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KNCV TUBERCULOSIS FOUNDATION

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Frank Koelewijn / Totaal Tekstproductie &
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Graphics
Netty Kamp (cover and page 19)
Rob Beuse (contents)
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KNCV Tuberculosis Foundation
(pages 6, 8, 9, 21, 22, and 23)
Linda Ouwehand (page 14)
Joseph Sywensky (pages 16, and 17)

Contents

KNCV Tuberculosis Foundation

- KNCV Tuberculosis Foundation's mission is to eliminate tuberculosis worldwide by developing and implementing effective control strategies.
- We subscribe to the worldwide goals for TB control as defined by WHO (the World Health Organization): achieving a case detection rate of 70 percent and a treatment success rate of 85 percent. We also endorse the United Nations' Millennium Development Goals to reverse the TB epidemic by 2015.
- We coordinate TB control in the Netherlands and work with over forty countries in Europe, Africa, Asia, and Latin America to fight tuberculosis.

Who We Are and What We Do

KNCV Tuberculosis Foundation – Royal Dutch Association for the Fight Against Tuberculosis

KNCV Tuberculosis Foundation fights tuberculosis all over the world. We are a Dutch organization of deeply passionate experts and professionals, including doctors, researchers, training experts, and nurses, all specializing in TB control.
Over the years, we have built up a wealth of knowledge and expertise, particularly by fighting tuberculosis successfully in the Netherlands. We share our knowledge and expertise with the rest of the world to facilitate optimum joint TB control.

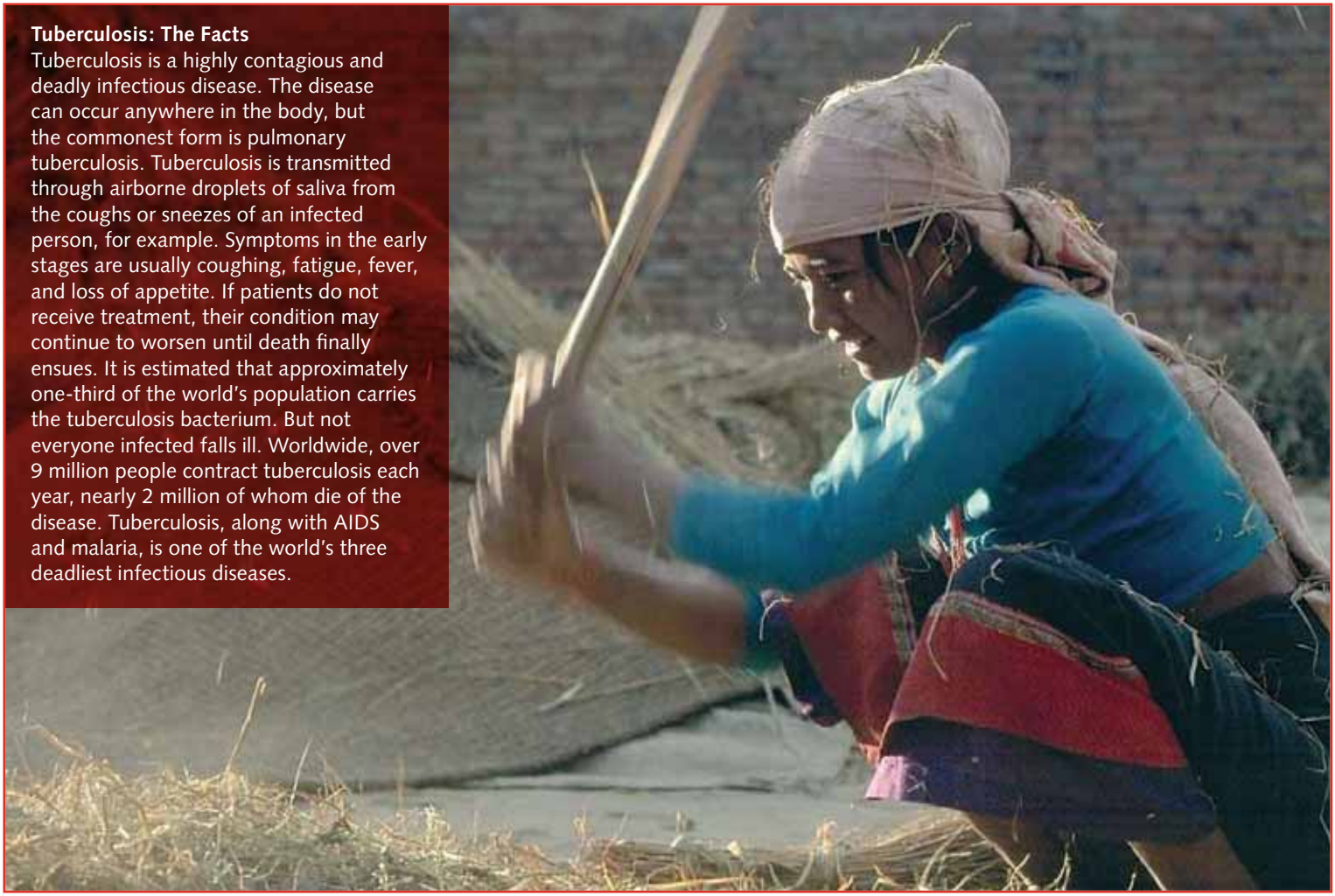
Tuberculosis has no borders, and, judging by the number of its victims, it is the world's second infectious disease—unnecessarily so, since patients can make a full recovery thanks to relatively inexpensive treatment. We find it unacceptable that there are still thousands of people who die of tuberculosis every day. Since it was established in 1903, KNCV Tuberculosis Foundation has thus ensured that tuberculosis patients are identified at an early stage, receive treatment, and recover from the disease.

And with success. In the forty-five countries in which we work, over 3 million patients are identified each year, of whom over 85 percent recover. This is largely attributable to the international TB treatment method that was developed with our support.

Local Support
In order to reach everyone, we work at all levels jointly in forty-five countries in Europe, Africa, Asia, and Latin America. We aim to capitalize on the population's individual strengths and responsibility, and thus focus on establishing and improving local and national TB control programs. We train local health workers in recognizing, identifying, and treating TB patients, and educate local researchers through projects for doctoral students from various project countries, among other initiatives. In this way, we ensure that the country, and thus the population, can ultimately fight tuberculosis without outside assistance.

Broad-Based Approach
We provide a full range of services to both national TB programs and worldwide platforms for policy development. These involve providing advice on, and support to, detection and treatment, an approach to fighting drug-resistant tuberculosis, managing the risk of infection, improving laboratory capacity, working with HIV/AIDS programs, policy development, professional development, strengthening general health-care systems, focusing on poor and vulnerable groups, and social mobilization.

Tuberculosis: The Facts
Tuberculosis is a highly contagious and deadly infectious disease. The disease can occur anywhere in the body, but the commonest form is pulmonary tuberculosis. Tuberculosis is transmitted through airborne droplets of saliva from the coughs or sneezes of an infected person, for example. Symptoms in the early stages are usually coughing, fatigue, fever, and loss of appetite. If patients do not receive treatment, their condition may continue to worsen until death finally ensues. It is estimated that approximately one-third of the world's population carries the tuberculosis bacterium. But not everyone infected falls ill. Worldwide, over 9 million people contract tuberculosis each year, nearly 2 million of whom die of the disease. Tuberculosis, along with AIDS and malaria, is one of the world's three deadliest infectious diseases.



Research
We also conduct scientific research. Using TB prevalence studies, we map out the TB situation and its cause in a particular country. Since the current treatment method is long-term and hard on patients, we conduct intensive research on more effective control strategies. We also focus extensively on TB prevention—for instance, by conducting preliminary studies on the efficacy of a TB vaccine.

Partnerships
KNCV Tuberculosis Foundation maintains a large network. Our partners include the World Health Organization (WHO); we are a co-founder of the Stop TB Partnership, a worldwide coalition of TB control organizations; and we provide guidance to the Tuberculosis Coalition for Technical Assistance (TBCTA), a coalition made up of eight leading technical organizations active in international TB control. We are considered one of the world's leading players in TB control.

Poverty Reduction
Ultimately, it is not just the TB patient who benefits from treatment, but the entire family as well. By the same token, the danger of further infection within the community is reduced. If a mother or father dies of tuberculosis, the family often loses its breadwinner. TB control therefore represents a sustainable investment in the future. We fight not only tuberculosis, but also poverty and HIV/AIDS, and thus reinforce a country's overall health system. We also ensure that the disease does not return to the Netherlands. As long as tuberculosis continues to occur throughout the world, the disease presents a real threat to the Netherlands. It is for this reason that we

must not and cannot relax our TB control efforts, not even in the Netherlands.

Transparency
We attach great importance to transparency, which we take to mean actively focusing attention on information relating to our work, the Board of our organization, and the results of our expenditure, even in times of reduced funding. In addition to revenue from institutional donors, our own fund-raising initiatives ensure continuity in our work, providing us with opportunities for making our own choices about allocating funds and for working on new and existing projects for which donors have not yet been identified.

The Fight Goes On
In the Millennium Development Goals, the United Nations has stated that the global TB epidemic must be halted in 2015. KNCV Tuberculosis Foundation is making every effort to achieve this goal.

As an ambassador for quality TB control, we continue to emphasize the seriousness of the disease and the urgency of control. After all, we know that the goal is realistic: Tuberculosis is under control in the Netherlands—now there's just the rest of the world to go!

STOP TB Strategy
TB patients can be cured by undergoing a course of treatment that involves a combination of various antibiotics. Patients take their medication each day under strict supervision. This treatment is part of the WHO (World Health Organization) STOP TB Strategy, recommended throughout the world. It constitutes the most cost-effective strategy for fighting TB. With the support of KNCV Tuberculosis Foundation, the physician Karel Styblo took the first steps toward developing the method in the 1980s with the DOTS Strategy.

Drug-Resistant Tuberculosis
Of great importance in treating tuberculosis is the fact that patients follow a strict schedule when taking their medication. Failing that, the medication will not work effectively, and multidrug-resistant tuberculosis (MDR-TB) or even extensively drug-resistant tuberculosis (XDR-TB) can develop. The treatment of MDR-TB requires other, more expensive drugs that have other side effects; furthermore, the course of treatment is longer. In patients with XDR-TB, the bacterium hardly responds at all to drugs. Good laboratory research is therefore crucial to the fight against MDR-TB and XDR-TB. For that reason, we are working to strengthen and expand our laboratory network in the project countries. We are also investigating better, affordable tests and are training laboratory staff.

Tuberculosis and HIV/AIDS
A major cause of the TB epidemic is HIV/AIDS. The body's immune system is weakened as a result of HIV infection. Consequently, individuals with a latent TB infection run a great risk of developing active tuberculosis. Conversely, tuberculosis further undermines the already compromised immune systems of those infected with HIV/AIDS. In fact, the two illnesses reinforce each other. The only solution is for both diseases to be treated simultaneously. Over the last few years, KNCV Tuberculosis Foundation has had great success in bolstering collaboration between local TB and HIV/AIDS control. TB patients are tested for HIV, and if they have been infected, they are given AIDS inhibitors. Conversely, HIV patients are tested for tuberculosis. If they are infected with TB, they undergo a preventative course of treatment with isoniazid (a drug often used to treat TB). If they have already developed tuberculosis, they undergo a complete course of treatment for TB. We also train new staff and teach health workers how to protect themselves from becoming infected with HIV.

Partnerships

National

RIVM/CIb – The Center for Infectious Disease Control (Netherlands) (CIb) of the National Institute for Public Health and the Environment (RIVM) plays a coordinating role in preventing and controlling infection. RIVM/CIb partly acts as a commissioning agency in respect of KNCV Tuberculosis Foundation.

Dutch Municipal Health Service (GGD'en) – The implementation of TB control – which involves surveillance, detection, treatment, and vaccination – is entrusted to the seven Municipal Health Service regions in the Netherlands. KNCV Tuberculosis Foundation supports them in these efforts. The Municipal Health Service reports its patient information to the Netherlands Tuberculosis Register (NTR), which is administered by KNCV Tuberculosis Foundation.

NVALT – The Netherlands Association of Physicians for Pulmonary Diseases and Tuberculosis is a member of KNCV Tuberculosis Foundation. We work closely with the association in developing new policy and creating conditions conducive to quality diagnostics and treatment.

AMC – KNCV Tuberculosis Foundation works with the Academic Medical Center of the University of Amsterdam in the field of research, education, and the supervision of PhD students. We also have partnerships with other universities.

International

TBCTA – KNCV Tuberculosis Foundation and seven international partners have joined efforts to form the Tuberculosis Coalition for Technical Assistance, a global collaborative partnership providing support to national control programs throughout the world.

DTLab – The Dutch Tuberculosis Laboratory Partnership is made up of KNCV Tuberculosis Foundation, the Royal Tropical Institute (KIT), and the National Institute for Public Health and the Environment (RIVM) and is dedicated to improving the capacity of TB laboratories in developing countries.

WHO – KNCV Tuberculosis Foundation works closely with the World Health Organization. We take part in technical working groups at the WHO headquarters in Geneva and in all six regions. We have also made important contributions to the creation of a new control strategy, the STOP TB Strategy.

STOP TB Partnership – We are a co-founder of the Stop TB Partnership, a worldwide coalition of organizations devoted to achieving the goals of the World Health Organization (WHO) for TB control. KNCV Tuberculosis Foundation sits on the partnership board and is active in all working groups.

USAID – The United States Agency for International Development is the American directorate for international cooperation which supports TB control throughout the world. From 2005 through 2010, TBCTA is receiving a project grant from USAID for the purpose of expanding and strengthening the STOP TB Strategy.

DGIS – KNCV Tuberculosis Foundation has enjoyed a fruitful collaboration with the Directorate-General for International Cooperation (the Netherlands) for many years. From 2006 through 2010, we are receiving a TMF Program Subsidy from DGIS in support of our international activities. We hope to achieve success with our new grant application for 2011–15 submitted for the Dutch Co-financing System II (MFS II).

LSHTM – Since 2005, KNCV Tuberculosis Foundation has worked with the London School of Hygiene & Tropical Medicine in the TARGETS Research Programme Consortium. The objective of this consortium is to develop and apply tools for fighting infectious diseases. Developing and evaluating strategies for reaching poor and vulnerable groups with TB control interventions is a special area of focus.

Aeras Global TB Vaccine Foundation – The aim of Aeras is to develop a vaccine against tuberculosis. KNCV Tuberculosis Foundation has long worked with Aeras to establish field sites for testing this vaccine in South Africa (since 2001), Kenya (2005), Uganda (2006), and Cambodia (2008).

AIGHD – KNCV Tuberculosis Foundation is a member of the Amsterdam Institute of Global Health and Development, a consortium of the Academic Medical Center which is dedicated to combating poverty reduction and improving health care in developing countries.

ETC Crystal – KNCV Tuberculosis Foundation has formed a strategic alliance with ETC Crystal, an organization focusing on consulting and research in the area of international health care. Together with ETC Crystal, we have submitted an MFS II grant application to the Directorate-General for International Cooperation (the Netherlands) for 2011–15.

Management Report

KNCV Tuberculosis Foundation continued to provide unwavering support to the international fight against TB in 2009. That support is badly needed: we are very concerned about the flagging detection rate and treatment of multidrug-resistant tuberculosis (MDR-TB) in particular. If the situation does not change, the Millennium Goals for 2015 will not be met, despite the fact that, between 1995 and 2008, 36 million people were cured of TB and 8 million TB deaths prevented. It is for this reason that we will continue to advocate a decisive, united strategy for fighting tuberculosis worldwide in 2010.

Our organization is now active in forty-five countries. In addition to our existing offices in Kenya, Kazakhstan, Indonesia, Nigeria, Namibia, Ethiopia, and Botswana, we have opened new offices in the Dominican Republic, Pakistan, and Vietnam. We now employ 120 local staff members. Thanks to them, we are able to quickly develop TB control programs in the relevant countries, thereby embedding knowledge at the local level.

Positive Evaluations

KNCV Tuberculosis Foundation's leading position in international TB control was underscored in 2009, when external organizations evaluated the outcomes of our two biggest projects, the Thematic Co-financing project funded by the Directorate-General for International Cooperation (DGIS) and the Tuberculosis Control Assistance Program (TB CAP), funded by our partner USAID (the United States Agency for International Development). Carried out by external organizations, both evaluations present a very positive assessment of the way in which we approach TB control. Because funding for these two projects will terminate in 2010, we have begun preparations for follow-up grants for 2011–15. With regard to the DGIS, this involves an application for the Co-financing System II (the successor to Thematic Co-financing); for USAID, this concerns a competitive tender published in early 2010. The decision regarding these applications, to be announced in 2010, will be a very important determining factor in our ability to continue our global activities.

Successful Advocacy Efforts

KNCV Tuberculosis Foundation also advocated a more decisive approach to global TB control at other international conferences – for instance, in Beijing in April, where ministers from the twenty-seven countries with a high prevalence of drug-resistant tuberculosis discussed flagging detection rates and treatment of MDR-TB patients.

Together with other civil society organizations in the Netherlands, we have called on our government to continue providing support to the Global Fund to Fight Aids, Tuberculosis and Malaria (GF). To that end, we organized a discussion meeting at the Clingendael Institute in March which featured the GF director Mr. Michel Kazatchkine as guest speaker. Strong support from the Lower House of the Dutch Parliament in the autumn was partly responsible for the government reducing the cut in its 2010 contribution to the GF from a proposed 30 percent to 15 percent.

Prize for TB Control in Europe

In 2009, the Coordinating Board of the STOP TB Partnership chose us as its representative of non-governmental organizations (NGOs), which means that we can exert more influence on international policy for TB control and can give a voice to the NGOs in our project countries. One highlight was winning the European NGO Award (second prize) for our TB control activities in Europe. The award was presented by the European Commission (EC), the European Centre for Disease Prevention and Control (ECDC), and the European regional office of the World Health

Mr. P.C.F.M. Gondrie, Executive Director, and Ms. G.T.M. Schippers, Finance and Organization Director

Organization (WHO Euro) at a TB control meeting held in Luxembourg in June. We took advantage of this opportunity to emphasize once again to the European Union the urgency of the TB situation in the European region. The pledge set out in the 2007 Berlin Declaration to arrive at a joint European approach to TB control at a high political level has yet to be fulfilled.

A New Strategic Plan
In order to lay a solid groundwork for the USAID and DGIS project proposals, we drew up our new strategic plan in 2009 for 2011-15. A participative structure was chosen, which allowed all staff members (even those working in offices outside the Netherlands), external stakeholders, and the international advisory council to provide input. It proved to be a productive process and very beneficial for critical reflection on our role and performance. The outcome is that we are more strongly promoting integrating elements in our new strategy. The three most important are:
(1) achieving synergies between all our activities – national, international, and research, as well as between national-level implementation and policy-making activities;
(2) more emphasis on linking TB control to strengthening general health care; and
(3) the further decentralization of our activities to the country and regional offices.
In addition, we will certainly be continuing to build on our strong points. The draft plan was drawn up by the Supervisory Board in February 2010 and will be presented to the General Membership Meeting in May 2010.

The Netherlands
In 2009, we started creating a new joint plan for TB control in the Netherlands with the Center for Infectious Disease Control in Bilthoven, the Netherlands. On March 24, World Stop Tuberculosis Day, we launched "Stop TB," our new fund-raising campaign.

Organizational Developments
In April 2009, the first report produced in connection with our organization-wide monitoring and evaluation (M&E) system was concluded. The results have been used to determine a number of improvement activities, with which we have started an entire first annual cycle of data collection, reporting, and analysis. In the DGIS evaluation, the M&E system was commended for being of great importance in continuing to set the right priorities in country support activities and, in this regard, functioning with the highest possible level of customer focus and efficiency.
On January 1, 2009, the International Unit was split into an Africa Unit and an International Unit. Peter Gondrie, who at the time was head of the International Unit, assumed the position of director of KNCV Tuberculosis Foundation on May 1. New unit heads were appointed for the Africa, International, and National Units in 2009.

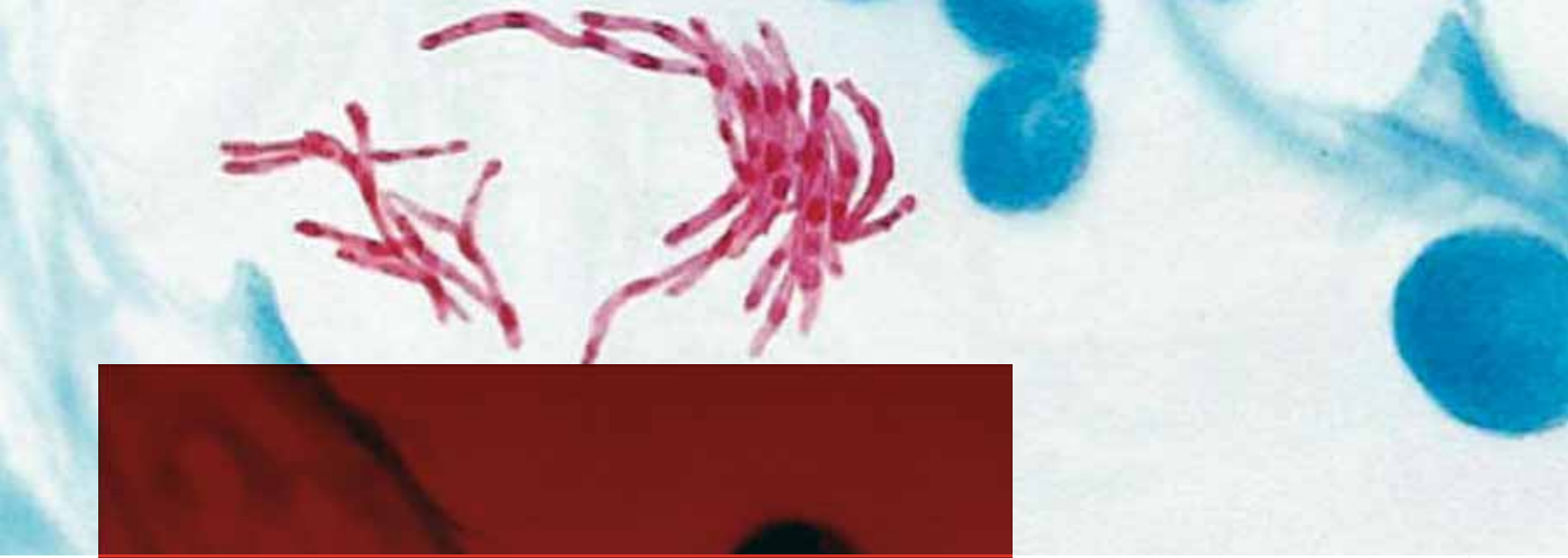
More information on the management structure, the application of the Good Governance Code for members of the Association of Fund-raising Organizations, the detailed financial annual report, and in-depth information on countries can be found at www.kncvtbc.nl.

Management Structure
KNCV Tuberculosis Foundation is an association. It has a two-member Executive Board charged with day-to-day management and assisted in this respect by the management team. A seven-member Supervisory Board assesses the performance of the Board and the organization. The Supervisory and Executive Boards are both accountable to the highest association body, the General Membership Meeting, to which the Supervisory Board reports on matters concerning its supervisory duties and the Executive Board on management.

The operational structure of the organization is composed of units representing the organization's core activities on the one hand and the facilitating part of the organization on the other.

The core activities are carried out by the
- National Unit,
- International Unit,
- Africa Unit,
- Research Unit,
- Data Management Unit, and
- TBCTA Unit (Project Management Unit for the USAID project).

A facilitating role is played by the
- Finance, Planning, & Control Unit,
- Facilities Unit,
- Executive Support Unit including Human Resources, and
- Communications and Fund-raising Unit.



What We Do in …

the Netherlands

In 2009, KNCV Tuberculosis Foundation intensified its partnership with the Center for Infectious Disease Control; the two organizations are working together to draw up a national TB control plan. The number of TB patients in the Netherlands increased in 2009 for the first time in three years. A worrisome development is that the number of patients with drug-resistant tuberculosis has also increased sharply. KNCV Tuberculosis Foundation is committed to maintaining knowledge of TB control. We provide support to various training courses for TB doctors and nurses, and conduct research.

A National TB Control Plan

We stepped up our collaboration with the Center for Infectious Disease Control of the National Institute for Public Health and the Environment (RIVM) in 2009. The government has charged the Center for Infectious Disease Control with overseeing infectious disease control in the Netherlands, and the Dutch Ministry of Health, Welfare, and Sport has instructed it to draw up a national TB control plan jointly with us. KNCV Tuberculosis Foundation had formulated its own TB control plan, entitled "Op weg naar eliminatie" ["On the Road to Elimination"] in 2008. The national TB control plan, which must be completed in 2010, will address subjects including the quality of laboratory diagnostics, the continued regionalization of the Dutch Municipal Health Service (GGD'en), screening issues, and policy on immigrants. By working together, we can both benefit from each other's knowledge and expertise, and develop a well-grounded national plan. The head of the National Unit is working on site at the Center for Infectious Disease Control one day a week for the purpose of optimizing our collaborative effort. Additionally, staff from the Center for Infectious Disease Control also make regular visits to our headquarters in The Hague, just as our staff visit the Center in

Bilthoven, the Netherlands. We provide the Center for Infectious Disease Control with insight into the interpretation of data pertaining to statutory notifications, such as those contained in the Netherlands Tuberculosis Register (NTR), which is administered by KNCV Tuberculosis Foundation.

A Complex Disease

The increase in the number of TB patients in 2009 is largely due to an increase in the number of immigrants with tuberculosis; this pertains to both the "normal" and the drug-resistant forms of the disease (see box). Fortunately, the number of infectious patients did not rise; consequently, there was no increased threat to public health. Over the last few decades, the complexity of the disease has greatly increased as a result of problems involving drug resistance, TB/HIV infections, and the explosive use of new drugs to treat such diseases as rheumatism which weaken the immune system. Treating and supporting patients with different cultural backgrounds and social problems requires a much higher degree of knowledge and skill from health-care workers than in the past. It is for this reason that a regionalization process consolidating knowledge and expertise has been under way in the Netherlands for several years.

Training

Professional development is of primary importance in maintaining quality TB control. We are thus delighted that three training places for TB doctors were allocated in 2009 by the College voor de Beroepen en Opleidingen in de Gezondheidszorg ["Board for Health Care Professions and Education"] (CBOG), a foundation established at the behest of the Dutch Ministry of Health, Welfare, and Sport in 2006. This is the first time since the CBOG was established that TB doctors will be given the chance to train. The Netherlands School of Public & Occupational Health (NSPOH) in Amsterdam will be offering the courses of study, which will commence in the autumn of 2010. KNCV Tuberculosis Foundation is participating as a member of the course advisory committee of the academic professional associations. Additionally, we offer, and provide support for, courses geared toward staff working in TB control departments of the Dutch Municipal Health Service; these include a basic course for medical and technical staff and a course module for TB nurses provided in collaboration with the NSPOH.

New DNA Fingerprinting Technique

An important development in TB control in the Netherlands is that a new DNA fingerprinting technique was introduced on January 1, 2009 – the so-called VNTR (variable number tandem repeats) type. This method can be used to quickly and easily determine which strain a particular tuberculosis bacterium belongs to. Storing, comparing, and exchanging research data is also very straightforward because the result is expressed as a figure rather than a bar code. All these factors contribute to faster detection and diagnosis of tuberculosis in the Netherlands.

Research in the Netherlands

We began a new study on the advantages of IGRA blood tests in detecting latent TB infections (LTBIs) in 2008. The research is being conducted as part of a project carried out by the Netherlands Organisation for Health Research and Development called *TB perspectief Nederland* ["TB Perspective: The Netherlands"], a collaborative undertaking between KNCV Tuberculosis Foundation, the Erasmus Medical Center, the Leiden University Medical Center (LUMC), and participating units of the Dutch Municipal Health Services. The main aim of this research is to determine to what extent there is evidence of latent TB infections in immigrants having recently arrived in the Netherlands. Secondly, the predictive value of a positive IGRA result for the development of active tuberculosis will be studied. At the end of 2009, half the number of immigrants required for this research had been examined. It is expected that the research will have been completed by the middle of 2010.

Tuberculosis in the Netherlands

In January 2009, according to provisional data, 957 patients were entered in the Netherlands Tuberculosis Register in 2008. Approximately one in seven TB cases is the result of a recent transmission within the Netherlands. The remaining cases are traceable to infections in the past or were "imported" from other countries with a high incidence of tuberculosis. Groups in the Netherlands with a relatively high incidence of tuberculosis are individuals who are in contact with TB patients, individuals from sub-Saharan Africa, asylum seekers, those infected with HIV, the homeless, and drug addicts. The Municipal Health Service is investigating the incidence of tuberculosis within these so-called risk groups. In 2008, nearly one in four TB cases (23 percent) was identified at an early stage thanks to such active case finding, thus preventing the risk of new infections.

A New Strategic Plan for HRH

In 2009, we developed a strategic plan for 2011–15 for Human Resource for Health (HRH) applicable to the entire organization (i.e., the National, International, Africa, and Research Units and HR). The management team discussed the plan in April. Once the new general strategic plan has been drawn up for our organization in 2010, we will be testing the HRH plan against it, modifying it where necessary, and then annexing it to the plan. The HRH Department has provided educational support to the further training of TB doctors.

KNCV Tuberculosis Foundation is active in over forty countries throughout the world. In 2008, a total of 4,551,880 TB patients were identified – an estimated 80 percent of all new patients with tuberculosis. Of them, 87 percent have been cured.

What We Do…

Worldwide

At a global level, the TB epidemic appears to be stabilizing. Treatment results of TB patients are good: The World Health Organization's worldwide goal of an 85 percent cure rate was reached by a wide margin of 87 percent in 2009. A point of concern, however, is that the increase in the number of patients identified is leveling off. The detection and treatment of drug-resistant tuberculosis in particular is lagging. But TB/HIV control did make advances in 2009. Also positive is that international TB control is focused more than ever on strengthening general health-care systems and the improved detection of TB among poorer population groups who do not have access to medical care.

More Active Case Detection

International TB control organizations are very concerned about the flagging detection rate of TB patients – 61 percent in 2009. That is why the DOTS Expansion Working Group of the STOP TB Partnership launched a new framework for active case finding in November 2009. The WHO's global goal of a 70 percent detection rate is no longer sufficient. To meet the Millennium Goals for 2015, we must identify as many TB patients as possible at an early stage. This means that we need to adopt an active approach to risk groups (e.g., poorer population groups, people with HIV, prisoners, drug users, and the homeless) and provide access to TB care to everyone.

Strengthening Health Care

More TB patients can be successfully identified only if TB diagnosis and treatment are permanently embedded in general health care. For this reason, one key objective of our policy is the strengthening of general health care to ensure sustainable, high-quality TB control (Health System Strengthening, or HSS).
We encourage national tuberculosis control programs (NTPs), private clinics, and local hospitals to work with public–private partnerships (PPPs). Doctors must routinely

ask their patients in hospitals or clinics if they have TB symptoms and provide them with a TB test if necessary. In this way, we make TB care more accessible to the local population and can detect and treat more TB patients. We also work with external partners. In 2009, we forged a strategic alliance with ETC Crystal, an organization focusing on HSS, with which we have submitted a joint grant application to the Directorate General for International Co-operation (DGIS). Another partner is the Amsterdam Institute of Global Health Development (AIGHD), a consortium of the Academic Medical Center (AMC) focusing on health care and poverty reduction. The Stop TB Partnership established an HSS working group in 2009 which was charged in 2010 with ensuring that HSS is embedded in the work of TB consultants worldwide. KNCV Tuberculosis Foundation has enlisted the services of a special consultant for HSS.

Tuberculosis and HIV/AIDS
The problems of TB/HIV represent an obstacle to effective TB control. Thanks to increased availability of HIV drugs and our active TB case detection among HIV patients, the number of TB/HIV patients undergoing treatment fortunately increased in 2009. We hope that this positive trend will continue. The strategy for managing the risk of TB infection is critical to our combined treatment of tuberculosis and HIV/AIDS. People who are infected with HIV are very susceptible to all kinds of infectious diseases, particularly tuberculosis. That is why people with HIV and TB patients are separated in hospitals as much as possible. Hospitals are making changes to their facilities and are protecting both patients and staff from infection with good ventilation, masks, and ultraviolet light. We support these efforts by furnishing guidelines, providing courses on infection control for staff and hospital architects, and distributing demonstration kits. We will be continuing these initiatives in 2010.

Drug-Resistant Tuberculosis
Of great concern is the flagging detection and treatment of multidrug-resistant (MDR) and extensively drug-resistant (XDR) tuberculosis. Nearly half a million people contract MDR-TB every year. Only 2 to 3 percent of them are identified and treated in accordance with international standards. To improve this situation, we supported the NTPs in countries including Indonesia, Ethiopia, Kenya, Namibia, China, Vietnam, and Kazakhstan in 2009 in implementing programmatic management of drug-resistant TB (PMDT). We also successfully improved the capacity and quality of laboratories. Good lab diagnostics are needed for rapid detection and proper treatment of M/XDR-TB. Together with the National Institute for Public Health and the Environment (RIVM) and the Royal Tropical Institute (KIT), we founded the DTLab (Dutch TB Laboratory Partnership) in 2009 which provides all TB control organizations in the world with information on, and support in, laboratory strengthening. We started supporting and developing a regional center of excellence for diagnosing and treating MDR-TB in Rwanda in 2009.

Regional Training Centers
We continued to provide support to the regional training centers in Indonesia, Nigeria, and Georgia in 2009. These centers organize international TB training courses in their regions with KNCV Tuberculosis Foundation's stamp of quality. We support the centers in developing training curricula, train their trainers in interactive training methods, and provide advice on building a team of trainers and positioning in the region. Things are progressing very well in Indonesia and Nigeria, where more and more training courses are being offered. The project got off to a slow start in Georgia because of the 2008 conflict with Russia. In 2009, we worked toward opening the center, scheduled for January 2010.

Human Resource for Health
We support NTPs in our project countries in formulating and implementing strategic plans for Human Resource for Health (HRH). For integrating the plans into the NTPs' general strategy, our HRH and general consultants regularly carry out joint missions. From an HSS standpoint, we had a great deal of contact in 2009 with the ministries of public health in the project countries to lobby for embedding HRH in general health care.

Prevalence Studies
We are conducting TB prevalence studies in various regions. Such research enables us to determine how many people have tuberculosis in a given country. A comparison of the results of successive studies provides insight into the effect of TB control. The results of our prevalence studies in Vietnam were published in academic periodicals in 2009. Data collection was completed in Bangladesh, and we provided support in analysis and reporting. We are currently preparing prevalence studies in Tanzania, Kenya, Zambia, Mali, Pakistan, South Africa, and Indonesia. When these studies will actually get under way depends on the availability of donor funds. Our aim is to carry out a study jointly with various partners in twenty-one countries prior to 2015.

Tuberculosis:
A Disease That Preys on the Poor
In our prevalence study in Vietnam, we sought to determine whether there is a relationship between tuberculosis and socio-economic status (SES) using a short questionnaire allowing us to predict expenditure per household on the basis of a minimum set of indicators. Our questionnaire covered nine data: the number of women and children, the ethnicity of the head of the household, the floor of the house, the main fuel used for cooking, and the presence of luxury items (e.g., TV, radio, motor, and car). We used this information to estimate the expenditure per household in our research in connection with TB incidence. The outcome was that tuberculosis in Vietnam is strongly related to poverty. In fact, tuberculosis incidence rates are 2.5 times higher in the poorest population group than in the wealthiest.

KNCV Tuberculosis Foundation is active in twenty-four African countries: Angola, Botswana, the Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Swaziland, Tanzania, Uganda (Research Unit only), Zambia, and Zimbabwe. In 2008, a total of 1,114,141 TB patients were identified in the twenty-three countries supported by the Africa Unit. Of them, 80 percent have been cured.

What We Do in …

Africa

KNCV Tuberculosis Foundation carries out the majority of its activities in Africa. We are achieving more and more success here in the fight against TB, having identified a record number of TB patients in 2009. Thanks in part to our integrated control of TB/HIV infection and increased access to antiretroviral drugs, the increase in the number of TB patients is slowing. The development of programmatic management of drug-resistant TB (PMDT) is well under way. As part of Human Resource for Health (HRH), we support countries in formulating their strategic plans and train health workers. We also conduct epidemiological research.

More Project Countries

We now have three new project countries in West Africa: Sierra Leone, Guinea-Bissau, and Liberia. The Africa and Research Units carried out a joint mission in Liberia. Liberia's national tuberculosis program (NTP) needs technical assistance in control activities and in conducting research, and we will start providing that assistance in 2010. In Angola, we successfully provided support in connection with a grant application submitted to the Global Fund to Fight Aids, Tuberculosis and Malaria (GF). We are also involved in research on multidrug-resistant tuberculosis (MDR-TB) and in drawing up a national TB control plan. We trained HRH staff in various African countries. In Swaziland, we drew up an inventory of existing and required HRH elements. We will be developing non-existent HRH activities in 2010.

The activities carried out by our country offices in Namibia, Nigeria, Botswana, and Ethiopia increased sharply in 2009. Our regional office in Kenya, which we share with our local partner KAPTLD (Kenya Association for the Prevention of Tuberculosis and Lung Disease), moved twice because the number

of staff had grown so quickly. Thirty people now work there. A great result!

PMDT Undergoing Rapid Development
Much progress has been made in the area of PMDT. In Namibia, where PMDT was implemented two years ago, we were able to analyze the initial treatment results. In Ethiopia, a country with a high incidence of MDR-TB, we intensified technical assistance and put more patients on a course of treatment. Kenya, Lesotho, Tanzania, and Botswana have also enthusiastically embraced PMDT. We will be bringing PMDT to other countries in 2010. A key objective continues to be better laboratory diagnostics.

We are supporting the development of an MDR-TB center of excellence in Rwanda, which will become the pre-eminent PMDT center in the region. A training center and an MDR-TB treatment center are already in operation but still need to be optimally integrated into the TB and HIV control programs. We will continue to develop this infrastructure in 2010.

TB Control in Prisons
The grant from the Canadian International Development Agency (CIDA) for our projects in Africa terminated in 2009. Our donor, the United States Agency for International Development (USAID), is taking over a number of projects within the Tuberculosis Control Assistance Program (TB CAP). CIDA is funding a new Stop TB Partnership project called TB REACH starting in 2010. The project focuses on the early detection and treatment of tuberculosis, particularly among population groups with limited access to TB care. In early 2010, we will be supporting the NTP in Zambia in submitting an application for TB REACH funding for TB control in prisons.

Competency-Based TB Training
In Kenya, we developed a three-week curriculum for a training course for nurses and laboratory assistants responsible for organizing the TB program at the district level. The course is practically oriented and encourages participants to share their experiences with one another. A pilot training course was held in November 2009. We will be improving the curriculum in 2010 based on the results of the pilot. The advantage is twofold: District staff are trained, and staff at the national level learn how to develop a practically oriented curriculum.

In Tanzania, we teamed up with the Royal Tropical Institute (KIT) to conduct research on the workload in TB control. We built on the results of a similar study in Zambia conducted in 2008, in which methods for determining the workload were developed. The results and methods will be made available in 2010. A heavy workload is a problem for many TB programs in Africa.

Good Results with Treatment at Home
We have concluded our research in Tanzania on patient preference for the provision of drugs during TB treatment. When patients take their TB medication at home – under the supervision of a caregiver they have designated themselves –, treatment is as successful as in clinics where patient compliance is monitored daily. This new strategy gets patients more involved in their own treatment, which in turn can have a positive impact on compliance. Further studies are planned for 2010.

In 2009, we selected thousands of children for our long-term cohort on the incidence (the annual number of new cases) of tuberculosis in Kenya and Uganda. The research is now well under way. Incidence studies are crucial in determining the scope of future field research for new TB vaccines and in building up the necessary staffing resources. We will be concluding the incidence studies and will be starting large-scale vaccine field trials in multiple countries in 2010.

PMDT Lobby Strategy
Since 2009, KNCV Tuberculosis Foundation has been working with the East, Central, and Southern African Health Community (ECSA-HC), an intergovernmental organization that aims to improve the general health-care systems of member countries. The biennial conference of the member states' public health ministers will be held in Uganda in February 2010. KNCV Tuberculosis Foundation provided support to ECSA-HC in its preparations. The aim is to make PMDT a political priority in the region. We want to implement a monitoring system with ECSA-HC to determine whether the PMDT strategy is being complied with properly. From our regional office in Nairobi, Kenya, we will be offering technical support for the building up of staffing resources for TB control. USAID is funding this important advocacy project through TB CAP.

KNCV Tuberculosis Foundation is active in eight countries in Asia: Afghanistan, Cambodia, China, India, Indonesia, Pakistan, the Philippines, and Vietnam. In 2008, a total of 3,154,840 TB patients were identified. Of them, 90 percent have been cured.

What We Do in …

Asia

Tuberculosis claims many of its victims in Asia. Multi-drug-resistant tuberculosis (MDR-TB) and dual TB/HIV infections are on the rise. In 2009, the countries that are home to 90 percent of all MDR-TB patients met in Beijing to work on plans for improved detection and treatment of MDR-TB. It was decided to set up an international registration and reporting system. This is an encouraging step in the right direction, but more is needed to face the threat of MDR-TB. For instance, the availability of sufficient MDR-TB drugs is a problem, and the organization of easily accessible MDR-TB treatments must be made a higher priority.

Indonesia

Our biggest project in Asia is in Indonesia and is funded by USAID (the United States Agency for International Development). We have our own office there, which employs eighty people. Because the office is becoming too small, we will be moving to a new, modern office in 2010. Since 2009, the USAID project has focused specifically on providing support to the national tuberculosis program (NTP) in introducing programmatic control of drug-resistant tuberculosis (PMDT). Indonesia is home to an estimated 40,000 MDR-TB patients. Because the detection and treatment of these patients has been poorly coordinated, a systematic approach to PMDT was prepared in 2009. Four hundred MDR-TB patients must be provided with treatment before October 2010. Important elements of the PMDT strategy are public–private partnerships (PPPs) between private doctors, general hospitals, TB clinics, and partner organizations; TB infection prevention and control; and improving laboratories.
In addition, we contributed with our own funds to the rebuilding of the TB control infrastructure in Padang following its total

collapse as a result of the earthquake in September 2009.

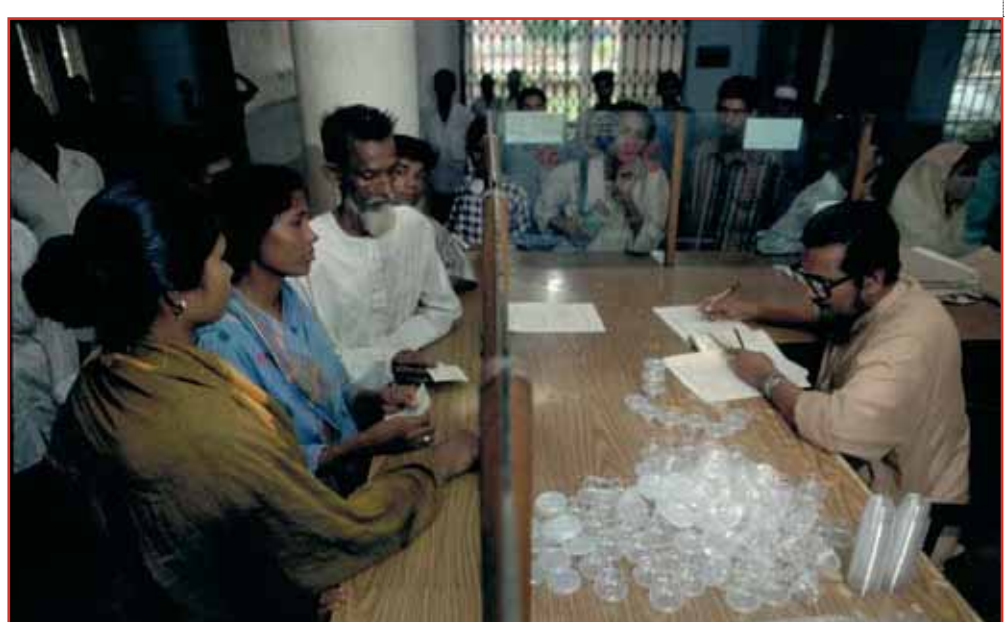
Our Own Office in Pakistan
We provided support to Pakistan in 2009 in carrying out a prevalence study and in formulating a strategic plan for Human Resource for Health (HRH). We opened our own office there in July, which employs four Pakistani staff members. The security situation in Pakistan continues to be a concern in terms of carrying out our work there. A new mission has been scheduled for March 2010. We were unable to provide direct support to the project in Afghanistan because of security reasons. The Royal Tropical Institute (KIT), however, was able to carry out two missions for us focusing on the further development of the strategic plan for HRH, which will be followed up in 2010. Our involvement in Iran continues to be limited. Our consultant there provides support to the NTP in TB/HIV control.

HRH in the Philippines and Cambodia
In December 2009, our consultant visited the Philippines to provide advice on the approach to TB infection control. The NTP in the Philippines has already built up much experience in MDR-TB control and treatment. With technical support from our consultant, the knowledge acquired has been incorporated into an MDR-TB training course for health workers. With our support, the NTP in Cambodia has drawn up a strategic plan for HRH. Health workers were given a training course on formulating and implementing a professional development strategy for health workers.

New Case Notification System in Vietnam
In 2009, we continued our USAID project in Vietnam focusing on strengthening laboratories. We hope to improve MDR-TB detection and treatment through this project. In addition, we provided technical support to the NTP in Vietnam in developing a new case notification system for TB patients and managing medication and other necessities. This system is managed over the Internet. The development process also allowed for the future possibility of incorporating other data relating to infectious and other kinds of diseases which must be reported to the Vietnamese government. The NTP will be testing the system in 2010. The system will be introduced in phases. The new Internet application is largely based on the approach employed by the Dutch surveillance system (Osiris).

New Tests for Resistance
In 2008, we conducted research in Vietnam and Indonesia on the efficacy of a new test for measuring resistance to isoniazid and rifampicin, two important TB drugs. It is a very fast test, providing results the next day. If the evaluation results had been good, this test would have represented a giant leap forward in diagnosing and treating MDR-TB. Yet research analysis in 2009 revealed that the evaluation results were less good than expected. In 2010, we will determine whether the test truly contributes to the diagnosis of patients in the sense that doctors can also actually use the test results, rather than waiting for two months on results produced by the regular resistance determinant. In addition, we will be conducting research on the efficacy of a new test for measuring resistance to second-line MDR-TB drugs in Vietnam and Indonesia in 2010. This is also a fast test, providing results the next day.

Travel Expenses Reimbursed for TB Patients in China
In 2009, we concluded an operational research course in China which involved four groups of researchers in two provinces drawing up a research protocol, collecting and analyzing data, and drafting a report. The group is publishing information on the project in international periodicals in 2010. One of the studies focused on the referral of probable TB patients by general hospitals in the province of Yunnan. It emerged that considerably more of these patients came to TB clinics for free diagnosis and treatment if their travel expenses to the clinic were reimbursed. The same effect was produced when doctors at TB clinics were paid a fee for identifying patients who had been referred but had not come to the TB clinic of their own accord within three days. Based on this research, the province of Yunnan has now adopted the policy of remunerating doctors and reimbursing patients' travel expenses.



KNCV Tuberculosis Foundation is active in nine countries in Eastern Europe and Central Asia: Georgia, Kazakhstan, Kyrgyzstan, Moldavia, Romania, Russia, Tajikistan, Turkmenistan, and Uzbekistan. In 2008, a total of 215,764 TB patients were identified. Of them, 64 percent have been cured.

What We Do in …

Eastern Europe and Central Asia

Tuberculosis control efforts in Eastern Europe and Central Asia are gradually being raised to a higher standard. Yet dual TB/HIV infections, multidrug-resistant tuberculosis (MDR-TB), and extensively drug-resistant tuberculosis (XDR-TB) continue to pose a major threat. In 2009, European countries met twice to discuss the TB situation in Europe and to take action on the agreements set out in the 2007 Berlin Declaration. Unfortunately, however, this did not result in a decisive region-wide strategy. It thus remains to be seen whether Europe will meet the WHO goals for 2015.

Regional Office Sees Strong Growth
Our own regional office for Central Asia, located in Kazakhstan, grew so fast that we had to move to larger premises in 2009. Now we must ask ourselves whether we want to continue expanding. More growth means increased scale, more departments, and more operational and financial specialists. Another factor is that we may be opening a second regional office in Uzbekistan which will have to be managed from Kazakhstan. These plans should become clearer in 2010.
From our office, we support the national tuberculosis programs (NTPs) in Kazakhstan, Tajikistan, Uzbekistan, and Kyrgyzstan. Our projects, funded by the United States Agency for International Development (USAID) and the Directorate General for International Co-operation (DGIS), focus on preventing and controlling TB infection, programmatic management of drug-resistant tuberculosis (PMDT), and TB control in prisons.

Partnerships and Our Own Projects
In Kazakhstan, Kyrgyzstan, and Tajikistan, we have teamed up with the AIDS Foundation East–West (AFEW) for a TB control project

focusing on risk groups, such as people living with HIV infection and intravenous drug users. The primary aim is to promote knowledge of tuberculosis – for example, the recognition of symptoms – so that individuals will present more quickly to a doctor.
In connection with the prison project in Tajikistan which we are carrying out jointly with Luxembourg Caritas, we provided staff members with training courses and workshops on TB control in 2009; these focused on raising awareness and transferring knowledge. The NTP in Kazakhstan has requested that we continue our TB control initiative in prisons and extend it to other provinces, which we will be doing in 2010.
In Kazakhstan, we run our own project for improving laboratory safety. We screened eight laboratories in 2009 for risk of infection, equipment maintenance carried out, and, where necessary, additional recommended measures. We will be inspecting fourteen more laboratories in 2010. We also provided a train-the-trainer course in Kazakhstan in the area of MDR-TB.

USAID Project Named Best Practice
In 2009, our new USAID project was launched, aimed at controlling MDR-TB and supporting MDR-TB patients in Kazakhstan, Tajikistan, Uzbekistan, and Kyrgyzstan. Together with local NGOs, we developed a model for psychosocial support for these patients. The response elicited was so positive that the partner organizations in these countries immediately adopted the model. We also provided training courses and workshops. USAID is very pleased with the project and wants to present it in the region and throughout the world as a best practice.
Together with international partners, we signed up to a USAID project in the region of Central Asia in 2009. With this project, USAID hopes to improve the quality of overall health care, TB control being the main focus. A decision as to who will implement the project will be made in 2010.

TB control in the Roma Community
IWe successfully continued our project in the Roma community in Romania in 2009. During the first six months, we worked toward raising awareness of tuberculosis in schools. We trained schoolchildren to act as health promoters within their families and in their surroundings. The active identification of TB patients was given a boost, as we directly involved community nurses and health care intermediaries from the Roma community in TB control. Similarly, we developed a strategy for strengthening the role of private doctors in TB control. An interim evaluation in July revealed that we must involve the Roma community more effectively in TB control, an initiative we began in the autumn of 2009. We will be continuing these efforts in 2010.

Management Training Course in Riga
Again in 2009, we organized our annual management training course for TB control organizations in Eastern Europe and Central Asia. This was the first time the course was given not in Warsaw, but in Riga, Latvia. The course is mainly intended to develop skills necessary for organizing and managing an NTP. This time, extra attention was paid to developing training curricula, as training staff is an important task performed by managers in NTPs.

Improved Registration in Kazakhstan
Since 2008, KNCV Tuberculosis Foundation and the NTP in Kazakhstan have worked together to improve the electronic TB case notification system. This is important because the NTP uses data on the prevalence, spread, and epidemiology of tuberculosis to determine where additional funding is needed for improving TB control. The project produced major results in 2009. Unlike before, data are now checked for errors right when they are entered. Additionally, the NTP carries out a check of the entire register every month. If errors are found, the regions are requested to correct them and to provide any missing information. The quality of the data is now so high that the NTP can use them to answer important questions – for example, those concerning trends in the number of new cases and the correlation between MDR-TB and HIV infection.

KNCV Tuberculosis Foundation is active in five Latin American countries: Cuba, the Dominican Republic, Mexico, Peru, and Suriname. In 2008, a total of 56,682 TB patients were identified. Of them, 88 percent have been cured.

What We Do in …

Latin America

The identification and treatment of TB patients in Latin America have not yet achieved the World Health Organization's global goals, but various countries are making great progress. KNCV Tuberculosis Foundation was able to pursue its activities in Cuba and Mexico in 2009. We opened our own office in the Dominican Republic and launched a new project there. We carried out a mission to Suriname for the first time in years. As a member of the regional technical advisory group for Latin America, we take part in the regional TB meeting each year.

New Country Office Opened

KNCV Tuberculosis Foundation opened its own country office and hired staff in the Dominican Republic in 2009. This will allow us to provide rapid, dynamic support to the national tuberculosis program (NTP). Our work focuses on TB control in twelve of the thirty provinces and in the capital Santo Domingo, where the prevalence of tuberculosis is the highest. In one of the poorest municipalities of Santo Domingo, we are integrating all the innovative aspects of the STOP TB Strategy in a pilot project. We will subsequently expand the initiative to the entire country. After a minor delay, we were able to start carrying out our new project in 2009. The project is funded by our donor USAID (the United States Agency for International Development) and focuses on active case finding, training, social mobilization, supervision, and laboratory improvement. We have accomplished much in a short period. The NTP office has been given a complete makeover, and the regional laboratories have been supplied with new equipment. We will be continuing this project in 2010.

PPP Workshop in Mexico
In August 2009, our consultant provided technical assistance during a three-day workshop given in Mexico on public–private partnerships (PPPs). Twenty-two doctors and nurses from six Mexican states – Mexico City, Guerrero, Hidalgo, Veracruz, Coahuila, and Jalisco – took part in the workshop. The workshop focused on involving the big hospitals in TB control with the aim of having general hospitals identify more TB patients and refer them to primary care health centers with DOTS so that patients can start their six-month treatment quickly with the assurance that they will complete it under supervision. Five of the six participating teams followed up this workshop with a local workshop in which they drew up their operational PPP plans. Subsequently, these states began to improve the quality of DOTS treatment in primary care. This is an important step forward, particularly for Mexico City, where patients come from all over the country.

Cuba Adopts Dutch Approach
TB control in Cuba is highly successful with patient numbers virtually at the same level as those in Western Europe – approaching the elimination phase. For several years, KNCV Tuberculosis Foundation's National and International Units have worked together to support the NTP in Cuba in implementing its elimination plan, which has been approved by the Global Fund to Fight Aids, Tuberculosis and Malaria (GF). The NTP wishes to adopt the Dutch approach to TB control and has asked us for help. In June 2009, we paid a visit funded by the Cuban government (i.e., not via a donor) mainly for the purpose of providing support in the area of laboratory techniques. The NTP wishes to do a sputum culture of all TB patients and determine how tuberculosis is transmitted using DNA fingerprinting techniques, which will provide a good overview of the regions and population groups with the highest risk of infection. The NTP can then bring TB control into line with these findings.

Suriname to Receive a GF Grant
In 2009, we carried out a support mission to Suriname for the first time in years at the request of the government. Suriname will receive a GF grant totaling USD 5.7 million for TB control activities from 2010 to 2015 thanks in part to KNCV Tuberculosis Foundation, which provided technical assistance to the NTP in Suriname in drafting the project proposal. In addition, we provided support jointly with the Pan American Health Organization (PAHO) and others in creating a TB training course for health workers in Suriname. At our request, a TB doctor from the Nijmegen branch of the Dutch Municipal Health Services provided support in presenting the course in October 2009. Suriname has indicated that it is interested in establishing a closer partnership with KNCV Tuberculosis Foundation.

Successful Training Course in Supervision
In November 2009, KNCV Tuberculosis Foundation provided a three-day train-the-trainer course on supervision in the Dominican Republic. Twenty trainers from both the NTP and partner organizations took part. The course introduced them to a number of new supervision instruments developed to facilitate the work of supervisors. These instruments will allow supervisors to provide quality, support-based supervision on all aspects of the STOP TB treatment strategy and to assess the quality of TB control, both operationally and in the area of management. The instruments are intended for use by supervisors at both the national and provincial level. The course also addressed the principles of quality TB control and methods for strategic planning. The participants' evaluations indicated that they found the course to be very instructive and successful. The supervision instruments were tested in twenty health centers in December.

Tuberculosis Coalition for Technical Assistance

The Tuberculosis Coalition for Technical Assistance (TBCTA) is a unique coalition made up of leading international TB control organizations. Since 2005, TBCTA – together with a growing number of international partners – has been carrying out the Tuberculosis Control Assistance Program (TB CAP), fully funded by the United States Agency for International Development (USAID). KNCV Tuberculosis Foundation is charged with project management.

The aim of TB CAP is to improve TB control worldwide. All patients with tuberculosis, HIV, and/or multidrug-resistant tuberculosis (MDR-TB) must be provided with access to quality diagnosis and treatment. TB CAP is reaching this goal by strengthening important aspects of TB control such as technical implementation, organization, policy development and advocacy, communication, and professional development. TB CAP is active in twenty-five countries.

Positive TB CAP Evaluation
A team of international experts evaluated TB CAP in 2009. Their assessment of the project was extremely positive. The following is a quote from the USAID report submitted to Congress: "TB CAP is a highly successful project that has made significant impact.... In countries it directly supported, TB CAP has improved capacity to provide better-quality services to control TB, and it has indirectly strengthened other countries through its significant contributions to TB control efforts." Needless to say, we are very pleased with this excellent result, which is spurring us on to continue our meaningful work.

Laboratory Reinforcement
Again in 2009, TB CAP worked toward improving laboratories, crucial to better identification of TB patients. In addition to the TB Laboratory Standard Operating Procedures and the Laboratory Management Information System, TB CAP has developed four new instruments for use throughout the world: a Logistics Management Tool; an External Quality Assurance package; a Culture & DST package; and a Country Roadmap. In 2010, remaining donor funds were used to purchase LED microscopes to replace conventional microscopes, thereby giving a major boost to laboratory strengthening. Together with the Union, we continued our efforts to provide support for setting up supranational reference laboratories in Tanzania and Uganda.

Framework for Infection Control
Infection control is a key objective in worldwide TB control, particularly in countries with a high prevalence of MDR-TB and TB/HIV. TB CAP did a great deal of work in this area in 2009. Consultants and trainers were trained, guidelines for infection control in prisons were drawn up, and initiatives to facilitate capacity building were undertaken. Plans for infection control were also drafted. A framework for implementing these plans was presented at the annual Union meeting in Cancún, Mexico, in December. Implementation of the plans will begin in 2010.

A Few Country Results
With support from TB CAP, five TB laboratories in Indonesia were awarded international certification in 2009.

TB CAP provided support to Ethiopia in preparing national guidelines for programmatic management of drug-resistant TB (PMDT). An MDR-TB training course was provided for eighty-six local health workers. Nigeria launched the Nigeria STOP TB Partnership in 2009 and received support from TB CAP in providing training courses on collaboration in TB/HIV control.

TB CAP Renewed
Initially, the TB CAP project was to be carried out from 2005 to 2010, but much to our satisfaction, USAID pledged to renew the project for eighteen months in 2009. Key objectives in this last period are infection control, programmatic control of MDR-TB – in which Ethiopia and Indonesia in particular are making good progress –, and the further development of instruments for laboratory strengthening.

Eight TB control organizations participate in TBCTA under the supervision and direction of KNCV Tuberculosis Foundation:
- American Thoracic Society (ATS)
- Centers for Disease Control and Prevention (CDC)
- Family Health International (FHI)
- The Union (formerly IUATLD, the International Union Against Tuberculosis and Lung Disease)
- Japanese Anti-Tuberculosis Association (JATA)
- Management Sciences for Health (MSH)
- World Health Organization (WHO)
- KNCV Tuberculosis Foundation

Stop TBC

On March 24, 2009, World Stop Tuberculosis Day, KNCV Tuberculosis Foundation launched its new fund-raising campaign "Stop TB."

With the campaign, we intend to raise awareness of Dutch people with tuberculosis and of TB control, recruit new donors, and systematically increase the number of private donations we receive. Thanks in part to our campaign ambassador, actor Peter Faber, Stop TB has received wide media exposure – it made the Dutch national evening news (NOS Journaal) and has been the subject of national and regional radio broadcasts, Internet editorial features, radio spots and advertisements, and billboards.

A Successful Start

Research carried out by TNS NIPO in 2009 showed that 15 percent of all Dutch people are now familiar with the Stop TB campaign and that it has helped raised our public profile. For a new "brand," that's quite high! In 2010, we hope to transform this success into a demonstrably higher number of private donations. We will go about this by focusing our campaign fund-raising initiative more on direct mailing and telemarketing. We will also be enlisting the services of a consultancy specializing in private fund-raising to ensure that our approach is both effective and professional.

Want to Become a Donor?

Donors are important in legitimizing the work that KNCV Tuberculosis Foundation does and in ensuring that that work can continue. Would you like to support us? Then we invite you to become a donor.

You can do so in several ways:

- sign up to receive our newsletter. Four times a year, we will send you information on our projects and a donation request. You decide yourself when to make a donation.
- transfer your donation to giro account 130 (account holder: KNCV Tuberculosis Foundation, The Hague).
- authorize us to debit an amount from your bank account (e.g., €5 each month or €60 each year). Every contribution goes toward our fight against tuberculosis. Direct debits provide us with a permanent revenue stream, allowing us to better organize our work.
- with a deed of gift. KNCV Tuberculosis Foundation is recognized as an *algemeen nut beogende instelling* ["public benefit organization"], which means that the whole of your gift to us is tax-deductible in the Netherlands.
- bequest: include KNCV Tuberculosis Foundation in your will.

For more information, please log on to www.stoptbc.nl. Questions? Don't hesitate to contact us by calling +31 (0)70 416 72 20, or send an e-mail to info@kncvtbc.nl.

Play the Sponsor Bingo Loterij

KNCV Tuberculosis Foundation is one of the beneficiary charities of the Sponsor Bingo Loterij. This popular lottery represents an important source of income for us. If you play for KNCV Tuberculosis Foundation, half your stakes go toward the fight against tuberculosis. See also: www.stoptbc.nl and www.sponsorloterij.nl.

Peter Faber: "Everyone can get better!"

AActor Peter Faber is the Stop TB campaign ambassador. Peter knows what it's like to have TB, having contracted it as a child. He lay in bed for seven long months until he was better. Peter is conveying the message for the Stop TB campaign that everyone can recover from tuberculosis. He says, "I survived it and am here to tell people about it now. Thankfully, the illness has practically disappeared in the Netherlands. But a lot of people don't know that tuberculosis is still the second deadliest infectious disease in the world. Each year, over 9 million people contract tuberculosis, which claims nearly 2 million lives. And it doesn't have to be that way: If detected early and treated properly, tuberculosis can be easily cured." Peter wants everyone to get better just as he did. That is why he is donating his time to our campaign and is also a Stop TB donor.

Seal of Approval

KNCV Tuberculosis Foundation has earned the Central Bureau on Fund-raising's (CBF) seal of approval, which guarantees the proper allocation of the donations that it receives. The seal of approval is awarded only to charities that fulfill strict requirements – for instance, they may spend no more than 25 percent of their income from fund-raising on expenses related to the production of income. KNCV Tuberculosis Foundation has also contributed to the Good Governance Guidelines of the Association of Fund-raising Organizations (VFI).

Internal Organization

Our organization grew again in 2009. The steady increase in the number of foreign offices is the main reason behind the many new activities and requires internal organization adjustments; this will also be the case in 2010.

Human Resources
In 2009, KNCV Tuberculosis Foundation again saw an increase in its activities outside the Netherlands with new offices opened in Pakistan, Vietnam, and the Dominican Republic. KNCV Tuberculosis Foundation now has nine offices outside the Netherlands.
A Field Office Manual has been written and introduced in the foreign offices.
The manual pays specific attention to the subjects of Human Resource for Health (HRH) and the security policy. A code of conduct has also been implemented. The personnel policy for expats working in The Hague has also been formulated. In 2009, we again carried out a risk inventory and evaluation (RI&E) in connection with working conditions. The resulting initiatives will be carried out in 2010. Workload is an important point for consideration. In 2009, thirteen employees left KNCV Tuberculosis Foundation, and twenty-one new staff members were hired. The organization employed ninety-six staff as at the end of 2009. Approximately 120 additional staff are employed by the foreign offices.

Facilities
The IT infrastructure was almost completely renewed at the end of 2009. All the servers were replaced, we migrated to the Windows 7 operating system, and we now use Office 2007. All the computers are now fully equipped for this purpose. The number of computers also grew. Most applications can be used independently of the workplace which should facilitate the use of flexible workplaces. The number of workplaces increased by fourteen. There are now ninety-six workplaces in total.
We will be exploring the possibility of installing a wireless network in 2010. The IT infrastructure will be prepared for providing knowledge management support. The role of Facilities in providing IT support to the foreign offices must also be defined. In 2010, we will be drafting a new ICT policy plan consistent with the general strategic plan for 2011–15.
In 2009, we started digitizing the publications owned by KNCV Tuberculosis Foundation, an initiative we will be pursuing in 2010. Existing audio-visual material and historical information materials were also made accessible.

Communications and Fund-raising
In 2009, the Communications and Fund-raising (C&F) Unit started drafting a new communication policy plan for 2011–15. Key elements include the continued development of the internal flow of information and the definition of various lines of communication for the different target groups. In 2010, once the general strategic plan for 2011–15 is ready, we will draw up the final communication policy plan.
A new plan for fund-raising has also been created for the purpose of increasing the number of permanent donors and our revenue from private donations starting in 2010. In August 2009, KNCV Tuberculosis Foundation received a very unexpected donation: One donor made a single donation of EUR 420,000. This generous gift went some way toward counterbalancing the decrease in income from private donors.
On World AIDS Day on December 1, we had a stand at the AIDS Conference in Amsterdam and held a workshop there. At the annual Union meeting in Cancún, Mexico, held from December 3 to 7, we successfully brought our organization to the attention of other professionals in TB control.

HRH Princess Akishino of Japan paid a private visit to KNCV Tuberculosis Foundation in the summer of 2009. Princess Akishino is the patroness of the Japan Anti-Tuberculosis Association (JATA), an associate organization of KNCV Tuberculosis Foundation. We organized an exhibition on TB control in the Netherlands specially for her visit.

Finance, Planning, & Control
In 2009, the proposed restructuring of the Finance, Planning, & Control Unit was satisfactorily carried out. The unit is now made up of three teams: one for office finance and two for project finance. The three teams took part in compiling an inventory of prioritized courses of action required for improvement and change. We are already focusing on certain matters, such as improving paper-based procedures and simplifying the process of drawing up statements for donors.

From an audit perspective, the visits made to the foreign offices in 2009 got off to a good start. The aim of the visits is twofold: to provide guidance to financial staff in the offices and to carry out an internal audit. Our office in Indonesia fully migrated to the Exact bookkeeping program in 2009. We also installed the program in Kazakhstan and are currently installing it in Nigeria. Both these offices will start using the program in 2010.

Financial Results

Notes to the Balance Sheet and the Statement of Income and Expenditure

The activities in the area of national and international control, research, and educational information and awareness have resulted in expenditure totaling €19.4 million, an increase of 50% compared with 2008. In total, nearly 90% of budgeted expenditure was spent on the intended purpose. A total of €1.8 million went to other expenses – for fund-raising, and for management and accounting. This represents a 4% increase compared with 2008. Total income came to €22.5 million, including a positive result on investments of €0.5 million, resulting in budgeted income of 96% having been realized.

Ultimately, a positive balance of €1.3 million was noted. Excluding the revaluation of investments (unrealized profits on investments), ordinary operations would have resulted in a positive balance of €1.1 million.

In the proposal for profit appropriation/ treatment of loss, approximately €0.1 million in expenditure was recorded which is covered by allocated reserves and funds. The budget had allowed for a higher amount to be allocated from these reserves and funds, namely €0.2 million. Owing to the proposed profit appropriation/treatment of loss, the continuity reserve has increased by €1.1 million. As at the end of 2009, total reserves fell within the scope set by the Central Fund-raising Bureau [Centraal Bureau Fondsenwerving]. To counterbalance fluctuations in available funds, a fund-raising organization may maintain a reserve amounting to one to one and a half times the costs incurred by the organization itself for one year. The factor for KNCV Tuberculosis Foundation is now 0.8. As two large-scale project funding sources will terminate in 2010 and uncertainty exists as to whether sufficient funding can be secured to fill the shortfall, KNCV Tuberculosis Foundation's Executive Board does not believe that the continuity reserve is excessively high.

Auditors' report

Introduction

We have audited whether the accompanying abbreviated financial statements of the Royal Netherlands Tuberculosis Association (KNCV), having its registered office at The Hague, for the year 2009 as set out on pages 24 to 28 have been derived consistently from the audited financial statements of the Royal Netherlands Tuberculosis Association, for the year 2009. In our auditors' report dated 19 April 2010 we expressed an unqualified opinion on these financial statements.
The Board of KNCV is responsible for the preparation of the abbreviated financial statements in accordance with the accounting policies as applied in the 2009 financial statements of the Royal Netherlands Tuberculosis Association. Our responsibility is to express an opinion on these abbreviated financial statements

Scope

We conducted our audit in accordance with Dutch law. This law requires that we plan and perform the audit to obtain reasonable assurance that the abbreviated financial statements have been derived consistently from the financial statements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, these abbreviated financial statements have been derived consistently, in all material respects, from the financial statements.

Emphasis of Matter

For a better understanding of the company's financial position and results and the scope of our audit, we emphasize that the abbreviated financial statements should be read in conjunction with the unabridged financial statements, from which the abbreviated financial statements were derived and our unqualified auditors' report thereon dated 19 April 2010. Our opinion is not qualified in respect of this matter.

The Hague, June 14th, 2010

BDO Audit & Assurance B.V.
for and on behalf of it,

J.J. Herst RA

Balance Sheet

KNCV Tuberculosis Foundation as at December 31, 2009,
amounts in euros after proposed profit appropriation/treatment of loss

	12/31/2009		12/31/2008	
ASSETS				
Renovations	209,383		247,060	
Office equipment	199,341		215,490	
Computer equipment	244,173		149,612	
Tangible fixed assets		652,897		612,162
Receivables and prepayments	3,303,229		3,390,402	
Securities	4,792,440		3,953,573	
Liquid assets	4,551,666		6,279,868	
		12,647,335		13,623,843
Total		13,300,232		14,236,005

	12/31/2009		12/31/2008	
LIABILITIES				
Reserves and funds				
Reserves				
• Continuity reserve	7,360,112		6,283,676	
• Appropriated reserve	1,094,482		1,162,376	
• Revaluation reserve	258,416		33,709	
• Allocated funds	652,897		612,162	
		9,365,907		8,091,923
Funds				
• Funds earmarked for special purposes	687,359		676,778	
		687,359		676,778
Taxes/social security contributions	341,198		375,476	
Accounts payable	737,981		910,916	
Other liabilities and accruals	2,167,786		4,180,912	
Short-term debt		3,246,966		5,467,304
Total		13,300,232		14,236,005

Statement of Income and Expenditure

KNCV Tuberculosis Foundation for 2009 in euros

FUND-RAISING

	Budgeted 2010	Budgeted 2009	Actual 2009	Actual 2008
Income				
• Income from fund-raising	2,067,500	2,245,600	2,018,921	1,835,974
• Income from third party initiatives	1,100,000	1,100,000	1,281,350	1,185,526
• Government grants	25,242,900	19,783,900	18,678,888	11,572,685
• Income from investments	235,000	225,000	465,189	-269,536
• Other income	27,000	28,000	25,955	23,432
Total income	28,672,400	23,382,500	22,470,303	14,348,081
Expenditure				
Spent on intended purposes				
• Control in countries with low TB prevalence	1,408,800	1,395,800	1,361,545	1,299,703
• Control in countries with high TB prevalence	23,048,900	17,457,200	15,445,620	9,445,076
• Research	1,805,700	1,909,200	1,674,185	1,504,148
• Educational information and awareness	975,200	992,000	931,360	703,849
	27,238,600	21,754,200	19,412,710	12,952,776
Recruitment income				
• Fund-raising expenses	372,700	412,600	341,679	189,291
• Expenses for third party initiatives	18,200	18,300	17,559	15,382
• Costs incurred in obtaining government grants	180,300	165,300	151,516	120,100
• Investment expenses	44,800	43,600	60,249	41,486
	616,000	639,800	571,003	366,259
Management and accounting				
• Management and accounting expenses	1,070,100	1,261,700	1,202,024	1,330,726
Total expenses	28,924,700	23,655,700	21,185,737	14,649,761
Result	-252,300	-273,200	1,284,566	-301,680
Ratio for expenditure related to the objectives	95.0%	93.0%	86.4%	90.3%
Ratio for fund-raising costs	18.0%	18.4%	16.9%	10.3%
Ratio for management and accounting	3.7%	5.3%	5.7%	9.1%
Profit appropriation/treatment of loss				
Allocation to/deduction from				
Continuity reserve	-48,700	-10,700	1,076,436	620,345
Allocated reserves	-115,500	-122,300	-67,893	-183,284
Revaluation reserve	0	0	224,707	-581,974
Allocated funds	13,300	-28,500	40,735	-42,419
Funds earmarked for special purposes	-101,400	-111,700	10,581	-114,348
Total	-252,300	-273,200	1,284,566	-301,680

Breakdown of expenses	Budgeted 2010	Budgeted 2009	Actual 2009	Actual 2008
Grants and contributions	82,000	78,000	59,913	60,626
Purchases and acquisitions	19,143,700	14,267,800	12,299,635	7,131,388
Outsourced work	80,000	60,000	59,600	69,713
Publicity and communications	381,000	392,500	390,947	230,715
Staff costs	8,267,200	7,955,200	7,545,014	6,356,681
Accommodation costs	487,300	460,300	442,775	399,780
Office and general costs	286,000	212,000	209,965	207,062
Depreciation and interest	197,300	229,900	177,888	193,796
Total	28,924,500	23,655,700	21,185,737	14,649,761

Allocation of expenses for intended purpose

Actual 2009	Intended purposes			
	Low prevalence	High prevalence	Research	Educational information/awareness
Grants and contributions	27,313	0	32,600	0
Purchases and acquisitions	344,063	10,947,911	574,558	124,476
Outsourced work	0	0	0	0
Publicity and communications	0	0	0	390,947
Staff costs	897,389	4,082,827	956,600	378,080
Accommodation costs	49,691	222,199	59,142	20,275
Office and general costs	23,563	105,367	28,045	9,615
Depreciation and interest	19,526	87,315	23,240	7,967
Total	1,361,545	15,445,619	1,674,185	931,360

Allocation of expenses for intended purpose

Actual 2009	Recruitment income				
	Fund-raising	Third party initiatives	Grants	Investments	**Management and accounting**
Grants and contributions	0	0	0	0	0
Purchases and acquisitions	186,715	0	0	47,729	74,183
Outsourced work	0	0	0	0	59,600
Publicity and communications	0	0	0	0	0
Staff costs	128,650	17,559	151,516	12,520	919,872
Accommodation costs	14,093	0	0	0	77,376
Office and general costs	6,683	0	0	0	36,692
Depreciation and interest	5,538	0	0	0	34,301
Total	341,678	17,559	151,516	60,249	1,202,024

Remuneration of board members	Budgeted 2010	Actual 2009	Actual 2009	Actual 2009	Actual 2008
	Total	**Executive Director[1)]**	**Director F&O**	**Total**	**Total**
Gross salary	246,900	90,099	110,102	200,201	229,393
Social insurance contributions	9,400	4,552	6,828	11,380	13,760
Pension	26,300	9,203	10,461	19,664	22,843
Allowances	10,000	1,385	3,154	4,539	8,215
AMC chair contribution	0	0	0	0	-33,098
	292,600	105,239	130,545	235,784	241,113

No loans, advances, or guarantees have been made to board members or supervisory authorities.
The members of the Supervisory Board receive compensation only for costs incurred.

[1)]The Executive Director was appointed on May 1, 2009; these figures thus pertain to a period of eight months.

Ratio	Norm	Actual 2008	Actual 2009	Budgeted 2010	Average over 3 years
Expenditure on intended purpose in relation to total income	n/a	90.3%	86.4%	95.0%	91.0%
Fund-raising expenses in relation to income from fund-raising	max. 25%	10.3%	16.9%	18.0%	15.3%
Management and accounting expenses in relation to total expenses	5-10%	9.1%	5.7%	3.7%	5.6%

Fund-raising expenses
KNCV Tuberculosis Foundation's policy in respect of fund-raising expenses is based first and foremost on the CBF guidelines.
Calculated over an average period of three years, the expenses may not exceed 25% of income.

Management and accounting expenses
The CBF requires that a norm be set for this cost category. KNCV Tuberculosis Foundation employs a standard minimum of 5% and a maximum of 10% of total expenses as measured over a three-year period.

Key to Abbreviations

AIDS	acquired immune deficiency syndrome
AFEW	AIDS Foundation East–West
AIGHD	Amsterdam Institute of Global Health and Development
AMC	Academic Medical Center (University of Amsterdam)
ATS	American Thoracic Society
C&F	Communications and Fund-raising
CBF	Central Bureau on Fund-raising (Netherlands)
CBOG	College voor de Beroepen en Opleidingen in de Gezondheidszorg ["Board for Health Care Professions and Education"]
CDC	Centers for Disease Control and Prevention
CIb	Center for Infectious Disease Control (Netherlands)
CIDA	Canadian International Development Agency
DGIS	Directorate-General for International Cooperation (Netherlands)
DOTS	Directly Observed Treatment Shortcourse (Strategy)
DTLab	Dutch TB Laboratory Partnership
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
ECSA-HC	East, Central, and Southern African Health Community
FHI	Family Health International
GF	Global Fund to Fight Aids, Tuberculosis and Malaria
GGD	Municipal Health Service (Netherlands)
HIV	human immunodeficiency virus
HRH	Human Resource for Health
HSS	Health System Strengthening
IUATLD	International Union Against Tuberculosis and Lung Disease (The Union)
JATA	Japanese Anti-Tuberculosis Association
KAPTLD	Kenya Association for the Prevention of Tuberculosis and Lung Disease
KNCV	Royal Netherlands Tuberculosis Association
KIT	Royal Tropical Institute (the Netherlands)
LSHTM	London School of Hygiene & Tropical Medicine
LTBI	latent tuberculosis infection
LUMC	Leiden University Medical Center (the Netherlands)
M&E	monitoring and evaluation
MDR-TB	multidrug-resistant tuberculosis; resistant to the two leading anti-TB drugs
MFS II	Medefinancieringstelsel ["Co-financing System"]
MSH	Management Sciences for Health
NGO	non-governmental organization
NSPOH	Netherlands School of Public & Occupational Health
NTP	national tuberculosis program
NTR	Netherlands Tuberculosis Register
NVALT	Netherlands Association of Physicians for Pulmonary Diseases and Tuberculosis
NVMM	Netherlands Society for Medical Microbiology
PAHO	Pan American Health Organization
PMDT	programmatic management of drug-resistant TB
PPP	public–private partnership
RI&E	risk inventory and evaluation
RIVM	National Institute for Public Health and the Environment (Netherlands)
SES	socio-economic status
TB	tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TBCTA	Tuberculosis Coalition for Technical Assistance
TMF	Thematische Medefinanciering ["Thematic Co-financing"]
USAID	United States Agency for International Development
VFI	Vereniging van Fondsenwervende Instellingen ["Association of Fund-raising Organizations"]
VNTR	variable number tandem repeats
VWS	Dutch Ministry of Health, Welfare, and Sport
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis; resistant to two of the leading anti-TB drugs in use and to two kinds of anti-MDR-TB drugs.

Parkstraat 17
NL-2514 JD The Hague
The Netherlands

PO Box 146
NL-2501 CC The Hague
The Netherlands

Telephone +31 (0)70 416 72 22
Fax +31 0(70) 358 40 04
info@kncvtbc.nl

www.kncvtbc.nl

KNCV TUBERCULOSIS FOUNDATION