TB, Advocacy, Communication and Social Mobilization, and Health Systems Strengthening. Most members are from KNCV- from the central, regional and country offices- as well as from other external organizations. These groups lead knowledge sharing in their field.

Sustaining the fight against Childhood TB

Omer Ahmed Omer hails from Ethiopia and is the KNCV Country Manager in Namibia. "*Our core business is providing technical assistance and capacity building of our clients. To perform this professionally and adequately, we must keep ourselves updated of all latest developments.*" This is the singular message Omer, as Chair of the KNCV Childhood TB Technical Working Group (TWG) preaches to his fellow members. The Group has 12 members from the central, regional and country offices, and part of its mandate is to highlight the importance of working on childhood TB, especially in a high HIV prevalence settings such as in this sparsely populated southern African nation. Childhood TB was one of the areas neglected for many years by the NTP but because of the HIV epidemic, it is now gaining the attention it warrants. "*We need to continuously advocate government to increase its investment in this critical area*", Omer explains.

In 2012, the Group had some notable achievements. It provided inputs to the 2013 KNCV Annual Plan, by stating the services and products of the TWG as well as providing inputs to the four strategic goals of the organization. During the international Meeting Week, the online and offline sessions on Childhood TB were well attended. The Group also provided inputs for the TB CARE I and II USAID joint review meeting in Washington in March 2013 and developed operational research concepts on Childhood TB. Childhood TB was also included in the mid-term review of the second-term Strategic Plan of the National TB and Leprosy Program in Namibia. Omer took on the role of Chair in September 2012 and Childhood TB is the first TWG to have its Chair based outside the central office. His challenges to date relate mainly to infrastructure, in particular, the quality and speed of connections impinging the use of audio and video. The other is the issue of staff time; technical experts are very busy with heavy workloads and demanding travel schedules. This perennial challenge, at times, compromises their involvement and contributions to the TWG.

Funding for TB in Namibia looks increasingly insecure, which is also impacting on KNCV as an entity within Namibia. During this period of transition, balancing between closure of projects and keeping abreast of all technical developments can be very tricky. Omer is confident of the role and competitive edge of KNCV and strongly advocates: "*donors and governments to continue investing in fighting TB-HIV, and Childhood TB, especially in the African context.*"

Some lessons learned

7. It took some time for all staff to embrace the E-portal, as it requires changes in working habits, mind-set and skills. E-portal participation of field office staff is still limited due to insufficient staff training and lack of clarity about E-portal tasks and responsibilities in the regional and country offices. Thematic group chairs are slowly learning, almost on a trial and error basis, how to use the E-portal to benefit the productivity of a group.
8. Participation from a distance in KNCV's learning events is challenging due to insufficient quality of audio equipment and staff skills to use the equipment. Chairs of thematic groups need training to how to maximize these technologies to ensure greater participation and more active involvement of participants.

Plans for 2013

We plan to continue providing basic and advanced E-portal training. Every KNCV Office will have a designated person for the E-portal to coordinate and promote its utilization. Coordinators of E-portal Groups will be supported to facilitate communities of practice. The KNCV library will be accessible on the E-portal for internal and external users and a document management system will be installed. New E-learning courses will be developed and launched, for example on Quality Consultancy and on PMDT. We plan to increase our investment in audio equipment that will enable our consultants to facilitate and increase participation in distance meetings and learning events. Regional and country offices will organize learning events in their countries. The induction program for all new KNCV consultants will include the Quality Consultancy E-learning course, undertaking combined missions with experienced colleagues and mentoring.

Strategic goal 2011-2015:
Structure and enabling environment

In 2015 KNCV's organizational structure and enabling environment is optimally supporting the primary process and promoting the envisaged culture for learning and knowledge sharing.

The regionalization process - Highlights in the results

In 2012, we developed a new strategy for the Knowledge, Research and Policy unit. KNCV's thematic groups on TB sub-specializations, with members from regional and country offices were involved in the annual planning cycle, thereby providing valuable inputs from the 'de-central' level of the organization.

Since the appointment of the Africa Regional Executive Director, based in Nairobi, the decentralization process for that region has been considerably accelerated. A strategic plan for the region is currently being developed and will serve as a lead guide to the process. At the same time, other institutional processes have been put into motion. Much progress has been made with the decentralization of technical staff. In 2013, 14 out of 17 senior technical staff working in the unit Africa will be stationed in Nairobi or in one of the other Africa country offices.

During 2012, the Director in Central Asia was heavily involved in acquiring and implementing two new projects in the region and developing the internal regional structure. The project in the Ukraine, financed by AFEW, focuses on the introduction of TB components in a HIV/AIDS program.

Childhood TB - the experience and perception of the patient and family's experience of treatment methods were documented as case studies, which will serve to provide inputs for a new model. The process of defining a regional strategy for Central Asia and an acquisition plan has started and will be concluded in 2013.

Also in 2012, the regional offices in Almaty and Nairobi were visited by fundraising staff to evaluate the capacities and develop a fundraising plan for the coming years. Missions, external trainings and on the job trainings have been scheduled for 2013. The target is that by 2016, all regional offices should be fully responsible and equipped to do their own fundraising.

I am a manager, not a doctor!

As part of KNCV's decentralization and regionalization plans, establishing a base on the African continent was always a high priority. Anne Ikiara was appointed the Regional Director for Africa in August 2012. Based in Nairobi, Kenya she's been hired to set up the necessary systems and structures needed, giving life to an idea first mooted back in 2009/10.

"*I like building organizations from scratch and having done this successfully in my previous job, I was attracted by the challenge KNCV is offering*."

Previously, everything was done out of the office in The Hague – administration, management, fundraising, monitoring etc. Now, this fledgling office is busy building itself with ongoing support, training and mentoring from colleagues in the Central Office. One of Anne's key achievements since coming on board has been drafting KNCV's African regional strategic plan. An additional three consultants have been recruited to serve the countries and by 2015, all management and technical functions will be fully decentralized. Reflecting on her own learning over the past six months or so, one of her key observations has been about how KNCV operates: "*Structurally, its a very flat organization that respects its employees and encourages openness and different opinions. Organizations in Africa tend to be more hierarchical and top-down*", she says. She's been struck by the casual and informal nature of interactions between management and other staff in the Central Office, often taking place over lunch or a cup of coffee. Not having a background in TB or in the medical field hasn't fazed this energetic and charismatic Kenyan woman. *"I cannot be a TB expert but I do need to have the necessary knowledge*" and to help her 'get to grips' with the TB world, a tailor made management development and capacity building trajectory has been formulated. She's been exposed to a diversity of international events, giving her valuable insights into the content and context of TB. "*I have learned that to realize our goal of becoming a global knowledge center for TB control, it is imperative to put research and knowledge management at the heart of our work*".

Looking ahead to 2013, formalizing KNCV as a locally registered international organization in Kenya is a priority. A complicated and lengthy process, Anne is busy harmonizing all the paperwork and the different legal realities between the two countries. Local fundraising is also of high importance. There are many opportunities and one of the first tasks is to do a scan of all donors – international, local, public and private sector actors involved and interested in funding work on TB control.

Fundraising and acquisition - Highlights in the results

The **private donor fundraising** strategy is based on a so-called 'giving pyramid'. The pyramid starts with creating a base, comprising of a large group of individual sponsors that donate a small amount of money to KNCV. This group forms the starting point of an upgrading strategy, which, moves up to into a structural gift of a larger annual amount. The final step of the 'giving pyramid' is when a private sponsor includes KNCV Tuberculosis Foundation in his or her endowment.

To strengthen and increase our donor database, we make use of mailings. The two important indicators are the response percentage and the average amount donated to KNCV. The indicator results for 2012 are listed in table 2. All total figures are shown in the financial statements.

Table 2: Indicators for private fundraising 2012

Indicator	Planned	Result
Number of addresses in prospect mailing	250,000	244,973
New donors	5,000	4,325
Response % new donors	2%	1.77%
Average donation made	€10.50	€11.11

In general, the number of new donors was slightly lower than expected. This is partly due to fewer prospective donors received a mailing and because some of the database selections used did not score as well as expected. The stiff competition from other charities might be a reason for this. More than ever before, people are receiving multiple prospect mailings from organizations seeking donations. The average amount donated is higher than expected. In other words, if people decide to donate, they are likely to give a higher amount. The total number of private givers that donated to KNCV in 2012 was 30,024, which is similar to 2011. We had expected a net increase of at least 3,000 more donations. It is imperative to invest at the 'bottom of the pyramid' in order to establish a stable private donor base for KNCV in the (near) future.

At the top of our donor-pyramid are the people who include KNCV in their endowment. A survey undertaken in 2012 showed that people who mentioned KNCV in their will donated 1,000 times more than what they would on average per year during their life. Investing in this form of fundraising is obviously very lucrative. In 2012, we ran a campaign to inform private donors and prospects about the option to include KNCV in their will. Almost 1,000 people received a mailing followed by a telephone call on this subject. The result of this campaign cannot be measured in the short term. We plan to continue activities around the issue of legacy in 2013 in order to strengthen donor relations with KNCV and to increase the possibilities of being included in the will.

The income received each year from the **Dutch Charity Lotteries** is not easy to influence. The Lotto donates an annual amount, which is the same for all Dutch Health Organizations that are part of the Stichting Loterijacties Volksgezondheid. We involved Lotto employees during events at Corpus - the exhibition, 'KNCV is Founding Father', and a presentation about our work. This was well appreciated by the Lotto and we plan to organize similar events in 2013.

The Vriendenloterij provides more scope for influencing our lottery income. Part of the contribution is a fixed percentage of the total revenues (so called un-earmarked lottery income). The other part can be earmarked by the lottery participant as a contribution to our work (earmarked lottery income). To date, KNCV has been unsuccessful in increasing this portion significantly, also caused by a limited budget. The strategy for 2013 is to keep this income stable. Staff

from the Vriendenloterij presented their organization and the concept of the lottery to KNCV staff and to the Board of Trustees, which contributes to mutual understanding each others' way of operating. In 2012 our contract was evaluated positively for the next five years.
The contribution made by the lotteries is unique. The current government has indicated the need to modernize the current policy, which will enable us to continue receiving the same or higher level of funding from lotteries. We hope that the proposed changes to the lottery policy will give more space to continue the fundraising for organizations like KNCV Tuberculosis Foundation.

Apart from isolated small successes, diversification of our **institutional fundraising** was not very successful in 2012. Two major applications were rejected, some were not written due to time or budget constraints. Internal coordination of application processes remains a challenge, especially in terms of finding the right people to write the proposals and for bringing technical focus to proposed activities.
The proposal to Lilly MDR-TB partnership was rejected due to a mismatch with the strategy of the partnership. We have continued investing in building a relationship with this donor, which we hope will materialize into new funding prospects in 2013. The second major application rejected was to USAID in Uganda.

Some lessons learned

9. One of the major challenges for all regions is finding the optimal linkage between institutional management capacity and TB technical management capacity. In the past, where most unit managers were also technical consultants, these components were combined in one position. With increased attention to institutional management, the components have been separated and inputs are now being provided by several positions. There is need to develop an optimal structure where these components communicate in an efficient and effective way.
10. In order to be more successful in acquiring funds from (institutional) donors we need to clarify and better explain expected project outcomes in our proposals. We need to place ourselves in the shoes of the funder when we write down what we are going to deliver to address the clients' needs.

Plans for 2013

- In 2013, major steps in the regionalization and de-centralization process will be taken. The regions will finalize their strategies and translate them into a fundraising plan. They will be further trained and supported to acquire their own funding. Additionally, we will finalize the implementation of new governance structures suitable for a de-centralized organization, including the required legal registration changes for the regional offices.
- By the end of 2013, at least one of the regions will have fully delegated responsibilities for the implementation of all strategies, including fundraising and daily internal management.
- We will strengthen the internal knowledge and expertise to meet the requirements of specific donors, through external training in 2013.

6. Social report

Table 3 provides an overview of the actual staffing compared with the formation in 2012. In total, KNCV had 80.0 Fulltime Equivalent (FTE) planned, including the staff members working abroad, contracted by KNCV The Hague. The difference of the actual staffing in FTE on a total level (81.0 FTE) is plus 1.0 FTE. The main reason for the difference is the fact that we had more FTE in management in country offices in 2012 than was expected when the annual plan was developed (closure of Pakistan took longer than planned, Uganda is a new office). During the whole year 3.7 FTE were filled with temporary staff and external hiring, including outsourcing of the IT helpdesk. Of the total 80.9 FTE for 2012 contracted by central office, 57.7 FTE (71%) had their duty station in The Hague (2011: 74%), 10.7 FTE (13%) in regional offices (2011: 16%) and 12.5 FTE (16%) in country offices (2011: 10%). The decrease at the regional level is fully caused by changes in the region Netherlands/Europe and the handing over process of activities to CIb. The other regional offices grew slightly.

Table 3: Actual staffing in FTE per unit compared with planned staffing 2012

Unit/team	Planned FTE in 2012	Actual FTE in 2012				Difference
		Indefinite employment	Fixed term employment	Seconded	Total	
Region Netherlands/Europe	7.4	5.7	0.8	0.8	7.3	-0.1
Region Africa	13.8	10.2	5.1	-	15.3	1.5
Region CAR, Asia and Latin America	14.4	5.9	8.0	1.0	14.9	0.5
Knowledge Research & Policy	12.2	10.7	1.0	-	11.7	-0.5
Project Management Bureau	9.8	8.6	0.9	-	9.5	-0.3
Fundraising & Marketing	2.6	1.0	1.5	-	2.6	-0.0
Communication and PA	2.8	2.9	-	-	2.9	0.1
Finance Planning & Control	8.9	5.9	1.8	0.8	8.5	-0.4
Facility Management & IT	3.3	2.2	-	1.2	3.4	0.1
Human Research Management	1.7	1.4	0.6	-	1.9	0.2
Executive Office	3.1	3.2	-	-	3.2	0.1
Total	**80.0**	**57.6**	**19.8**	**3.7**	**81.0**	**1.0**

Table 4 gives an overview of staff numbers on 31 December for a 5-year period. In 2012, 16 employees with an employment contract left the organization and 11 members of staff were recruited, the net outflow was five.

Table 4: Composition of staff with a contract of employment on 31 December 2008-2012

Year	Total			Men					Women				
	#	FTE	Average parttime factor	#	%	FTE	%	Average parttime factor	#	%	FTE	%	Average parttime factor
2008	85	77.82	0.92	26	31%	25.28	32%	0.97	59	69%	52.54	68%	0.89
2009	96	87.96	0.92	33	34%	31.78	36%	0.96	63	66%	56.18	64%	0.89
2010	95	86.61	0.91	33	35%	31.89	37%	0.97	62	65%	54.72	63%	0.88
2011	93	84.68	0.91	31	33%	29.48	35%	0.95	62	67%	55.20	64%	0.87
2012	88	78.92	0.90	33	38%	31.31	40%	0.95	55	63%	48.61	62%	0.88

In 2012, there was an increase in the percentage of men compared to the percentage of women. Men now account for 38% of the total staff complement.
The details and causes of inflow and outflows are shown in table 5.

Table 5: Details of inflow and outflow 2012

Activity	# of employees	
	In	Out
Downsizing operations - end of 2011/beginning of 2012	-	8
Handing over of activities to CIb	-	1
Unilateral ending of fixed term contracts for various reasons	-	-
Retirement	-	1
Temporary replacement - maternity leave/vacancies	2	-
Natural attrition - central office	4	3
Natural attrition and growth - regional and country offices	5	3
Total	11	16

Diversity within the management of the organization in terms of gender is as follows:

- Board of Trustees – 4 men and 3 women;
- Executive Board - 1 man, 1 woman;
- Unit Heads - 4 men and 3 women;
- Field Office Management - 5 women and 11 men;
- International Advisory Council – 4 men and 2 women.

KNCV is an international organization, both at the head office and field offices, with staff originating from many different countries. Outside the Netherlands, our local hiring policy for country offices is first to hire staff from the country itself, then from the region. For our regional offices, we prefer to hire regional staff and failing that we consider the possibility of hiring staff from outside the region. In general, we have the policy not to draw capable staff from national programs in order to prevent a brain drain.
The average age of KNCV staff in 2012 was 46.2 years old. Over the years, this has not changed significantly. In comparison to the average age of the workforce in the Netherlands, which was 41.2 in 2011[7], this is high.

Table 6: Age data 2008-2012

Year	Average			Youngest	Oldest
	Total	Men	Women		
2008	44.3	50.7	41.4	25	64
2009	44.8	49.6	42.3	26	67
2010	45.9	50.4	43.3	27	68
2011	45.8	49.1	44.2	26	63
2012	46.2	49.4	44.3	27	64

[7] Source: Central Bureau of Statistics the Netherlands. Data for 2012 pending.

Figure 7 shows staff over 50 years remains high and has continued to increase over the last 3 years. In 2012, 48% of staff were 50 years or older; in 2011 this was 39%.

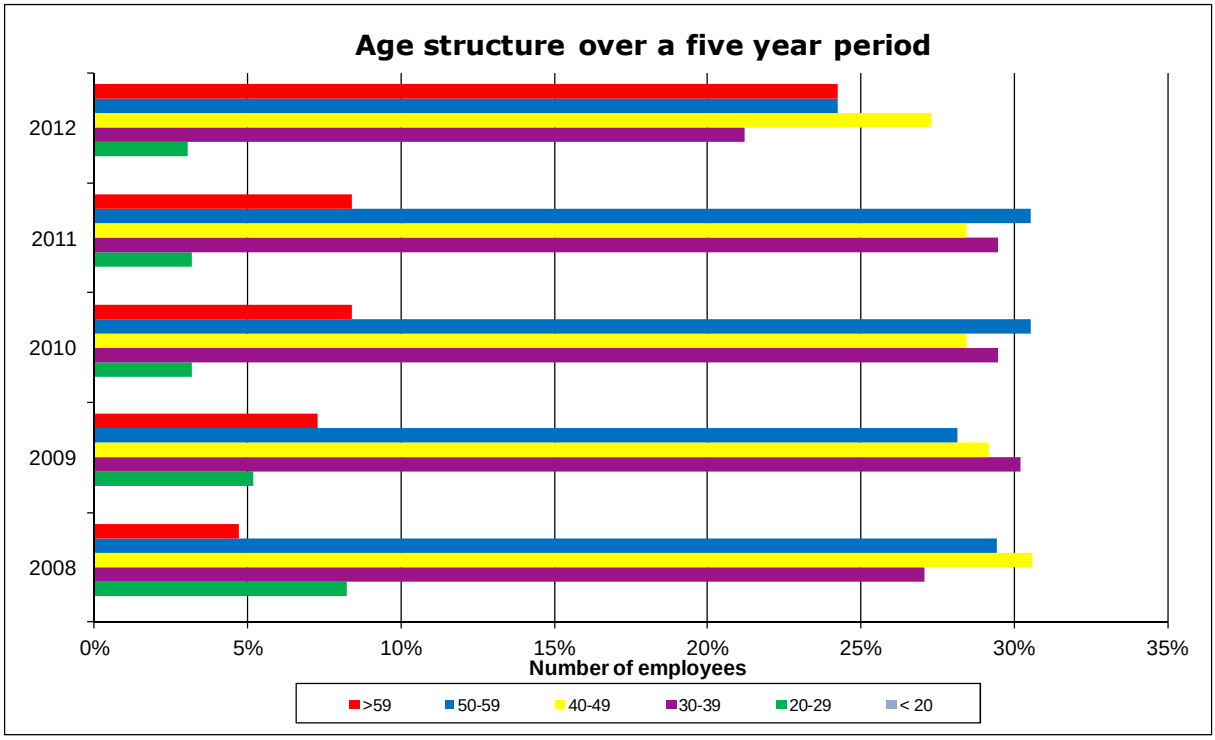

Figure 7: Age structure 2008-2012

KNCV will need to prepare itself for a number of retirements in the next few years, with decisions needing to be made, taking note of the decentralization strategy towards regional offices and the financial circumstances.

The figures in table 7 show that the sick leave percentage decreased by 1.3 % compared to 2011. This is mainly due to the reintegration of three cases of long term sick leave (longer than 2 months). The average sick leave percentage for the workforce in the Netherlands is 3.9% in the first half of 2012[8]. The sick-reporting frequency decreased slightly. The average number of sick leave days is calculated based on recovery reports. This means that the days for a sick leave which started in an earlier year are included in the average calculation of 2012 and that is the reason why it increased compared to 2011.

Table 7: Sick leave without pregnancy leave

Indicator	2008	2009	2010	2011	2012
Sick leave percentage	2.6%	3.7%	3.3%	4.2%	2.9%
Sick reporting frequency	1.4	1.3	1.0	1.0	0.9
Average sick leave in days	7.0	12.1	22.4	18.1	20.9

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

7. Governance report

Statutory name, legal state and place of residency

The 'Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose' (KNCV or KNCV Tuberculosis Foundation) has its central office in The Hague, The Netherlands. The last version of the statutes passed the notary deed on 23 August 2012.

General Assembly

The members of KNCV Tuberculosis Foundation are organizations with a mission or task of TB control. The General Assembly, comprising of 10 members, appoints the Board of Trustees and governs the activities of KNCV optimally, thereby contributing to the statutory mission of the organization. Moreover, the General Assembly is in a position to advice the Board of Trustees and the Executive Board. The General Assembly met on 30 May 2012. The members as per 31 December 2012 were:

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

Honorary members

Individuals with significant contribution or influence on TB control or for KNCV as an organization can be appointed as honorary members of the Foundation. At present these are: Dr. M.A. Bleiker, Dr. A. Rouillon and Dr. H.B. van Wijk.

Board of Trustees

The Board of Trustees is there to govern and supervise the management of the organization, during the planning phase and to ensure accountability. The Board has 5-7 members with the following competences: international and domestic public health, TB control; academic research; finance, fiduciary and financial control; international development; organizational management; institutional and private fundraising.

Appointing members to the Board of Trustees is the responsibility of the General Assembly. Members are appointed for a term of four years. A member is usually reappointed once and can be reappointed, in special circumstances, for a maximum of two terms. Membership to the Board of Trustees is a voluntary position without remuneration (as dictated by the governance code). Out of pocket expenses to attend meetings are reimbursed in addition to a generic expense compensation of € 100 for each Board of Trustees meeting attended. Trustees are also encouraged to attend courses in governance development.

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

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

Depending on ongoing developments, temporary committees can be established on an ad hoc basis; for example, in 2012, a selection committee convened to identify a new member to the Board of Trustees and a recruitment committee started the process of finding a new Executive Director.
In 2012 one member of the Board of Trustees attended one of the meetings between the Executive Board and the Works Council. The Board of Trustees, at 31 December 2012 was as follows:

Member	Appointed	Expiring
Drs. D. Boonstra, chair	May 2010 (*2nd term*)	2014
Dr. J.M.M. de Gouw, vice-chair	May 2009 (*2nd term*)	2013
Dr. M.J.A. van Putten	May 2009 (*2nd term*)	2013
Prof. Dr. J. Lange	May 2011 (*2nd term*)	2015
Mrs. X. Sun	May 2011 *(1st term)*	2015, *eligible for 2nd term*
Drs. M. Verhagen	May 2011 *(1st term)*	2015, *eligible for 2nd term*
Drs. D.S. Dotinga	May 2012 *(1st term)*	2016, *eligible for 2nd term*

In 2012, the Board of Trustees met four times: 14 February, 24 April, 18 September and 20 November.
In a closed meeting, without the attendance of the Executive Board, the Board of Trustees evaluated its own functioning and performance. The Trustees identified a need to re-direct their attention to KNCV's core business strategy. In order to increase their focus on the long term strategy and to ground their deliberations solidly in external developments, the Directors are requested to provide a synthesis report analyzing external developments and to prepare for reflective discussions with the Board of Trustees (and Advisory Council) in 2013. Furthermore, the Trustees desire more insight into the HRM policy and succession planning, and have expressed their commitment to attend these meetings.
For all other subjects and meetings, the members of the Executive Board were present.

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

Member	Other positions
D. Boonstra	Board member Greenpeace Netherlands, board member Cornelis Jetses foundation
J.M.M. de Gouw	Executive director Municipal Health Service 'Holland Midden', member of the advisory committee of the Center for Infectious Disease Control, chair of ZonMW's committee for infectious disease control

Member	Other positions
M.J.A. van Putten	Member of the Independent Review Mechanism African Development Bank, Vice-chair of the European Centre for Development Policy Management (ECDPM), member of the Board of Trustees of the Royal Tropical Institute, chair of the advisory board of Eastern Europe Skan Foundation, managing director Global Accountability, Senior Advisor Complaints mechanism European Investment Bank
J. Lange	Professor of Medicine, Head of the Department of Global Health Academic Medical Center University of Amsterdam, Executive Scientific Director Amsterdam Institute for Global Health and Development, chairman Supervisory Board PharmAccess Foundation, Advisor to the Board of the Health Insurance Fund
X. Sun	Supervisor Chinese DeHeng law office, board member CNEXPO foundation, board member Chinese Enterprises Association
M. Verhagen	Medical doctor TB control Municipal Health Service 'Limburg-Noord', chair of the Committee Practical TB Control in The Netherlands
D.S. Dotinga	Chair Alzheimer Netherland – region Haaglanden, member of the Board of Trustees Haagse Milieu Services

Executive Board

The statutory Executive Board of KNCV Tuberculosis Foundation is made of two directors. The Board in principle meets every two weeks to discuss and formalize all decisions concerning strategy development, annual planning, quarterly monitoring, annual reporting, operational management, internal control and human resource management. In 2012, the board held a total of 20 meetings. The Executive Board presently consists of:

Member	Appointed
Drs. P.C.F.M. Gondrie, Executive Director	May 2009
G.T.M. Schippers, MSc, Director of Finance and Organization	January 2004

Both directors have indefinite employment contracts.

Each director's performance and the collaboration between the directors are assessed annually during interviews with the appraisal and remuneration committee of the Board of Trustees. The committee reports their findings to the full Board of Trustees.

The Executive Board is supported by a Management Team.

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

Director	Organization	Position	Qualitate Qua /Personal	Period
P.C.F.M. Gondrie	Coordinating Board, Stop TB Partnership, representing NGOs in the north	Member	QQ	2 years
	Core Group, Dots Expansion Working Group, Stop TB Partnership	Board member	QQ	Indefinite
	Program Steering Group, TB Reach, Stop TB Partnership	Board member	Personal	2 years
	Technical Advisory Group, WHO - EURO	Member	Personal	Indefinite
	Technical Advisory Group, WHO - PAHO	Member	Personal	Indefinite
	Stichting Mondiale Tuberculosebestrijding (SMT)	Advisor	QQ	Indefinite
	's Gravenhaagse Stichting tot Steun aan de Bestrijding van Tuberculose	Advisor	QQ	Indefinite
	Tuberculosis Surveillance and Research Unit	Member	QQ	Indefinite
	International Tuberculine Surveillance Center	Chair	QQ	Indefinite
	Strategic and Technical Advisory Group for TB	Observer	QQ	Indefinite
	Executive Committee Union Europe Region	Member	QQ	Indefinite
	Wolfheze Program Committee	Chair	QQ	Indefinite
	TB Alliance stake holder consultation	Member	QQ	Indefinite
	Steering Committee Amsterdam Institute of Global Health and Development	Member	QQ	Indefinite
G.T.M. Schippers	's Gravenhaagse Stichting tot Steun aan de Bestrijding van Tuberculose	Board Member	QQ	Indefinite
	Stichting Loterijacties Volksgezondheid	Board member	QQ	Indefinite
	Stichting Mondiale Tuberculosebestrijding (SMT)	Advisor	QQ	Indefinite
	Dr. Wessel Stichting	Board member	QQ	Indefinite
	Stichting Voorzieningenfonds Oud Personeel KNCV Tuberculosefonds	Board member	Personal	Indefinite

International Advisory Council

To ensure continuous strategic inputs from our international network, KNCV has established an International Advisory Council, which meets at least once a year. In 2012, this took place in June. Council members are: Dr. Shahimurat Shaimovich Ismailov (Kazakhstan), Prof. Dr. Anthony Harries (United Kingdom), Mr. Ezio Tavora dos Santos Filho (Brazil), Dr. Frits van der Hoeven (The Netherlands), Dr. Jeremiah Muhwa Chakaya (Kenya), Dr. Wang Lixia (China), Mrs. Dorette Corbey (The Netherlands).

Works Council

Issues and views of employees, especially pertaining to labor and conditions of employment are channeled through the Works Council, comprising of five members, each serving a term of four years. Every other year, members step down, alternating in twos and threes in accordance with a schedule drawn up in advance. All employees that have worked for KNCV for more than one year are eligible to be on the Works Council. Those who have worked at the organization for at least six months are eligible to vote. Formal meetings between the Works Council and the Executive Board are held at least six times a year. In between, a number of informal meetings take place. The Works Council has appointed a subcommittee to prepare and endorse any adjustments to the labor conditions.

At the end of December 2012, the Works Council members were:

Member	Appointed	Expiring
I. Huitema, chair	2010 *(1st term)*	2014, *eligible for 2nd term*
S. van den Hof, vice chair	2011 *(1st term)*	2016, *eligible for 3rd term*
E. Klinkenberg	2011 *(1st term)*	2016, *eligible for 3rd term*
J. Klein	2012 *(1st term)*	2016, *eligible for 2nd term*

There was one vacancy.

Quality control

We consider feedback from clients an important source of information to improve the our quality of consultancy. Our consultants are trained to ask for client feedback and use this information to improve individual performance and to contribute to KNCV's internal Quality Consultancy discussions. Practicing feedback with clients and colleagues are big steps in an international and intercultural working environment, with different perceptions of feedback and openness.

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

world, we need to safeguard KNCV's core values and re-discuss these values with colleagues, which have different backgrounds.

To sustain the quality of internal management and processes within the organization, KNCV uses a cycle of strategic and annual planning, implementation, monitoring and evaluation, adaptation of plans and accounting for results. This process has been described in the document "Management and supervision of KNCV Tuberculosis Foundation, the Good Governance Code applied." The overall functioning of the organization and progress of the implementation of plans is continuously monitored by the Management Team and regularly discussed during every Board of Trustees meeting. For the projects and programs funded by institutional donors, interim reports are sent to the funders and evaluated for effectiveness and efficiency through external reviews. External oversight and auditing of the administrative and financial operations is carried out by PriceWaterhouseCoopers Accountants NV. The external auditor was appointed by the General Assembly in 2011. The directors have regular progress meetings with the auditor. Every year, the auditor reports his/her findings to the Audit Committee. All audit reports and management letters are shared with the Board of Trustees.

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

Risk management

In 2012, the organizational risks of the primary processes and operations were identified and updated in a risk assessment report. The following were identified as subjects for further improvement:

1. Management control measures and governance structures around field offices, also in relation to the decentralization strategy;
2. Security policy implementation at country level;
3. Workload among staff.

In 2012, the Executive Board was notified of suspected financial irregularities taking place in one of the country offices. These suspicions were serious and led to a forensic audit being undertaken. The reported findings showed that fraudulent activities had taken place amounting to US$ 26,000. Disciplinary measures were put in place towards the appropriate staff. According to the auditor, our procedures are deemed to be clear and sufficient. However, the control mechanisms need improvement, and all suggested measures have now been instituted.

External Quality Hallmarks

KNCV Tuberculosis Foundation is subject to the governance and quality requirements of the CBF and has, since July 1998, received the CBF certificate up to 2015. The last annual review by the CBF indicated some required changes in the statutes, rules and regulations, all of which have been addressed. The document "Management and governance at KNCV Tuberculosis Foundation - the code for Good Governance Code application" describes our governance structure, management procedures and regulations in detail. Changes in CBF requirements and internal changes have led to new versions of the document. A summary of the accountability report, outlined below, is sent

annually to the CBF.

Codes of conduct

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

- General code of conduct;
- Code of Conduct for the use of E-mail, Social Media, Internet and Telephone Facilities;
- Policy and protocol for undesirable behavior at work;
- Whistle blower policy

Media policy

KNCV Tuberculosis Foundation uses national and international media to raise the profile of its work in fighting to control tuberculosis. Through the media, we aim to reach the public, professionals, politicians and policy makers. We actively monitor information and the (social) media around TB control and react on actualities and possible (negative) issues, if and when they arise.

Summary of the CBF accountability report on management and governance

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

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

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

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

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

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

In figure 8 a schematic overview of the governance structure is explained.

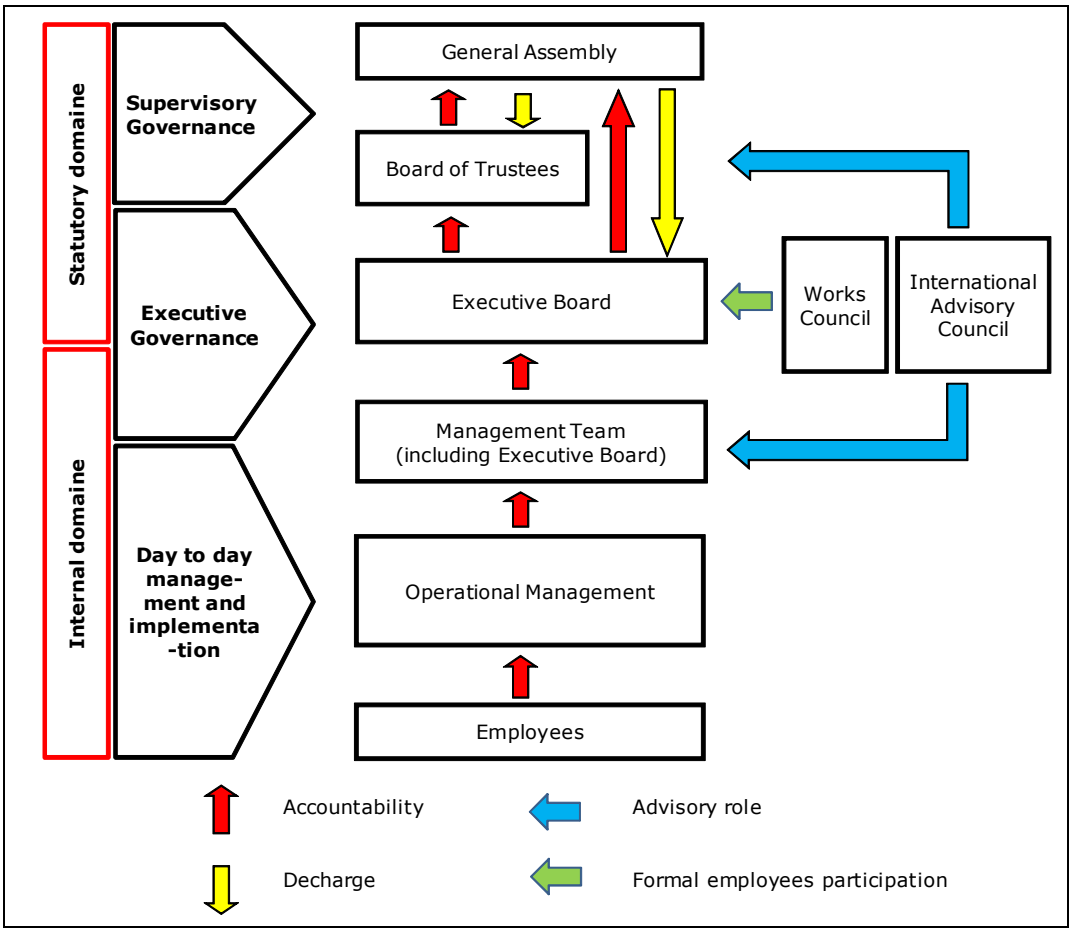

Figure 8: KNCV Tuberculosis Foundation model for governance and management

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

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

Ad 2. The continuous improvement of efficiency and effectiveness in mission related activities

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

- A planning, monitoring and evaluating process composed of a strategic long term plan and an annual planning and control cycle, both for mission related goals and for resources. Performance indicators are used to assess the progress in reaching strategic goals.

- A procedure for assessing new projects or acquisition proposal development before they start, in order to prepare the decision making process at unit level and in the Management Team.
- Monitoring and evaluation systems for major projects and at an institutional level.

Ad 3. Optimizing the communication and relationships with stakeholders

KNCV Tuberculosis Foundation is part of a large partner network of public and private organizations and individuals, all contributing to realizing our mission. Creating and maintaining support (both tangible and intangible), transparency, and accountability in all our processes is the focus of our communication with all stakeholders. The structure and composition of our network is outlined in figure 9.

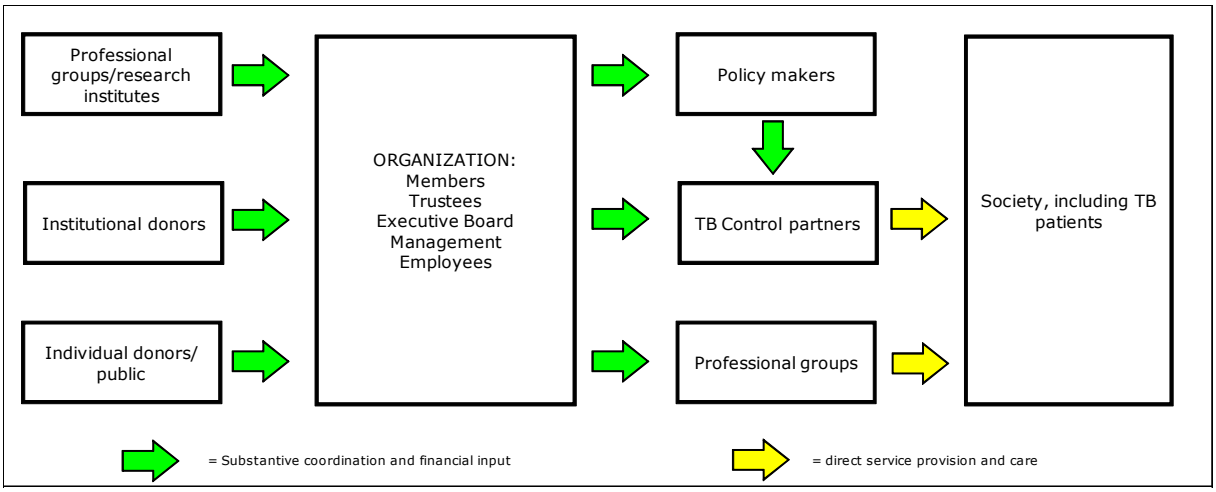

Figure 9: KNCV Tuberculosis Foundation partner network

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

Apart from the involvement of the International Advisory Council, the Boards and the Management Team promote and encourage stakeholder participation in KNCV's operations, for example:

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

KNCV Tuberculosis Foundation, in general does not use the services of volunteers. Accountability to stakeholders is done both prior to and after implementation. The results are presented at the General Assembly meetings, on the website, in newsletters and in project reports.

8. Financial indicators and monitoring data

Financial data 2008-2013

The 650 Guideline for annual reporting of charities and the requirements from the CBF dictate that a number of financial monitoring data is shown for a longer period (table 8):

Table 8: Financial monitoring data compared to standards

Monitoring data	Standard	Actual 2008	Actual 2009	Actual 2010	Actual 2011	Actual 2012	Budget 2013	Average for 3 years
Spent on the mission compared to total expenses	Not applicable	88.4%	91.6%	96.7%	95.6%	96.6%	96.1%	96.4%
Spent on the mission compared to total income		90.3%	86.4%	95.2%	98.1%	95.4%	97.5%	96.1%
Spent on private fundraising compared to income	Max. 25%	10.3%	16.9%	23.2%	20.4%	23.8%	23.5%	22.4%
Spent on administration and control compared to total expenses	5-10%	n/a	n/a	2.2%	2.6%	1.9%	2.5%	2.2%
Spent on administration and control compared to total expenses excluding partners share in activities	5-10%	9.1%	5.7%	4.0%	4.9%	3.2%	3.8%	4.0%

Expenditures on the mission

Compared to total expenses, since 2009, over 90% of KNCV's budget is being spent on mission related activities. This indicator is closely monitored. Influences on the indicator can be due to (temporarily) increases and decreases of expenditures for fundraising and for administration and control.

Compared to the total income, expenditures on the mission (in percentage) can differ from the previous indicator because in some years earmarked reserves and funds are used to cover the expenditures or there is a surplus occurring.

KNCV's policy for costs for fundraising

With regard to expenditures for fundraising, KNCV Tuberculosis Foundation complies with the guidelines issued by the CBF. Calculated as an average over a 3 year period, the costs cannot be higher than 25% of the income from own fundraising activities. As a consequence of our ambitions and modest position in the private fundraising market, we have chosen to stay close to the possible maximum, as witnessed in 2011 and 2012, and reflected in the budget for 2013. Uncertain and unpredictable factors in this strategy are the level of success of using new fundraising methods and the income from legacies. KNCV's internal policy on level of costs for fundraising is that if, in the course of a budget year, the results are not satisfactory, we adjust our budgets downwards in order to prevent a percentage above the 25% standard. Expenses in 2012 are 23.8% of the income from own fundraising activities, below the 25% maximum. The 3-year average is 22.4%.

KNCV's policy for administration and control costs

The allocation of costs in the category, 'administration and control' is done using the guideline and recommendations of the VFI, published in January 2008. The CBF requires an organization to have an internal standard for this cost category. KNCV uses 5% of the total costs as a minimum and 10% as a maximum. The reasons for this range of percentages are:

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

In 2012, the percentage of 1.9% is lower than what was budgeted for (3.6%). Following the analysis made in 2011 of all organizational costs to identify where further savings could be realized, savings in various cost categories (for example housing, IT and a large budget for contingencies) have been made in 2012. Also, due to the increased level of coalition activities compared to the budget, the percentage of costs spent on administration and control is lower than planned.

Internal monitoring data

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

- The number of project days realized compared to planned days; In 2012, a total number of 11,648 project days were planned and 11,499 were realized, which is 98.7% of the planned days. In 2011 this was 95%.
- Indirect costs compared to direct personnel costs made in The Hague, as an internal method; All project days in total represent an amount in direct personnel costs. All other personnel costs and costs for facilities are accounted as indirect costs. In 2012, the planned percentage was 88.65%, and realized is 81.49%. The decrease in 2012 compared to the budget is due to savings in various cost categories.
- Indirect costs compared to direct personnel costs made in The Hague, in compliance with the USAID rules for accounting;

Although the methodology does not differ drastically from our internal methodology, some cost categories and personnel categories included in our internal method have to be excluded as indirect costs in the USAID method. According to the USAID calculations, the percentage for 2012 is 69.75%, while 74.62% was planned. In 2011 the percentage was 75.1%. The decrease in percentage is in line with the development of the internal indirect cost rate percentage and is caused by savings on various cost categories. The decrease in indirect cost percentage is in line with our long term aim to be more cost competitive.

The results of our internal key performance data shows an improvement compared to last year. Our goal to reach the planned number of direct days (100%) has not been realized (98.7%). Implementation of a new online monitoring tool during the course of 2012 will help to achieve this goal in 2013.

Budget 2013 and possible risks

The full budget for 2013 is shown in the Statements of Income and Expenditure. The total income is budgeted on a consolidated level of €52.8. Of that amount, €26.2 million is compensation for implemented activities by the coalition partners of TBCARE I. Therefore, excluding consolidation, the total income is budgeted at €26.6 million, which is €0.7 million more than the actual for 2012. Income from government grants is budgeted to increase, related to the plans for activities under TBCARE I in 2013. Income from our share in third parties activities (e.g. lottery income) is budgeted to decrease, as well as investment income. No unrealized gains and losses on investments are budgeted.
The total level of consolidated expenditures amounts to €53.6 million. Excluding the partners' activities, this leads to a total budgeted cost level of €27.4 million, which is €2.1 million higher than the actual for 2012. TB control in high prevalence countries is increasing compared to 2012, related to the pace of activities in the third full year of the TBCARE I program.

A number of budgetary and control risks can be identified:

- Controlling the balance between direct and indirect days is crucial for the financial results.
- A large part of KNCV's income for personnel fees is in US dollars. We have included an exchange rate in the budget of US$1.30 against €1. The actual rate at time of budgeting was US$1.2987 (1 November 2012). Careful liquidity planning and making use of simple hedging techniques will be needed to further control the risk.
- A large part of the budget is for material costs in countries for the TBCARE I program. There is a risk that costs are identified as unallowable for USAID by auditors in countries or by the auditor who executes the overall audit.
- The income from legacies is budgeted at €250,000. This is an average amount reached in the past years, but it can still be lower.

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

Long term financial plan

An indication of a longer term financial plan is depicted in table 9. This overview excludes the reservation and use of a decentralization budget, because of its incidental character.
In the forecast, the effects on the level of FTE's at the central office as a result of further de-centralizing to regional offices has been taken into account. Possible growth of regional offices and their activities is not included, because it is hard to predict and it highly depends on access to funding and success of acquisition processes.

Table 9: Long Term Financial Plan 2014-2015

Profit & Loss account	Budget 2013 *In € 1 mln*	Long term forecast 2014 *In € 1 mln*	Long term forecast 2015 *In € 1 mln*
Organizational costs			
Personnel related costs	7.58	6.86	6.36
Regional office costs	0.30	0.32	0.36
Other indirect costs	1.47	1.35	1.20
Subtotal organizational costs	9.34	8.53	7.91
Charged to projects	-8.74	-7.99	-7.31
Incidental costs for reorganizing	0.50	0.53	-
Total organizational costs not charged to projects	1.10	1.06	0.60
Investment and general income	0.10	0.08	0.08
Net result organizational costs	-1.00	-0.99	-0.53
Activity costs			
Costs for fundraising	0.47	0.63	0.65
Other activity costs	0.14	0.13	0.13
Total Activity costs	0.61	0.76	0.78
Activity income			
Own fundraising	0.92	0.97	1.00
Lotteries	1.09	1.23	1.27
Total Activity income	2.02	2.20	2.27
Net result Activities	1.41	1.44	1.48
Project costs			
Charges organizational costs	8.74	7.99	7.31
Travel and accomodation	0.61	0.62	0.59
Material costs	16.25	15.00	15.00
Expenses coalition partners TBCARE I	26.24	20.00	20.00
Total Project costs	51.84	43.61	42.90
Project income			
Funding donors - fee	7.53	6.75	6.18
Funding donors - travel and accomodation	0.60	0.57	0.54
Funding donors - other direct project costs	15.95	14.83	14.73
Endowment funds contribution	0.31	0.35	0.35
Other income for projects	0.01	0.02	0.02
Income coalition partners TBCARE I	26.24	20.00	20.00
Total Project income	50.65	42.52	41.83
Net result Projects	-1.19	-1.09	-1.07
General Result (minus is a deficit)	**-0.78**	**-0.64**	**-0.11**
Covered by earmarked reserves / donated to earmarked reserves	**-0.82**	**-0.64**	**-0.11**
Influence on/movements other reserves	**0.04**	**-0.00**	**-0.00**

9. Notes to the Financial Statements

Guideline 650 for accounting and reporting

KNCV Tuberculosis Foundation is subject to the 650 Guideline for Annual Reporting by Fundraising organizations. In the attached statements, the financial results of all activities and projects are presented according to the formats of the 650 Guideline. In the following notes the composition of the Balance Sheet is analyzed and commented. Furthermore, significant deviations between the 2012 results and budget and between 2012 and 2011 as shown in the Statement of Income and Expenses are clarified.

Consolidation

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

Balance sheet per 31 December 2012 - Assets

Fixed Assets

The book value of fixed assets ultimo 2012 amounts to €414,356, which is about €55,000 lower compared to 2011. All fixed assets are used for operational management of the organization, like office inventory, office reconstructions and ICT equipment. KNCV does not possess any mission related assets which are activated on the balance sheet. Investments in new fixed assets for 2012 amounting to €129,174 were for, ICT equipment. Total depreciation is calculated at €177,765. Assets that are no longer in use and are completely depreciated have been divested for an amount of €72,192.

Accounts receivable

The balance of accounts to be received is €50.1 million, which is €29.1 higher than in 2011. The bulk of this amount consists of current account balances with projects, accounts receivables from donors and the financial contractual relation with coalition partners. Overall, the annual level of activities executed influences this balance significantly. Acquiring more or less grants from institutional donors can lead to a structural and significant decrease or increase of the amount. The total account receivable from USAID for the TBCARE I project, based on approved project workplans, increased from €32.7 million to €48.0 million. This amount is directly related to the amounts under projects to be exectuted and accounts payable to coalition partners represented under liabilities.

Investments

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

KNCV's objective is to optimize the return on investments, taking into account that:

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

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

The composition and results of the portfolio is described below and depicted in tables 10 to 13. As far as is relevant a comparison with 2011 is shown.

To determine the maximum level of investments, the level of the existing reserves and funds is used as a guiding target. In principle, 10% of total reserves is kept as liquidity, which leads to a maximum available level for investments of 90%. Calculations based on this principle shows that as per 1 January 2012, € 7.7 million was available and as per 1 January 2013, €8.3 million. Both balance value (€5.8 million) and market value (€4.9 million) of the investments are below the maximum. Naturally, apart from this mathematical approach, an assessment of the situation on the market is also taken into account when transactions take place.

In table 10 the allocation of assets according to the reporting of ABN AMRO/MeesPierson is shown[9]. Part of the bank balance is attached to the investment portfolio and is kept as revolving fund for transactions in investments. This amount is therefore taken into account in the table. In 2012 this amount decreased due to investments in bonds and stocks. Ultimo 2012 bonds are underweighted compared to the target. The total of shares, real estate and alternatives is overweighed. All asset categories stay within the range allowed according to the investment policy.

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

Table 10: Composition of the investment portfolio and historical values

Fund	Interest	Nominal value	Historic purchase value	Value in balance sheet	Transactions in reporting year in actual prices			Nominal value	Historic purchase value	Value in balance sheet
	%	1/1	1/1	1/1	Purchased	Sold	Redemp-tion of bonds	31/12	31/12	31/12
Shares										
ASN Duurzaam Fund 3			46.307	72.273	46.593				92.900	126.879
ASN Environment and Waterfund			23.884	45.104	26.115				49.999	75.625
Aviva Eur.Soc. Resp. EQ FD			76.675	100.909					76.675	119.457
Calvert Soc. Inv. FND-A-Eq.			44.759	94.061	15.206				59.965	121.908
Calvert World Int. Eq. Fund			84.015	89.181					84.015	102.952
Celsius Sust Emerging Markets			-	-	198.072				198.072	214.116
Domini Social Equity Fund			23.843	50.972		50.972			-	-
F&C Stewardship			65.099	94.108					65.099	106.547
Henderson FND - Ind. of the Future			64.943	67.893	41.385				106.328	117.280
ING Duurzaam Aandelen Fonds			-	-	129.057				129.057	128.908
Kempen Sense Fund			75.187	96.089	2.952				78.139	120.625
Triodos Sust. Eq. Fund r share			50.894	73.876	38.626				89.520	121.331
Subtotal shares		-	555.606	**784.467**	**498.006**	**50.972**	-	-	1.029.769	**1.355.628**
Real estate/Alternatives										
CFS Retail Prop Trust			-	-	106.507				106.507	100.953
Hammerson Plc a GBP 0.25			-	-	55.293				55.293	56.889
Triodos Real Estate Fund			85.025	58.850	2.711				87.736	51.076
Triodus Renewable Europe			-	64.500					-	62.200
Triodus II/Microfin I cap			-	195.028					-	212.372
Simon Property Group. Inc			125.531	146.470		100.791			24.740	55.132
Unibail - Rodamco			120.903	125.010		17.363			103.540	141.011
Units Respons glb Micro fin fd			-	63.806					-	65.640
Subtotal real estate/altern.		-	331.459	**653.664**	**164.511**	**118.154**	-	-	377.816	**745.273**
Bonds										
BNG 98-13	5,375	209.000		209.000		220.767				-
BNG sr. 05-15	3,375	266.000		266.000		285.445				-
BNG 10-17	2,500	-		-	138.801	37.723		95.000	100.000	100.717
Duitsland 09-20	1,750	190.000		219.583	125.839			290.000	290.000	339.264
Var Fortis lux.fin 05-12	4,750	160.000		160.000		160.000				-
ING Groep NV 01-12	5,500	103.000		103.000		103.000				-
ING Groep NV 02-13	5,250	198.000		198.000				198.000	198.000	198.000
Ned.Water. Bank 04-14	4,250	265.000		265.000		284.451				-
Ned.Water. Bank 05-20	3,875	-		-	206.100	46.556		140.000	159.544	158.020
Nederland 08-18	4,000	150.000		150.000		41.153		115.000	115.000	115.000
Nederland 09-19	4,000	-		-	268.718	47.640		195.000	221.078	218.597
Oostenrijk 05-16	4,000	-		-	331.080	338.940				-
Rabobank 2003-2013	4,250	159.000		159.000		162.005				-
Rabobank 10-17	3,375	150.000		150.000				150.000	150.000	150.000
SSGA euro sustainable corp bonds		850.000		850.000	904.854			1.685.974	1.754.854	1.861.316
Subtotal bonds		2.700.000	-	**2.729.583**	1.975.392	1.727.679	-	2.868.974	2.988.476	**3.140.914**
Total		2.700.000	887.065	4.167.714	2.637.909	1.896.805	-	2.868.974	4.396.061	5.241.815

Table 11: Asset allocation ultimo 2012 compared to the policy (source: Quarterly report ABN AMRO/MeesPierson)

Investment	Investment policy		1 January 2012		31 December 2012	
	Range	Target	In € million	%	In € million	%
Bonds	80-50%	70%	2.85	48.4%	3.10	53.4%
Shares/Real Estate/Alternatives	50-0%	30%	1.44	24.4%	2.10	36.2%
Liquidities		0%	1.60	27.2%	0.60	10.3%
Total			5.89	100.0%	5.80	100.0%

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

Table 12: Maturity of bonds

Running period remaining	2010	2011	2012
0 to 2 years	17.9%	0.0%	6.3%
2 to 5 years	52.3%	40.5%	0.0%
5 to 8 years	25.2%	15.4%	18.6%
>8 years	4.6%	5.6%	75.1%

An overall result of 9.9% (benchmark: 12.0%; 2011: 0.5%) is realized. Below, a comparison between our 2012 portfolio, the benchmark and the results for 2011 is shown per asset category:

- Bonds; 2012 9.3%, benchmark 10.7%[10], 2011 2.9%
- Shares; 2012 18.0%, benchmark 15.5%[11], 2011 -8.8%.
- Real estate/alternative assets; 2012 12.7%[12], benchmark 14.5%, 2011 9.5%.
- Liquidity available for investments; 2012 0.0%, benchmark 0.3%[13], 2011 1.3%.

In absolute terms and in comparison with the long term expected result of 5% the portfolio performed satisfactory. Compared to the benchmark it did not perform optimal. During the first half of the year, the investment bank under-weighed the proportional part in both shares and bonds. This is the main cause for the underperformance, which was partly compensated by a better performance of the shares portfolio as such.

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

Table 13: Investment results 2008-2012

Description	2008	2009	2010	2011	2012
Bond income	171,721	150,681	148,093	105,740	88,899
Depreciation of amortization	-	-	-	-	-12,496
Dividend	24,272	10,704	21,161	18,094	34,085
Realized exchange results	32,895	23,168	48,771	8366	99,942
Unrealized exchange results	-649,177	178,371	176,480	-104,208	275,842
Interest on cash on hand and deposits	150,753	102,265	34,266	25,585	17,948
Gross investment income	-269,536	465,189	428,771	53,577	504,220
Investment expenses	11,869	19,055	19,781	28,690	17,500
Nett investment income	-281,405	446,134	408,990	24,887	486,720

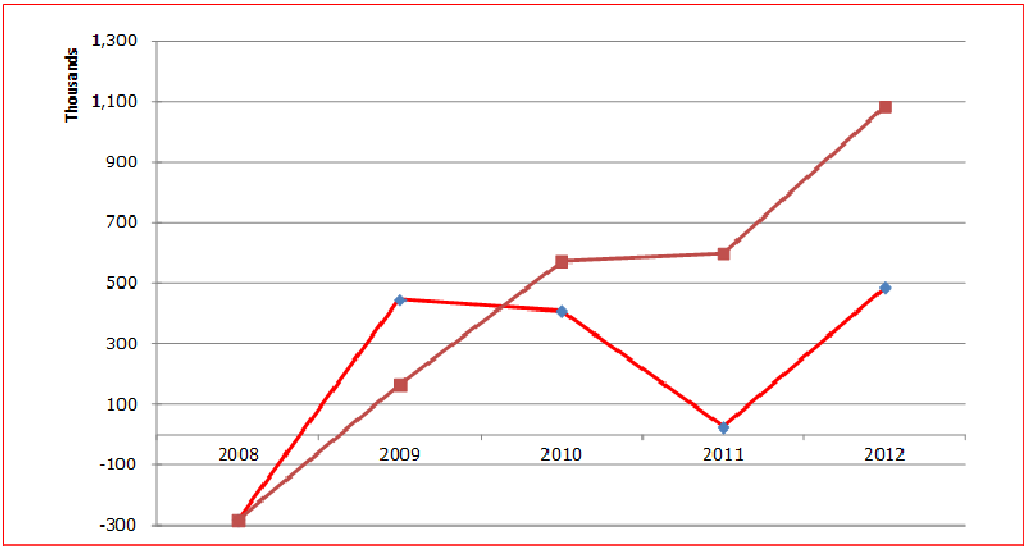

Figure 10: Net investment income 2008-2012

[10] 55% EU, 33% USA, 4% developed Asia and 8% emerging markets.
[11] 60% EMU states, 40% EMU credits.
[12] 50% Rel Value, 25% directional, 25% real estate.
[13] 3 months Euribor.

The Executive Board confirms that all transactions in 2012 have been executed in compliance with the Investment Policy. This has been monitored by analyzing the monthly and quarterly reports of the investment bank and by discussing the results during periodical meetings.

Cash and banks

The balance of cash and banks increased compared to 2011, with €4.2 million to a level of €9.3 million. The main reason for this increase is the monthly advance received from USAID at the end of December and paid out to all coalition partners in early January (€1.6 million) and higher bank balances within country offices related to earlier approval of TBCARE I work plans compared to 2011.

Ultimo 2012 no deposits were available, because interest rates on deposits during 2012 were still not more beneficiary to the result than balances on savings accounts.

Part of the bank balance is still available for long term investment in shares or bonds, once there are more positive developments in the global financial markets.

Balance sheet per 31 December 2012 - Liabilities

Reserves

- Continuity reserve

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

As a reasonable maximum level of the reserve, we use 1 to 1.5 times the estimated and budgeted expenditures for the organization for one year. Mission related activity expenditures are excluded of the calculation. Based on the budget for 2013 for organizational costs (€10.4 million) the continuity reserve's maximum is €10.4 to €15.6 million. The reserve ultimo 2012, €6.2 million, stays within the maximum (0.64 times the budget for organizational costs in 2013). The underlying risks to be covered by the continuity reserve are analyzed each year during the annual planning and budgeting process. At that point possible risks are identified and, if possible, quantified to calculate the maximum amount needed in the continuity reserve. It is expected that the risk of discontinuity of (parts of the) organization and long term commitments can be covered by the current level of the continuity reserve.

- Earmarked project reserves

Some parts of our equity have been earmarked by the Board to a number of specific objectives, with approval of the Board of Trustees. This gives the organization the possibility to either anticipate on unexpected opportunities or to give extra focus to strategic areas. In the coming years, parts of the reserves will be used for extra activities in research and high- and low prevalence TB control. In 2012, an amount of €200,697 has been withdrawn from the earmarked project reserves for these kinds of activities. For 2012 €260,800 is budgeted to be used.

- Decentralization reserve

In 2011, a decentralization reserve was formed to the amount of €1,230,727 to account for expenses to be incurred in the regionalization process during the years 2012-2015. In 2012, the amount of €61,529 was withdrawn from this reserve.

- Revaluation reserve

This reserve serves as a revolving fund for unrealized exchange results on investments, which are not available for mission related activities until they are actually realized. In compliance with Guideline 650, unrealized exchange results are accounted for in the Statement of Income and Expenditure and are therefore part of the surplus or deficit in the annual accounts. Ultimo 2012 the reserve contains €543,721.

- Fixed asset reserve

KNCV Tuberculosis Foundation separates equity, needed to finance the remaining value of fixed assets, which is allowed by Guideline 650. In 2012, the reserve decreased to an amount of €414,356.

Funds earmarked by third parties

In the past, some resources received from third parties have not been used in full and still have an earmarked spending purpose. In the coming years, parts of these funds will be used for international and research activities. Most of the funds do not have spending deadlines. Use of the funds is budgeted according to the activity plans. In 2012 an amount of €35,145 was used.

Various liabilities

The total of Various liabilities has increased from €20.8 million in 2011 to €54.6 million in 2012 and includes under Other liabilities €16.8 million of contractual committed projects still to be executed for USAID and €32.6 million value of sub-agreements with coalition partners. As clarified on the Accounts receivable side, the level of projects and activities agreed in grants is the main cause for fluctuation in the liabilities.

A large part of Other Liabilities and Accrued Expenses is taken up by a provision for leave hours, which have not been used by employees up to now. The level of the amount for this provision at the end of 2012 is €695,219, which is almost the same as 2011. As from January 2012, a new leave hours policy was implemented in which measures are included that will further prevent significant increases in the provision.

Statement of Income and Expenditure

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

Income

In table 14 the total income for 2012 is compared with the budget and with 2011. In the tables to follow each income category is further clarified.

Table 14: Total income

Total income	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
Own share	28.30	25.90	23.40	-9%	10%
Coalition partners share	12.40	23.80	16.30	92%	32%
Total	40.76	49.70	39.70	22%	20%

The total income in 2012 is higher than 2011. In 2011 country activities for TBCARE I started in a late stage, due to delays in budget approval.

Table 15: Private fundraising

Private fundraising	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
	1.39	1.40	1.71	1%	-22%

The private fundraising income in 2011 was positively affected by a change in the valuation of legacy income, which has lead to an incidental extra income in that year of €339,000. This explains the significant decrease compared to 2012.

Table 16: Share in third parties activities

Share in third party activities	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
	1.14	1.24	1.22	9%	2%

This income consists of contributions from two large Dutch lottery organizations: the VriendenLoterij and De Lotto. The amount consists of earmarked sold lottery tickets, general participation in the lotteries and settlements from previous years. The latter is caused by the fact that each year at the time of the closing date, the contribution from De Lotto is not announced yet and is therefore based on an estimate. Deviations from this estimate are accounted for as settlements from previous years. In the budget we always chose to estimate the income from lotteries conservatively, which is the cause of the difference with the actual figure.

Table 17: Government grants

Government grants	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
Own share	25.60	22.70	20.40	-11%	10%
Coalition partners share	12.40	23.80	16.30	92%	32%
Total	38.00	46.50	36.70	22%	21%

KNCV's 2012 share in the USAID funded program TBCARE I, with €44.9 million, amounts to 97% of the total figure for government grants. The contribution to TB control in The Netherlands from the CIb has decreased to €0.7 million in 2012, as a result of the shift of some responsibilities to the RIVM. From a large group of other smaller donors, a total of €0.9 million was received, which is in line with the budgeted amount. For 2012, government grants determined 94% of KNCV's budget.

Table 18: Investment income and other income

Investment income and other income	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
	0.20	0.50	0.09	150%	82%

With our investment portfolio and interest on bank balances, we earned an amount of €0.2 million as realized income and made a profit of €0.3 million as unrealized exchange differences. The unrealized part was never budget for, which explains the difference with the budget. In 2011, the unrealized exchange differences were a loss of €0.1.

Expenditure

In table 19 the total expenses for 2012 are compared with the budget and with 2011. In the tables to follow each income category is further clarified.

Table 19: Total expenditure

Total expenditure	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
Own share	29.20	25.30	24.45	-13%	3%
Coalition partners share	12.40	23.80	16.30	92%	32%
Total	41.60	49.10	40.75	18%	17%

96.6% of the total income is spent on mission related activities. The increase of 18% is, again, caused by the delayed start up of many country activities for TBCARE I in 2011 and the earlier workplan approval in 2012.

Table 20: Expenses to mission related goals

Expenses in mission related goals	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
Own share	27.10	23.60	22.70	-13%	4%
Coalition partners share	12.40	23.80	16.30	92%	32%
Total	39.50	47.40	39.00	20%	18%

In 2012, 96.6% of all expenses are spent on mission related activities. In 2011, this percentage was 95.6%. The activities in low prevalence countries took 2% of the total amount, high prevalence countries 95%, research activities 2% and education/awareness 1%. The increase compared to 2011 runs parallel with the increase in income from government grants and can be fully clarified by the increased pace of TBCARE I activities in high prevalence countries.

Table 21: Expenses to fundraising

Expenses to fundraising	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
	0.66	0.73	0.71	11%	3%

In all categories of fundraising and acquisition activities, including those for private fundraising, €0.73 million was spent. This was higher than the budget and slightly higher than the level of 2011. For private fundraising, 23.8% of the income has been spent as costs. This is within the CBF maximum of 25%.

Table 22: Administration and control

Administration and control	Budget 2012 in € million	Actual 2012 in € million	Actual 2011 in € million	% difference budget	% difference last year
	1.50	0.96	1.07	-36%	-11%

Costs for administration and control were 36% lower than planned, mostly due to the decrease in cost level as a result of the reorganization in 2011. Expenses related to the reorganization were budgeted in 2012, but reported in 2011. Also savings were realized on other expense categories (IT, housing). Compared to 2011, the costs are 11% lower.

Result

The balance between income and costs is a surplus of €0.6 million, while a deficit of €0.9 million was planned. The main cause of the difference with the budgeted figures is an unrealized investment income of €0.3 million, lower expenses for administration and control (€0.5 million), including the fact that the reorganization expenses for staff made redundant at the end of 2011 was taken as an expense in 2011, but was budgeted in 2012 (€0.25 million).

A proposal for appropriation of the result is presented as part of the annual report, on page 90.

KNCV To eliminate TB

TUBERCULOSISFOUNDATION

FINANCIAL STATEMENTS 2012

10. Accounting policies

Organizations' general data

The 'Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose' (KNCV, using the name KNCV Tuberculosis Foundation) resides at Parkstraat 17 in The Hague, The Netherlands.
Under its Articles of Association, KNCV Tuberculosis Foundation has as its statutory objective:
The promotion of the national and international control of Tuberculosis by, amongst others:

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

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

General accounting policies

The accounting policies are unchanged compared to the previous year.

Guideline 650

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

Valuation

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

Translation of foreign currencies

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

Balance sheets of local KNCV representative offices

The balance sheets of KNCV representative offices are consolidated in KNCV Tuberculoses Foundations' balance sheet per asset/ liability group against the exchange rates as at 31 December 2012.

Accounting policies - assets and liabilities

Tangible fixed assets

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

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

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

Investments

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

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

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

Cash and banks

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

Receivables and liabilities concerning projects

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

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

Coalition consolidation

In the annual accounts 2012 all receivables and liabilities concerning the USAID program have been fully consolidated, including those sub-agreed to coalition partners. The receivables represent the amount obligated to the coalition on both contracts minus the amounts already received. The liabilities represent the part of the obligation that still needs to be executed. This liability is shown separately for KNCV and other coalition partners.

Accounting policies – Statement of Income and Expenditure

Allocation to accounting year

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

Depreciation fixed assets

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

Legacies and endowments

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

Grants

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

Coalition consolidation

In the annual accounts 2012 all income and expenses concerning TBCARE have been included, including the part sub-agreed to coalition partners.

Share in fundraising third parties

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

Income and expenses concerning projects

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

Pension contribution

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

The pension funds coverage grade ultimo 2012 was 101%. Pension premiums compared to the previous year changed from 23.4% to 23.8% for retirement. The percentage for disability remained at a level of 0.4%.

Allocation expenditure

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

Organizational unit	Charge argument
Netherlands, low prevalence	All expenses charged on 'TB control in low prevalence countries'
Other countries, high prevalence	3% of staff expenses charged on 'Expenses government grants'
	All other expenses charged on 'TB control in high prevalence countries'
Project management	3% of staff expenses charged on 'Expenses government grants'
	All other expenses charged on 'TB control in high prevalence countries'
Research	3% of staff expenses charged on 'Expenses government grants'
	All other expenses charged on 'Research'
Communication	All expenses charged on 'Information, education and awareness'
Fundraising	Absolute expenses charged on 'Expenses actions from third parties'
	Staff expenses charged on 'Information, education and awareness' (33%) and 'Expenses private fundraising' (67%) based on timewriting.
	40% of all other expenses charged on 'Information, education and awareness'
	60% of all other expenses charged on 'Expenses private fundraising'
Directors office	Grants to third parties for scientific research charged on 'Research'
	Expenses for public affairs charged on 'Information, education and awareness'
	2% of staff expenses charged on 'Expenses fundraising third parties'
	3% of staff expenses charged on 'Expenses government grants'
	3% of staff expenses charged on 'Expenses financial assets'
	All other expenses charged on 'Expenses administration and control'

Organizational unit	Charge argument
Human resource management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Facility management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Finance Planning & Control	Staff exclusively working for project finance is charged to the objective-categories
	All other expenses charged on 'Expenses administration and control'

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

Accounting policies – cash flow statement

The cash flow statement is determined using the indirect method, presenting the cash flow separately as the sum of the shortage or surplus and the costs for depreciation.
Cash flows in foreign currencies are included using an average exchange rate. Currency fluctuations and income and expenses from interest are added to the cash flow from operational activities.

Notes to the remuneration of the management

The Board of Trustees has, upon the recommendation of the Remuneration Committee, determined the amount of the management remuneration and additional benefits to be paid to management. The remuneration policy is regularly reviewed, most recently in April 2013.

In determining the remuneration policy and remuneration, KNCV Tuberculosis Foundation adheres to VFI's advisory scheme for the remuneration of the management of charitable organisations ("Adviesregeling Beloning Directeuren van Goede Doelen") and the code of governance for charitable organisations ("Code Wijffels"; see www.vfi.nl).

Under the advisory scheme[14], a maximum annual remuneration is determined on the basis of weighted criteria. At KNCV Tuberculosis Foundation, this weighting was performed by the Remuneration Committee. This resulted in a so-called basic score for management positions ("Basis Score voor Directiefuncties" - BSD) of 500 points and a maximum annual remuneration of 87% of €140,046 for 1 FTE in 12 months for each director, which is €121,840.

In 2012, the actual incomes of management for the purposes of assessment of compliance with VFI's maximum annual remuneration were as follows: P. Gondrie €140,548 (1 FTE/12 months) including € 13,037 taxable allowances; G. Schippers €126,587 (1 FTE/12 months). The VFI standard is based on a 36-hour working week, while KNCV's directors are contracted for a 40-hour workweek. The remuneration to Mr. Gondrie, in absolute terms, exceeds the VFI standard by 15%. Taking into account a 40 hour working week against a 36 hour standard, this is 4%. The Board of Trustees takes the view that the salary matches the skills and competencies required for successfully fulfilling a position in the (inter)national medical and scientific environment. A lower remuneration would make it impossible to recruit an executive director with the expertise and background needed to advocate for KNCV's viewpoints in the global policy development fore for TB control. The income for Mrs. Schippers, in absolute terms, is above the VFI standard by 4%. Taking into account a 40 hour working week against a 36 hour standard, it is below the standard with 6%.

In the financial statements, the size and composition of the management remuneration is reported in the notes to the statement of operating income and expenditure. Besides the annual income, management remuneration also includes the national insurance and pension contributions and, if applicable, any severance payments upon termination of employment. The latter was not the case in 2012

Apart from compliance with the VFI remuneration advisory scheme, KNCV Tuberculosis Foundation also has to comply with the rules and standards of the Dutch Government, being an organization which receives government funds. The income of both directors complies with the standard as used by the Dutch Government.

[14] Advisory scheme for remuneration of directors, VFI, September 2011

Result appropriation

To the Board of Trustees and the General Assembly, in their respective meetings of 23 April 2013 and 28 May 2013, we propose to appropriate the deficit of 2011 according to the following division:

	In €
Continuity reserve, contribution	168,800
Decentralization reserve, contribution	100,000
Decentralization reserve, withdrawal	-/- 61,529
Earmarked project reserves, contribution	410,000
Earmarked project reserves, withdrawal	-/- 200,697
Unrealized exchange differences on investments, contribution	275,842
Fixed asset fund, withdrawal	-/- 55,301
Third party earmarked funds, withdrawal	-/- 35,145
	601,970

The withdrawals are specified on pages 81 and 82 of the financial statements. KNCV Tuberculosis Foundation's policy towards reserves and funds is clarified in chapter 9.

Dina Boonstra
Chair of the Board of Trustees

Sjaak de Gouw
Vice chair of the Board of Trustees

Peter Gondrie
Executive Director

Gerdy Schippers
Director of Finance and Organization

Annex 1. List of scientific publications 2012

1. Banu S, **Hossain S**, Uddin MKM, Rahman Md, Khatun R, Zaman K, Quaiyum MA, **van Leth F.** Comparison of Macroscopic and Microscopic Assessment of Specimens Collected for the Diagnosis of Tuberculosis. The Open Infect Dis J 2012;6:1-4.
2. Blok L, **van den Hof S**, Mfinanga SG, Kahwa A, Ngadaya E, Oey L, Dieleman M. Measuring workload for tuberculosis service provision at primary care level: a methodology. Hum Resour Health 2012;10:11.
3. Brouwer M, Gudo PS, Mage Simbe C, Perdigão P, **van Leth F**. The effect of Tuberculosis and antiretroviral treatment on CD4+ cell count response in HIV-positive Tuberculosis patients in Mozambique. BCM Public Health 2012;12(1):670.
4. Buregyeya E, **Mitchell EMH**, Rutebemberwa E, Colebunders R. Criel B, Kiguli J and Nuwaha F. Acceptability of masking and patient separation to control nosocomial Tuberculosis in Uganda: a qualitative study. J Public Health 2012.
5. Buregyeya E, Nuwaha F, Wanyenze RK, **Mitchell EMH**, Criel B, **Verver S**, Kasasa S, Colebunders R. Utilization of HIV and Tuberculosis Services by Health Care Workers in Uganda: Implications for Occupational Health Policies and Implementation. PloSone 2012;7(10):e46069.
6. **Buu TN**, van Soolingen D, Huyen MN, Lan NT, Quy HT, **Tiemersma EW**, Kremer K, Borgdorff MW, **Cobelens FG**. Increased transmission of Mycobacterium tuberculosis Beijing genotype strains associated with resistance to streptomycin: a population-based study. PloS One 2012;7(8):e42323.
7. Cobelens F, **van den Hof S**, Pai M, Squire SB, Ramsay A, Kimerling ME. Which new diagnostics for tuberculosis, and when? J Infect Dis 2012;205 Suppl 2:S191-8. [Epub ahead of print]
8. **Cobelens FG**, **van Kampen S**, Ochodo E, Atun R, Lienhardt C. Research on implementation of interventions in tuberculosis control in low- and middle-income countries: a systematic review. PLoS Med 2012;9(12):e1001358.
9. **Dara M**, de Colombani P, Petrova-Benedict R, Centis R, Zellweger J, Sandgren A, Heldal E, Sotgiu G, **Jansen N**, Bahtijarevic R, Migliori G; on behalf of the members of the Wolfheze Transborder Migration Task Force. The Minimum Package for Cross-Border TB Control and Care in the WHO European Region: a Wolfheze Consensus Statement. Eur Respir J 2012;40(5):1081–1090.
10. Datema TA, Oskam L, Engelberts MF, van Beers SM, Shinnick TM, Baker M, Ridderhof JC, **Scholten J**, van Deun A, Gilpin C, Klatser PR. Global laboratory initiative tool for a stepwise process towards tuberculosis laboratory accreditation. Int J Tuberc Lung Dis 2012;16(5):704-5.
11. Demers AM, **Verver S**, Boulle A, Warren R, van Helden P, Behr MA, Coetzee D. High yield of culture-based diagnosis in a TB-endemic setting. BMC Infect Dis 2012;12:218.
12. Harper I, **Mitchell E**, Theobald S. Improving qualitative research in the Journal. Int J Tuberc Lung Dis 2012;16(1):2-3.
13. Hatherill M, **Verver S**, Mahomed H. Consensus Statement on Diagnostic End Points for Infant Tuberculosis Vaccine Trials. Clin Infect Dis 2012;54(4):493-501.
14. Hatherill M, **Verver S**, Mahomed H. The Taskforce on Clinical Research Issues, Stop TB Partnership Working Group on TB Vaccines. Consensus Statement on Diagnostic End Points for Infant Tuberculosis Vaccine Trials. Clin Infect Dis 2012;54(4):493-501.
15. Hedt BL, **van Leth F**, Zignol M, **Cobelens F,** van Gemert W, Nhung NV, Lyepshina S, Egwaga S, Cohen T. Multidrug Resistance Among New Tuberculosis Cases: Detecting Local Variation Through Lot Quality-assurance Sampling. Epidemiology 2012;23(2):293-300.
16. Hoa NB, **Cobelens FG**, Sy DN, Nhung NV, Borgdorff MW, **Tiemersma EW**. Yield of interview screening and chest X-ray abnormalities in a tuberculosis prevalence survey. Int J Tuberc Lung Dis 2012;16(6):762-7. [Epub ahead of print]

17. **Hossain S**, Quaiyum MA, Zaman K, Banu S, Husain MA, Islam MA, Cooreman E, Borgdorff M, Lönnroth K, **Salim AH**, **van Leth F**. Socio Economic Position in TB Prevalence and Access to Services: Results from a Population Prevalence Survey and a Facility-Based Survey in Bangladesh. The Open Infect Dis J 2012;6:1-4 1.
18. Huyen MN, Kremer K, Lan NT, **Cobelens FG**, **Buu TN**, Dung NH, Caws M, **Tiemersma EW**, van Soolingen D. Mixed tuberculosis infections in rural South Vietnam. J Clin Microbiol 2012;50(5):1586-92.
19. **Klinkenberg E**, **van den Hof S**, Tursynbayeva A, Kipruto H, Wahogo J, **Pak S**, **Kutwa A**, **L'Herminez R**. Integration of HIV testing in tuberculosis drug resistance surveillance in Kazakhstan and Kenya. Int J Tuberc Lung Dis 2012;16(5):615-7. [Epub ahead of print]
20. Korthals Altes H, Kremer K, **Erkens C**, van Soolingen D, Wallinga J. Tuberculosis seasonality in the Netherlands differs between natives and non-natives: a role for vitamin D deficiency? Int J Tuberc Lung Dis 2012;16(6):762-7. [Epub ahead of print]
21. Langendam MW, **Van der Werf MJ**, Huitric E. Manissero D. Prevalence of inappropriate tuberculosis treatment regimens: a systematic review. Eur Respir J. 2012;39(4):1012-20.
22. Machingaidze S, **Verver S**, Mulenga H, Abrahams DA, Hatherill M, Hanekom W, Hussey GD, Mahomed H. Predictive Value of Recent QuantiFERON Conversion for Tuberculosis Disease in Adolescents. Am J Respir Crit Care Med 2012;186(10):1051-6.[Epub ahead of print]
23. Migliori GB, Langendam MW, D'Ambrosio L, Centis R, Blasi F, Huitric E, Manissero D, **van der Werf MJ**. Protecting the tuberculosis drug pipeline: stating the case for the rational use of fluoroquinolones. Eur Respir J 2012;40(4):814-22. [Epub ahead of print]
24. **Moyo S**, **Verver S**, Hawkridge A, Geiter L, Hatherill M, Workman L, Ontong C, Msemburi W, Tameris M, Geldenhuys H, Mulenga H, Snowden MA, Hanekom WA, Hussey G, Mahomed H. South African Tuberculosis Vaccine Initiative Neonatal Study Team. Tuberculosis case finding for vaccine trials in young children in high-incidence settings: a randomised trial. Int J Tuberc Lung Dis 2012;16(2):185-91.
25. **Mulder C**, **Erkens CG**, Kouw PM, Huisman EM, Meijer-Veldman W, Borgdorff MW, **van Leth F**. Missed opportunities in tuberculosis control in The Netherlands due to prioritization of contact investigations. Eur J Public Health 2012;22(2):177-82.
26. Murray CJ, Vos T, Lozano R, Naghavi M, Flaxman AD, Michaud C, Ezzati M, Shibuya K, Salomon JA, **van der Werf MJ**, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2012;380(9859):2197-223.
27. Ricks PM, Mavhunga F, Modi S, Indongo R, **Zezai A**, Lambert LA, DeLuca N, Krashin JS, Nakashima AK and Holtz TH. Characteristics of multidrug-resistant tuberculosis in Namibia. BMC Infect Dis 2012;12:385.
28. Sagwa E, Mantel-Teeuwisse AK, **Ruswa N**, Musasa JP, Pal S, Dhliwayo P, van Wyk B. The burden of adverse events during treatment of drug-resistant tuberculosis in Namibia. South Med Rev. 2012;5(1):6-13.
29. Salomon JA, Vos T, Hogan DR, Gagnon M, Naghavi M, Mokdad A, Begum N, Shah R, Karyana M, **van der Werf MJ** et. al. Common values in assessing health outcomes from disease and injury: disability weights measurement study for the Global Burden of Disease Study 2010. Lancet 2012;380(9859):2129-43.
30. Ssengooba W, Kateete DP, Wajja A, Bugumirwa E, Mboowa G, Namaganda C, Nakayita G, Nassolo M, Mumbowa F, Asiimwe BB, Waako J, **Verver S**, Musoke P, Mayanja-Kizza H, Joloba ML. An Early Morning Sputum Sample Is Necessary for the Diagnosis of Pulmonary Tuberculosis, Even with More Sensitive Techniques: A Prospective Cohort Study among Adolescent TB-Suspects in Uganda. Tuberc Res Treat 2012;2012:970203.
31. Suthar AB, **Klinkenberg E**, Ramsay A, Garg N, Bennett R, Towle M, Sitienei J, Smyth C, Daniels C, Baggaley R, Gunneberg C, Williams B, Getahun H, **van Gorkom J**, Granich RM. Community-based multi-disease prevention campaigns for controlling human immunodeficiency virus-associated tuberculosis. Int J Tuberc Lung Dis 2012;16(4):430-6.

32. van Hest NA, Ködmön C, **Verver S**, **Erkens CG**, **Straetemans M,** Manissero D, **de Vries G**. Tuberculosis treatment outcome monitoring in European Union countries: systematic review. Eur Respir J. 2012 Jul 12. [Epub ahead of print]
33. **Van der Werf MJ**. Courtesans and Consumption: How Sexually Transmitted Infections Drive Tuberculosis Epidemics by N.J.D. Nagelkerke. Reviewed in Tuberculosis 92: 543.
34. **Van der Werf MJ**, Langendam MW, Sandgren A, Manissero D. Lack of evidence to support policy development for management of contacts of multidrug-resistant tuberculosis patients: two systematic reviews. Int J Tuberc Lung Dis 2012;16(3):288-96.
35. **Van der Werf MJ**, Sandgren A, Manissero D. Management of contacts of multidrugresistant tuberculosis patients in the European Union and European Economic Area. Int J Tuberc Lung Dis. 2012;16(3):426.
36. **Van der Werf MJ**, Langendam MW, Huitric E, Manissero D. Knowledge of tuberculosis treatment prescription of health workers: A systematic review. Eur Respir J 2012;39:1248–1255.
37. **Van der Werf M**, Langendam M, Huitric E, Manissero D. Multidrug resistance after inappropriate tuberculosis treatment: a meta-analysis. Eur Respir J 2012;39(6):1511-9.
38. Vos T, Flaxman AD, Naghavi M, Lozano R, Michaud C, Ezzati M, Shibuya K, Salomon JA, Abdalla S, **van der Werf MJ**, et al. Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2012;380(9859):2163-96.
39. Zaman K, **Hossain S**, **Banu S**, Quaiyum MA, Barua PC, Salim MA, Begum V, Islam MA, Ahmed J, Rifat M, Cooreman E, **van der Werf MJ**, Borgdorff M, **van Leth F**. Prevalence of smear-positive tuberculosis in persons aged ⩾15 years in Bangladesh: results from a national survey, 2007-2009. Epidemiol Infect 2012;140(6):1018-27.
40. Zwerling A, **van den Hof S**, **Scholten J,** Cobelens F, Menzies D, Pai M. Interferon-gamma release assays for tuberculosis screening of healthcare workers: a systematic review. Thorax 2012;67(1):62-70.

You can find facts about tuberculosis and news on KNCV Tuberculosis Foundation's activities through the following channels:

www.tuberculose.nl	Website for all stakeholders containing corporate information and information for the general public in Dutch.
www.stoptbc.nl	Website for private donors, supporting the STOP TBC campaign.
www.tbcare1.org	Website for stakeholders interested in the TB CARE I program, funded by USAID.
www.kncvtbc.org	Website for all stakeholders containing corporate information and information for the general public in English.
www.kncvtbc.nl	Website for Dutch professionals.
info@kncvtbc.nl	General corporate e-mail address.
info@stoptbc.nl	E-mail address for private donors.
Twitter account @kncvtbc	Tweets about tuberculosis and related developments for our international stakeholders. Also used for recruitment of staff.
Twitter account @STOPTBC	Dutch tweets about tuberculosis and related developments for our private donors.
LinkedIn group account KNCV Tuberculosis Foundation	Interaction with individuals and groups active on LinkedIn, is also used for the recruitment of staff.