KNCV TUBERCULOSIS FOUNDATION

To eliminate TB

NEXT

ANNUAL REPORT 2016

PHOTO: MAARTEN BOERSEMA

TABLE OF CONTENTS

Colophon

De Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose ('KNCV'which uses the name KNCV Tuberculosis Foundation in English) is located at Benoordenhoutseweg 46 in The Hague, the Netherlands.

Design: isvormgeving.nl, Leiden

Cover photo: *Thanks to contact investigation following the diagnosis of her father, 1,5 year old Dahlia's infection with TB was detected early. After 6 months of treatment, she is now cured.*

INDEX

Workinesh is a MDR-TB survivor.
PHOTO: GIDEON VAN AARTSEN

DIRECTOR'S REPORT

2016: A Changing Global TB Environment

The global TB community is often regarded as technically oriented, with rather weak global advocacy. But 2016 marked an important shift towards the recognition of TB as a significant global public health problem. With 1.8 million deaths annually, and a significant spread in drug-resistant forms, the most deadly infectious disease is finally getting the attention that it deserves. Examples of increased political awareness are the 2016 announcements of a WHO Global TB and SDG Ministerial Conference 2017 hosted by the Russian Federation, and a UN General Assembly meeting on TB, which will take place in 2018. The latter is a unique event as it will be the first time ever that TB has featured on the General Assembly's agenda, and hopefully Heads of State will agree on effective measures to support the End TB strategy.

Related positive developments are the explicit inclusion of TB in Global Health Security and Universal Health Coverage as well as in the Global Antimicrobial Resistance (AMR) Review.
The global review on AMR, chaired by economist Jim O'Neill, served as an eye-opener outside the TB community, showing that 29% of AMR deaths are due to TB. This greatly increased the attention paid to TB and highlighted the cost of inaction. Simultaneously, the parliamentarian TB caucus led by Nick Herbert in the UK, started to expand, which led to the decision to form regional parliamentarian TB groups worldwide. As a result, an all-time record number of parliamentarians attended the Union Conference on Lung Health in Liverpool, and more are expected to join the global parliamentarian TB movement in the coming years. This is absolutely crucial for increased country ownership.

All these developments should not be underestimated and in 2016, KNCV engaged in, and supported, related initiatives at both national and global levels, here are just a few examples: KNCV became core technical partner of the WHO and Russia in the preparation of the Global Ministerial Conference; KNCV contributed to AMR related meetings organized by the Dutch Ministry of Health as well as the launch of the Obama White House National Action Plan for combating drug-resistant TB; Mrs. Beatrijs Stikkers, KNCV's head of advocacy and public affairs, now serves as vice-chair of the Audit and Finance Committee of the Global Fund; Under a TB and HIV advocacy grant from Capital for Good, KNCV strengthens Dutch engagement and policy development for Global Health. For example, in partnership with AIGHD and Topsector Life Sciences and Health, KNCV prepared a meeting on Global Health in close collaboration with and hosted by, the renowned Clingendael Institute.

> 2016 showed that the urgency to eliminate TB has reached a wider audience than the TB community alone.

We were also successful in our bid to bring the Union World Conference on Lung Health back to the Netherlands in 2018. The last time the Netherlands hosted the global Union conference was in 1967 and before that in 1932. With the support of the Dutch Government, a wide variety of national and international technical partners, corporate sector allies and Dutch associations, KNCV and the municipality of The Hague put together a convincing bid that beat the competition and will make The Hague 'the Global City on TB' in 2018.

New KNCV Technical Achievements and Initiatives

In 2016, KNCV's consultants supported more than 25 countries with a great variety of technical assistance activities. Most, but not all, technical assistance work was implemented under the U.S. Agency for International Development's

>>

INDEX

>> (USAID) flagship project, 'Challenge TB' and the 'Making Global Fund Money Work' project funded by the Dutch Directorate-General for International Cooperation. Under the latter, KNCV added an innovative TB/HIV public-private mix care delivery model in the Philippines and Global Fund implementation support in Swaziland and Nepal. Both countries report that KNCV staff have been very effective in taking away barriers to Global Fund implementation and smoothening collaboration between country stakeholders. The Challenge TB project, led and managed by KNCV and executed by a consortium of nine international partners, is operational in 22 countries and includes four thematic core projects. In addition, KNCV increasingly receives requests for specific specialized technical assistance from countries not directly linked to the aforementioned projects. An example is the support provided to Papua New Guinea in the context of its drug resitant TB crisis.

> So far, the results of the triage system in countries in Central Asia are amazing, with children and adults with severe MDR/XDR-TB escaping certain death.

Ministerial Meeting for Ending TB in the South East Asia Region

In line with KNCV's strategic plan 2015-2020, the Technical Division has been organized into a number of specialized teams. Additionally, in 2016 several cross-cutting initiatives were developed, that we believe will be of great importance for the innovation needed to 'End TB'. These initiatives are illustrative of the end-to-end technical package that KNCV offers, including social science, technical and medical innovations.

The first initiative focuses on stigma reduction. Building on our successful 'Stigma Measurement Meeting' in May, and the stigma symposium during the October Union Conference on Lung Health in Liverpool, KNCV will continue to work on this important subject that is crucial for health seeking behavior and treatment success. As such, stigma reduction is considered as important as the introduction of new medical tools and interventions.

However, KNCV also recognizes the need for technical solutions, which is reflected by two other initiatives: 'digital health' and 'new drugs and regimens'.

In 2016, KNCV developed a digital health strategy and a digital health 'assessment package' to identify programmatic gaps and formulate digital solutions. KNCV applies digital health in three areas of work: diagnosis and care, awareness and education, and surveillance and monitoring. We strongly believe that technical solutions can improve holistic patient-centered approaches. The introduction of new products such as 'Computer Aided Diagnostics' and the connectivity between laboratory equipment and its users - both patients and doctors - can play an important role in earlier diagnosis and treatment. Finally, we see great value in the linkage of diagnostic data with socio-demographic data systems to identify TB hotspots and inform local policy development.

The third initiative is related to what we have all been waiting for: new drugs and regimens that have the potential to reduce both the length and toxicity of drug resistant (MDR/XDR) TB treatment, while achieving better outcomes. The KNCV DR-TB and Evidence teams have developed a novel triage system that ensures drug-resistant patients receive the best individual treatment, benefiting from shorter MDR-TB regimens and new drugs such as Bedaquiline. At the same time, KNCV laboratory experts have intensified support to the design and quality of laboratory networks, including the rapid-test for resistance to key MDR-TB drugs. Obviously, laboratory diagnosis and triage of patients go hand in hand. So far, the results of the triage system in countries in Central Asia are amazing, with children and adults with severe M/XDR-TB escaping certain death. Patients that could not even stand are walking again, reflecting a brighter future.

Innovation was not only limited to our international work. In 2016, the Dutch ZonMw project 'TB ENDPoint' started the enrollment of immigrants for Latent TB Infection (LTBI) screening. This project examines the feasibility and effects of screening for LTBI among three different high-risk migrant groups. In order to overcome cultural barriers we work closely with representatives of the target populations in this project. We consider LTBI management a crucial component of the global End TB Strategy, and I am proud to announce that KNCV was part of a winning coalition that will introduce LTBI treatment using a novel treatment regimen in high prevalence countries.

The last month of 2016 brought another significant milestone in our strategic approach towards sustainable TB control. In Indonesia, where we have been working for many years, the Yayasan KNCV Indonesia was established as an independent local NGO within the KNCV international network. The Yayasan (meaning 'foundation') was established by three inspiring women in Indonesian TB control and will be led by Jhon Sugiharto, longtime technical director of KNCV Indonesia.

KNCV's Financial Health

I am proud to report that we ended 2016 with a positive financial result, which will enable us to contribute to the continuity reserve. The surplus is mostly due to higher income (mainly government grants) and higher expenses due to acceleration of the Challenge TB and DGIS projects, increased income from legacies, and a reduced indirect cost rate compared to 2015.
The contribution to the continuity reserve is of great importance given the preparation for a responsible transition into a 'post Challenge TB era' by 2020. For that reason, KNCV invests in the mobilization of diversified resources. We were able to recruit an experienced Head of Resource Mobilization, who joined us in the last quarter of 2016, and are part of several consortiums that were awarded grants of different sizes from a number of donor programs such as UNITAID and Horizon 2020. Also, with support from 'De Langen Stichting voor Mondiale Tuberculosebestrijding', we research and test strategies for obtaining non-earmarked core funding, These activities were partly delayed by the late arrival of the Head Resource Mobilization, but will be intensified in 2017.
KNCV's solvency, although slightly decreased due to higher liabilities related to the acceleration of the Challenge TB project, is sufficient and the liquidity is unchanged.

KNCV Organization: Form Follows Function

In January 2015, a new KNCV organizational structure was introduced to create an optimal supportive environment to pursue the KNCV mission. This structure builds on three pillars: the Finance Division, the Operations Division, and the Technical Division. The aim of the restructuring was to strengthen both technical performance and >>

Risk management

Clearly, the size of the Challenge TB project and the related decentralization within the countries we support, requires robust mechanisms to prevent, monitor and mitigate potential risks as much as possible. We acknowledge the importance of internal control and risk management systems. The Executive Director reports about these subjects to the Board of Trustees on a regular basis. Once a year a risk analysis is done, assessing risks, controls, and mitigating actions. This assessment involves senior management and is discussed in the Management Team meeting. In addition, once a year, the Executive Director discusses the internal risk analysis, as well as significant changes and major improvements in internal controls, with the Audit Committee and the full Board of Trustees. In that context we have also designed a procedure to carefully screen the local partners we consider working with. KNCV's Executive Director is not currently aware of any significant change in the organization's internal control that occurred during 2016 that has materially affected, or is reasonably likely to materially affect, the organization's internal control over financial reporting.

>> project management capacity. In addition, we set up country teams with representatives from all three divisions and the country office to ensure optimal coordination, country-specific support and efficiency. In 2016, we organized an external review to assess the strengths and weaknesses of this new structure and related governance processes. The external review and subsequent internal discussions identified areas for improvement, which were mostly related to the collaboration between teams and the clarification of the roles and responsibilities of new positions. Corrective actions were taken during the last quarter of 2016, which will be evaluated in 2017.

The aforementioned review also revealed that many KNCV staff members believe that they have a high workload, and indeed, the combination of our dedication towards our mission, frequent long distance travel, donor pressure and the rapid growth of the organization, ask quite a lot of all of us. Therefore, the human resource management team, in close collaboration with the Works Council, has taken a number of actions to reduce the burden and improve the coping and management of workloads by individual staff members. Sick leave at The Hague office was 5.6% in 2016 versus 4.0% in 2015, mainly due to an increase in long-term sick leave.

We have developed a 'Roadmap for strengthening country offices and responsible engagement of local partners' in the context of further decentralization. This roadmap will allow KNCV to include more local partners, while limiting related reputational and financial risks.

In December, we hosted an External Review of the Challenge TB project management. Although overall management was ranked highly, some areas were identified that will require follow-up in 2017.

Lastly, the Human Resource Management team conducted a salary benchmark exercise to compare our current salary structure with 'BV Netherlands', academic hospitals and a number of similar Dutch NGOs. The results will inform the new salary structure that will be developed next year in close consultation with the Works Council.

Together We Can End TB

We are fully aware that our work would not be possible without the contribution of KNCV partners: the governments in the countries we assist, our technical partners, donors, local communities, patient organizations, and of course the members of the KNCV Board of Trustees, who raise justified questions and provide us with useful advice.

I want to express my thanks to our staff in The Hague and our offices abroad. In 2016, we were confronted with the risks our staff faces, such as road accidents and tropical diseases. As a result of the latter, we lost Jan Voskens, our greatly loved and respected Indonesian country director. We mourned with his family and celebrated his achievements.

Dear friends of KNCV, dear colleagues and fellow TB fighters, let's follow the spirit of advocacy seen in 2016, and prepare for the rise in global attention for TB. Let's show what is possible, produce and share results, and mobilize as many parties as necessary to eliminate this disease as soon as possible.

Dr. Kitty van Weezenbeek, Executive Director

INDEX

KNCV IN KEY FIGURES

Income from private fundraising € **1,125,626**

20,715 private donors

Income from lotteries € **1,144,439**

1% of income spent on fundraising

425 members of staff worldwide

Income from government grants € **69,550,163**

97.4% of expenses spent on mission related goals

1.6% of expenses spent on administration and control

2016: INNOVATING FOR IMPACT

KNCV's approach to eliminating TB is rooted in three core elements: innovation, partnership, and sustainability. We took major steps forward in all of these in 2016.

The implementation of new techniques and drugs and regimens offer exciting new possibilities to treat and cure TB patients, who have up until now had to go without proper treatment.

In 2016 our experience with 'digital health' over the past years led to the development of the *digital health initiative*, a cohesive approach to use available techniques for better communication and decision-making.

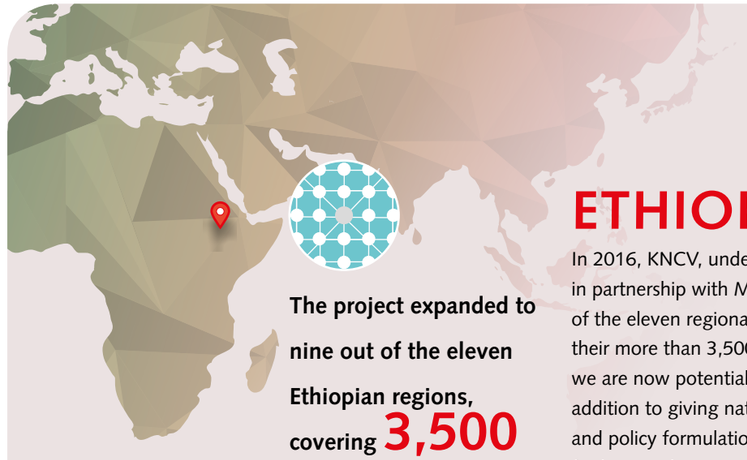
Even more challenging and rewarding innovations are the implementation of newly available TB drugs and regimens. In the past year we paved the way to reach out to thousands of multi-drug resistant TB patients, who finally have a reason to be hopeful again.

Next to improving access to diagnosis and care, we consider the treatment of latent TB infection, before people actually get sick, a crucial component to truly End TB. In the TB ENDPoint project, which started this year, we partner with experts at all levels, including patients, to gain and share knowledge.

We firmly believe that the only path to sustainable TB control is to embed it into national health programs, involving all relevant parties. Therefore, we are very proud that 2016 saw the establishment of the Yaysan KNCV Indonesia, an independent, local NGO, working within the international KNCV network. ■

INDEX

POINTS OF PROGRESS IN COUNTRY OFFICES IN 2016



The project expanded to nine out of the eleven Ethiopian regions, covering 3,500 health facilities and reaching out to 85 million people.

More than 2,700 healthcare workers were trained, 33% of which were women.

ETHIOPIA

In 2016, KNCV, under the Challenge TB project and in partnership with MSH, expanded to support nine of the eleven regional health bureaus in Ethiopia and their more than 3,500 health facilities. This means we are now potentially reaching 85 million people in addition to giving national level assistance in strategy and policy formulation. To effectively support health facilities in this enormous area, we implemented a zonal approach. When the quality of TB care in a zone is sustainably improved, the zone graduates to a different approach, requiring less intensive attention. This way funds are directed where they are needed most.

In June 2016, we started a pilot for the treatment of drug-resistant TB patients with new second-line drugs, with 24 patients enrolled since then. For these patients, there was previously no hope of a cure, but now most of them are showing clear improvements. The success of this pilot brings new hope for the approximate 70 new drug-resistant TB patients each year, for whom regular drugs do not work. The pilot will be scaled-up to the rest of the country. Laboratory staff have already been trained and were actively engaged in providing second-line drug-resistance tests in six regional laboratories in early 2017.

In collaboration with the National TB Program, KNCV also piloted the integration of Childhood TB within the overall Integrated Management of Newborn and Childhood Illnesses program. Through this program, children are checked for the main childhood illnesses as standard. In those facilities that took part in our pilot, the number of child TB patients reported increased by 180%. When scaled-up to the rest of the country, this strategy will definitely contribute to a reduction in newborn and infant mortality from TB in Ethiopia.

Digital Health:

ENABLING HEALTHY COMMUNITIES

Significant advances in the availability and use of technology have opened up new and exciting possibilities to improve patient-centred care and turn data into useful and available information for policymaking. Mobile technology and network coverage have transformed the way we interact with each other and conduct business. Obtaining and sharing information instantly is quickly becoming the norm in most aspects of daily life. Despite all the technological advances and their ever-increasing availability and affordability, the majority of TB information is still paper-based. Collecting and managing this by hand and on paper is both time-consuming and inefficient, while using the right technology enables better informed and timely decision-making. This is why KNCV is actively applying digital health solutions for TB care around the world.

Digital Health, sometimes called electronic health ('eHealth') or mobile health ('mHealth'), is the use of information and communication technologies for health purposes. With paper-based systems, TB patients may not learn about their diagnosis in time to begin the right treatment, and a lifesaving TB drug may become unavailable because its stock was not efficiently monitored, resulting in a new order not being placed in time. Efficient information management can therefore save lives. Building on more than 110 years of experience in TB control, KNCV supports countries to effectively implement digital health solutions to turn data into practical information that is available for empowered decision-making by patients, healthcare workers, and National TB Programs.

Our impact in short

In 2016, we have empowered decision-making for patients and doctors by strengthening information-systems and improving the use of existing information.

Diagnosis and care

Rapid and accurate diagnosis of TB is essential to start treatment on time and, ultimately, to control the TB epidemic by limiting transmission. An important initial screening test for the detection of TB is the use of a chest X-ray. However, it takes a lot of experience to determine whether a chest X-ray show signs of TB. Experts with this type of knowledge and experience are scarce, especially in high-burden TB countries. The CAD4TB software, developed in the Netherlands, uses a computer algorithm to identify abnormalities on a chest X-ray. A specialized radiologist is no longer required as recent publications show that the CAD4TB software now performs as well as clinical officers.

Diagnostic Connectivity

The GeneXpert diagnostic test that is currently being implemented in many countries, provides results within two hours, where traditional methods can take days or months. Connecting the GeneXpert machines to an online platform to receive real-time results makes test results immediately available to patients and doctors. An automatic SMS message can be sent to the patient when the result is known, and at the same time that the doctor receives the test results allowing them to make better-informed decisions.

GxAlert automatically gathers information from all the connected devices, and analysis of these data can inform the National TB Program where TB hotspots are located.

Using consumption data, it is possible to better predict the quantity of resources and supplies that are required, potentially preventing problems in the supply chain such as surpluses or shortages.

Surveillance and Monitoring

Where previously TB information was collected on paper (slow, inefficient, and error-prone), we see that by linking different information systems, increasingly precise information about the TB epidemic becomes available in countries. By collecting up-to-date patient information including socio-economic and health data, the control of TB outbreaks can be facilitated, the effectiveness of National TB Programs can be evaluated, and epidemiological studies can be undertaken.

In 2016, KNCV provided technical assistance to countries moving from paper-based systems to interoperable case-based and electronic systems in Mozambique, Indonesia, Malawi, and Swaziland. The implementation of these systems ensures a

>>

Integrated systems

The National TB Program of Indonesia started the revision of their TB surveillance systems with the support of KNCV. The aim is to have an integrated system for all TB patients that is also fully integrated with the overall Health Management Information System from the Ministry of Health. This will be a huge step forward for both patient and program management and a learning experience from which many other countries will benefit.

KNCV'S DIGITAL HEALTH INITIATIVE

In 2016, KNCV developed the digital health initiative to share expertise and build partnerships to support countries and programs. Through the digital health assessment package we help countries to determine their current digital health situation, identify programmatic gaps, and develop a digital health roadmap.

>> higher quality of information. To take full advantage of the opportunities of health information, it is essential that TB surveillance systems are linked with laboratory information systems, patient management, and logistical information systems.

The Next Step

In the future, we foresee that more diagnostics will be linked, creating significant opportunities to quickly identify the correct treatment regimen for each individual TB patient, and to identify resistance patterns of bacteria at national and regional levels. Building on digital health activities in 2016, KNCV will work with partners to test the feasibility of linking other diagnostics.

> Strengthening data systems and increasing the use of existing data are vital in building resilient and sustainable systems for health.

When it comes to treatment, digital health solutions like SMS adherence promotion, customized pill strips, or electronic medication boxes are becoming more common. They provide the opportunity to automatically collect data regarding how well each individual patient adheres to treatment. This can lead to specific interventions and differentiation of care. This improves the effectiveness of therapy by, for example, the use of food vouchers, mobile money or increasing personal guidance to patients.

Digital health solutions have the potential to bring medical, social, and behavioral sciences closer to each other. As a result, TB care could be tailored to the needs of the individual patient and further improve the quality of treatment. In this way, the right use and analysis of digital health data will lead to an even more patient-centered approach for TB treatment. ■

Diagnostic Connectivity

KNCV supported the implementation of diagnostic connectivity in Botswana, Bangladesh, Nigeria and Malawi. In these countries, we are involved in ensuring that new digital health solutions contribute to programmatic impact by building local capacity of the National TB Program and laboratory staff.

INDEX

POINTS OF PROGRESS IN COUNTRY OFFICES IN 2016

KENYA

The KNCV office in Kenya is the driving force behind the Cross-Border TB Initiative, which focuses on the prevention of TB amongst mobile populations such as nomads, pastoralists and refugees in the East Africa region. The initiative brings together four Kenya border areas with Somalia, Ethiopia, Uganda, and Tanzania. In 2016, we set up Cross-Border Health committees in all areas except for Moyale in Ethiopia, where a state of emergency hindered implementation. These committees will be critical in the establishment of communication and the linkages necessary for patient follow-up between border counties and districts in neighboring countries.

The Cross-Border TB Initiative brings together 4 Kenya border areas with Somalia, Ethiopia, Uganda and Tanzania, to prevent TB among mobile populations.

30 healthcare workers in Somalia and Rwanda were trained as trainers on Childhood TB.

NIGERIA

9% **increase in TB patients found and notified in supported states.**

More than 348 GeneXpert diagnosis machines are operational in Nigeria, with KNCV providing technical assistance, maintenance and training.

1,112 **healthcare workers were trained to diagnose and treat TB patients in the best possible way.**

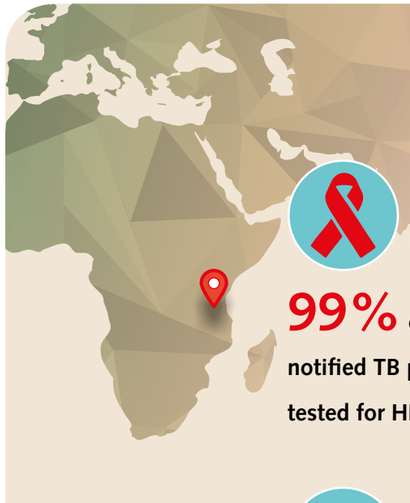
In Nigeria, it is estimated that only one out of every three TB-patients is found and registered, which means far too many patients do not receive the proper treatment. That is why we focus on expanding services and expertise on TB diagnosis and treatment. In 2016 we made steady progress, for example with the expansion of AFB microscopy services which are now available in 480 healthcare facilities. Directly observed treatment (DOT) was also expanded to 188 new facilities, 54% of which are in the private sector, resulting in a total of 1,378 DOTS centers in supported states. Many patients first visit private clinics who do not always have the experience and training necessary to diagnose and treat TB. Through the 'Making the Global Fund money work' project, funded by the Dutch Ministry of Foreign Affairs, we engage and train these facilities in TB services.

Even more patients can now be found and registered because of the rollout of the GeneXpert diagnostic system through KNCV's collaboration with the National Agency for the Control of AIDS (NACA). Together we installed 135 machines and trained 68 people with a 'Training of Trainers' approach. They in turn have trained a total of 282 laboratory technicians to operate the GeneXpert machines, and 294 clinicians to do the appropriate referral and ensure that patients are put on treatment when TB is detected.

Special attention was paid to a system for the transport of sputum that is needed to perform the diagnostic tests at facilities where GeneXpert is available. Working together with the National TB and Leprosy Control Program, we helped to establish a system for sputum transport in twelve states, to enable timely diagnosis for patients living in rural areas.

INDEX

POINTS OF PROGRESS IN COUNTRY OFFICES IN 2016



TANZANIA

99% **of all notified TB patients are tested for HIV.**

Services were brought closer to home for multidrug-resistant TB patients through 20 additional facilities

In 2016, we helped the Central TB Reference Laboratory to upgrade their accreditation to three stars out of five, compared to two in the year before. This was achieved though in-house training of laboratory staff, improvement of documentation and procedures, and the reorganizing and renovation of the laboratory.

The engagement of the Tanzanian Government was further enhanced by increasing TB awareness among 283 Tanzanian Parliamentarians. This was followed by the launch of the country's first TB Caucus by a member of the Global TB Caucus, which was signed by all parliamentarians who attended the session. The parliamentarians pledged full commitment and support for TB control in their constituencies. Importantly, the Minister of Health pledged to increase the budget for TB control activities in the next financial year.

KNCV's New Drugs and Regimens Initiative:

INTRODUCING NEW HOPE

Forty years without any new drugs or regimens, combined with inadequate TB treatment, have led to the development of drug-resistant TB. In 2015, more than half a million people had a drug-resistant form of TB. These people require treatment with second-line anti-TB drugs, yet according to the 2016 WHO report, only about twenty percent were diagnosed and enrolled on treatment. Even with this treatment, which uses toxic drugs and can take up to two years, only around half of patients are successfully treated. With new drugs and shorter regimens finally available, there is hope for hundreds of thousands of these patients. In 2016 KNCV paved the way for their safe and successful implementation with a comprehensive approach: the new drugs and regimens initiative.

Under the umbrella of the USAID-funded Challenge TB Project, KNCV coordinated and led the technical support for the introduction of new TB drugs and regimens through our country offices. In May 2016, WHO guidelines were issued, recommending the use of tests for the early detection of resistance to key second-line drugs and the introduction of shorter, nine to twelve month treatment regimens for drug-resistant TB.

The new drugs Bedaquiline and Delamanid have been approved by national drug regulatory authorities. Both drugs, when used correctly and in combination with existing medications, significantly improve treatment success rates and enable shorter regimens, providing new hope for drug-resistant TB patients who currently have limited treatment options.

Patient Triage

The introduction of shorter regimens and new drugs are directly linked. We supported the implementation through KNCV's Right Diagnosis, Right Treatment Approach, which is based on our triage concept. This allows for early allocation of the best treatment regimen when resistance to second-line drugs is detected or suspected. Patients without resistance are placed on short-term regimens, while patients with extensive resistance to second-line drugs will be placed on conventional 20-24 month treatment, with new and/or repurposed drugs added to the regimen.

A Comprehensive Approach

Tools and guides for the introduction of new drugs and regimens were developed and shared with all project countries under the Challenge TB project. These tools and guides include a national introduction and scale-up planning tool, a generic programmatic and clinical guide, guidance on the management of drug-related adverse events, a training curriculum, and materials and tools to estimate the numbers of drug-resistant TB patients eligible for the shorter treatment regimen and individualized treatment regimens containing Bedaquiline or Delamanid.

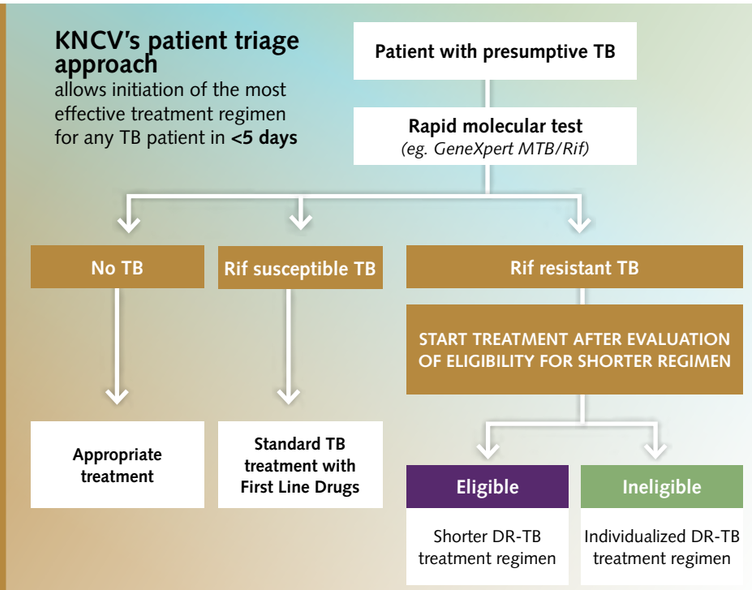
KNCV provided intensive technical support in planning and monitoring implementation and scale-up activities, including generating evidence to guide >>

Our impact in short

KNCV helped countries to prepare the necessary medical and technical requirements for the safe and fast introduction of newly available drugs and regimens for multi-drug resistant TB patients.

The KNCV Patient Triage Approach

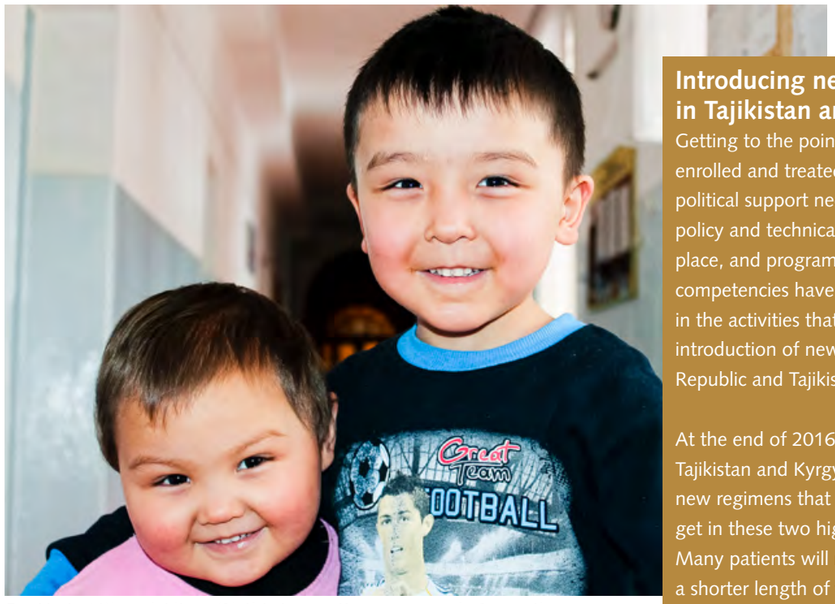
KNCV believes that each individual deserves the most appropriate care, with the correct diagnosis using the latest rapid molecular based diagnostic tests, and treatment with access to new drugs and regimens. To rapidly determine the best treatment for patients based on their specific needs and anticipated outcome of care, we developed the KNCV Patient Triage Approach. The concept begins with an individual who is presumed to have TB disease and ends with a permanently cured patient. The presence of TB disease can be confirmed with GeneXpert and the TB patient can then be 'triaged' to either a first-line or second-line drug regimen.



Experiences from the field

"For many reasons, the preparations took much longer than everyone expected. But now here we are; we prevailed and succeeded. It is a huge success for us personally. Many parts of the process were new for everyone involved, ourselves included, which provided the opportunity to learn together with our colleagues from the national teams, other technical partners and the doctors and nurses. We were honored to be welcomed as part of their team and to feel the trust they have in us, which at the same time felt like a huge responsibility. We also work directly with patients, that's why it is so great to see that they have new hope. These are mainly young people with dreams about life, family and having children, and we are so grateful that we can provide them with hope".

Gunta Dravniece & Maria Idrissova, KNCV Access to Care Team



For Yuriy (4)) and Alima (2) this innovation means only 9 months of treatment instead of 24.

>> scale-up. Steady progress has been made in all the supported countries, with an increasing number of countries enrolling drug-resistant TB patients on new drugs and regimens.

A Foundation for Progress

The introduction of new drugs and regimens offers hope to patients who cannot be treated with existing drugs, as well as the opportunity for more tolerable, completely oral, short-course regimens that could fundamentally transform MDR-TB treatment. Safe and successful implementation demands the strengthening of the health system platform on different levels, from government to local laboratories and healthcare workers. Once it is built, this strengthened health systems platform can be utilized in the future to introduce new diagnostic tools, drugs or treatment regimens. If the goals of the WHO's End TB Strategy are to be achieved, new and innovative diagnostics and drugs will be required. The work currently being done by KNCV in relation to the introduction of new drugs and regimens for drug-resistant TB patients is strengthening the capacity of health systems to be able to implement such innovations for the benefit of patients, health systems and society as a whole. ■

> Safe and successful implementation of new drugs and regimens demand the strengthening of the health system platform on different levels.

Introducing new drugs and regimens in Tajikistan and Kyrgyz Republic

Getting to the point where patients can be enrolled and treated can be a long road: political support needs to be secured, proper policy and technical guidance have to be in place, and programmatic and clinical skills and competencies have to be built. This is exemplified in the activities that were required prior to the introduction of new drugs and regimens in Kyrgyz Republic and Tajikistan.

At the end of 2016, the first MDR-TB patients in Tajikistan and Kyrgyz Republic were initiated on new regimens that previously were impossible to get in these two high MDR-TB burden countries. Many patients will now be able to take drugs for a shorter length of time and still be cured. Patients with more extensive drug-resistance will still need to be treated for a longer duration, but with much better prospects of survival.

In Kyrgyz Republic, the process of strengthening health systems to be ready for the introduction of the new drugs and regimens took from July 2015 to January 2017. The patient-centered approach applied by KNCV and its local partners meant patient safety took center stage through the introduction of drug-safety monitoring, human resource development (including staff training), and the establishment of electronic data collection and analysis. KNCV Tuberculosis Foundation and the Challenge TB project are proud partners of the Tajik and Kyrgyz National TB Programs. This experience is paving the way in the Central Asian and Eastern European regions, on which future progress can be built.

INDEX

POINTS OF PROGRESS IN COUNTRY OFFICES IN 2016

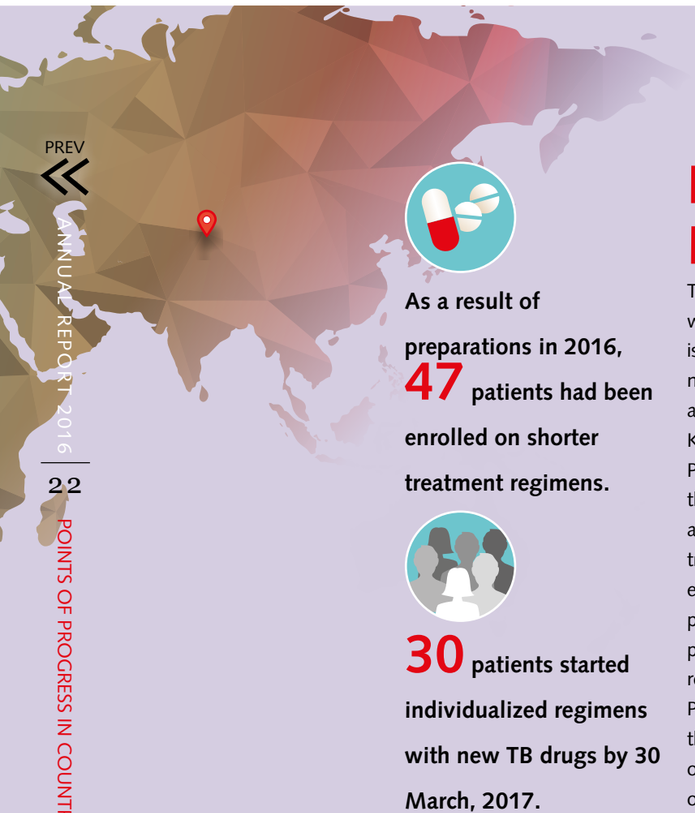
MALAWI

In 5 districts, Committees for Infection Prevention and Control where trained to introduce the FAST strategy for active case-finding.

2,574 healthcare workers including laboratory staff, health surveillance assistants, nurses, clinicians, ward clerks, anti-retroviral treatment clerks, and TB officers were trained.

Malawi's National TB Reference Laboratory, which had not functioned since September 2015, was almost fully rehabilitated and handover is planned for April 2017. As part of the rehabilitation, KNCV supported the National TB Program to revise national level guidelines, the national laboratory strategic plan, and the methods needed to conduct external quality assurance of laboratories. We also built the capacity of laboratory staff on drug-susceptibility testing, TB culture and identification, and AFB microscopy.

Two teams were installed in Blantyre and Lilongwe to train and mentor healthcare workers on TB in local TB and HIV facilities. These teams successfully trained healthcare workers to better screen and diagnose patients. We built the capacity of people in five districts on infection control, and the scale-up of FAST (Finding, Actively, Separating, and Treating), a strategy to increase active case-finding and prevent infection at health facilities.



As a result of preparations in 2016, 47 patients had been enrolled on shorter treatment regimens.

30 patients started individualized regimens with new TB drugs by 30 March, 2017.

KYRGYZ REPUBLIC

The Kyrgyz Republic is one of thirty countries in the world dealing with a high burden of MDR-TB, and it is estimated that every year there are around 1,400 new MDR-TB cases. The recently endorsed new anti-TB drugs bring hope to these patients. In 2016, KNCV assisted the Kyrgyz Republic National TB Program in the development of a national plan for the introduction of new TB drugs such as Bedaquiline and Delamanid and a shorter (nine to twelve month) treatment regimen for MDR-TB. This resulted in the enrollment of the first patients in January 2017: 30 patients started a shorter treatment regimen and 29 patients were enrolled on individualized treatment regimens with new TB drugs. The National TB Program and KNCV worked closely together to make this happen. A national plan for the implementation of new drugs and shorter regimens for the treatment of MDR/XDR-TB was approved in April 2016. Clinical guidelines and standard operating procedures were approved by the Ministry of Health in December 2016. In the same month, we facilitated the inclusion of Bedaquiline on the list of drugs that can be imported without registration. We made sure that key clinicians from the pilot sites as well as specialists from the National Reference Laboratory were trained. A new diagnostic algorithm was also implemented at the pilot sites.

Over the next few years we plan to support the National TB Program to provide countrywide access to new drugs and regimens, and to build the local technical and human resource capacities in close collaboration with national and international partners.

TB ENDPoint

TREATING LATENT TB TO TRULY END TB

The Dutch National Tuberculosis Control Plan 2016-2020 aims for a 25% reduction in TB cases by 2020, in alignment with the WHO End TB strategy. This will be primarily accomplished through TB prevention in high-risk groups. Migrants are the largest high-risk group for TB in the Netherlands, making up almost three quarters of all patients. KNCV leads the TB ENDPoint project, which examines the implementation and effects of latent TB infection screening among three different high-risk migrant groups. To optimize the outcome, both healthcare workers and migrants are actively involved in the setup.

The four-year TB ENDPoint project is split into two separate phases to accommodate the use of various research methods. The first phase started in 2016 and consisted of three different pilots that implement latent TB infection (LTBI) screening and preventive treatment among three different migrant groups. The first pilot focused on entry-screening of immigrants. The second pilot replaces the existing radiological follow-up screening with LTBI screening among asylum seekers.
The third pilot, to be executed in 2017, will not focus on newcomers but on migrant groups already living in society. Eritrean and Somali migrant groups, the target group for the third pilot, have the highest TB incidence in the Netherlands. This third pilot will examine how to best reach and motivate these communities to participate in both LTBI screening and preventive treatment by promoting community involvement.

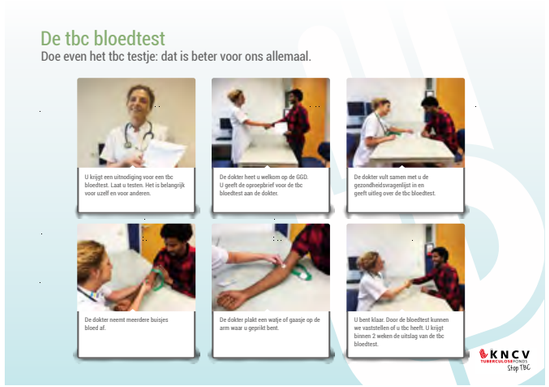
Pilot 1: LTBI Entry-screening among immigrants

In 2013, a KNCV study confirmed the feasibility of LTBI screening among immigrants, a group mainly consisting of students, expats and reunited families. However, it also identified some important barriers, such as out-of-pocket expenditures for preventive >>

Our impact in short

By optimizing TB disease prevention among high-risk migrant groups, KNCV is accelerating TB elimination in the Netherlands.

INDEX



Cultural Sensitive Education

"An important component of TB control in the Netherlands is awareness. People are entitled to accurate, clear, and complete information in order to make an informed decision about the research and treatment of TB. With the elimination of TB in mind, we are now transitioning from active-TB screening to LTBI screening among the highest-risk groups for TB. Participatory research with Eritrean asylum seekers gave us insights into existing knowledge and wishes in respect to communication. These insights were combined with scientific insights about communication and behavior, and led to the development of new information materials for LTBI screening and preventive treatment."

Annet Reusken,
KNCV TB nurse consultant

>> treatment and a lack of proper educational materials. At the start of the TB ENDPoint project these barriers were discussed in a workshop with the different stakeholders. A protocol was designed based on these prerequisites, and two months later the first client was screened for LTBI. In total, 573 clients of all ages were screened for LTBI, and blood tests found 18% had latent TB. Three people were found to have active TB, including one child with extra-pulmonary TB, and were put on treatment. Preventive treatment was offered free of charge to all those diagnosed with LTBI. The data from the pilot is currently being analyzed by KNCV and an article is expected in the summer of 2017.

> We consider LTBI management a crucial component of the global End TB Strategy

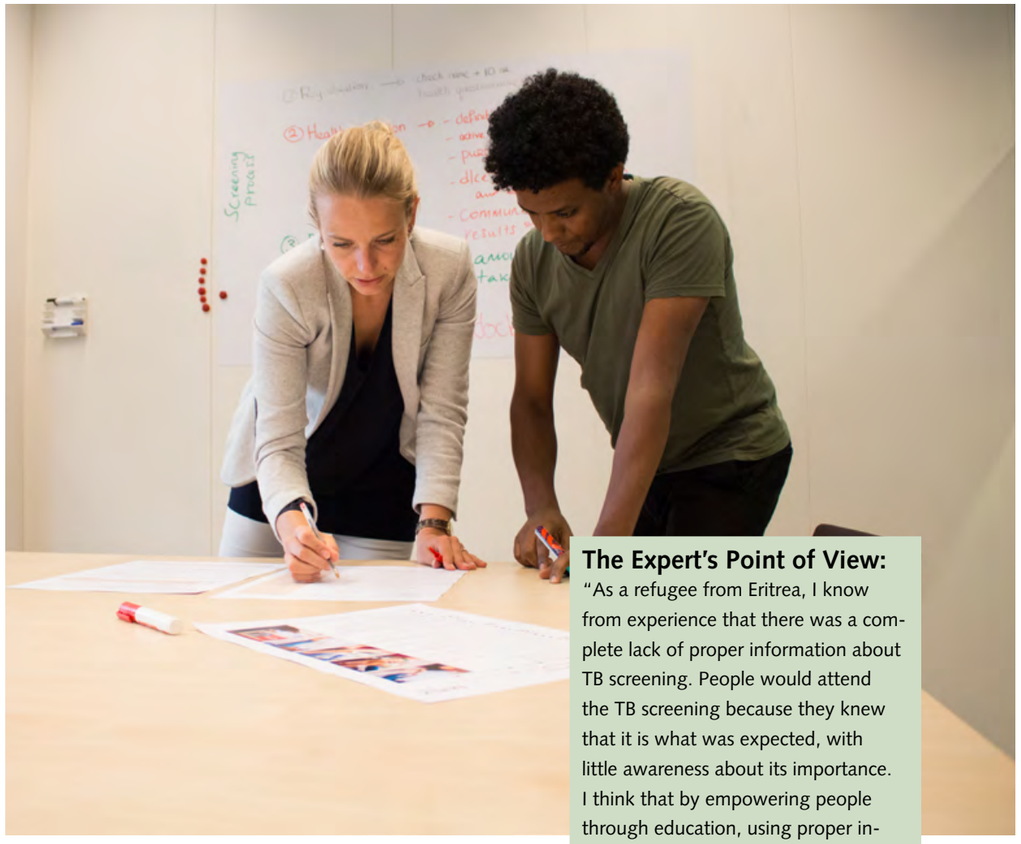
Pilot 2: LTBI follow-up screening among asylum seekers

In the Netherlands, all migrants born in countries with a TB incidence of more than two hundred TB cases for every 100,000 people are eligible for a voluntary follow-up of the initial entry-screening which takes place when they arrive in the country. This screening is currently performed with an X-ray every six months for a period of two years. The second pilot of the TB ENDPoint project looked at replacing this with LTBI screening. The pilot focused on asylum seekers living in reception centers, aiming to find an optimal approach for LTBI screening and preventive treatment.

As with the first pilot, we started with a kick-off meeting involving different organizations that work on the health and wellbeing of this group of immigrants. Representatives of the municipal health service (MHS) offices nationwide were present, as were people that organize housing and preventive healthcare for asylum seekers in reception centers.

Eight MHS offices agreed to participate in the pilot, and subsequently 400 asylum seekers were screened. The majority of these people were born in Ethiopia or Eritrea, and were almost all young adults. Preliminary results show that 24% of the people screened were diagnosed with LTBI and subsequently received treatment.

Alongside the screening, we worked on the development of education materials, tailored to this target group. Qualitative research shows that if proper health education takes place, the attitude towards the screening is more positive, as it is perceived as something that might improve your health status. An upcoming interim report will be discussed in a meeting with all stakeholders. All the lessons learned from the first phase will then be implemented in the second phase of the pilot, which in turn will screen another 400 asylum seekers. A final report of this pilot is expected in the fall of 2017. ■



The Expert's Point of View:

"As a refugee from Eritrea, I know from experience that there was a complete lack of proper information about TB screening. People would attend the TB screening because they knew that it is what was expected, with little awareness about its importance. I think that by empowering people through education, using proper information material, you will be able to create awareness and thereby a higher level of acceptance for screening. We try to improve knowledge on TB and LTBI through short education sessions and information brochures. After each education session, which takes place before the LTBI screening, you notice a visible increase in self-confidence. I think that is a beautiful thing."

Dawit T Haile, research assistant TB ENDPoint project

INDEX

PREV

BOTSWANA

GxAlert has been rolled-out and implemented in 29 GeneXpert sites.

More than 25,000 TB test results were reported through the use of GxAlert, allowing patients to start on treatment as fast as possible.

In collaboration with the National TB Program, KNCV introduced and implemented GxAlert. This system allows for automatic real-time reporting of test results from GeneXpert diagnostic machines to health providers. By the end of 2016, GxAlert rollout was completed in 29 facilities, with more than 25,000 test results already reported. With this fast communication system, lives are being saved because patients can be started on treatment immediately.

The National TB Reference Laboratory was closed for almost two years but has been successfully renovated and was again fully operational as of September 2016. Through the USAID-funded Challenge TB project, KNCV made a significant financial contribution to support the refurbishment in addition to providing continued technical support.

With new drugs and regimens for MDR-TB patients becoming available, we supported the National TB Program in preparing for their implementation. The national workgroup for drug safety (pharmacovigilance) was revitalized and new guidelines were developed. Furthermore, preparations were made for a combined national TB and HIV prevalence survey. Botswana will be the first country ever to conduct such a combined survey, with KNCV being the prime technical partner.

POINTS OF PROGRESS IN COUNTRY OFFICES IN 2016

NAMIBIA

2,721 people living with HIV do not have to travel to the hospital as they can now get their anti-retroviral therapy closer to home at TB DOT points

580 healthcare workers and 179 field promoters were jointly trained to provide integrated TB/HIV services

In Namibia, we strive to integrate TB and HIV services for optimal patient-centered care. In 2016, we conducted joint trainings for 580 healthcare workers and 179 field promoters in various technical areas. Joint trainings strengthen the provision of integrated services for TB and HIV, so this model is now promoted in all assisted facilities. We did two assessments that showed that over 85% of all facilities now provide some form of integrated TB and HIV services. Through these assessments, we will be able to further integrate services, and to prioritize which sites need our support. Another example of integration of TB and HIV services is to use containers that were put in place for TB treatment, also as facilities for preventive therapy for people living with HIV. We piloted this approach in the Engela district, where TB treatment containers were placed under the TB CARE I project. In 2016, 2,721 people living with HIV, who originally had to travel to the hospital to receive the needed anti-retroviral therapy, can now obtain it closer to home at the TB treatment points.

INDEX

NEXT

Yayasan KNCV Indonesia

A FOUNDATION FOR SUSTAINABLE TB CONTROL

The 15th of December 2016 proved to be a significant milestone in KNCV Tuberculosis Foundation's 114-year history. This day saw the official establishment of Yayasan KNCV Indonesia, the first independent local NGO that is building on KNCV's past work and experience in Indonesia and around the world. Based on KNCV's principals of producing sustainable local solutions and realizing effective capacity building, the organization was founded by three Indonesian women, passionate about fighting TB. In a country with one of the highest TB burdens in the world, the Yayasan KNCV Indonesia is uniquely positioned to provide solutions tailored to the local context and utilize international partnerships, while building on more than a century of KNCV experience fighting TB all over the world.

TB in Indonesia

As the fifth most common cause of death in Indonesia, TB claimed a hundred thousand lives in 2015. Indonesia is on the list of six countries that account for sixty percent of all new TB cases worldwide and, together with Nigeria and India, accounts for almost half of the 4.3 million gap between incident and notified cases. Multidrug-resistant TB is a significant problem in Indonesia. Low enrollment on treatment for this dangerous variation of TB puts the country on the list of five countries that account for sixty percent of the global gap between MDR-TB notification and treatment.

KNCV in Indonesia

KNCV has had a long history in Indonesia. It was a decade and a half ago when the first country office opened its doors to assist in the national fight against TB. KNCV Indonesia has since assisted in the local implementation of USAID's global TB-control programs TB CAP, TB CARE I, TBCTA and the current KNCV led Challenge TB project, the largest global TB-control initiative. Working on all levels within the Indonesian context has earned KNCV the reputation as a trusted partner with a respectful hands-on approach. Because of an emphasis on local capacity building, KNCV Indonesia is primarily staffed by Indonesian TB-professionals who apply their expertise within their familiar local context.

The road to the first independent local KNCV

With many important advancements in Indonesian TB-control realized over the years, the next step towards sustainable impact in the future >>

Our impact in short

In Indonesia, KNCV's focus on sustainability, local capacity building and effective partnerships has led to the establishment of the first independent local NGO under the KNCV umbrella.

The Founders of Yayasan KNCV Indonesia

The Yayasan was founded by three inspiring women; Ms. Ulli, a former MDR-TB patient and chair of one of the first Indonesian Patient Support Groups, Ms. Tutti, who worked with KNCV as an initiator of hospital DOTS linkage in Indonesia, and Ms. Harini, who dedicated her life to the TB laboratory network development. The organization will be led by KNCV Indonesia's current Technical Director Jhon Sugiharto, a dedicated professional in the field who has been working in Indonesian TB control for over a decade. Jhon Sugiharto has a long history working within Indonesian Civil Society, including helping victims of the devastating 2002 Jakarta floods and assisting in the relief efforts following the 2004 Indian Ocean Tsunami.

From left to right: Lintang Suryaningtyas (YKI Governing Board), Kitty van Weezenbeek (Executive Director KNCV Tuberculosis Foundation), Monique Rijkers (YKI Governing Board) and Jhon Sugiharto (Director YKI).

YAYASAN KNCV INDONESIA untuk eliminasi TB

>> is the founding of a local, legally independent, organization. The 'Yayasan KNCV Indonesia' (Yayasan means 'foundation'), will make it easier to retain experienced staff on a consistent basis, avoid regulatory difficulties related to international NGOs, and allow for local resource mobilization.

My dream is to support all provinces and help people who currently do not have access to TB care. The Yayasan makes it much more likely to be able to help, advise and strengthen civil society and patient support groups, and will play a big role in TB advocacy in Indonesia.

– Jhon Sugiharto, Yayasan KNCV Indonesia

Most importantly, the organization will be optimally equipped to help integrate TB care and prevention into the local health system.

On the 15th of December 2016, the Yayasan KNCV Indonesia became a reality. The organization was established by three inspiring women in Indonesian TB control. Led by Jhon Sugiharto, longtime technical director of KNCV Indonesia, the organization will be a sub-recipient for the Indonesia Global Fund TB grant, organizing technical assistance for the two principle recipients and implementing all other projects funded from non-USAID sources. The organization is a legally independent local NGO, that has signed a partnership agreement with KNCV in The Netherlands to be able to operate within the larger KNCV network.

Because of KNCV's reputation for collaborative, respectful, and effective assistance in Indonesia's struggle with TB, the Yayasan KNCV Indonesia starts on a strong footing. With a name known throughout the Indonesian National TB Program, a dedicated team of local experts, and opportunities to diversify funding, the Yayasan KNCV Indonesia is poised to make a significant impact on TB control in Indonesia. ■

POP TB

In 2016 KNCV helped to establish the national TB patient organization POP TB, bringing together eight local patient organizations. The founding of POP TB is reminiscent of KNCV's own origins, which started in 1903 in The Netherlands as a joint initiative of local TB control organizations. Furthermore, POP TB aims to provide a platform for the voices of TB patients, represent TB patients in national level discussions and forums, contribute to planning and decision-making, and participate in monitoring the implementation of national policies. POP TB also aims to promote and facilitate the establishment of more local TB patient organizations across Indonesia and to build the capacity of its members.
Since its establishment, POP TB has already become a member of the Country Coordinating Mechanism, which puts the organization in a strategic position in country-level multi-stakeholder partnerships, enabling the development and submission of grant proposals to the Global Fund based on national priorities and the needs of patients. After grant approval, POP TB oversees progress during implementation and the organization is also a member of the Tuberculosis Technical Working Group and the global Stop TB Partnership.

INDEX

POINTS OF PROGRESS IN COUNTRY OFFICES IN 2016

To be able to find more TB patients faster, the number of GeneXpert machines increased by 735% (from 82 to 603).

We helped to strengthen the voice of TB patients, by supporting the establishment of POP TB, a national association of 8 patient-support groups.

INDONESIA

In Indonesia, great progress was made with the development of district ownership and funding for TB control. This way TB care and prevention is further integrated into the healthcare system, working towards sustainable TB control. In order to get district funding, districts are now obliged to produce a TB action plan. We helped develop a national guideline for district planning, as well as to develop a tool to estimate the TB burden at both district and provincial levels. These tools are now used for planning nationwide.

To be able to identify and timely treat more TB and MDR-TB patients, the number of available GeneXpert machines for diagnosis increased from 82 to 603. This year 132 machines were installed throughout 34 provinces, with another 471 machines procured and awaiting installation in early 2017. The accelerated scale-up is funded by the Global Fund (320 machines) and domestic sources (201 machines), with KNCV providing technical advice and funding for procurement, placement, installation, and training for laboratory technicians and regional GeneXpert teams on support and troubleshooting.

Prisoners are a key population at-risk of contracting TB. We therefore worked together with the Directorate General of Correction Ministry of Law and Human Rights and FHI 360 to create the 'Prisoners Action Plan'. This work plan, which was signed by all participating parties in April, aims to provide all inmates with access to effective TB, DR-TB, and TB/HIV services, and to develop a post-release program.

In 2016, we helped to establish two important Indonesian TB organizations. The first, POP TB, follows in KNCV's footsteps as an association of local TB organizations. The second, the Yayasan KNCV Indonesia, is a local NGO, working under the umbrella of the KNCV quality network.

COUNTRIES WHERE WE WORK

INDEX

PREV

TAJIKISTAN

In total 228 health providers were trained to help patients be treated with new drugs and regimens

In Tajikistan KNCV successfully started the enrollment of patients on new drugs and shorter regimens, using the KNCV Patient Triaging Approach. The enrollment covers patients from Dushanbe, the capital, and Rudaki District. Based on WHO recommendations, we made all the necessary preparations, including policy development and producing the necessary technical documents through the Challenge TB project. Guidelines and a national plan were approved by the Ministry of Health, including revized recording and reporting forms. We also developed clinical protocols and optimized the diagnostic algorithm needed to assess the right treatment for every patient.

To manage adverse events and prevent serious side effects, we established a system for drug safety monitoring and management, and supported the procurement of necessary equipment, such as ECG machines, ultrasound scanners, audiographs, negatoscopes, and mechanical scales. We also trained TB and primary healthcare staff to manage patients on new treatment regimens. In total 228 people were trained: health providers including physicians and nurses, laboratory specialists, consilium members and representatives of the State Pharmaceutical Control Service, as well as 87 drug management specialists who received an updated Logistic Management Information System training. All these preparations will now make it possible to help patients suffering from MDR/XDR-TB, for whom these new drugs and regimens are life-saving.

INDEX

NEXT

VIETNAM

The National Childhood TB policy was rolled-out and evaluated in 3 additional provinces, preparing for countrywide implementation of Childhood TB contact screening.

174 physicians, radiographers, and pediatricians were trained on reading radiographic film to detect TB infection.

The introduction and scale-up of GeneXpert machines is making a significant contribution to the diagnosis of MDR-TB in Vietnam. In addition to the 71 existing GeneXpert systems, 20 new systems were implemented in 2016. Since GeneXpert was introduced in Vietnam in 2012, more than 85,000 tests have been performed.

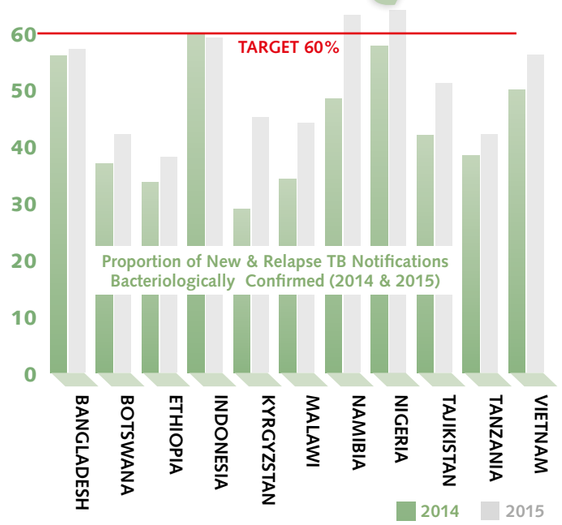
The scale-up of programs for the Programmatic Management of Drug Resistant TB (PMDT) is progressing well. KNCV plays an important role in advising and supporting the National TB Program in terms of policy, work plan development, implementation and quality assessment. In 2015 Vietnam pioneered the KNCV Patient Triage Approach for rifampicin resistant TB (RR-TB) patients. In 2016, a total of 88 pre-XDR and XDR-TB patients, for whom new drugs hold the only hope of a cure, were enrolled on appropriate treatment. The treatment of eligible MDR-TB patients with the shorter nine-month regimen was implemented in April 2016, with 104 MDR-TB patients enrolled so far. The KNCV Triage Approach enables MDR-TB patients to be treated with the most appropriate and least toxic regimens currently available. ■

PHOTO: DAVID ROCHKIND/GROUND MEDIA

STRATEGIC GOALS 2020 RE PORT

The data presented here are based on the 2016 WHO Global TB report and the WHO online TB database. The annual WHO report is disseminated around October and reports on data from the previous year – 2015.

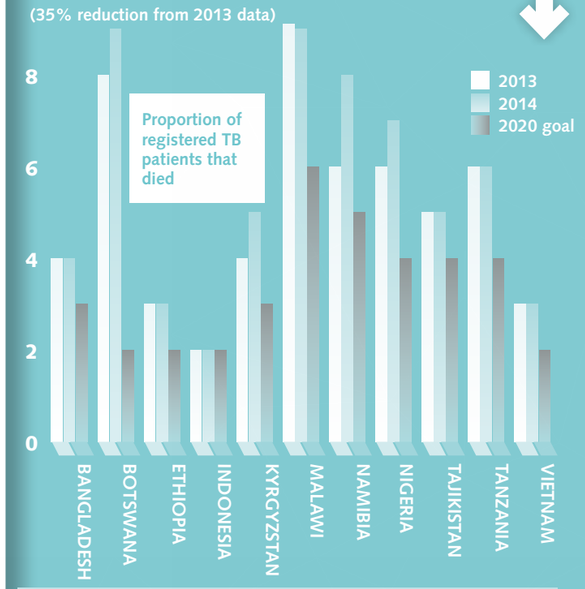
FIND MORE MISSING PATIENTS



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

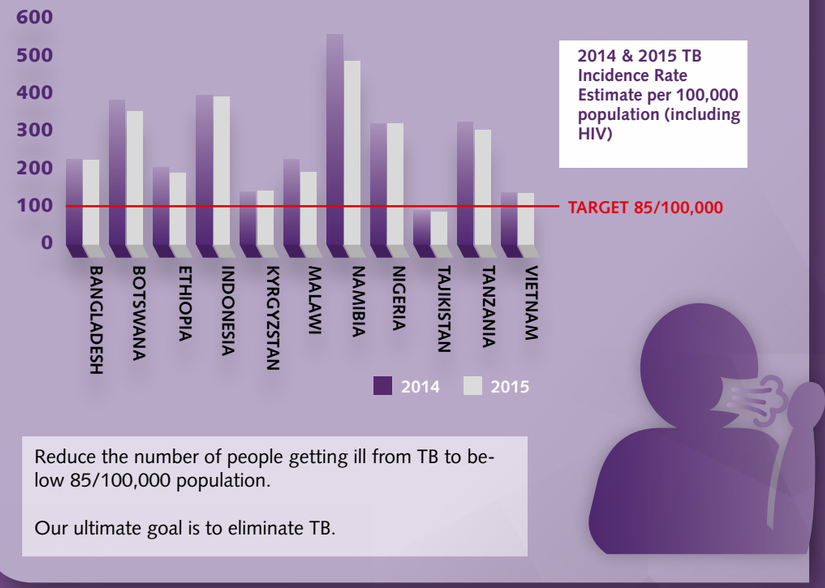
REDUCE THE PERCENTAGE OF REGISTERED TB PATIENTS THAT DIE OF THE DISEASE BY 35%

(35% reduction from 2013 data)



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

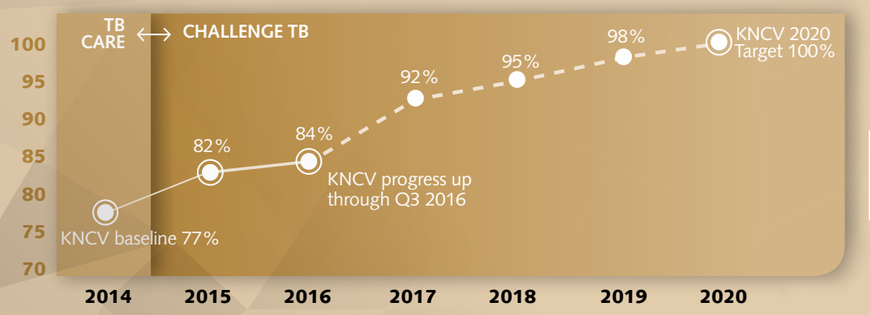
PREVENT MORE PEOPLE FROM DEVELOPING ACTIVE TB DISEASE



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

Our ultimate goal is to eliminate TB.

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



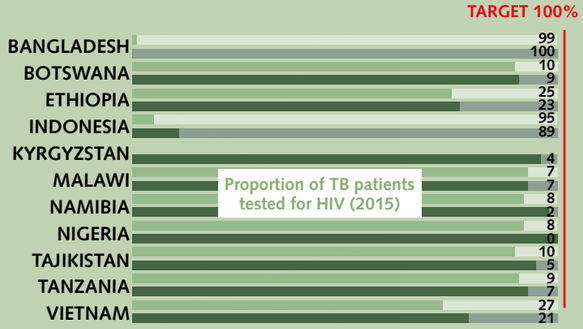
Proportion of detected MDR-TB patients enrolled on treatment

MDR treatment initiation rate in KNCV countries

Target MDR treatment inititation rate in KNCV countries

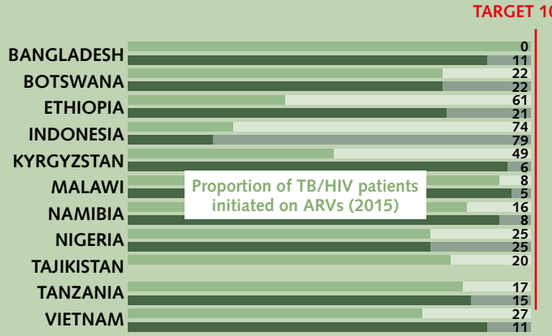
Starting all identified drug-resistant patients on appropriate treatment is an essential early step in preventing the spread of these forms of TB.

TEST ALL REGISTERED TB PATIENTS FOR HIV



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

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



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

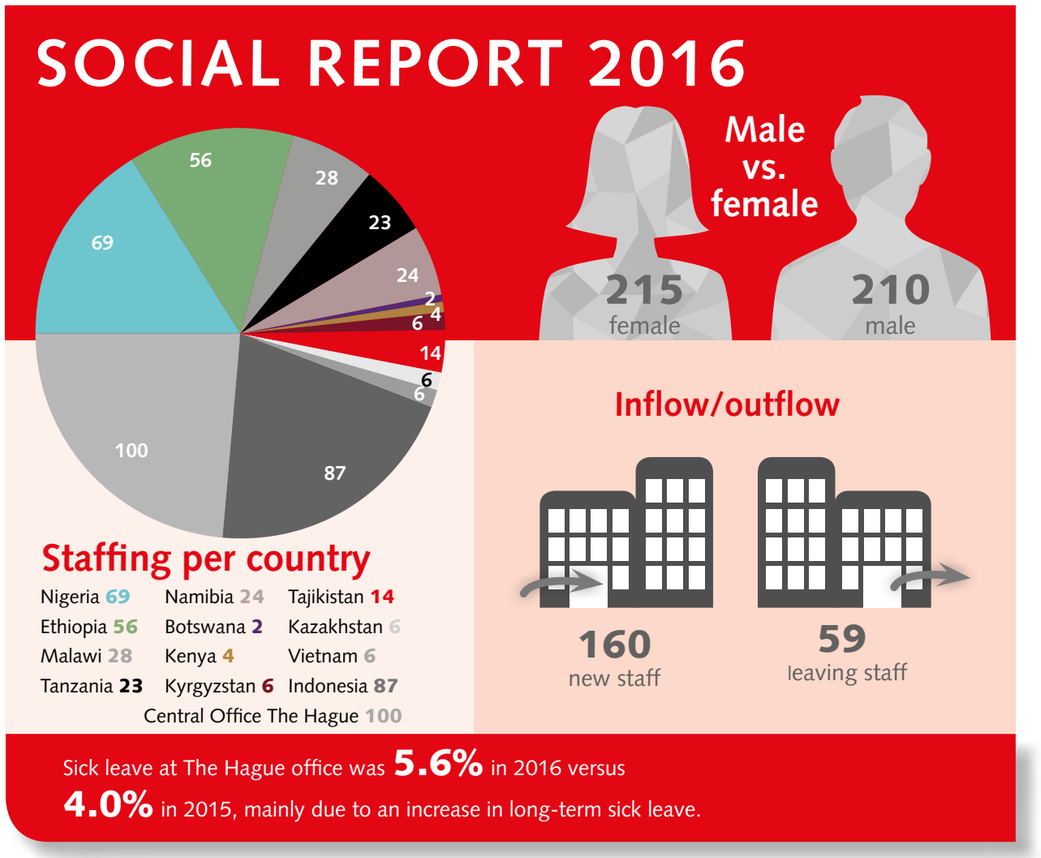
INDEX

ORGANIZATIONAL HIGHLIGHTS IN 2016

Optimizing Operational Processes

In 2016 KNCV worked on further strengthening the organizational structure into three pillars (Technical, Finance and Operations) as initiated in 2015, and aimed to optimize the internal collaboration between the different disciplines. Both technical and project management capacity was expanded to meet the needs of several large projects. In February 2016, Diana Numan joined KNCV as the new Director of the Operations Division, completing the management team.

KNCV invested in improvements to organizational resource planning in monitoring tools as well as project management tools. We visited other organizations (e.g., IRC and the University of Wageningen) to share experiences, gather best practices, and come to a well-informed decision on the preferred integrated project management system. KNCV's planning and reporting cycle was reviewed, and we developed a Project Balanced Scorecard and introduced a tool to monitor reporting deadlines. In November 2016, KNCV organized the International Advisory Board meeting on country offices and the decentralization process, to which we invited several other Dutch organizations. It resulted in an inspiring meeting for all participants and produced valuable input for KNCV going forward.



Strengthening capacity in our country offices is an on-going process that is also incorporated in day-to-day project implementation, international meetings, on-the-job coaching of country office staff, and support visits. In 2016, working with local partners has been a specific topic of focus. Tools were provided to assist in local partner selection and monitoring, and a start has been made on the development of country-specific plans relating to local partners. Furthermore, KNCV developed a framework and classification method based on the three country offices that had been selected to start piloting local resource mobilization: Nigeria, Ethiopia and Indonesia. This will be further elaborated on in 2017.

Besides regular statutory and project audits, the project in Afghanistan led by MSH was audited by an external auditor on behalf of the US Inspector General's Office. No major issues were found, but the fact that staff on lower salary scales were paid in cash was commented upon. MSH is working on improving this by using new digital payment methods.

The statutory independent auditor PriceWaterhouseCoopers N.V. visited our offices in Ethiopia during our regular annual internal audit and evaluated the internal audit process. The resulting recommendations will be implemented during internal audits in 2017.

During 2016, a banking crisis in Tajikistan led to the freezing of our bank balances with the AgroInvest bank in Dushanbe, Tajikistan. We immediately opened bank accounts with Amonatbank and worked on transferring funds to this new bank. In April 2017, all remaining funds were released from the AgroInvest bank.

KNCV's annual International Finance Meeting took place in August and focused on due diligence with sub-awardees, exchange rate differences, and accountability in a multi-donor environment.

> KNCV invested in improvements to organizational resource planing in monitoring tools as well as project management tools.

Broadening Our Funding Base

Alongside the USAID-funded Challenge TB project, in 2016 we implemented several other multi-year projects and partnerships. Funded by the Dutch Directorate-General for International Cooperation, the 'Making the Global Fund Money Work' project focuses on strengthening private sector engagement and enhancing investments made by the Global Fund to combat TB/HIV co-infection. The project was implemented in three additional countries, >>

Kazakhstan, Nigeria, and the Philippines, over the course of 2016.

KNCV was a member of several consortiums that submitted extensive funding proposals to European donors (UNITAID, EDCTP, Horizon 2020, and TB REACH) and was successful in securing a number of partnerships that will introduce or rollout innovative new regimens and prevention methods in Africa and Asia.

In 2016, KNCV was also successful in its bid to co-host the 'Union World Conference on Lung Health', the global TB gathering that will be held in The Hague in 2018. This conference will provide KNCV with an excellent opportunity to connect with a broad range of stakeholders and build lasting partnerships, including with the corporate sector. The conference will also be an important event to showcase the achievements of the Challenge TB project, highlight collaboration with coalition partners, and foster partnerships with existing and potential new partners and donors.

Local resource mobilization was boosted in 2016, as KNCV prioritized the sustainability of the country offices, through investment in enhanced external communications and institutional fundraising. Three countries were selected for pilots, and additional capacity and funding was made available for resource mobilization. Where feasible, KNCV registers local entities in order to foster local ownership and to be able to receive funding in-country.

Through a special financial contribution from the 'De Langen Stichting voor Mondiale Tuberculosebestrijding' KNCV was given the opportunity to invest in research and planning for future core funding. The 2016 action plan's implementation was delayed due to the lack of a Head of Resource Mobilization. The Young Professional program commenced in 2015 with the support of the aforementioned foundation in combination with the 's-Gravenhaagse Stichting tot Steun aan de bestrijding van Tuberculose'. In 2016, Stichting Sonnevanck and the Bakhuys Roozeboom Stichting also contributed to this program which will now enroll two young professionals annually. Through this program, we are investing in a new generation of TB experts that combine solid knowledge with new skills and working dynamics.

Campaigning and Private Fundraising in the Netherlands

The results of our private fundraising improved in 2016 compared to the previous year. This was largely due to more income from private institutions and legacies. We have been diversifying our methods of fundraising by working on a more segmented approach, including door-to-door appeals, online marketing and collecting donations via SMS. Our ambassador, Dutch actress and former TB patient Imanuelle Grives, visited Ethiopia to see our work first-hand and had several encounters with TB patients. Her visit resulted in several promotional materials, including a Socutera commercial which ran twice for a one week period in 2016.

World TB Day on 24 March is always an important publicity moment for KNCV, but this year we had to withdraw part of our planned campaign due to news events around that date. The follow-up campaign was not as successful as we had hoped, but specifically targeted online approaches were.

These investments in new approaches have not yet made up for the decline in the number of donors, but the percentage of regular givers is on the rise, and the average gift amount is higher than the previous year. We are growing our online presence and engagement and this has resulted in a rapid growth in our Facebook community and online donations.

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

International Policy and Advocacy

KNCV's international policy and advocacy engagement is a core activity in support of the mission to eliminate TB. It is also an enabling function, by influencing Dutch policy and funding for TB and enhancing the positioning of the organization. In 2016, KNCV stepped up its engagement in advocacy, which also supports the required diversification in funding.

The 2016 annual plan for advocacy and international policy engagement set out five goals and the following was achieved:

1. In January 2016, KNCV co-hosted a panel discussion with Bill Gates at the Dutch Royal Tropical Institute (KIT). As a result, the Dutch TB research field received attention at the EU Commission during the Dutch EU presidency Council meeting on research and development, building on an earlier White Paper about the Dutch contribution to Global End TB Research.
2. KNCV, together with partner Aidsfonds, were invited and successfully submitted a follow-up grant proposal at the completion of the 'Capital for Good' funded TB and HIV advocacy grant in March.
3. In 2016, KNCV's Global Fund advocacy and policy engagement focused on country grant absorption. Policy engagement led to information which was utilized to inform the Global Fund hub activities under the Challenge TB and DGIS grants. In May 2016, Beatrijs Stikkers was appointed as vice-chair of the Audit and Finance Committee. In this leadership position policy engagement at the GF secretariat was stepped up and is starting to provide openings for broader KNCV engagement at the Global Fund Secretariat, such as on stigma and TB modeling.
4. KNCV support to in-country advocacy capacity building was welcomed during the annual country directors' meeting in June. Planning of actual activities in a selected set of countries is expected to begin in mid-2017.
5. Looking ahead to the 2018 conferences in the Netherlands: KNCV initiated a successful bid to co-host, with the City of The Hague, the Union World Conference on Lung Health. This provides further opportunities to position TB in the International AIDS Conference 2018, that will be held in Amsterdam. Collaboration has been enhanced with TB and HIV partners in the run up to the events in 2018, as well as linking the two conferences programs together. ■

Chair Dina Boonsta leaves KNCV's Board of trustees with a legacy

In May 2016, Dina Boonstra chaired her last meeting as a member of the Board of Trustees. She showed her continuing commitment by presenting KNCV with a unique farewell gift, the 'Jakob & Carolina Fund'. This fund provides money for training Patient Support Group members around the world. Dina Boonstra started the fund in memory of her father Jakob Boonstra, and in the name of Carolina, a former TB patient from Kenya who now supports other patients with completing their treatment.

Board of Trustees member Maurits Verhagen accepted a job as a coordinator of X-ray equipment in Ghana and therefore had to quit the Board of Trustees. In December, the KNCV General Assembly appointed Wieneke Meijer as new member of the Board of Trustees to replace him. Wieneke Meijer is currently active in the TB Department of the Amsterdam Public Health Service (GGD). We welcome Ton van Dijk as the new chair, with Mirella Visser serving as vice-chair of the Board of Trustees as of May 2016.

BOARD OF TRUSTEES REPORT

New Organizational Structure

In 2016 KNCV Tuberculosis Foundation grew strongly, mostly because of the implementation of the Challenge TB project (2015-2019). To be able to manage and execute this project successfully, the Board of Trustees' main priority was to ensure proper governance of organizational developments. A new organizational structure has been introduced that fits the size and technical requirements of our projects as well as our ambition to stay as one of the frontrunners in the elimination of TB worldwide.

In 2016, a significant change in the Executive Board took place with the resignation of the Chief Scientific Officer Frank Cobelens. He took up the prestigious position of the chair of the Amsterdam Institute of Global Health and Development (AIGHD), as successor to Joep Lange, former KNCV Board of Trustees member, who very sadly died in the crash of flight MH17 in 2014. The Board of Trustees agreed to the implementation of a new board structure in which the Executive Director is the sole head of the organization and is supported by a Management Team that consists of the three division directors.

In the fall, an external review of the new organizational structure was carried out. The recommendations of the review provide a sound basis for the future development of the organizational structure. As a result, the Operational Coordination meeting group was established with the purpose of further relieving the Executive Director from ongoing operational issues. In addition, a Strategy Team was introduced with the purpose of discussing strategic issues with all Division and Unit heads. The Board of Trustees will evaluate the changes in the organizational structure in 2017.

Changes in the Board of Trustees

Chair Dina Boonstra said farewell at the General Assembly Meeting in May 2016 after serving for ten years as a member, and later chair, of the Board of Trustees. We are very thankful for her strong commitment and the professional way she led the Board of Trustees; her valued contributions and perspectives will be sorely missed. Ton van Dijk is temporarily replacing Dina Boonstra as chair until a new chair is appointed. Mirella Visser was appointed vice-chair, succeeding Dirk Dotinga. Board of Trustees member Maurits Verhagen also resigned from his position in May 2016, following his appointment as coordinator of a TB project in Ghana. We will miss his expertise and are thankful for his commitment to KNCV's mission. Keeping with the tradition that the chair of the Committee for Practical TB Control Netherlands (CPT) is a member of the KNCV Board of Trustees, Wieneke Meijer has been appointed by the General Assembly in December 2016. Chair of the Audit Committee Dirk Dotinga announced his resignation as of May 2017. With a wide diversity of experience and knowledge available in the Board of Trustees, this was the right time for him to handover. To ensure a smooth handover, Maria van der Sluijs was appointed as his successor as chair of the Audit Committee in September. During the first part of 2017 two new board members will be recruited, ensuring a balanced distribution of expertise and experience.

Self-assessment Board of Trustees

The Board of Trustees conducted the annual self-assessment and shared the outcomes with management.

Diversification of funding and resource mobilization

Management and the Board of Trustees focused on future funding scenarios beyond 2019, when the USAID-funded Challenge TB project will end. 2016 was characterized by continuous efforts to diversify funding in the medium-term. This topic featured on the agenda of the annual retreat with the Management Team that took place in June 2016. A new Head of Resource Mobilization was appointed in October 2016, which will enable KNCV to make significant progress on funding diversification through continued reactions to calls for proposals and active outreach to corporates and foundations as well as exploring in-country possibilities.

Strategic outcomes of the Board of Trustees' annual retreat

During the annual retreat, the following strategic positioning areas for KNCV were identified as key areas of attention and oversight for the Board of Trustees:

- To remain a global player in the elimination of TB worldwide;
- To participate in global policy development;
- To be a preferred provider of technical assistance;
- To become recognized as an educator.

The Board of Trustees will continue to monitor these ambitions, and in particular the fourth area as it is currently the least developed.

Looking ahead into 2017

The Board of Trustees commends the organization for the transition to a strengthened and much expanded organization over the course of the year. We look ahead to the coming years with confidence, and take pride in the evolving mission and role of KNCV in ending TB. ■

Board of Trustees,

Chair
Ton van Dijk

Vice-Chair
Mirella Visser

INDEX

GOVERNANCE AND ORGANIZATIONAL REPORT

Statutory name, legal state and place of residency

The 'Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose' (KNCV or KNCV Tuberculosis Foundation) is a Vereniging according to Dutch law and has its central office in The Hague, The Netherlands. The latest version of the statutes passed the notary deed on 23 August 2012 and can be found on our website. For an overview of KNCV offices worldwide please refer to the contact list for KNCV offices in the Annexes.

General Assembly

The members of KNCV are organizations with a mission or task in the field of TB control. KNCV's General Assembly, comprised of ten members, appoints the Board of Trustees and governs the activities of KNCV, thereby contributing to the statutory mission of the organization. The General Assembly may advise the Board of Trustees and the Executive Board. The General Assembly met on 18 May 2016. At the end of 2016, members are:

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

Honorary Members

Honorary members of KNCV are individuals who made a significant contribution to TB control and/or to KNCV as an organization. At present our honorary members are Dr. M.A. Bleiker and Dr. H.B. van Wijk.

Board of Trustees

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

The Board of Trustees, at 31 December 2016 was as follows:

Member	Appointed	Expiring
Ton van Dijk (chair)	May 2013 (1st term)	2017, eligible for 2nd term
Mirella Visser (vice-chair)	May 2015 (1st term)	2019, eligible for 2nd term
Dirk Dotinga	May 2012 (2nd term)	2020
Jan Hendrik Richardus	May 2015 (1st term)	2018, eligible for 2nd term
Maria van der Sluijs-Plantz	May 2015 (1st term)	2018, eligible for 2nd term
Wieneke Meijer	December 2016 (1st term)	2020, eligible for 2nd term

The full Board of Trustees meets four times a year, and once a year a retreat is held together with the senior management of KNCV. Three permanent sub-committees have been established with the following preparatory tasks:

- An agenda setting committee to prepare the board agenda;
- An audit committee to assess in detail the annual plan, annual report, and the findings of the independent 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. By year's end 2016, a nomination committee consisting of Ton van Dijk and Maria van der Sluijs-Plantz has been setup in order to recruit two new members for the Board of Trustees.

Supervisory governance during 2016

In May 2016, Dina Boonstra resigned at the annual General Assembly meeting. For ten years she was a member, and later also chair of the Board of Trustees. Next to that, Board of Trustees member Maurits Verhagen resigned because he accepted a position abroad. Dirk Dotinga has been reappointed by the General Assembly in May 2016 for a second term. However, in late 2016 he announced his resignation as of May 2017. In December 2016, Wieneke Meijer has been appointed by the General Assembly to succeed Maurits Verhagen.

In 2016, the Board of Trustees held four regular meetings (February, May, September, and November). An annual retreat with the Executive Director and the Management Team to discuss strategic decision-making took place on 30 June 2016. The Audit Committee met twice (April and >>

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

Member	Positions
Ton van Dijk	Director of public health (region Haaglanden) and director of medical disaster management (region Haaglanden)
Mirella Visser	Center for Inclusive Leadership, Founder and Managing Director; Member Advisory Council International Affairs for Dutch Ministry of Foreign Affairs;
Dirk Dotinga	Chair Alzheimer Netherland – region Haaglanden, member of the Board of Trustees Haagse Milieu Services, board member Stichting Noodopvang Haaglanden
Jan Hendrik Richardus	Professor, Department of Public Health, Erasmus University Medical Center; numerous scientific advisory committee positions in the Netherlands and overseas; Chair Committee Research, infectious disease association the Netherlands; Chair IDEAL consortium;
Maria van der Sluijs-Plantz	TMF Orange Holding B.V. non-executive Board Member; Telefonica Europe B.V. non-executive Board Member; various advisory and volunteer positions; Member of the Board of financial supervision Curaçao and Saint Martin (nominated by Saint Martin)
Wieneke Meijer	Medical doctor and head of the Tuberculosis Department of the Public Health Service (GGD) in Amsterdam; chair of the Committee for Practical TB Control Netherlands (CPT); member of the Steering Committee Tuberculosis from GGD GHOR Netherlands

>> October). The appraisal and remuneration committee conducted performance assessments with Executive Board, sharing outcomes with the full board. In September 2016, the annual self-assessment for the Board of Trustees took place with the purpose of identifying potential areas for improvement and ways to strengthen the role of the Board of Trustees. Two members of the Board of Trustees attended the Works Council meeting in the December.

Executive Board

The Executive Board governs the organization. Up to January 2016 the Executive Board was composed of an Executive Director (who holds statutory powers solely) and a Chief Scientific Officer (CSO). On 1 January 2016 Frank Cobelens resigned as CSO with KNCV and assumed the position of leading the Amsterdam Institute for Global Health and Development. As of this date, the Executive Board shifted to being a one-person board:

Member	Appointed
C.S.B. van Weezenbeek, MD, PhD, MPH, Executive Director	September 16, 2013

The Executive Director is supported in decision-making by the Management Team, which meets biweekly and is composed of the three division directors of KNCV (Technical Division, Finance Division, and the Operations Division). Next to that, a Strategy Team meeting is held every quarter with the purpose of discussing medium-term strategic issues. The Strategy Team consists of the Executive Director, the three division directors, the Challenge TB project director, all unit heads, and technical coordinators.

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

International Advice and Counsel meeting

In November 2016, KNCV organized an International Advisory Board meeting on country offices and the decentralization process, for which we invited several other Dutch organizations. It resulted in an inspiring meeting for all participants and produced valuable input for KNCV going forward.

Works Council

The chair of the Works Council, Ineke Huitema, has been occupied in the Nigeria office throughout 2016. Upon her return in Central Office she is to resume her role as chair. In her place, Irma Lamp replaced her as Chair of the Works Council. During the same period, the Works Council added an additional member, Sara Massaut. 2016 was also the election year for three positions in the Works Council. We are thankful for the continued support and re-election of Jenny Klein, Irma Lamp, and Job van Rest.

2016 was an active year for the Works Council on several topics. The Works Council gave advice through an External Evaluation, and their consent on the updated Employee Conditions, Code of Conduct, Vaccination Policy and Whistleblower Procedure. Other topics included home to work commute compensation and the salary scheme. One of the important issues of 2016 was staff workload and experience, for which a work experience survey was conducted by Schouten & Nelissen in close collaboration with the Works Council. Human Resources is now taking the lead to translate the results into interventions and next steps. We are dedicated to keeping this important issue on the organizational agenda for 2017.

The Works Council strives to maintain a good balance between looking at employees' wellbeing, interests, and working conditions on the one hand, and the organizational interests on the other.

The Executive Director held during 2016 the following relevant positions and responsibilities:

Organization	Position	Qualitate Qua / Personal	Period
Dr. C. de Langen Stichting voor Mondiale Tuberculosebestrijding (SMT)	advisor	QQ	Indefinite
's-Gravenhaagse Stichting tot Steun aan de Bestrijding van Tuberculose	advisor	QQ	Indefinite
Coordinating Board of the Stop TB Partnership	member	QQ	Indefinite

At the end of December 2016, the Works Council members were:

Member	Appointed	Expiring
I. Huitema	*2014 (2nd term)*	*2018, eligible for 3rd term*
J. Klein	*2016 (2nd term)*	*2020, eligible for 3rd term*
I. Lamp, chair while I. Huitema is working in Nigeria	*2016 (2nd term)*	*2020, eligible for 3rd term*
S. Massaut (temporary during absence I. Huitema)	2016	End 2017
J. van Rest	*201 (2nd term)*	*2020, eligible for 3rd term*
E. Tiemersma	*2014 (2nd term)*	*2018, eligible for 3rd term*

Quality Control

KNCV considers quality an essential hallmark of all the work we do. In 2016, to ensure quality in our activities, deliverables, and results the organization implemented processes that support standardized, high-quality performance. This includes standards of excellence and review processes for key KNCV technical functions, such as providing short-term technical assistance through consultancies at country level and developing high-quality work plans and reports. KNCV tracks and reports on the outcomes of all short-term technical assistance and provides systematic technical quality review for deliverables generated by its USAID-funded Challenge TB project.
To ensure that KNCV staff are up-to-date on the latest technical developments in TB control and elimination, the Technical Division has instituted "home weeks" when key technical staff from headquarters and the field gather in The Hague for week-long technical discussions on innovations. KNCV has also drafted an "innovations paper" to help the organization focus its contributions to the global evidence-base on promising new approaches and technologies for TB control.

To sustain the quality of internal management and processes within the organization, KNCV uses a cycle of strategic and annual planning, implementation, monitoring and evaluation, adaptation of plans, and accounting for results. This process has been described in the document "Management and supervision of KNCV, the Good Governance Code applied." The overall functioning of the organization and progress of the implementation of plans is continuously monitored by the Management Team and Executive Board, and is regularly reviewed in Board of Trustees meetings. For the projects and >>

>> programs funded by institutional donors, interim reports are sent to the funders and evaluated for effectiveness and efficiency. External oversight and auditing of the administrative and financial operations is carried out by PriceWaterhouseCoopers Accountants N.V. The independent auditor was appointed by the General Assembly in 2011. The directors have regular progress meetings with the independent auditor. Every year, the independent auditor reports their findings to the Audit Committee. All audit reports and management letters are shared with the Board of Trustees.

Compliance with 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 2016, the organizational risks were identified and updated in a risk assessment report using a survey among all country directors and unit heads. The following risks were identified as subjects for further improvement:

a. The various insurances related to liability were assessed on completeness and updated.
b. The KNCV Field Office Manual was updated in 2015. The section on procurement needs to be extended. In 2017, a full revision of the Field Office Manual will take place.
c. A plan for retention of key staff will be drafted in 2017.
d. In light of new laws, a section on data protection has been added to the risk assessment. The information security policy was drafted in 2016.
e. KNCV Tuberculosis Foundation is bound by tax regulations in the countries in which we operate. Misinterpretation or lack of (local) knowledge could result in non-compliance and associated fines/penalties. Hiring local expertise is part of the Terms of Reference for setting up a new office. Annual local checks will be performed by independent auditors. Plans have been developed for an external review of compliance in all country offices.

External Quality Hallmarks

KNCV is subject to the governance and quality requirements of the CBF and has, since July 1998, received the CBF certificate up to 2015. Since the transition to the 'Erkenningsregeling' in 2016 KNCV has been acknowledged as a CBF recognized charity, based on a self-assessment that was performed in 2016.

The document "Management and governance at KNCV - the code for Good Governance Code application" describes our governance structure, management procedures and regulations in detail. A summary of the accountability report, outlined below, is sent to the CBF annually.

Codes of Conduct

KNCV has a number of codes of conduct which guide the ethical behavior of staff and protect their employment with the organization. These are:

- General code of conduct, updated 2015 and re-introduced during the International Meeting Week in January 2016 to strengthen staff awareness and compliance monitoring;
- Code of Conduct for the use of e-mail, social media, internet and telephone facilities;
- Policy and protocol for undesirable behavior at work;
- Whistle-blower policy.

Media Policy

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

Social Responsibility

KNCV wants to be a responsible organization when it comes to our organizational footprint. We try to balance our strategic goal of a world free of TB with social, economic and environmental responsibilities. An important part of our work is related to stigma reduction, which also includes gender bias and sexual orientation. As an employer, we promote equal employment opportunities. We avoid paper wastage by enforcing double-sided printing, we reused most of our old furniture after our move to new offices in 2015 and we have used carpeting produced from recycled waste. Obviously, an important side effect of our work in southern countries is the emission of CO2 because of the number of flights we take. We have decided not to financially compensate for this emission, since this would take funding away from our core objective. We try to combine missions as much as possible, aim to reduce the number of trips we make, and try to work through remote support.

Data Leak Policy

KNCV adheres to the new policy on the obligation to report data leaks "meldplicht datalekken in de Wet bescherming persoonsgegevens (Wbp)" introduced on 1 January 2016. KNCV has developed a data security policy and a procedure on how to report data leaks. KNCV has appointed a data security officer. In 2017, the security policy will be updated and all staff will be trained on data security.

Volunteers Policy

KNCV does not make use of volunteers on a large-scale, but we do have a volunteer in our central office in The Hague. In 2017, a volunteer policy will be developed which describes the roles and responsibilities of the employer and the volunteer.

Summary of the CBF accountability report on management and governance

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

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

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

AD 1. DIVISION OF TASKS IN GOVERNANCE, MANAGEMENT AND OPERATIONS

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

- Implement the requirements for governance and ensure there are sufficient visible 'checks and balances'.
- Frequently audit the management and governance >>

>> structure in order to assess and comply with new developments according to relevant regulations and laws.
- Create a frame and guideline for the different management layers in the organization and connect the various policy documents and by-laws. The document serves as a manual for all governing bodies and their appointed members.

In Figure 1 a schematic overview of the governance structure is explained.

In addition to the articles of association, the operational modalities of all governance structures are described in the following regulations and documents, available upon request:
- Rules and Regulations for the General Assembly;
- 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.

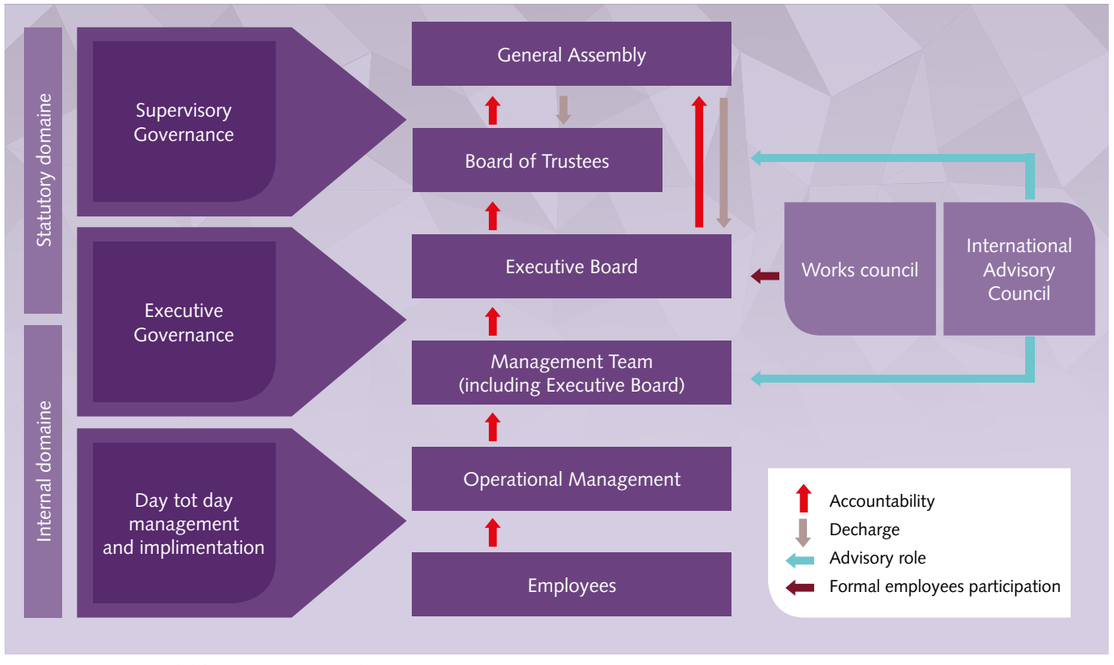


Figure 1: KNCV model for governance and management

AD2. THE CONTINUOUS IMPROVEMENT OF EFFICIENCY AND EFFECTIVENESS IN MISSION RELATED ACTIVITIES

KNCV has developed and implemented a set of mechanisms to continuously and coherently strive for improvement in its operations, especially in terms of efficiency and effectiveness. These include:
- A planning, monitoring and evaluating process composed of a strategic long-term plan and an annual planning and control cycle, for mission related goals, for resource allocation and enabling environment. Performance indicators are used to assess the progress in reaching strategic and organizational goals.
- A procedure for assessing new projects and/or acquisition proposal development.
- Monitoring and evaluation systems at project and institutional level.

AD 3. OPTIMIZING THE COMMUNICATION AND RELATIONSHIPS WITH STAKEHOLDERS

KNCV is part of a large partner network of public and private organizations and individuals, all contributing to the realization of our mission.

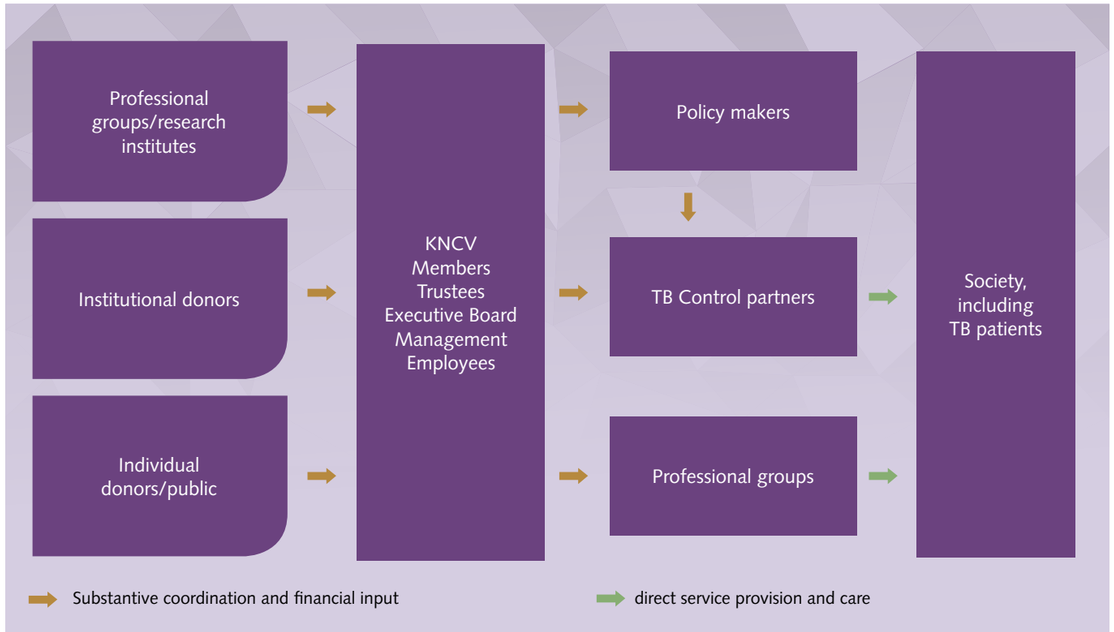


Figure 2: KNCV partner network

The structure and composition of our network is outlined in Figure 2.

Creating and maintaining support (both material and immaterial), transparency, and accountability in all our processes, is the focus of our communication with all stakeholders. The overall goal of our corporate communication is to support our mission by creating, maintaining, and protecting KNCV's reputation, prestige, and image. Our communication with stakeholders is based on the following principles:
- We are transparent and report on our successes and lessons learned;
- We communicate pro-actively, where possible;
- We communicate in unambiguous and consistent key messages;
- We tailor our communication messages and media to reach our key audiences and target groups.

We use a diversity of methods to communicate with our growing network of stakeholders, striving for greater transparency and dynamic interactions.
We encourage all stakeholders, including private donors, to share their opinions, ideas and complaints with us by telephone, e-mail or post. The responsible unit head or officer will address the issue and communicate directly with the sender. Complaints are formally registered and monitored.
In addition to our continuous operational engagement with key stakeholders, including TB-affected populations at country, regional and global level, KNCV also ensures that a diversity of perspectives is reflected in our governance structures and processes. In addition to annually convened International Advice and Counsel meetings, the organization also seeks stakeholder participation at other important moments, for example:
- During the strategy development process every five years;
- By participating in knowledge exchange forums;
- By monitoring and evaluating (e.g., donor satisfaction survey);
- By inviting ideas and complaints through the website.

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

INDEX

FINANCIAL INDICATORS AND MONITORING DATA

The financial results for 2016 show a positive result. The income grew substantially compared to 2015, mainly because of increased government grants.

KNCV Tuberculosis Foundation is pleased with the increase in income from private fundraising. Income from legacies is highly unpredictable, but showed an increase in 2016 compared to 2015 due to one large legacy of € 122,000,-. Income from endowment funds remained at the 2015 level due to some additional grants for our Young Talent program and support to develop our core funding strategy that continued in 2016. Income from corporate partners increased slightly due to project grants for projects in India and Nigeria. From the perspective of diversification of funding, we are pleased to see this part of our income growing.

We learned at the annual Goed Geld Gala that income from the Vriendenloterij increased compared to 2015. This includes an increase in lottery tickets sold that were earmarked for KNCV. A campaign to achieve higher numbers of earmarked lottery tickets started in November 2015 and the results are visible in 2016. Lotto income decreased compared to 2015, this was due to the fact that 2015 included an additional incidental payment from the Lotto.

Income from government grants again showed a significant increase in 2016 compared to last year. This is mainly related to the fact that activities for the 5-year USAID-funded Challenge TB project have accelerated after an initial startup period. 2016 was also the second year of activities for the five year DGIS grant, that counts as cost share towards the Challenge TB project.

Income from investments decreased due to stock market developments in 2016, which resulted in an unrealized exchange loss.

Expenses in 2016 increased compared to 2015, although slightly less than planned.

Expenses for TB control in low prevalence countries (mainly The Netherlands) increased due to a grant from ZonMW and activities funded from earmarked reserves.

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

Expenses for research increased. In cooperation with USAID through the Challenge TB project KNCV is working on a large research project focused on Prevention. In 2015, this project was in the setup phase and 2016 was the first full year of implementation. A second large research project on Transmission was cancelled.

Expenses for education and awareness increased in 2016 as was planned.

Expenses for private fundraising decreased in 2016 because some activities are no longer outsourced, which resulted in cost savings.

Financial monitoring data compared to standards

MONITORING DATA	Standard	Actual 2012	Actual 2013	Actual 2014	Actual 2015	Actual 2015 adjusted	Actual 2016	Budget 2017	Average 2014-2016
Spent on the mission compared to total expenses	not applicable	96,6%	96,7%	95,7%	95,9%	95,9%	97,4%	97,8%	96,5%
Spent on the mission compared to total income		95,4%	96,0%	95,2%	94,1%	94,6%	96,9%	98,8%	95,8%
Spent on private fundraising compared to private fundraising income[1]	max. 25%	23,8%	17,4%	24,6%	12,6%	28,5%	20,5%	35,8%	24,4%
Spent on administration and control compared to total expenses	2.5 - 5%	1,9%	2,0%	2,5%	2,6%	2,5%	1,6%	1,2%	2,1%
Spent on administration and control compared to total expenses excluding TBCTA coalition share in activities[2]	2.5 - 5%	3,8%	5,1%	5,0%	5,1%	5,0%	3,2%	2,5%	4,6%

Expenses for administration and control are lower than planned because the budgeted contingency was not needed.

A proposal for allocation of the result 2016 is presented on page 87.

Financial data 2012-2017

The financial statements have been prepared in accordance with the revised Dutch Accounting Standard for Fundraising Institutions (RJ650) introduced in 2016. The figures for 2015 have been adjusted to reflect the changes in presentation because of the Accounting Standards. This adjustment on the annual accounts 2015 has had no effect on results or reserves. The effect of these changes is explained in detail in the sections of the annual accounts that were impacted.
According to the 650 Guideline for annual reporting of charities and the requirements from the CBF a number of financial monitoring data is shown for a longer period in Table 8.

In total KNCV Tuberculosis Foundation generated less income in 2016 (€ 73,2 million) than was planned (€ 76,0 million), but more than 2015 (€ 49,2 million).

Total expenditures in 2016 were € 72,8 million, which is € 3,9 million lower than budgeted. The decrease is caused by lower expenditures in the category “TB in high prevalence countries”. Expenditures in the categories “fundraising” showed a decrease compared to budget (mainly expenses for government grants and private donors) and expenses for “administration and control” showed a decrease compared to budget.

[1] The percentage spent on private fundraising compared to private fundraising income has increased, because in the adjusted figures for 2015 and in the figures for 2016 only income from individual private donors is taken into account in line with the new RJ guideline, whereas in the past also income from organizations was included.
[2] Challenge TB is partly implemented by partners in the Tuberculosis Coalition for Technical Assistance (TBCTA)

Expenditures on the mission (R9)

Compared to total expenses, since 2010, over 95% of KNCV's budget is being spent on mission related activities. This indicator is closely monitored. Influences on the indicator can be due to (temporary) increases and decreases of expenditures for fundraising and for administration and control. Compared to the total income, expenditures on the mission (as a 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 regards 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. Because of our ambitions and modest position in the private fundraising market, we have chosen to stay close to the possible maximum. 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, during a budget year, the results are not satisfactory, we adjust our budgets downwards to prevent a percentage above the 25% standard. Expenses in 2016 are 20,5% of the income from own fundraising activities for private donors, well below the 25% maximum. The 3-year average is 24,4%. The three-year average based on 2015, 2016 and the budget for 2017 is 28,3%. In the past, this percentage was calculated as a percentage of all fundraising income. Because income in the new RJ650 guideline is broken down in various income sources (individuals, companies, and other non-profit organizations) this percentage is now calculated based on income from individual private donors only.

KNCV's policy for administration and control costs

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

- Our activities are funded by private, corporate and public donors, all of whom demand the highest level of transparency and accountability on what has been spent to the mission and the allocation to projects.
- We want to spend as much of our resources as possible in an efficient and effective manner 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.
- Regarding determining a range between the minimum and maximum, the organization must also consider the widely fluctuating levels of activities within projects and contracts, funded by institutional donors. In the realization of plans, the organization depends on the available resources and implementation pace of third parties. The level of managerial and administrative efforts required, do not immediately respond in an equal way and at an equal pace. For this reason, also, the average rate over a period of several years is presented.

The range has been adjusted downwards in 2015 by 5-10% because the volume of activities has increased due to the five-year Challenge TB award, allowing for an overall percentage reduction.
In 2016, the percentage of 1.6% is lower than what was budgeted for (2.2%) due to cost savings on audits and general consultancy.

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 2016, a total number of 15.784 project days were planned and 15.408 were realized, which is 98% of the planned days. In 2015, this was 105%. Income related to direct project days increased due to a higher indirect cost rate.
- Indirect costs compared to direct personnel costs made in The Hague, as an internal method;
  All project days in total represent an amount in direct personnel costs. All other personnel costs and costs for facilities are accounted for as indirect costs. In 2016, the planned percentage of indirect costs on direct costs was 66,15%, and realized is 70.64%. The increase in 2016 compared to the budget is due to a lower number of direct days.
- Indirect costs compared to direct personnel costs made in The Hague, in compliance with the USAID rules for accounting;
  Although the methodology does not differ drastically from our internal methodology, some cost categories and personnel categories included in our internal method must be excluded as indirect costs in the USAID method. According to the USAID calculation the percentage for 2016 is 59,84%, while 52,81% was planned. In 2015, the percentage was 69,19%.

Our long-term aim is to be more cost-effective and show a decrease in the percentage.

The results of our internal key performance data show an improvement compared to last year, although our goal to reach the planned number of direct days (100%) has not been realized (98%).

Budget 2017 and possible risks

The full budget for 2017 is shown in the Statements of Income and Expenditure. The total income is budgeted on a consolidated level of € 95,1 million. Of that amount, € 51,9 million is compensation for implemented activities by the coalition partners of Challenge TB. Therefore, excluding consolidation, the total income is budgeted at € 43,2 million, which is € 3,9 million higher than the actual for 2016.
Income from government grants is budgeted to increase, related to the plans for activities in the third year of Challenge TB. Income from our share in third parties' activities (e.g., lottery income) is budgeted to decrease slightly, due to lower than expected Lotto income. Investment income is budgeted conservatively at a slightly reduced level from the budget for 2016. No unrealized gains and losses on investments are budgeted.
The total level of consolidated expenditures amounts to € 96,1 million. Excluding the partners' activities, this leads to a total budgeted cost level of € 44,2 million, which is € 5,2 million higher than the actual for 2016. TB control in high prevalence countries is increasing compared to 2016, related to the activities in the third year of the Challenge TB project.

Several budgetary and control risks can be identified:

- Controlling the balance between direct and indirect days is crucial for the financial results.
- A large part of KNCV's income for personnel fees is in US dollars. We have included an exchange rate in the budget of US$ 1.12 against € 1. Careful liquidity planning and making use of simple hedging techniques will be needed to further control the risk. A strong dollar improves our competitive position and cost effectiveness in US$.
- A large part of the budget is for material costs in countries for the Challenge TB project. There is a risk that costs are identified as unallowable for USAID by independent auditors in countries or by the independent auditor who executes the overall audit.
- The income from legacies is budgeted at € 400,000. This is an average amount reached in the past years, but this income is very difficult to estimate and the amount can be significantly higher or lower.

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

Long-term financial plan

An indication of a longer term financial plan is depicted in Table 1. This overview excludes the reservation and use of a decentralization budget, because of its incidental character.
Possible growth of regional activities is not included, because it is hard to predict and it depends highly on access to funding and success of acquisition processes.

Table 1: Long-term Financial Plan 2017-2019

PROFIT & LOSS ACCOUNT *In € 1 mln*	Budget 2017	Long-term forecast 2018	Long-term forecast 2019	Long-term forecast 2020
Organizational costs				
Personnel related costs	11,54	11,37	11,90	11,83
Other indirect costs	1,79	1,64	1,94	1,64
Subtotal organizational costs	13,33	13,01	13,84	13,47
Charged to projects	-12,97	-13,13	-13,39	-13,66
Total organizational costs not charged to projects	0,36	-0,12	0,45	-0,19
Investment and general income	0,11	0,14	0,14	0,14
Net result organizational costs	**-0,25**	**0,26**	**-0,31**	**0,33**
Activity costs				
Costs for fundraising	0,50	0,51	0,52	0,53
Other activity costs	0,09	0,09	0,09	0,09
Total Activity costs	0,59	0,60	0,60	0,62
Activity income				
Own fundraising	1,18	1,23	1,28	1,33
Lotteries	1,07	0,80	0,80	0,80
Total Activity income	2,25	2,03	2,08	2,13
Net result Activities	**1,66**	**1,43**	**1,48**	**1,51**
Project costs				
Charges organizational costs	12,97	13,13	13,39	13,46
Travel and accommodation	1,43	1,46	1,49	1,52
Material costs	28,90	25,00	25,00	25,00
Expenses coalition partners Challenge TB	**51,87**	**50,00**	**50,00**	**50,00**
Total Project costs	**95,17**	**89,59**	**89,88**	**89,98**
Project income				
Funding donors - fee	10,93	11,25	11,78	12,01
Funding donors - travel and accommodation	1,33	1,35	1,38	1,41
Funding donors - other direct project costs	28,26	24,40	24,40	24,40
Endowment funds contribution	0,45	0,32	0,64	0,32
Other income for projects	0,01	0,01	0,01	0,01
Income coalition partners Challenge TB	51,87	50,00	50,00	50,00
Total Project income	**92,85**	**87,33**	**88,21**	**88,15**
Net result Projects	**-2,32**	**-2,26**	**-1,67**	**-1,83**
General Result (minus is a deficit)	**-0,92**	**-0,58**	**-0,51**	**0,01**
Covered by earmarked reserves / donated to earmarked reserves	**-0,90**	**-0,80**	**-0,60**	**-0,40**
Influence on/movements other reserves	**-0,02**	**0,22**	**0,09**	**0,41**

Brother and sister, Mbare, Zimbabwe (c) The Union/ Tristan Bayly

FINANCIAL STATEMENTS 2016

BALANCE SHEET KNCV TUBERCULOSIS FOUNDATION PER 31 DECEMBER 2016

In Euro, after result appropriation

Assets		31-12-16		31-12-16	
Fixed Assets	B1		502.824		589.414
Accounts Receivable	B2	75.402.547		59.916.705	
Investments					
-Shares	B3	1.713.137		1.417.448	
-Bonds	B3	3.318.398		3.075.108	
-Alternatives	B3	666.628		707.116	
Cash and Banks	B4	13.988.192		15.871.523	
Current Assets			95.088.902		80.987.900
Total			**95.591.726**		**81.577.314**

Liabilities		31-12-16		31-12-15	
Reserves and funds	B5				
- Reserves					
Continuity reserve		8.267.913		7.694.196	
Decentralization reserve		1.052.159		1.063.137	
Earmarked project reserves		1.835.577		1.644.080	
Unrealized exchange differences on investments		492.777		657.175	
Fixed Assets reserve		502.824		589.414	
			12.151.250		11.648.002
- Funds					
Earmarked by third parties	B6	425.604		437.064	
			425.604		437.064
Various short-term liabilities	B7				
-Taxes and social premiums		675.212		434.546	
-Accounts payable		792.997		297.592	
-Other liabilities and accrued expenses		81.546.663		68.760.110	
			83.014.872		69.492.248
Total			**95.591.726**		**81.577.314**

STATEMENT OF INCOME AND EXPENDITURE KNCV TUBERCULOSIS FOUNDATION 2016

in euro

		Budget for the year ended 31 December 2017	Budget for the year ended 31 December 2016	Actual for the year ended 31 December 2016	Actual for the year ended 31 December 2015
Income					
- Income from individuals	R1	1.162.400	845.500	1.125.626	967.012
- Income from companies	R2	69.500	347.800	375.803	215.671
- Income from lotteries	R3	1.070.000	1.092.500	1.144.439	1.066.763
- Income from government grants	R4	90.736.300	73.194.600	69.550.163	45.935.405
- Income from allied non-profit organizations	R5	452.000	385.800	348.250	445.000
- Income from other non-profit organizations	R6	1.583.800	142.400	576.993	562.199
Total fundraising income		95.074.000	76.008.600	73.121.274	49.192.050
- Income for supply of services	R7	23.000	23.000	25.291	28.698
- Other income	R8	13.400	13.400	8.442	15.237
Total income		95.110.400	76.045.000	73.155.007	49.235.985
Expenses					
Expenses to mission related goals	R9				
- TB control in low prevalence countries		960.800	820.200	872.219	808.339
- TB control in high prevalence countries		90.503.600	71.243.200	67.824.500	43.722.427
- Research		1.362.500	1.475.300	1.326.022	1.243.902
- Education and awareness		1.152.800	869.900	857.159	812.487
		93.979.700	74.408.600	70.879.900	46.587.155
Expenses to fundraising					
- Expenses private fundraising		416.600	365.900	230.609	275.412
- Expenses share in fundraising with third parties		40.100	51.500	49.652	49.608
- Expenses government grants		524.300	622.700	450.677	435.394
		981.000	1.040.100	730.938	760.414
Administration and control					
- Expenses administration and control		1.113.000	1.284.300	1.161.406	1.223.751
Total Expenses		96.073.700	76.733.000	72.772.244	48.571.320
- Nett investment income		61.900	66.900	114.581	289.634
Surplus / Deficit		**-901.400**	**-621.100**	**497.343**	**954.299**
Spent on mission compared to total expenses		97,8%	95,9%	97,4%	95,9%
Spent on mission compared to total income		98,8%	97,8%	96,9%	94,6%
Spent on private fundraising compared to income		1,0%	1,4%	1,0%	1,5%
Spent on administration and control compared to total expenses		1,2%	2,2%	1,6%	2,5%
Result appropriation					
Surplus / Deficit appropriated as follow					
Continuity reserve		47.800	86.800	573.717	513.663
Decentralization reserve		-150.000	-171.100	-10.978	-21.654
Earmarked project reserves		-749.300	-536.800	191.497	146.912
Unrealized differences on investments		0	0	-164.398	6.039
Fixed Assets reserve		-49.900	0	-86.590	348.790
Earmarked by third parties		0	0	-5.905	-39.451
Total		**-901.400**	**-621.100**	**497.343**	**954.299**

INDEX

EXPENSE ALLOCATION KNCV TUBERCULOSIS FOUNDATION 2016

in euro

Expenses	Budget for the year ended 31 December 2017	Budget for the year ended 31 December 2016	Actual for the year ended 31 December 2016	Actual for the year ended 31 December 2015
Grants and contributions	28.000	28.000	17.016	23.437
Contributions to allied organisations	51.872.000	41.390.000	36.034.875	23.987.470
Purchases and acquisitions	22.264.600	8.979.700	9.082.808	4.886.533
Outsourced activities	845.700	2.921.800	3.054.953	851.508
Publicity and communication	871.500	710.000	530.546	570.218
Personnel	16.398.600	16.444.100	17.639.875	11.610.769
Housing	297.800	295.800	281.586	493.066
Office and general expenses[1)]	3.222.500	5.764.700	5.916.221	5.922.755
Depreciation and interest	273.000	198.900	214.363	225.565
Total	**96.073.700**	**76.733.000**	**72.772.244**	**48.571.320**

[1)] Because the donor reporting requirements for KNCV country offices are not completely alligned with the RJ guidelines costs for housing and communication at local level are included under Office and general expenses.

Allocation to destination	Related to the mission goals			
Actual for the year endend 31 December 2016	Low prevalence countries	High prevalence countries	Research	Education and Awareness
Grants and contributions	11.766	0	5.250	0
Contributions to allied organizations	0	36.034.875	0	0
Purchases and acquisitions	34.065	9.006.161	3.480	0
Outsourced activities	23.146	3.030.606	1.200	0
Publicity and communication	0	0	0	415.624
Personnel	668.783	13.929.831	1.243.347	399.034
Housing	17.926	186.641	23.896	14.789
Office and general expenses	102.548	5.496.094	30.207	16.173
Depreciation and interest	13.985	140.290	18.643	11.538
Total allocated	**872.219**	**67.824.500**	**1.326.022**	**857.159**

Allocation to destination	Income fundraising			Administration & Control
Actual for the year endend 31 December 2016	Private fundraising	Share in third parties activities	Grants	
Grants and contributions	0	0	0	0
Contributions to allied organisations	0	0	0	0
Purchases and acquisitions	0	33.000	6.102	0
Outsourced activities	0	0	0	0
Publicity and communication	105.529	0	0	9.393
Personnel	91.153	15.616	403.919	888.192
Housing	3.439	366	13.577	20.951
Office and general expenses	27.803	384	16.487	226.525
Depreciation and interest	2.683	286	10.593	16.345
Total allocated	**230.609**	**49.652**	**450.677**	**1.161.406**

CASH FLOW STATEMENT KNCV TUBERCULOSIS FOUNDATION 2016

in euro

	Actual for the year ended 31 December 2016		Actual for the year ended 31 December 2015	
Surplus excl interest	474.273		935.314	
Interest paid/ received	23.070		18.985	
Total surplus	497.343		954.299	
Depreciation - Fixed Assets	214.628		222.336	
Cash Flow from income and expenditure		**711.971**		**1.176.635**
Investments	-498.491		417.343	
Accounts receivable	-15.491.398		-28.388.863	
Non-current liabilities	-		-	
Current liabilities	13.522.623		29.740.011	
Increase/ (Decrease) net working capital		-2.467.266		1.768.491
Cash flow from operational activities		**-1.755.295**		**2.945.126**
Disinvestments fixed assets	6.128		35.393	
Investments fixed assets	-134.165		-606.519	
Cash flow from investments fixed assets		**-128.037**		**-571.126**
Net cash flow		**-1.883.332**		**2.374.000**
Cash and banks as at 1 January	15.871.523		13.497.523	
Cash and banks as at 31 December	13.988.192		15.871.523	
Increase/ (Decrease) Cash on hand		**-1.883.332**		**2.374.000**

INDEX

13. Notes to the Financial Statements

Guideline 650 for accounting and reporting

KNCV Tuberculosis Foundation is subject to the 650 Guideline for Annual Reporting by Fundraising organizations. KNCV has chosen to implement the new 650 Guideline (2016) for fiscal year 2016 (required from 2017). In the attached statements, the financial results of all activities and projects are presented per the revised formats of the 650 Guideline. The change does not affect the result nor the reserves. In the new RJ 650 guideline valuation of bonds against amortized cost price is no longer allowed. From 2017 KNCV will value its bonds at market value. The comparing figures for 2016 will be adjusted in the annual accounts 2017 for 2016. In the following notes the composition of the Balance Sheet is analyzed and commented. Furthermore, significant deviations between the 2016 results and budget and between 2016 and 2015 as shown in the Statement of Income and Expenses are clarified.

Consolidation

KNCV Tuberculosis Foundation is the prime contractor of the United States Agency for International Development (USAID) funded Challenge TB project, which runs from 1 October 2014 up to 30 September 2019. The project 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 considered in both the balance sheet and the statement of income and expenses of KNCV Tuberculosis Foundation. At the de-central level, where KNCV has a regional office and country offices, subaccounts are maintained for all local financial transactions. The subaccounts are fully consolidated in both the balance sheet and the profit & loss statement.

BALANCE SHEET PER 31 DECEMBER 2016 - ASSETS

Assets

B1 Fixed Assets

Movements in the tangible fixed assets are as follows:

	Office reconstruction work	Office inventory	Computers (including regional office)	Total
as at 1 January, 2016				
Cost / Actual value	344.533	221.384	854.395	1.420.312
Accumulated depreciation	-110.589	-143.832	-576.477	-830.898
Book value	**233.944**	**77.552**	**277.918**	**589.414**
Increase / (Decrease) 2016				
Acquisitions		28.843	105.322	134.165
Disinvestments			-18.597	-18.597
Depreciation on disinvestments			12.469	12.469
Depreciation	-57.085	-11.315	-146.227	-214.627
	-57.085	**17.528**	**-47.033**	**-86.590**
as at 31 December, 2016				
Cost / Actual value	344.533	250.228	941.120	1.535.881
Accumulated depreciation	-167.674	-155.148	-710.235	-1.033.057
Book value	**176.859**	**95.080**	**230.885**	**502.824**

The book value of fixed assets ultimo 2016 amounts to € 502,824, which is lower than 2015. All fixed assets are used for operational management of the organization, such as 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 2016 amounting to € 134,165 were mainly for ICT equipment. Total depreciation is calculated at € 214,627. Assets that are no longer in use have been divested for an amount of € 18,597. The part of their book value that was not depreciated yet is included in the depreciation for 2016. Tangible fixed assets are those assets needed to operationally manage the business. No assets have been included in the tangible fixed assets figures that have been directly used in the scope of the main activities.

Accounts Receivable (B2)

The balance of accounts to be received is € 75,4 million, which is € 15,5 million higher than in 2015. 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.

B2 Accounts Receivable	31-12-2016	31-12-2015
Interest (on bonds)	22.146	18.927
Lotteries	303.220	245.546
Current Accounts project countries	115	-788
Debtors	160.194	104.412
Payments in advance general	586.567	404.438
Payments in advance projects	77.009	146.182
Legacies in process	339.902	220.861
Other receivables	171.961	54
Receivable USAID Challenge TB	310.203	345.254
Current account USAID	1.728.638	-
Accounts receivable USAID based on agreement	71.702.592	58.431.819
	75.402.547	**59.916.705**

The total account receivable from USAID for the Challenge TB project, based on approved project work plans, increased by € 13,3 million to € 71,7 million. This amount is directly related to the work still to be performed for the Challenge TB project amounts under liabilities (B7). The receivable will be reimbursed based on implemented activities. The fair value approximates the book value. The receivables include an amount of € 0 in receivables that fall due in more than one year.

INDEX

Investments (B3)

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, considering that:

- The risk of revaluation must be minimized and a sustainable result must 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 must keep pace with the evolution of inflation;
- The influence on the whole portfolio of yield reduction of individual segments is limited.

For investments in government bonds, AAMP will only invest in bonds issued by governments that have an above-average sustainability score.
Sustainability of a country is based on its score on some 30 criteria, such as: CO2 emissions and reduction targets, production of renewable energy, biodiversity, education, income distribution, quality of life, child labor, civil liberties, defense spending, corruption, effectiveness of government, and adherence to major international treaties.
AAMP will not invest in government bonds of countries that seriously curb press freedom, infringe on civil liberties, practice the death penalty, possess and have the discretion to use nuclear weapons, generate an above-average percentage of electricity with nuclear power or have not signed or ratified major international treaties (for instance to ban controversial weapons, to ban nuclear testing or to counter climate change).

Controversial products to be addressed are:

- Nuclear energy (production and services);
- Weapons;
- Tobacco;
- Alcohol;
- Adult entertainment;
- Addictive forms of gambling and
- Fur & specialty leather products.

Controversial activities to be addressed are:

- Animal welfare;
- Factory farming;
- Animal testing and
- GMOs.

AAMP will not invest in funds that invest in companies that have a strategic involvement in the following products or services:

- Tobacco;
- Nuclear power generation;
- Weapons production (including specifically designed components);
- Addictive forms of gambling or;
- Production or processing of fur and specialty leather.

For investments in equities and corporate bonds, ABN AMRO MeesPierson (AAMP) selects investment funds that employ a disciplined and well defined sustainability screening process. This process must address the major topics that fall under the Environmental, Social and Governance themes. Topics to be addressed must include:

- Business ethics;
- Environment;
- Employees;
- Society & community;
- Clients & competitors;
- Supply chain management and
- Corporate governance

The performance of ABN AMRO/MeesPierson as an administrator of the portfolio is assessed by the Audit Committee of the Board of Trustees annually and on a more frequent basis by the Executive Director and the Director Finance. The bank is instructed to take decisions for selling and buying within the limits of KNCV's investment and treasury policy.
The composition and results of the portfolio is described below and depicted in Tables 2 to 5.

As far as is relevant a comparison with 2015 is shown.
To determine the maximum level of investments, the level of the existing reserves and funds is used as a guiding target. In principle, 10% of total reserves are kept as liquidity, which leads to a maximum available level for investments of 90%. Calculations based on this principle show that as per 1 January 2016, € 10,5 million was available and as per 1 January 2017, € 11,0 million. Both balance value (€ 5,7 million) and market value (€ 5,8 million) of the investments are below the maximum. Naturally, apart from this mathematical approach, an assessment of the situation on the market is also considered when transactions take place.
In Table 2 the allocation of assets according to the reporting of ABN AMRO/MeesPierson is shown . Part of the bank balance is attached to the investment portfolio and is kept as revolving fund for transactions in investments. This amount is therefore considered in the table. In 2016, this amount increased due to sale of bonds and stocks. Ultimo 2016 bonds are slightly overweighted compared to the target. The total of shares, real estate and alternatives is underweighted. All asset categories stay within the range allowed according to the investment policy.

B3 Investments	Shares	Bonds [3]	Alternatives	Total
Balance as at 1 January, 2016	1.417.448	3.075.108	707.116	5.199.672
Purchases and sales	266.905	170.672	0	437.577
Redemption of bonds	0	0	0	0
Realized stock exchange result	136.243	33.311	0	169.554
Unrealized stock exchange result	-107.459	58.402	-40.488	-89.545
Amortization	0	-19.095	0	-19.095
Balance as at 31 December, 2016	**1.713.137**	**3.318.398**	**666.628**	**5.698.164**

[3] Stock Exchange value of bonds as at 31 December, 2016 is € 3,387,383

TABLE 2: COMPOSITION OF THE INVESTMENT PORTFOLIO AND HISTORICAL VALUES

Fund	Interest %	Nominal value	Historic purchase value	Value in balance sheet	Transactions in reporting year nominal			Transactions in reporting year in actual prices			Nominal value	Historic purchase value	Value in balance sheet
		1/1 2016	1/1 2016	1/1 2016	Purchased	Sold	Redemption of bonds	Purchased	Sold	Redemption of bonds	31/12 2016	31/12 2016	31/12 2016
Shares (00300)													
ABN Amro Global Sust Equit acc		-	60.405	81.929	-	-	-	87.861		-	-	148.267	181.853
ASN Duurzaam Fund 3		-	64.727	112.499	-	-	-	50.884	27.797	-	-	100.341	133.409
ASN Milieu en Waterfonds		-	63.585	109.834	-	-	-	7.058	20.679	-	-	60.673	104.372
Luxellence sust Europe eq		-	84.763	148.155	-	-	-	52.216	24.849	-	-	121.678	170.502
Calvert Internat equity		-	98.336	130.019	-	-	-	40.540	42.668	-	-	104.403	123.234
Calvert Equity portfolio		-	114.339	149.023	-	-	-	13.854	18.652	-	-	114.242	139.416
Celsius Sust Emerging Markets		-	148.515	140.887	-	-	-	101.202	92.352	-	-	160.745	167.645
F C Responsible Global equity		-	50.894	102.922	-	-	-	59.729	20.925	-	-	100.375	148.713
Henderson Global Care Fd		-	54.419	99.239	-	-	-	69.478	24.578	-	-	110.512	151.145
NN Duurzaam Aandelen Fonds		-	67.640	101.732	-	-	-	15.571	111.587	-	-		
Kempen Sust small cap		-	73.398	142.297	-	-	-	33.275	49.335	-	-	80.046	120.410
Pictet eur Sustainable		-	-	-	-	-	-	127.441		-	-	127.441	133.160
Triodos Sust. Equity Fund dis		-	55.703	98.912	-	-	-	76.632	35.415	-	-	111.148	139.279
Subtotal shares		**-**	**936.724**	**1.417.448**	**-**	**-**	**-**	**735.742**	**468.836**	**-**	**-**	**1.339.872**	**1.713.138**
Real estate/Alternatives (00305)													
Previum Sustainable Alternatives		**-**	**622.900**	**707.116**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**622.900**	**666.628**
Subtotal real estate/altern.		**-**	**622.900**	**707.116**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**622.900**	**666.628**
Bonds (00320)													
Duitsland 09-20	1,750	290.000	345.422	318.150	15.000	42.000	-	18.342	50.598	-	263.000	284.549	284.549
Ierland 04-20	4,500	230.000	272.504	258.336	-	230.000	-	-	272.941	-	-	-	-
Ierland T bond 13-23	3,900	-	118.055	115.048	100.000	-	-	124.200	-	-	100.000	232.784	232.784
Ierland T bond 14-24	3,400	100.000	-	-	200.000	-	-	242.688	-	-	300.000	237.352	237.352
European Inv bank 14-26	1,250	140.000	-	-	168.000	-	-	182.286	-	-	308.000	180.857	180.857
SSGA euro sustainable corp bonds	perp	1.535.076	1.438.094	2.383.574	-	-	-	157.634	230.940	-	1.595.728	2.239.848	2.382.856
Subtotal bonds		**2.295.076**	**2.174.075**	**3.075.108**	**483.000**	**272.000**	**-**	725.150	554.478	-	2.566.728	3.175.390	3.318.398
Total		**2.295.076**	**3.733.699**	**5.199.672**	**483.000**	**272.000**	**-**	**1.460.892**	**1.023.315**	**-**	**2.566.728**	**5.138.162**	**5.698.164**

TABLE 3: ASSET ALLOCATION ULTIMO 2016 COMPARED TO THE POLICY

(source: Quarterly report ABN AMRO/MeesPierson)(source: Quarterly report ABN AMRO/MeesPierson)

Investment	Investment policy		31 December 2015		31 December 2016	
	Range	Target	In € million	%	In € million	%
Bonds	80-50%	70%	3,10	49,2%	3,30	45,2%
Shares/Real Estate/Alternatives	0-50%	30%	2,10	33,3%	2,40	32,9%
Liquidities		0%	1,10	17,5%	1,60	21,9%
Total			6,30	100,0%	7,30	100,0%

TABLE 4: MATURITY OF BONDS

Running period remaining	2014	2015	2016
0 to 2 years	0%	0%	0%
2 to 5 years	22%	19%	9%
5 to 8 years	25%	4%	20%
>8 years	53%	77%	71%
>8 years	48%	53%	77%

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 4.

An overall result of 1.9% (benchmark: 3.6%; 2015: 4.5%) is realized. Below, a comparison between our 2016 portfolio, the benchmark and the results for 2015 is shown per asset category:

- Bonds; 2016 3.6%, benchmark 1.9% , 2015 0.1%
- Shares; 2016 2.6%, benchmark 8.1% , 2015 12.5%.

BofA Merril Lynch Euro Government 1-10 year

50% MSCI Europe, 40% MSCI World ex-Europe, 10% MSCI Emerging Markets

50% GPR-250 Property, 50% Euribor + 2%.

INDEX

- Real estate/alternative assets; 2016 1.7%, benchmark 5.1% , 2015 10.8%.
- Liquidity available for investments; 2016 0.8% (includes investment expenses), benchmark -0.4% , 2015 1.2%.

In absolute terms and in comparison with the long-term expected result of 5% the portfolio underperformed. Compared to the benchmark it also underperformed, mostly due to the sector allocation of shares. The energy sector, the sector with the best performance in 2016, was underweighted related to the sustainable nature of the portfolio. Bonds showed a good result compared to the benchmark due to overweighing in corporate bonds.

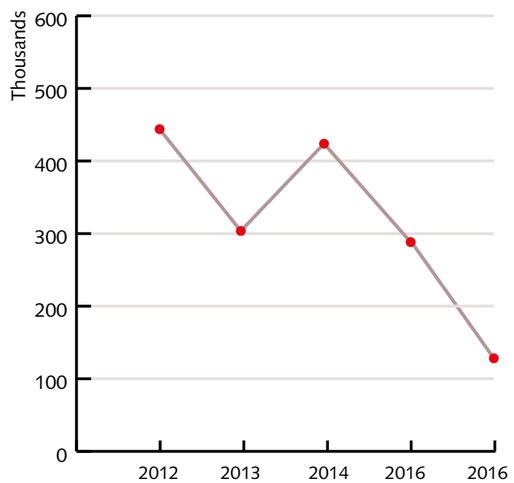
In Table 5 and Figure 3, as required by the sector organization for charities, Goede Doelen Nederland, the investment results over a 5-year period are depicted. The figure also shows the accumulated result over the years.

TABLE 5: INVESTMENT RESULTS 2011-2015

Description	2012	2013	2014	2015	2016	5 year average
Bond income	88.899	109.447	78.764	64.538	33.687	75.067
Depreciation of amortization	-12.496	-35.906	-26.842	-17.128	-19.095	-22.293
Dividend	34.085	28.435	44.986	48.736	46.248	40.498
Realized exchange results	99.942	-6.075	226.913	246.851	169.554	147.437
Unrealized exchange results	275.842	250.743	145.253	7.735	-89.545	118.006
Interest on cash on hand and deposits	17.948	16.676	11.485	18.985	23.070	17.633
Gross investment income	504.220	363.320	480.559	369.717	163.919	376.347
Investment expenses	56.256	63.108	70.759	80.083	49.338	63.909
Net investment income	**447.964**	**300.212**	**409.800**	**289.634**	**114.581**	**312.438**

Investment expenses include allocated organizational expenses.

FIGURE 3: NET INVESTMENT INCOME 2012-2016



The Executive Board confirms that all transactions in 2016 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 (B4)

The balance of cash and banks decreased compared to 2015, with € 1,9 million to a level of € 14,0 million. The main reason for this increase is that an advance payment for project expenses Challenge TB for the first two months of 2016 was received at the end of December 2015 and only partly distributed to coalition partners. At the end of 2016 this amount has already been distributed to coalition partners. Ultimo 2016 no deposits were available, because interest rates on deposits during 2016 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.

B5 Cash and banks	31-12-2016	31-12-2015
Immediately available		
Petty cash	18.400	11.722
ING	195.045	105.884
ABN AMRO bank	1.328.435	1.876.042
ABN AMRO (USD account)	7.454.633	6.939.828
ABN AMRO investment account	1.622.788	1.101.346
ABN AMRO Challenge TB	1.379.336	2.958.143
Bank accounts country offices	1.989.555	2.878.558
	13.988.192	**15.871.523**

Balance sheet per 31 December 2016 - Liabilities

Reserves (B5)

- **Continuity reserve**

The continuity reserve serves as a buffer for unexpected fall backs, both in expenditures and in income. The objective of the reserve is to temporarily guarantee the continuity of the activities, while having enough time to take measures to adjust the organizational structure, and volume, to fluctuations in the volume of mission related activities. For this continuity demand, the Board has not earmarked the reserve with a specific spending destination.
We use 1 to 1.5 times the estimated and budgeted expenditures for the organization for one year as a reasonable maximum level of the reserve. Mission related activity expenditures are excluded of the calculation. Based on the budget for 2017 for organizational costs (€ 20.2 million) the continuity reserve's maximum is € 20.2 to € 30.3 million. The reserve ultimo 2016, € 8.3 million, stays well within the maximum (0.41 times the budget for organizational costs in 2017). The underlying risks to be covered by the continuity reserve are analyzed each year during the annual planning and budgeting process. At that point, possible risks are identified and, if possible, quantified to calculate the maximum amount needed in the continuity reserve. It is expected that the risk of discontinuity of (parts of the) organization and long-term commitments can be covered by the current level of the continuity reserve.

	Balance as at 01-01-2016	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31-12-2016
Continuity reserve	7.694.196	0	-	573.717	8.267.913

INDEX

• **Earmarked project reserves**

Some parts of our equity have been earmarked by the Board to several specific objectives, with approval of the Board of Trustees. This gives the organization the possibility to either anticipate on unexpected opportunities or to give extra focus to strategic areas. In the coming years, parts of the reserves will be used for extra activities in innovation, research and high- and low prevalence TB control. In 2016, an amount of € 311,632 has been withdrawn from the earmarked project reserves for these kinds of activities. The budget had an amount of € 707,900 planned to be deducted from the earmarked reserves. Due to prioritization of Challenge TB activities the actual deduction was lower. For 2017 € 749,300 is budgeted to be used.

	Balance as at 01-01-2016	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31-12-2016
Fund national policy planning	184.443	0	0	-26.870	157.573
Fund international policy planning	232.966	0	0	0	232.966
Fund research policy planning	182.344	0	0	-18.778	163.566
Fund special needs	131.077	0	0	0	131.077
Fund innovations	215.118	0	0	-127.146	87.972
Fund capacity building	398.132	0	0	-142.322	255.810
Fund monitoring tools	150.000	0	0	20.000	170.000
Fund advocacy	150.000	0	0	-16.516	133.484
Fund Childhood TB				3.129	3.129
Fund education center				500.000	500.000
Total earmarked by the board	**1.644.080**	**0**	**0**	**191.497**	**1.835.577**

New reserves have been formed for

- The development of education and training center activities under the KNCV umbrella € 500,000,-. The allocation is intended to support a team that will work on a business case, including a scoping of already existing training activities and a financial model. The allocation should also support start up activities.
- A contribution of € 3,129 to a KNCV Childhood TB project in Ethiopia focusing on using stool samples to diagnose TB in children. The amount is a supplement to the € 6,871 raised by KNCV staff for this project during the City Pier City run.

• **Decentralization reserve**

The Decentralization Reserve is the portion of reserves which is dedicated by the Board of Trustees to serve as a buffer for expenses related to the planned decentralization of the organization.
In 2016, the decentralization reserve was allocated towards expenses to be incurred for the capacity building of country office staff in the years 2014-2017. In 2016, the amount of € 10,978 was withdrawn from this reserve. For 2017, an amount of € 150,000 is planned to be withdrawn.

	Balance as at 01-01-2016	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31-12-2016
Decentralization reserve	1.063.137	-	-	-10.978	1.052.159

• **Unrealized exchange difference on investments**

This reserve serves as a revolving fund for unrealized exchange results on investments, which are not available for mission related activities until they are 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 2016 the reserve contains € 492,777.

The movement in the reserve is as follows:

	Balance as at 01-01-2016	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31-12-2016
Total revaluation reserve	657.175		0	-164.398	492.777

• **Fixed Assets reserve**

KNCV Tuberculosis Foundation separates equity, needed to finance the remaining value of fixed assets, which is allowed by Guideline 650. In 2016, the reserve decreased to an amount of € 502,824.

	Balance as at 01-01-2016	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31-12-2016
Total revaluation reserve	589.414		0	-86.590	502.824

Funds earmarked by third parties (B6)

In the past, some resources received from third parties have not been used in full and still have a spending purpose earmarked. 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 2016, an amount of € 5,905 is used.

	Balance as at 01-01-2016	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31-12-2016
Fund TSRU	157.873	-5.555	-	-6.648	145.670
Fund Special Needs	255.610	-	-	0	255.610
Funds Van Geuns	0	-	-	0	0
Unspent Funds for objectives	4.927	-	-	-4.927	0
Jakob and Carolina fund	0			5.670	5.670
Young Talent Scolarship	18.654	0	0	0	18.654
	437.064	**-5.555**	**-**	**-5.905**	**425.604**

Fund Tuberculosis Surveillance and Research Unit (TSRU)

In 1993, the financial management of the TSRU was transferred to KNCV Tuberculosis Foundation, as one of the members of the TSRU. KNCV Tuberculosis Foundation henceforth became responsible for the funds transferred to it, its corresponding financial management and reporting to the steering Committee of the TSRU. The utilization of these funds has no time limit. The movement of €5,555 is a correction on previous years. The withdrawal in 2016 of € 6,648 is the difference between the income from members and the costs related to the annual conference.

Fund special needs

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

Unspent funds for mission related goals

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

Jacob and Carolina Fund

By way of farewell gift, departing Board of Trustees' chair Dina Boonstra, has created a fund under the umbrella of KNCV Tuberculosis Foundation, the Jakob & Carolina Fund. This was announced during the General Assembly 2016. The fund will support the training of people who give support to TB patients during their lengthy and difficult treatment.

Young Talent Scholarship

This fund relates to KNCV's Young Talent Program. This program will now enroll two young professionals annually. Through this program, we are investing in a new generation of TB experts that combine solid knowledge with new skills and working dynamics.

Various short-term liabilities (B7)

The total of various liabilities has increased from € 68.8 million in 2015 to € 81.5 million in 2016 and includes under Other liabilities € 34.0 million of contractual committed projects still to be executed for USAID and € 39.1 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. The liability will be paid out based on implemented activities. The fair value approximates the book value. 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 2016 is € 448,710, which is lower than the amount in 2015, because leave hours were paid out to some staff members with high leave balances.

B7 Various short-term liabilities

	31-12-2016	31-12-2015
Taxes and social premiums		
Income tax and VAT	456.395	400.454
Social premiums	43.291	10.726
Pension premiums	175.526	23.366
	675.212	**434.546**
Accounts payable	792.997	297.592
Other liabilities and accrued expenses		
Provision for holiday pay	333.585	275.324
Provision for annual leave	448.710	644.060
Declarations from staff	21.219	33.208
Audit fees	52.368	63.629
Current Accounts project countries	251.265	17.701
Current accounts sub awardees	340.964	-
Payable WHO	4.182	63.029
Current account - Dutch Ministery of Foreign Affairs	1.287.112	1.768.088
Other donors	2.416.505	853.938
Other liabilities	207.743	174.497
Project payables KNCV country offices	1.017.948	698.730
Current account USAID	-	3.074.406
KNCV projects to be executed	729.305	-266.126
Dr. C. de Langen stichting	81.439	-
Other	404	3.927
Accruals TBCTA partners balance	1.285.518	2.180.495
Projects to be executed under Challenge TB	33.977.499	39.959.295
Accounts payable TBCTA coalition partners	39.090.897	19.215.909
	81.546.663	**68.760.110**

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

Liabilities not included in the balance sheet

Office rental contract

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

The rental contract for KNCV Tuberculosis Foundation's regional office in Almaty, Kazakhstan is € 15,430 annually. This contract ends 31 December 2017.

Conditional commitments

Challenge TB

On 30 September 2014 KNCV Tuberculosis Foundation signed a cooperative agreement with USAID for a five-year program with a ceiling of US$ 524,754,500 (€ 482,909,432) and a cost share of US$ 36,732,815 (€ 33,803,660).
Up to 31 December 2016 the declared cost share is US$ 14,966,660, including DGIS funding.

Challenge TB

The audit according to the USAID guidelines of the second year of Challenge TB has yet to be conducted. As a consequence, the indemnities of the related project expenditures have not been finalized. Their costs and revenues are accounted for in the profit and loss statement for 2016. For this uncertainty, which is based on currently known data, the financial impact cannot be estimated.

DGIS

On 29 January 2014, KNCV Tuberculosis Foundation received a five-year grant from DGIS (Dutch Ministry of foreign affairs) of € 7,500,000 as cost share towards the USAID Challenge TB award.

Statement of Income and Expenditure

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

Income

In total KNCV Tuberculosis Foundation generated more income in 2016 (€ 73,2 million), compared to 2015 (€ 49,2 million).

In Table 6 the total income for 2016 is compared with the budget and with 2015. In the tables that follow, each income category is further clarified.

Table 6: Total income

Total income	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
Own share	34,66	37,13	25,25	7%	32%
Coalition partners share	41,39	36,03	23,99	-13%	33%
Total	**76,05**	**73,16**	**49,24**	**-4%**	**33%**

INDEX

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

Table 7: Income from individuals (R1)

Income from individuals	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	0,85	1,13	0,97	33%	14%

Income from individuals was 33% higher than planned and 14% higher than last year, mostly due to higher legacy income.

R1 Income from individuals	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Donations and gifts				
Direct marketing campaigns	682.000	545.000	563.797	475.376
Gifts- other	100.000	0	5.548	89.343
Total donations and gifts	**762.000**	**545.000**	**569.345**	**564.719**
Contributions by association members	400	500	370	390
Legacies and endowments	400.000	300.000	555.911	401.903
Total income from individuals	**1.162.400**	**845.500**	**1.125.626**	**967.012**

Table 8: Income from companies (R2)

R2 Income from companies	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Various companies through fundraising campaigns	20.000	20.000	17.082	46.307
Cepheid	49.500	277.800	139.800	169.364
Sponsoring	0	50.000	218.921	0
Total income from companies	**69.500**	**347.800**	**375.803**	**215.671**

Income from companies decreased compared to 2015 due to less activities for Cepheid in 2016. The expectation is that activities in Vietnam will reduce further in 2017. The amount of gifts received from companies as a result of our fundraising campaigns also decreased. In 2016, an in-kind contribution was received from Sanofi.

Table 9: Income from lotteries (R3)

Income from lotteries	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	1,09	1,14	1,07	5%	6%

Income from lotteries increased by 5% compared to budget, and 6% compared to 2015 due to the fact that an additional contribution over 2015 was accounted for, because Lotto income 2015 turned out to be higher than the accrued amount.
The income from third party campaigns consists of contributions from two large Dutch lottery organizations: The **VriendenLoterij** and **De Lotto.** The amount consists of earmarked lottery tickets sold, general participation in the lotteries, and settlements from previous years. The latter is due to the fact that each year at the time of the closing date, the contribution from De Lotto is not yet announced and is therefore based on an estimate. Deviations from this estimate are accounted for as settlements from previous years.

R3 Income from lotteries		Budget 2017	Budget 2016	Actual 2016	Actual 2015
Settlement previous years		-	-	85.723	72.861
Vriendenloterij	earmarked lottery tickets	770.000	770.000	95.959	80.676
Vriendenloterij	non-earmarked lottery tickets			640.257	635.101
De Lotto		300.000	322.500	322.500	278.125
Total from fundraising third parties		**1.070.000**	**1.092.500**	**1.144.439**	**1.066.763**

Table 10: Income from government grants (R4)

Government grants	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
Own share	**31,80**	**33,57**	**21,95**	**6%**	**35%**
Coalition partners share	**41,39**	**36,03**	**23,99**	**-13%**	**33%**
Total	**73,19**	**69,60**	**45,94**	**-5%**	**34%**

KNCV's 2016 share in the USAID-funded Challenge TB project, with € 66,0 million, amounts to 95% of the total figure for government grants. The DGIS income for 2016 was € 1.5 million. This income counts as cost share towards the USAID-funded Challenge TB project.
The contribution to TB control in The Netherlands from the CIb has decreased to € 0.5 million in 2016, as a result of an announced three-year grant reduction. The budgeted amount for this grant in 2017 will be € 0.6 million, including a project subsidy for the biannual Wolfheze conference.
From a large group of other government donors, a total of € 1.0 million was received, which is lower than the budgeted amount, but significantly higher than 2015. For 2016, government grants determined 95% of KNCV's budget.

R4 Government grants	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Center for disease control	596.400	512.800	512.510	556.737
DGIS	3.125.900	759.300	1.479.638	395.259
USAID	33.531.300	28.682.400	31.394.487	19.068.337
WHO	0	0	93.446	164.414
Global Fund/GFATM	136.900	401800	467.983	181.136
Other Donors	1.473.800	1.448.300	987.218	1.582.052
Subtotal	38.864.300	31.804.600	34.935.282	21.947.935
USAID grants coalition partners	51.872.000	41.390.000	34.614.881	23.987.470
Total government grants	**90.736.300**	**73.194.600**	**69.550.163**	**45.935.405**

Table 11: Income from allied non-profit organizations

Income from allied non-profit organizations	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	0,39	0,35	0,45	-10%	-29%

Income from allied non-profit organizations decreased compared to 2015, because part of the allocated funds for 2016 were not spent in 2016 and activities were transferred to 2017.

Income from allied non-profit organizations	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Sonnevanck Foundation	22.000	22.500	22.000	22.500
Mr. Willem Bakhuijs Roozeboom Foundation	10.000	20.000	10.000	10.000
Dr. C. de Langen Foundation for global Tuberculosis	360.000	283.900	256.250	352.500
-Gravenhaagse stichting tot steun aan de bestrijding der tuberculose	60.000	59.400	60.000	60.000
Total incom from allied non-profit organizations	**452.000**	**385.800**	**348.250**	**445.000**

Table 12: Income from other non-profit organizations (R6)

Income from other non-profit organizations	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	0,14	0,58	0,56	314%	3%

Income from other non-profit organizations remained at the level of 2015 and includes contributions from Eli Lilly Foundation and Capital for Goods.

Table 13: Income for supply of services

Income for supply of services	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	0,23	0,25	0,29	9%	-16%

INDEX

Income for supply of services remained at the level of 2015 and mainly consists of fees for trainings in The Netherlands.

R7 Income for supply of services	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Endowment funds fee on administration & control costs	3.000	3.000	2.479	2.479
Trainings	20.000	20.000	22.812	26.219
Total income for supply of services	**23.000**	**23.000**	**25.291**	**28.698**

Table 14: Net investment income (R10)

Net investment income	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	0,07	0,11	0,29	57%	-164%

With the investment portfolio and interest on bank balances KNCV we earned an amount of € 0.25 million as realized income and made a loss of € 0.17 million as unrealized exchange differences. The exchange differences were not budgeted for, which explains the difference with the budget. In 2015, the unrealized exchange differences were a profit of € 0.08 million. The decrease compared to 2015 is caused by the stock market developments in 2016.

R10 Investment income	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Dividends	36.000	31.400	46.248	48.736
Bond earnings	64.000	71.300	15.687	46.538
Bond earnings on behalf of Fund Special Needs	18.000	18.000	18.000	18.000
Realized exchange gains	-	-	169.554	246.851
Unrealized exchange results	-	-	-89.545	7.735
Interest on cash on hand and deposits	25.000	15.000	23.070	18.985
Depreciation of amortization of bond value	-15.000	-	-19.095	-17.128
Total from investments	**128.000**	**135.700**	**163.919**	**369.717**
Total out of pocket costs investments	26.000	26.000	29.737	29.980
Allocated costs	40.100	42.800	19.601	50.103
Net investment income	**61.900**	**66.900**	**114.581**	**289.634**

In line with the new guideline 650 investment income is presented after deduction of investment costs.

Expenditure

Total expenditures in 2016 were € 72.8 million, which is € 3.9 million lower than budgeted. The decrease is caused by lower expenditures in the category "TB in high prevalence countries". Expenditures in the category "fundraising" and "administration and control" showed a decrease compared to budget.

In Table 15 the total expenses for 2016 are compared with the budget and with 2015. In the tables that follow each income category is further clarified.

Table 15: Total expenditure

Total expenditure	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
Own share	**35,31**	**36,77**	**24,66**	**4%**	**33%**
Coalition partners share	**41,39**	**36,03**	**23,99**	**-13%**	**33%**
Total	**76,70**	**72,80**	**48,65**	**-5%**	**33%**

Ninety-seven percent of the total expenses were spent on mission related activities. The increase of € 24.2 million compared to 2015 is, again, caused by higher expenses for KNCV and coalition partners, mainly due to the implementation of Challenge TB.

Table 16: Expenses to mission related goals (R9)

Expenses to mission related goals	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
Own share	**33,01**	**34,85**	**22,68**	**6%**	**35%**
Coalition partners share	**41,39**	**36,03**	**23,99**	**-13%**	**33%**
Total	**74,40**	**70,88**	**46,67**	**-5%**	**34%**

In 2016, 97% of all expenses were spent on mission related activities. In 2015, this percentage was 96%. The activities in low prevalence countries took 1% of the total amount, high prevalence countries 96%, research activities 1% and education/awareness 1%.

R9 Expenses to mission related goals	Budget 2017	Budget 2016	Actual 2016	Actual 2015
- TB control in low prevalence countries	960.800	820.200	872.219	808.339
- TB control in high prevalence countries				
-- executed by KNCV	38.631.600	29.853.200	32.709.990	19.734.957
-- executed by Challenge TB coalition partners	51.872.000	41.390.000	35.114.510	23.987.470
- Research	1.362.500	1.475.300	1.326.022	1.243.902
- Education and awareness	1.152.800	869.900	857.159	812.487
Total expenses to the mission	**93.979.700**	**74.408.600**	**70.879.900**	**46.587.155**

Specification - per country, independent from nature of the project	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Netherlands	1.036.700	817.400	958.850	954.581
Africa				
- Regional Office	-	-	650.530	838
- Botswana	580.000	433.400	630.185	398.739
- Congo	-	81.800	93.841	35.989
- Ethiopia	6.528.700	4.007.000	3.534.931	1.417.220
- Kenya	1.431.960	6.300	24.864	-
- Malawi	3.035.100	3.903.100	3.772.567	645.481
- Mozambique	401.000	146.600	160.351	91.110
- Namibia	1.645.400	932.400	1.950.369	2.661.254
- Nigeria	4.379.600	4.556.900	7.769.980	4.456.368
- Rwanda	-	-	-	53
- South Sudan	-	22.000	1.186	18.149
- Swaziland	448.600	-	323.822	-
- Tanzania	2.618.800	2.140.500	2.671.398	1.113.690
- Zambia	-	-	9.353	-
- Zimbabwe	35.300	32.700	52.862	66.977
Subtotal Africa	21.104.460	16.262.700	21.646.239	10.905.868
Asia				
- Afghanistan	-	4.600	908	6.549
- Bangladesh	217.400	340.600	321.625	366.208
- Cambodia	110.200	19.700	58.658	9.634
- India	1.570.400	165.000	284.453	185.938
- Indonesia	5.743.500	6.760.000	3.531.909	3.745.678
- Myanmar	278.100	130.000	163.760	115.975
- Nepal	-	-	142.901	-
- Pakistan	-	-	-	11.226
- Papua New Guinea	-	-	10.049	-
- Philipinnes	-	-	238.722	-
- Sri Lanka	-	-	-	28.028
- Vietnam	557.600	769.800	762.209	628.846
Subtotal Asia	8.477.200	8.189.700	5.515.194	5.098.082
Eastern Europe				
- Regional office	-	254.000	66.672	174.494
- Kazakhstan	-	456.600	264.598	66.439
- Kyrgyzstan	754.100	241.600	339.033	210.897
- Ukraine	302.500	188.200	118.954	102.986
- Uzbekistan	164.100	439.200	135.865	137.760
- Tajikistan	787.000	696.800	1.048.474	814.572
Subtotal Eastern Europe	2.007.700	2.276.400	1.973.596	1.507.148
Non-country or region related projects	9.010.888	7.220.300	6.978.427	5.296.333
Challenge TB coalition partners	51.872.000	41.390.000	35.114.510	23.987.470
Expenses charged to other expenditure categories [5]	470.752	-1.747.900	-1.306.916	-1.162.327
Total expenses to the mission	**93.979.700**	**74.408.600**	**70.879.900**	**46.587.155**

Table 17: Expenses to fundraising

Expenses to fundraising	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	1,08	**0,73**	**0,76**	**-32%**	**-4%**

In all categories of fundraising and acquisition activities, including those for private fundraising, € 0.73 million was spent. This was lower than the budget, due to the fact that some activities were postponed and some activities were no longer outsourced, which resulted in cost savings. For income from fundraising from individual private donors a percentage of 20.5% of the income has been spent as costs. This is below the CBF maximum percentage.

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

INDEX

Table 18: Administration and control

Expenses to Administration and control	Budget 2016 in € million	Actual 2016 in € million	Actual 2015 in € million	% difference budget	% difference last year
	1,24	1,16	1,22	-6%	-5%

Costs for administration and control were lower than planned, due to the fact that a contingency amount in the budget of € 0.175 million for unexpected unrecoverable costs was not needed.

	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Personnel expenses				
Salaries	8.673.900	7.896.600	8.033.204	6.565.348
Accrued annual leave	60.000	60.000	104.255	34.388
Social security premiums	841.500	791.600	762.414	630.838
Pension premiums	836.400	729.300	615.311	574.330
External staff/temporary staff	250.000	155.000	400.720	404.243
Expenses regional offices	228.000	210.400	55.810	101.734
Capacity building decentralization	0	0	2.445	2.629
Sub total	10.889.800	9.842.900	9.974.159	8.313.510
Oncharged staff expenses to third parties	-	-	0	0
Salaries KNCV country offices	4.709.000	5.925.900	6.949.729	2.750.895
Sub total	15.598.800	15.768.800	16.923.888	11.064.405
Additional staff expenses				
Commuting allowances	110.500	115.500	135.500	112.412
Representation	3.000	6.100	3.455	3.638
Social event	6.600	6.100	13.661	18.420
Congresses and conferences	63.000	48.500	42.816	49.868
International contacts	52.100	58.600	53.542	53.577
Training & Education	173.700	158.500	117.090	72.007
Recruitment	25.000	15.000	53.237	52.065
Insurance personnel	22.000	22.000	19.162	16.289
Catering	25.000	22.000	21.598	21.385
Works council	22.500	22.300	34.223	20.575
Expenses regional offices	8.800	3.200	11.009	21.858
Other	216.500	157.400	171.809	115.216
Allocated to investment income	-13.400	-15.900	-18.640	-18.735
Sub total	715.300	619.300	658.462	538.575
Other human resource management costs				
Development of tools	20.000	20.000	12.988	2.245
Safety training	64.500	36.000	44.537	5.544
Sub total	84.500	56.000	57.525	7.789
Total personnel expenses	16.398.600	16.444.100	17.639.875	11.610.769
Average number of fte's			425,0	322,0

	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Housing expenses				
Rent	160.000	160.000	155.586	249.489
Repairs and maintenance	5.000	4.000	8.202	8.143
Cleaning expenses	36.000	30.000	32.388	43.651
Utilities	66.000	65.000	63.391	68.186
Insurance and taxes	2.000	1.800	1.463	1.318
Plants and decorations	12.400	16.000	12.802	101.142
Housing expenses regional offices	16.400	19.000	7.754	21.137
Total housing expenses	297.800	295.800	281.586	493.066

	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Office and general expenses				
General office supplies	14.000	15.500	11.799	10.097
Telephone	40.400	57.000	33.841	43.905
Postage	8.000	12.000	6.718	8.245
Copying expenses	23.000	30.000	18.503	27.603
Maintenance - machines, furniture	1.000	1.000	89	183
Professional documentation	4.000	4.300	3.129	2.502
IT costs	204.000	177.200	189.533	142.813
Audit fees	90.000	85.000	90.955	101.282
Board of Trustees	10.000	10.000	6.925	49.103
Consultancy	45.000	52.500	68.365	77.339
Bank charges	20.000	25.000	30.661	34.045
Other	161.800	172.300	58.436	90.868
Office and general expenses regional and country offices	2.601.300	5.122.900	5.397.267	5.334.770
Total office and general expenses	**3.222.500**	**5.764.700**	**5.916.221**	**5.922.755**
Depreciation and interest				
Office reconstruction work	55.000	32.800	57.085	74.050
Office inventory	40.700	41.000	11.315	45.346
Computers	203.000	151.000	145.499	136.357
Regional offices	1.000	1.000	729	1.179
Allocated to investment income	-26.700	-26.900	-265	-31.367
Total depreciation and interest	**273.000**	**198.900**	**214.363**	**225.565**

The audit expenses can be broken down in various categories:

	Budget 2017	Budget 2016	Actual 2016	Actual 2015
Audit costs				
Audit of the annual accounts	90.000	85.000	86.489	67.034
Project audits	60.000	70.000	71.348	74.538
Other audit assignments	-	-	-	22.766
Tax advice	-	-	-	11.482
Costs related to previous years	-	-	4.466	-
Total	**150.000**	**155.000**	**162.303**	**175.820**

Audit costs are charged to the year to which they relate. Project audit costs are reported under expenses to mission related goals.

Operating result

The balance between income and costs is a surplus of € 0.50 million, while a deficit of € 0.6 million was planned. The main causes of the difference with the budgeted figures are incidental: higher income from individuals, mainly legacies € 0.38 million and fewer expenses for projects to be covered from earmarked reserves € 0.4 million. Also positive currency exchange gains were realized for € 0.22 million and a contingency amount in the budget of € 0.175 million for unexpected unrecoverable costs was not needed.

A proposal for appropriation of the result is presented as part of the annual report, on page 86.

Cash flow statement

The decrease in cash and banks in 2016 is caused by a positive cash flow from income and expenses and a negative cash flow resulting from the increase in project liabilities compared to project receivables. This is caused by the fact that payments to partners at year end 2015 were paid in 2016, whereas payments at year end 2016 were paid in 2016. This results in a negative cash flow from operational activities and a negative cash flow from tangible fixed assets (investments).

INDEX

ACCOUNTING POLICIES

Organizations' general data

The 'Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose' with Chamber of commerce number 40408837 (KNCV, using the name KNCV Tuberculosis Foundation) resides at Benoordenhoutseweg 46 in The Hague, The Netherlands. Under its Articles of Association, KNCV Tuberculosis Foundation has as its statutory objective:
The promotion of the national and international control of Tuberculosis by, amongst other things:

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 financial statements are drawn up in accordance with the provisions of Title 9, Book 2 of the Dutch Civil Code and the firm pronouncements in the Dutch Accounting Standards, as published by the Dutch Accounting Standards Board ('Raad voor de Jaarverslaggeving').
The annual accounts are drafted in accordance with the Reporting Guideline for Fundraising Institutions, Guideline 650. KNCV Tuberculosis Foundation has incorporated the changes to Guideline 650 in its 2016 annual accounts. Representation of figures from 2015 has been adjusted accordingly, not affecting the balance sheet total, reserves nor the reported surplus. In the new RJ 650 guideline valuation of bonds against amortized cost price is no longer allowed. From 2017 KNCV will value its bonds at market value. The comparing figures for 2016 will be adjusted in the annual accounts 2017 for 2016.

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.

Estimates

In applying the principles and policies for drawing up the financial statements, the management of KNCV Tuberculosis Foundation makes different estimates and judgments that may be essential to the amounts disclosed in the financial statements. If it is necessary in order to provide the true and fair view required under Book 2, article 362, paragraph 1, the nature of these estimates and judgments, including related assumptions, is disclosed in the notes to the relevant financial statement item.

Translation of foreign currencies

Items included in the financial statements are measured using the currency of the primary economic environment in which KNCV Tuberculosis Foundation operates (the functional currency). The consolidated financial statements are presented in Euros. The annual accounts are in Euros. Assets and liabilities in foreign currencies are translated at the official rates of exchange ruling at the balance sheet date. Non-monetary assets valued at fair value in a foreign currency are converted at the exchange rate on the date on which the fair value was determined.
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 Tuberculosis Foundations' balance sheet per asset/liability group against the exchange rates as at 31 December 2016.
All legal entities that can be controlled, jointly controlled or significantly influenced are considered to be a related party. Also, entities which can control KNCV Tuberculosis Foundation are considered to be a related party. In addition, statutory directors, other key management of KNCV Tuberculosis Foundation and close relatives are regarded as related parties.
Transactions with related parties are disclosed in the notes insofar as they are not transacted under normal market conditions. The nature, extent and other information is disclosed if this is necessary in order to provide the required insight.

Accounting policies - assets and liabilities

Tangible fixed assets

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

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

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

Investments

With respect to investments, KNCV has setup an investment policy. The essence of the policy is to invest only when it concerns such an excess of liquidities that they cannot be used in the short-term for the main activities. As far as that is the case the derived objectives will be: risk avoiding investments and realizing as optimum as possible returns which will be durable for the duration. For that reason, KNCV is investing predominantly in bonds. The policy of the board will also be directed at hedging price risks by reserving unrealized exchange differences in the reserve 'unrealized gains/losses on investments'. Shares which are held for trading are carried at fair value after initial recognition. Changes in the fair value are recognized directly in the income statement.
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'. In the new RJ 650 guideline valuation of bonds against amortized cost price is no longer allowed. From 2017 KNCV will value its bonds at market value. The comparing figures for 2016 will be adjusted in the annual accounts 2017 for 2016.

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. Receivables are recognized initially at fair value and subsequently measured at amortized cost. If payment of the receivable is postponed under an extended payment deadline, fair value is measured on

INDEX

the basis of the discounted value of the expected revenues. Interest gains are recognized using the effective interest method. When a trade receivable is uncollectible, it is written off against the allowance account for trade receivables.

The actual expenses are deducted from the advances.
On initial recognition current liabilities are recognized at fair value. After initial recognition current liabilities are recognized at the amortized cost price, being the amount received, taking into account premiums or discounts, less transaction costs. This usually is the nominal value.

Coalition consolidation
In the annual accounts 2016, 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
The result is the difference between the realizable value of the goods/services provided and the costs and other charges during the year. The results on transactions are recognized in the year in which they are realized.

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. This 75% is applied to all categories of legacies and does not distinguish between cash, investments and real estate. The remaining balance, which can be influenced by fluctuations in value of houses and investments, is included in the financial year of receipt.

Grants
Subsidies are recorded as income in the income statement in the year in which the subsidized costs were incurred or income was lost or when there was a subsidized operating deficit.

Coalition consolidation
In the annual accounts 2016, all income and expenses concerning Challenge TB have been included, including the part sub-agreed to coalition partners.

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

Income and expenses concerning projects
Income and expenses concerning projects are allocated to the periods to which they relate and in which they can be accounted for as declarable to a donor, if 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.

INDEX

Interest income
Interest income and expenses are recognized on a pro rata basis, taking account of the effective interest rate of the assets and liabilities to which they relate.

Salaries & Wages
Salaries, wages and social security contributions are charged to the income statement based on the terms of employment, where they are due to employees and the tax authorities respectively.

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 regarding any deficits and consequences hereto for future pension premiums is not available.
The pension funds coverage grade ultimo 2016 was 90.1%. In their action plan "Actuariële en Bedrijfstechnische Nota 2017" the pension fund describes mitigating measures to avoid deficits.
Pension premiums compared to the previous year remained unchanged at 24.4% for retirement. The percentage for disability remained at a level of 0.4%.

Allocation expenditure
All expenditure is allocated to three main categories 'objectives (main activities)', 'raising income' and 'administration and control'. Furthermore, expenditure is allocated to organizational units, which activities can be matched to the three main categories. When units are active or supportive for other units the expenses will be

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'
	5% of staff expenses charged on 'Expenses financial assets'
	All other expenses charged on 'Expenses administration and control'
Human resource management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Facility management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Finance Planning & Control	
	Staff exclusively working for project finance is charged to the objective-categories
	All other expenses charged on 'Expenses administration and control'

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.

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

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

Executive remuneration

In compliance with standard reporting form of GDN

Name		**C.S.B. van Weezenbeek**
Position in the board		**Executive Director**
Contract		
Legal status		Indefinite
Number of hours		40
FTE		100%
Period for reporting year		1/1 - 31/12
Remuneration		
Annual income	106.838	
Gross salary	9.259	
Holiday allowance	8.903	
Extra month		
Variable/performance allowance		
Subtotal		125.000
Social securities, employers part	9.413	
Taxable allowances		
Pension premium, employers part	10.767	
Pension compenzation		
Other allowance, long-term	9.816	
Payment in relation to beginning of end of contract		
		29.996
Total remuneration 2016		154.996
Total remuneration 2015		**187.956**

No loans, advances nor guarantees are issued to members of the Executive Board or members of the Board of Trustees. The members of the latter are only reimbursed for expenses made.

Notes on the remuneration of the management

The Board of Trustees has, upon the recommendation of the Remuneration Committee, determined the amount of the management remuneration and additional benefits to be paid to management. The remuneration policy is regularly reviewed, most recently in September 2013, when a new Board of Directors was installed. In determining the remuneration policy and remuneration, KNCV Tuberculosis Foundation adheres to Goede Doelen Nederland's advisory scheme for the remuneration of the management of charitable organizations ("Adviesregeling Beloning Directeuren van Goede Doelen"), which finds its base in the 'Wet Normering Topinkomens' (WNT) and the code of governance for charitable organizations ("Code Wijffels"; see www.goededoelennederland.nl).
Under the advisory scheme , a maximum annual remuneration is determined on the basis of weighted criteria. At KNCV Tuberculosis Foundation, this weighting was performed by the Remuneration Committee. This resulted in a so-called basic score for management positions ("Basis Score voor Directiefuncties" - BSD) of 500 points (J)[9] and a maximum annual remuneration of 100% of € 145,000 for 1 FTE in 12 months for the statutory director.
In 2016, the actual incomes of management for the purposes of assessment of compliance with Goede Doelen Nederland's maximum annual remuneration were as follows:

K. van Weezenbeek € 125,000 (1 FTE/ 12 months). The Executive Director is contracted for a 40-hour workweek.

The annual income for the Executive Director is within the limit of € 145,000/12 months according to the Regeling beloning directeuren van goede doelen ten behoeve van besturen en raden van toezicht. The total remuneration 2016 (gross income, taxable allowances, employer's contribution to pension premiums and pension compensation, and other allowances) is below the maximum.

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.

Result appropriation

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

To the Board of Trustees and the General Assembly, in their respective meetings of 25 April 2017 and 10 May 2017, we propose to appropriate the surplus of 2016 according to the following division:

	In €
Continuity reserve, contribution	573,717
Decentralization reserve, withdrawal	-10,978
Earmarked project reserves, contribution	523,129
Earmarked project reserves, withdrawal	-331,632
Unrealized exchange differences on investments, contribution	-164,398
Fixed asset fund, withdrawal	-86,590
Third party earmarked funds, withdrawal	-5,905
	497,343

The withdrawals are specified on pages 69 and 71 of the financial statements. KNCV Tuberculosis Foundation's policy towards reserves and funds is clarified in chapter Accounting policies.

Events occurring after the balance sheet date

There have been no material post balance sheet events that would require adjustments to KNCV Tuberculosis Foundation's Financial Statements per 31 December 2016.

Ton van Dijk
Chair of the Board of Trustees

Mirella Visser
Vice chair of the Board of Trustees

Kitty van Weezenbeek
Executive Director

[8] Advisory scheme for remuneration of directors, Goede Doelen Nederland
[9] The weighting will be reviewed in 2017

Independent auditor's report

To: the board of trustees of KNCV Tuberculosis Foundation

Report on the financial statements 2016

Our opinion

In our opinion the accompanying financial statements give a true and fair view of the financial position of KNCV Tuberculosis Foundation as at 31 December 2016, and of its result for the year then ended in accordance with the Guideline for annual reporting 650 'Charity organisations' of the Dutch Accounting Standards Board.

What we have audited

We have audited the accompanying financial statements 2016 of KNCV Tuberculosis Foundation, The Hague ('the foundation').

The financial statements comprise:
- the balance sheet as at 31 December 2016;
- the income statement for the year then ended;
- the notes, comprising a summary of the accounting policies and other explanatory information.

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

The basis for our opinion

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

Independence

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

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

Ref.: e0402071

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

INDEX

Report on the other information included in the annual report

In addition to the financial statements and our auditor's report thereon, the annual report contains other information that consists of:
- the directors' report;
- KNCV key figures;
- recapitulation 2016 - Innovating for impact & Points of progress in country offices 2016;
- organizational highlights in 2016;
- board of trustees report;
- governance and organizational report;
- financial indicators and monitoring data.

Based on the procedures performed as set out below, we conclude that the other information:
- is consistent with the financial statements and does not contain material misstatements;
- contains all information that is required by the Guideline for annual reporting 650 'Charity organisations' of the Dutch Accounting Standards Board.

We have read the other information. Based on our knowledge and understanding obtained in our audit of the financial statements or otherwise, we have considered whether the other information contains material misstatements.

By performing our procedures, we comply with the requirements of the Dutch Standard 720. The scope of such procedures was substantially less than the scope of those performed in our audit of the financial statements.

Management is responsible for the preparation of the other information, including the directors' report pursuant to the Guideline for annual reporting 650 'Charity organisations' of the Dutch Accounting Standards Board.

Responsibilities for the financial statements and the audit

Responsibilities of management

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

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

Our responsibilities for the audit of the financial statements

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

Materiality affects the nature, timing and extent of our audit procedures and the evaluation of the effect of identified misstatements on our opinion.

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

Rotterdam, 16 May 2017
PricewaterhouseCoopers Accountants N.V.

Original has been signed by M. van Ginkel RA

Appendix to our auditor's report on the financial statements 2016 of KNCV Tuberculosis Foundation

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

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

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

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

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

POLICY BODIES IN WHICH KNCV WAS ACTIVE IN 2016

In 2016, KNCV was actively involved in:

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

KNCV staff were also on the Editorial Board of:

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

KNCV PARTNERS IN 2016

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

In the Netherlands:

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

In other countries and globally:

- Action Aid, Malawi
- Adelaide Supranational TB Reference Laboratory
- AIDS Center of Almaty City, Kazakhstan
- AIDS Foundation East West (AFEW) Kazakhstan
- ALERT, Ethiopia
- Almaty City healthcare department
- American Thoracic Society (ATS)
- Armauer Hansen Research Insititute (AHRI), Ethiopia
- Association of Family Doctors, Kazakhstan
- Aurum Insititute, South Africa
- Avenir Health
- Bill & Melinda Gates Foundation
- Capital for Good, USA
- Centers for Disease Control and Prevention (CDC)
- Clinton Health Access Initiative (CHAI)
- Club des Ami Damien (CAD) Democratic Republic Congo
- Damien Foundation Belgium (DFB)
- Development Aid from People to People (DAPP),Zimbabwe
- Duke University, USA
- DZK (German Central Committee against Tuberculosis)
- Eli Lilly MDR-TB Partnership
- Ethiopian Public Health Institute (EPHI, former EHNRI)
- European Centers for Disease Prevention and Control (ECDC)
- European and Developing Countries Clinical Trials Partnership
- Federal Office of Public Health (Switzerland)
- FHI 360
- The Finnish Lung Health Association (Filha)
- Foundation for Innovative New Diagnostics (FIND)
- German Leprosy Relief Association (GLRA)
- Regional GLCs (Green Light Committees)
- Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)/Project Implementation Unit (PIU) Global Fund
- GHC Global Health Committee
- Gondar University, Ethiopia
- GSK Biomedicals
- Hain Life Sciences
- Haramaya University, Ethiopia
- Harvard Medical School
- Indonesian Association against Tuberculosis (PPTI)
- Initiative Inc, Democratic Republic Congo
- Institute of Human Virology, Nigeria
- IRD (Interactive Research and Development)
- Japan Anti-Tuberculosis Association (JATA)
- Kazakhstan Union of People Living with HIV (PLHIV)
- Kazakhstan Prison System
- Korean Institute of Tuberculosis
- Korea International Cooperation Agency (KOICA)
- La Fondation Femme Plus, Democratic Republic of Congo
- Latvia TB Foundation
- Leprosy Mission International
- Les ambassadeurs de Sud-Kivu, Democratic Republic of Congo
- Ligue national contre la lèpre et la tuberculose du Congo (LNAC)
- Liverpool School of Tropical Medicine (LSTM)
- London School of Hygiene and Tropical Medicine (LSHTM) Tuberculosis Modelling Group
- Makerere University, Uganda
- Malawi TB Research Network
- Management Sciences for Health (MSH)
- Maternal and Child Health Integrated Program (MCHIP), Zimbabwe
- McGill University
- Médecins Sans Frontières (MSF)
- Mekelle University, Ethiopia
- Ministry of Health (in many countries)
- Namibian Red Cross Society
- National Agency for Control of AIDS (NACA), Nigeria
- National TB Reference Laboratories in the countries
- Netherlands-African partnership for capacity development and clinical interventions against poverty-related diseases (NACCAP)
- National TB Control Programs (NTPs) in many countries
- NGO Doverie Plus, Kazakhstan
- NGO Zabota, Kazakhstan
- Office of the US Global AIDS Coordinator
- Organization for Public Health Interventions and Development (OPHID) Trust, Zimbabwe
- Partners in Health (PiH)
- Penduka, Namibia
- Population Services International (PSI)
- Private Health Sector Program, Ethiopia
- Program for Appropriate Technology in Health (PATH)
- Project Hope (in Kazakhstan, Kyrgyzstan, Namibia, Tajikistan)
- Regional Center of Excellence on PMDT, Rwanda
- Regional Health Bureaus (Ethiopia)
- Rehabilitation and Prevention of Tuberculosis (RAPT), Zimbabwe
- RESIST-TB
- Resource Group for Education and Advocacy for Community Health (REACH), India
- Riders for Health, Zimbabwe
- St Peter specialized Hospital, Ethiopia
- Stellenbosch University
- Stop TB Partnership
- Swiss Tropical and Public Health Institute
- TB Alliance
- TB Europe Coalition
- TB Proof
- Tuberculosis Modelling and Analysis Consortium (TB MAC)
- Tuberculosis Operational Research Group (TORG), Indonesia (including representatives of University of Indonesia, Padjadjaran University, Gadjah Mada University, Universitas Seblas Maret, Diponegoro University, University of Surabaya, Udayana University, and others)
- Tuberculosis Research Advisory Committee TRAC, Ethiopia
- UNICEF - University Clinical Centre
- The Union (IUATLD)
- United Nations Development Program (UNDP)/Global Fund
- United States Agency for International Development (USAID)
- University of Antwerp, Belgium
- University of California San Francisco (UCSF)
- University of Cape Town - SATVI
- University of Gadjah Mada, Indonesia
- Vanderbilt University, USA
- World Health Organization (Headquarters and Regions)
- Zimbabwe National Network of People Living with HIV (ZNNP+)
- And many others…

INDEX

ABBREVIATIONS

AFEW AIDS Foundation East-West

AIDS Acquired Immune Deficiency Syndrome

AIGHD Amsterdam Institute for Global Health and Development

ARV Antiretroviral

ATS American Thoracic Society

BCG Bacillus Calmette-Guérin

BMC BioMed Central (journal)

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

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

CCM Country Coordinating Mechanism

CEO Chief Executive Officer

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

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

CIb Centrum Infectieziektebestrijding (Center for Infectious Disease Control)

COA Centraal Orgaan opvang Asielzoekers (central asylum seekers reception authority)

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

CSO Chief Scientific Officer

CSO Civil Society Organization

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

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

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

DR Congo Democratic Republic of Congo

DTU District TB Unit

EDCTP (European and Developing Countries Clinical Trials Partnerships)

E&M Health Electronic & Mobile Health

ER Emergency Department

EURO European regional office WHO TB Technical Advisory Groups

FOPC Finance and Operational Performance Committee

FTE Full-time equivalent

GDF Global Drug Facility

GDI Global Drug resistant TB Initiative

GDF Global Drug Facility

GeneXpert® (See Xpert MTB/RIF assay, below)

GGD Municipal Public Health Services

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

GHWA Global Health Workforce Alliance

GLI Global Laboratory Initiative

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

GxAlert An online application for Laboratory Information Systems (LIS). (

HIV Human Immunodeficiency Virus

HRM Human Resource Management

ICT Information and Communication Technology

IJTLD International Journal of Tuberculosis and Lung Disease

IPT Isoniazid Preventive Therapy

JV Inkai LLP A mining company in Kazakhstan

KNCV Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose

(Royal Netherlands Tuberculosis Association)

LTBI Latent Tuberculosis Infection

M&E Monitoring and Evaluation

MDR Multidrug-Resistant

MDR-TB Multidrug-resistant Tuberculosis

MPH Master of Public Health

MSH Management Science in Health

MTB Mycobacterium Tuberculosis

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

NACA National AIDS Control Agency

NGO Non-Governmental Organization

NTP National Tuberculosis Program

NTRP Netherlands Tuberculosis Research Platform

PATH Program for Appropriate Technology in Health

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

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

PhD Doctor of Philosophy

PMDT Programmatic Management of Drug-Resistant TB

PMU Project Management Unit

PRC Proposal Review Committee

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

QuanTB Quantification and Cost Estimation Tool

QQ Qualitate Qua

RESIST TB Research Excellence to Stop TB Resistance

RIF Rifampicin

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

RJ650 Dutch Accounting Standard for Fundraising Institutions

RVO Rijksdienst voor Ondernemend Nederland (Netherlands Enterprise Agency)

SEARO WHO TB South-East Asia Regional Office

SHA Stakeholders Association

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

STAG/STAG-TB Strategic and Technical Advisory Group

TAG-TB Technical Advisory Group on TB Control

TB Tuberculosis

TBAP Regional TB Action Plan

TB/HIV Tuberculosis and/or Human Immunodeficiency Virus

TBCTA Tuberculosis Coalition for Technical Assistance

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

TBEC TB Europe Coalition

TRP Technical Review Panel

TSRU Tuberculosis Surveillance and Research Unit

Union International Union Against Tuberculosis and Lung Disease

USAID United States Agency for International Development

USD US Dollar

US$ US Dollar

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

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

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

WHO World Health Organization

WHO/Europe World Health Organization Regional Office for Europe

WPRO WHO TB Western Pacific Regional Office

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

XDR-TB Extensively Drug-Resistant Tuberculosis

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

CONTACT LIST KNCV COUNTRY OFFICES

KNCV Tuberculosefonds
Benoordenhoutseweg 46
2596 BC The Hague, The Netherlands

KNCV Tuberculosis Foundation Trust
Private Bag 00269
Gaborone, Botswana

KNCV Tuberculosis Foundation in the Kyrgyz Republic
19 Razzakov str., office 403
720040, Bishkek, Kyrgyzstan

KNCV Tuberculosis Foundation in the Republic of Tajikistan
37/1, Bokhtar Street, Office 604
734025, Dushanbe, Tajikistan

KNCV Tuberculosis Foundation in Ethiopia
Bole subcity, Woreda 03 House Number 4-048
Behind tele medhanialem branch
Addis Ababa, Ethiopia

KNCV Tuberculosis Foundation in Indonesia
Gedung Menara Bidakara 2, Lt.7
Jl. Jend. Gatot Subroto Kav. 71-73
Pancoran – Jakarta Selatan 12870, Indonesia

KNCV Tuberculosis Foundation in Malawi
Area 99, Plot 379
Lilongwe, Malawi

KNCV Tuberculosis Foundation in Namibia
Florence Nightingale Street (Bell Harris Building)
Windhoek, Namibia

KNCV Tuberculosis Foundation
Block B 4th Floor
Plot 564-565
Independence Avenue
Central Business District
Abuja, Nigeria

KNCV Tuberculosis Foundation
Off-Haille Selassie Road, Plot 8&10 Oysterbay,
Dar es Salaam, Tanzania

KNCV Tuberculosis Foundation
130 Mai Anh Tuan Str., DongDa Dist.
Hanoi, Vietnam

The Royal Netherlands Tuberculosis Association (KNCV Tuberculosis Foundation)
5th floor, Silkwood Office Suites, Ngong Road
P.O. Box 44871-00100
Nairobi, Kenya

Representative Office of The Royal Netherlands Tuberculosis Association in Central Asia
62/2 Bogenbay batyr street (corner Zverev str)
050010, Almaty, Kazakhstan

KNCV TUBERCULOSISFOUNDATION
To eliminate TB

INDEX

PREV

KNCV TUBERCULOSIS FOUNDATION

To eliminate TB

P.O. Box 146
2501 CC The Hague
The Netherlands
Tel. +31 (0)70 416 72 22

info@kncvtbc.org
www.kncvtbc.org
KNCVTBC
kncv-tuberculosis-foundation