KNCV
TUBERCULOSIS FOUNDATION
To eliminate TB

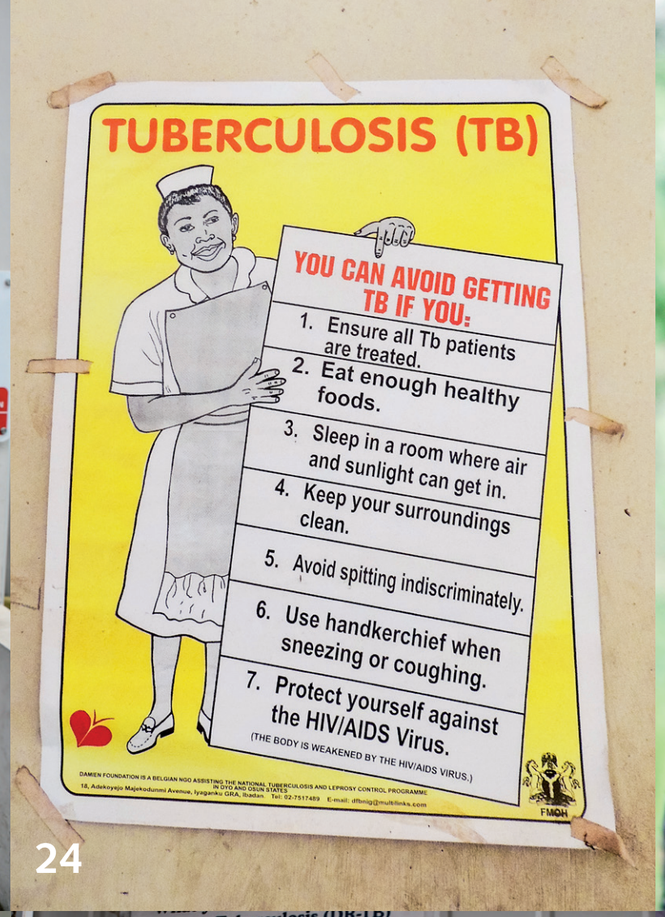


KNCV TUBERCULOSIS FOUNDATION

ANNUAL REPORT 2017



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‘Great steps to prepare for a big leap forward’

Dr. Kitty van Weezenbeek

MESSAGE FROM OUR EXECUTIVE DIRECTOR

The year 2017 flew by as a ‘comet’, bringing exciting developments for KNCV and the broader tuberculosis (TB) community, both from a technical and political perspective.

More patients than ever before were able to benefit from new drugs and treatment regimens. Countries with a high burden of drug-resistant TB, are now scaling up life-saving treatments with the assistance of KNCV Tuberculosis Foundation (KNCV). I am proud of all KNCV staff involved in building the sustainable systems to make this happen. And I want to explicitly thank all staff who took part in events to raise money for food for these very sick patients. KNCV recognizes the need for holistic case management. Drugs alone cannot do the job!

Another development I want to highlight is our work on a great variety of digital solutions along the patient pathway, ranging from tools that make life easier for both patients and health care providers, to tools that strengthen surveillance and connectivity between diagnostic systems. Connectivity, may sound like a cold hardware solution, but in reality brings ‘warm’ experiences for the end users, most notably the patients and their families.

I am also very proud of the results of our efforts to expand our revenue base with the acquisition of several new grants from existing and new institutional donors. Their continued support is crucial for our work.

Lastly, I want to reflect on 2017 as a year of increasing political momentum for TB during a large variety of ‘political meetings’ such as the G20, and culminating in the Moscow resolution during the Ministerial meeting on TB in Moscow. Great steps to prepare for a big leap forward during the upcoming UN General Assembly High Level meeting on TB in 2018.



Indeed, 2018 will be an important year for global TB control and for KNCV. This year we hope to finally get Heads of State to commit to ending TB and mark 115 years of KNCV's fight against tuberculosis. It will be the first time in the history of the UN that TB, the deadliest infectious disease ever, will be addressed at this political level. This is very necessary, because despite the positive developments and successes, almost 5000 people still die off tuberculosis a day.

Recognizing the importance of political commitment to fulfill our KNCV mission, we will step up advocacy efforts to support the United Nations General Assembly preparatory process. It is literally now or never! For that purpose we will join forces with relevant partners, both public and private, to raise awareness, prepare the case, and provide the evidence base for necessary interventions. In that context we will work closely with the Global Caucus ('parliamentarians for TB'); the Dutch Government; the Lancet Commission; and involve KNCV country offices in local advocacy.

And of course, we will use the outputs of the UN High Level Meeting (HLM) to inform the other event that KNCV is looking forward to: the 49th UNION World Conference on Lung Health. The UNION Conference comes back to The Netherlands! I have no doubt that the UNION 2018 'vibe' that has hit the organization on January 2nd will last until the closing ceremony on October 28th. Our goal is to assist the UNION in organizing a great conference that will be remembered as innovative, energetic, inspirational and inclusive, while celebrating the theme that fits the City of Peace and Justice so well: "Declaring Our Rights: Social and Political Solutions". Let's hope that the UN HLM will provide the basis for that message and celebration.

I am proud looking back at last year's achievements and incredibly eager to make 2018 a success for the sake of the patients that need our support.



Dr. Kitty van Weezenbeek
Executive Director of
KNCV Tuberculosis Foundation

RISK MANAGEMENT

As an organization, we also acknowledge the importance of risk management systems and internal controls. Our work in countries that often have a higher risk profile then The Netherlands requires robust mechanisms to prevent, monitor and mitigate potential risks as much as possible. A description of KNCV's risk assessment and mitigating actions can be found in the Governance and organizational report. We are not currently aware of any significant change in the risk exposure and the organization's internal control that occurred during 2017 that has materially affected, or is reasonably likely to materially affect, the organization.

KNCV IN KEY FIGURES & EVENTS

Income from lotteries
€ 1,273,916

97.2%
spent on mission related goals

Income from private fundraising
€ 966,765

501 members
of staff worldwide

20,514
private donors

1.2% of expenses
spent on fundraising

1.6% of expenses
spent on administration and control

Income from government grants
€ 88,389,252

40
More than 40 scientific publications

KEY EVENTS:

KNCV PRESENT AT WHO GLOBAL MINISTERIAL CONFERENCE
On 16 and 17 November 2017, the WHO Global Ministerial Conference "Ending TB in the Era of Sustainable Development: A Multisectoral Response" was held in Moscow. Ministers of Health, Finance and other sectors were present to discuss the global TB epidemic. The conference was opened by president Vladimir Putin of the Russian Federation. Kitty van Weezenbeek, executive director of KNCV Tuberculosis Foundation, presented and was the moderator of one of the ministerial panels during the conference.

UNION WORLD CONFERENCE IN THE HAGUE
In 2017 we received the announcement that the 49th Union World Conference on Lung Health will be held this year in The Hague, The Netherlands from 24-27 October 2018, and will focus on human rights, an apt theme for the city of peace and justice. The Hague and KNCV Tuberculosis Foundation will be the local hosts of this Union World Conference.



‘Our goal remains to impact real people to avoid any suffering from TB’

Michael E Kimerling

MESSAGE FROM OUR TECHNICAL DIRECTOR

For KNCV, 2017 was a year of developing new partnerships and growing our reach under several division-wide initiatives previously launched. As the stories below tell, we greatly expanded access to new TB drugs and regimens in the countries where we work under the KNCV led, USAID funded Challenge TB project, and we have highlighted the important barriers to quality care caused by stigma. Our goal remains to impact real people to avoid any suffering from tuberculosis.

As of December, 2017, KNCV consultants had worked successfully with our country offices and national TB staffs to introduce new drugs (bedaquiline and/or delamanid) in 20 of 22 Challenge TB countries. The shortened MDR-TB regimen of nine months, approved by WHO only one year ago (December 2016), has been introduced already into 16 countries with four additional countries awaiting delivery of their drug orders. These drugs bring new hope to both patients and programs.

Stigma was highlighted by a December meeting at the KNCV office of global stakeholders and stigma experts to review the current state-of-the art in TB measurement and to finalize intervention packages to be used by countries. Working with the Stop TB Partnership, we will launch a global assessment of stigma-related issues in 2018.

A new partnership was established with the Bill and Melinda Gates Foundation to introduce digital-based adherence technologies that empower patients to better participate in and self-manage their own treatment. These novel technologies, described below, will be introduced through a collaboration with the TB REACH program of the Stop TB Partnership.

Finally, we have started a new collaboration with Dutch partners, under EDCTP funding, to introduce pharmacovigilance into several key African countries. In addition, the Evidence Team is leading a pathways analysis and costing project in collaboration with the TB Alliance, an important drug development partner that is preparing to introduce a novel regimen for XDR-TB in 2019. KNCV is proud to have been asked by them to assist them to determine the market and plan for the future.

In this context, we have selected the stories that follow as examples of our successes and expanding partnerships.



Michael E Kimerling,
Director, Technical Services Division

IMPROVING TREATMENT THROUGH INNOVATIVE MOBILE TECHNOLOGY

Digital adherence monitoring technologies can improve medication adherence, persistence on treatment, and eventually TB treatment success rates by facilitating data-driven, differentiated TB care.

When the World Health Organization first declared a global TB emergency in 1993, it looked to the then-new strategy of Directly Observed Therapy Short-course (DOTS). The strategy aimed to standardize TB control measures and give countries an official recommendation on how to address the challenge. Since that time, DOTS has contributed to substantial improvements in TB treatment outcomes across the globe. But despite its success over the past two decades, the approach is not without its limitations.

Burdensome on patients

Facility-based DOTS requires patients to regularly travel to health facilities, resulting in the loss of autonomy, privacy and money. It makes the approach resource intensive and highly burdensome on patients, providers and health systems. As a result, DOTS is often inadequately implemented whereby self-administration is becoming the norm. This presents a particular challenge for TB management as irregular TB treatment adherence is associated with disease relapse and development of drug resistance.

Improve medical adherence

To address this challenge in today's modern information era, KNCV Tuberculosis Foundation (KNCV), Stop TB Partnership, the World Health Organization, and the Bill & Melinda Gates Foundation, (among others) looked towards the use of specific mobile phone and computer-based technologies to bridge this gap. Increasingly, major players in the global TB space are optimistic that digital adherence monitoring technologies can improve medication adherence, persistence on treatment, and eventually TB treatment success rates by facilitating data-driven, differentiated TB care.

'Smartboxes' at home

So, how does it work? Digital adherence monitoring technologies are systems that use mobile phone, computer, and/or web-based technology to give alternatives for how a patient's adherence to their treatment regimen can be tracked. They range from innovative call-in systems for enhanced self-reporting to at-home 'smartboxes' that automatically help to track how often pills are taken out for daily medication.

Real-time dosing histories

These digital adherence monitoring technologies can supply accurate, real-time and detailed dosing histories to give healthcare workers ▶

WHAT IS DOTS?

Directly Observed Treatment, Short-course. Standardized anti-TB treatment given under direct observation by a nurse or TB clinician at a health facility. Patients must travel daily to the site to take their medicine and have their adherence recorded.

The full DOTS strategy also includes policy, drug, diagnostic, and data elements:

1. **Government commitment**
2. **Case detection by microscopy**
3. **Standardized treatment**
4. **Regular drug supply**
5. **Standardized recording and reporting**





Audio and visual reminders of both dosing and refill actions can also be activated to remind patients to regularly take their medication

an opportunity to make data-driven decisions about when, how, and to whom differentiated care can be provided. This way we notice in time that individual patients are showing low adherence rates. To motivate them to keep up with the treatment they can receive additional counselling or home visits, while others can continue self-administration during routine healthcare interactions.

Demonstration projects

In the coming year, KNCV will assess the opportunity and efficacy of these digital adherence technologies by conducting demonstration projects in several countries. The specific adherence technologies KNCV will explore are 99DOTS, MERMS, and VideoDOT.

Hidden phone number

The first one, 99DOTS, is an unobtrusive, inexpensive adherence monitoring approach that leverages the use of both paper and mobile tools. Medication blister packs are fitted within a custom-printed paper sleeve that allows the patient to reveal a hidden phone number when they push out the pills for their daily dose. The patient – hopefully - calls this randomized toll-free number and their adherence for the day is registered on a dashboard visible to their nurse, TB clinicians, and/or other TB case supporters. This system also allows for configuration of patient SMS reminders. For example, if it's past 17:00 and the patient has not yet called in their dose for the day, they will receive an SMS to remind them to take their pill. So far, this technology has been piloted on a large scale in India with over 50,000 DS-TB patients.

Observation by box

Then we have MERMS, or Medication Event Reminder Monitor Systems. These are 'smart boxes' that use an inexpensive sensor housed within the box to track when and how many times the box is opened for dosing during the course of treatment. Pill packs are stored within this cardboard or plastic box, and every time it is opened, data are sent to a server, enabling remote electronic 'observation' of medication taking. Audio and visual reminders of both dosing and refill actions can also be activated to remind patients to regularly take their medication and/or return to the clinic for examination or refill. Additionally, dosing instructions and treatment information can be printed in- or outside of the box. Published studies from China have evaluated the approach accuracy, acceptance among patients and providers and its ability to improve treatment adherence.

Face time through video

Just like DOTS, the video-observed therapy (VideoDOT) provides a mechanism for health workers to observe a patient taking their medication. Where these differ is that with VideoDOT, the observation is being done either via real-time video call (like Skype, for example) or asynchronously, by viewing a patient's recorded video that was recorded earlier in the day. This approach preserves the direct observation aspect of DOTS, but enables the patient to take their medication at home or elsewhere away from the clinic, avoiding the time and money constraints associated with daily travel to the health facility. It could also have benefits in infection control, with less frequent visits to busy waiting rooms where some patients may still be contagious. As recently as January 2018, KNCV began a demonstration project of VideoVOT in Bishkek, Kyrgyzstan. This technology is promising as a flexible and less invasive option to ensure that patients maintain accountability but still receive the face time with clinicians and support they may need to complete treatment successfully.

TIMELINE TB & TECHNOLOGY: HOW FAR HAVE WE COME?

- **1970:** Karel Styblo invents and begins testing DOTS strategy in high-burden countries with a high burden of TB
- **1993:** The World Health Organization (WHO) declares TB a global emergency with deaths from TB higher than any previous year in history
- **1995:** DOTS adopted as WHO's official TB control strategy. First outbreak of multi-drug resistant TB (MDR-TB) is recorded
- **1999:** Iconic Nokia "brick" mobile phone first released
- **2000:** Millennium Development Goals (MDGs) set a target to halt and begin to reverse the incidence of HIV, TB, malaria and other major diseases by 2015
- **2002:** Kenyans with a mobile phone: 9% (USA at 63%)
- **2010:** Launch of GeneXpert molecular test for TB. This rapid test is endorsed by WHO and hailed as a major breakthrough
- **2014:** Kenyans with a mobile phone: 82% (USA at 89%)
- **2015:** Ethiopians with access to clean water: 42% vs. Ethiopians with a mobile phone: 50%
- **2018:** WHO recommends the use of adherence technologies to provide improved differentiated care for TB patients on the DOTS approach
- **2018:** KNCV begins conducts demonstration projects in several countries to assess the use of digital adherence technologies for improved TB outcomes

TB STIGMA: BRIDGING THE GAP BETWEEN SCIENCE AND STRATEGY

A KNCV journey, partly funded by USAID, towards quantifying the negative impacts of TB Stigma upon people, policies, outcomes and access.

Painful stories of hardship and loss are familiar to anyone with even a cursory understanding of TB. Stigma has been a consistent theme for centuries, but progress in its reduction has been elusive. A raft of disperse efforts and one-off projects dots the history of TB control.

In 2015, there was no road map, no toolbox, no set of indicators. There was no repository or clearing house for TB stigma. Most champions of TB stigma had retired or moved on to better-funded topics. Yet there was an ascending drum beat demanding action. Stories of drug-resistant tuberculosis (DR-TB) patients denied care and support continued to horrify and galvanize KNCV staff and others in the TB community. Starting in 2016 KNCV began to plumb the roots of suffering and to chart its consequences in a new way. We began by asking the practical questions for which we are best known: How to quantify the negative impacts of TB stigma upon people, policies, outcomes, and access?

Common frame

The task was formidable. Just assembling a team with the expertise was a challenge. Sociologists, psychologists, anthropologists, statisticians, human rights lawyers, health economists, activists, and advocates were recruited. But developing a common frame to tackle the problem was not easy. Fortunately there was good will and a broad consensus that the damage caused by stigma needed to be fully understood without delay.

KNCV spearheaded the publication of 11 scientific papers and 3 editorials in a TB stigma supplement in the International Journal of TB and Lung Disease (IJTLD) to lay out a common understanding of what is known, where the field needs more depth, and promising strategies to be brought to scale. Downloaded more than 2,000 times in the first weeks, the supplement had whet an appetite for evidence and actionable guidance. The resulting TB Stigma Measurement Guidance, is an anthology of best practices, covering ▶

SCIENTIFIC POWERED PACKAGE

KNCV's Allies Approach to TB Stigma reduction is a scientifically powered digital and experiential package that reconnects health care workers with their core values: solidarity, justice, and equity. By dissecting stereotypes and assumptions, improving policies, and removing structural barriers to safe and respectful collaboration-KNCV's Allies Approach tackles stigma at the emotional, cognitive, and practical levels. We recognize that stigma not only harms patients, but also erodes health care workers' commitment to high quality care. An effective approach must therefore protect everyone's rights as a cornerstone of patient-centered care.



In 2015, there was no road map, no toolbox, no set of indicators

the full range of established and experimental methodologies. Edited by KNCV, with 24 experts from 13 countries it pulled together a chorus of diverse voices for a common purpose: rigorous measurement of TB stigma.

Kick start new collaborations

Very quickly, innovative TB stigma measurement projects percolated in Ethiopia, Vietnam, Nigeria, Kazakhstan, and Indonesia. Once in the hands of country experts, the tools evolved further, reflecting local needs, priorities, and problems. South-South exchanges in December helped forge a mechanism for sharing insights and leveraged expertise across sites. A stigma reduction meeting December brought stakeholders from 30 countries to assess the progress and to kick start new collaborations.

One of KNCV's main contributions to TB stigma reduction movement in 2017 has been drawing the academic, activist, and policy communities into a constructive dialog around a set of practical tools and approaches. While many had called for action on TB stigma for decades, no one had ever attempted to bridge the gaps between the science and the strategies. Moving from slogans to spreadsheets is not easy, but it helps to have over one hundred years' experience of solving practical problems with patients. Capacity building is the next challenge on the horizon for KNCV. Empowering stakeholders to use the techniques to answer their burning questions with require translation, testing, and trial and error. In 2018, KNCV will build multi-lingual webinars, and electronic platforms to reach deep into high burden settings.

PROMISING APPROACHES

To achieve impact, KNCV mined the broader stigma science field for promising approaches. As the only TB expert at last summer's US National Institutes for Health's Science of Stigma Reduction meeting, KNCV has embraced the larger scientific movement aligned with the United Nations Joint Resolution on reducing discrimination in health care. KNCV's human rights stance is a reflection of the fact that TB stigma is inseparably linked to other forms of prejudice undermining the rights and dignity of TB patients.





Patients are treated long-term and often far away from home

FOOD SUPPORT FOR TAJIKISTAN

KNCV believes in a holistic approach to make TB patients better. One of the components that helps the treatment of TB is of course good healthy food.

Unfortunately this is not always possible. In the Machiton Hospital in Tajikistan, where KNCV works as part of the USAID funded Challenge TB project, patients with multidrug resistant tuberculosis (MDR-TB) are being treated. It's the only place in Tajikistan where patients with the most severe, drug-resistant form of tuberculosis can go to get better.

One cup of soup

As a result, patients are treated long-term and often far away from home. It is distressing to see how the basic needs of these seriously ill people can't be met. Adequate and healthy diet is important for their treatment, but unfortunately the hospital can only offer one cup of soup per day, in addition to tea and bread.

Cow to milk

The director of the Machiton hospital is a resourceful physician and together with KNCV country director Mavluda Makhmudova, they developed various initiatives to tackle this problem until a sustainable solution is found. For instance: they obtained a cow with local help to milk and they grow fruit and vegetables in the vegetable garden of the hospital.

Food packages

KNCV Tuberculosis Foundation started in 2017 with providing these patients with food packages including eggs, milk, juice and hot meals to support the medication intake. This is an interim solution until we reach a sustainable food supply for these patients with the hospital and other (local) parties. The food packages are composed locally. KNCV tries to raise as much money as possible in order to provide all 50 patients with proper nutrition until we have realized a sustainable solution.

‘NEW DRUGS AND REGIMENS ARE ON A ROLL’

In recent years the global TB community has seen exciting developments with the advent of new rapid diagnostics technologies and new and repurposed drugs becoming available for drug-resistant TB (DR-TB).

Results of clinical trials released in 2017 support the use of repurposed and new drugs including bedaquiline and delamanid for patients with multidrug resistant TB (MDR-TB) along with a shortened treatment regimen. In diagnostics, many technologies have now received WHO endorsement and further life-changing products are in the pipeline, including the small, portable Xpert Omni. Efforts to introduce these new technologies and treatment regimens in the field, initially hindered by a lack of readiness, are now beginning to take effect thanks to the expertise in the TB community to understand, address and solve these issues. Problems ranged from fragmented planning to critical gaps in clinical guidance at points of care. Governments facing programmatic hurdles and patient management challenges required specialized technical support to allow them to benefit from these medical advances.

Right Diagnosis, Right Treatment

Acceleration was needed and came with KNCV’s Right Diagnosis, Right Treatment initiative. It has been fundamental in providing comprehensive guidance to spur those processes required for the adoption, implementation and scale-up of new technologies and TB drugs and regimens and in the context of the programmatic management of TB. At its core is a patient triage concept, which ensures that every TB patient receives the right diagnosis and right treatment as quickly as possible.

Statistics available from Challenge TB supported countries demonstrate great progress. This KNCV led, USAID funded project reports that 21 of the 22 countries are now enrolling patients on either new drugs and/or shorter treatment regimens. Very encouraging news for the future of MDR-TB. By December 2017, 1,411 patients had been enrolled in bedaquiline-containing regimens, 205 in Delamanid-containing regimens and 1,802 on shorter treatment regimens.

Under the framework of the Right Diagnosis, Right Treatment approach, KNCV is paving the way to assist governments in streamlining programmatic and clinical management policies/guidelines and activities for dealing with MDR-TB. In 2017, KNCV developed and dispersed technical guidance tools to facilitate and standardize diagnosis and treatment, including treatment for adverse drug reactions.

Many technologies have now received WHO endorsement

Train-the-trainer

To further help build knowledge and skills, KNCV developed a modular training package for program managers and clinicians. The package includes facilitators guides, presentations, case studies and exercises and a training evaluation tool. It has been developed so that other staff in the countries can also benefit from the training.

By 2017, 21 countries had introduced new drugs and shorter treatment regimen, 18 received technical assistance via 82 short-term technical assistance missions to support the introduction, implementation and expansion of new drugs and shorter treatment regimen. The work implemented through short-term technical assistance is comprehensive including among other elements such as an assessment of country readiness, development of guidance documents and operational plans, calculation of drugs for procurement and monitoring of programmatic management.

KNCV experts in the programmatic management of drug resistance TB not only continue to shape policy via their active memberships in various global, technical committees, they are also very much involved in contributing in the development and review of essential documents. ◀







TREATING TB IN RECORD TIME

Kyrgyzstan - Maxime was not even two when he was diagnosed with multi-drug resistant TB (MDR-TB), for which the normal treatment would take up to 24 months to complete. Luckily, when he got sick, Kyrgyzstan had just started introducing a shorter treatment regimen for drug-resistant TB, with the assistance of the USAID-funded Challenge TB project. The shorter regimen is a 9 to 12-month treatment for drug-resistant TB and is specifically for patients who have never had TB before, such as Maxime. It is a much better alternative to the standard treatment, which takes 2 years to complete and includes 8 months of daily injections and up to 20 pills every day, some of which cause severe side effects such as nausea, headaches and permanent damage to the stomach and liver.

When they heard of the shorter regimen, Maxime's family was relieved, although even 9 months seemed too difficult for such a small child. "What did he do to deserve this?" Maxime's grandmother, Olga, kept asking, even months after Maxime was diagnosed. "During the first few weeks I couldn't calm down, my whole family was infected with TB", she said, holding Maxime to her chest.
One by one Maxime's family got TB, first his grandfather and then his uncle were infected with MDR-TB in early 2015, then his mother, Irina, was diagnosed with MDR-TB in December 2016, and finally he got it in February 2017.

For two months, Olga stayed day and night with her grandson in the Bishkek's Pediatric TB hospital, while his mother was on treatment in another hospital. "The treatment is already so painful for adults," she said, with her daughter nodding silently by her side. Maxime had daily injections for four months, half as many as he would have had on standard regimen treatment. "He got used to the pain very fast," said his grandmother, "but he is covered in bruises".

He is happy and energetic and wants to run around

"This regimen is much better for children, as in the long term it has much less impact on their organs," said Aysalkin Teshebaeva, head of the National TB Hospital's children's department. "So far none of the children have had side effects on this treatment. We've started to use the shorter regimen more than the standard regimen for children in the National TB hospital, and we really hope that the results will be good".

For Maxime taking his pills every day has become routine. His mother usually crushes the pills into a spoon of yogurt, but sometimes he swallows them like an adult with some juice. He is happy and energetic and wants to run around, like any other two-year-old, and luckily he has recovered. "He was restless in the hospital, especially after taking his pills," said his grandmother Olga, "He wanted to run about in the corridor, but it wasn't allowed."
Nine months on, little Maxime is completely cured, and his mother and him are now back home in their village in the Issyk-Ata region of Kyrgyzstan. They decided not to tell most of their relatives that they have TB because there is still too much stigma associated with the disease. Olga realized this when her sister-in-law visited them back when her husband had TB. She set the table for tea and gave everyone the same glasses and spoons, except for her husband, who was given disposable plastic dishes. It is a common misunderstanding that TB can be transmitted through physical contact, like the flu, and that even patients who are on treatment are still infectious.

"The hardest is behind us," says Olga, who was counting the days until Maxime finished treatment. With every family member finally recovering from TB, she is allowing herself to relax and be hopeful for the future.



TEAMING UP FOR CAROLINE

Mozambique - 2017 was an intense and sad year for Caroline, a 19 year old student from the village of Quilimane, Zambezia Province in Mozambique. After being diagnosed with XDR-TB in June 2016 and starting treatment that included daily injections, her health deteriorated significantly. Her chest X-ray showed extensive lung compromise and her weight had dropped to 37kg. After nine months into her XDR-TB treatment her sputum smear results became positive again.

Caroline lives with very little means with her brother and mother, who at that point was unemployed. Nonetheless, through persistent efforts by the treating clinician sputum samples were sent to the capital city of Mozambique to test for extensively drug resistant TB (XDR-TB), a worse type of TB that is resistant to more powerful drugs. XDR-TB was confirmed in June 2017. Caroline was the first XDR-TB patient diagnosed in Mozambique.

At the time, XDR-TB treatment with new drugs, was only available in reference facilities in Maputo, far from Caroline's home. The treatment here is part of the USAID funded, Challenge TB project, which in Mozambique is led by FHI 360 with KNCV as a partner. In Caroline's province there was no system in place to deal with her type of disease; clinicians were not familiarized with monitoring and managing XDR-TB. In the meantime, Caroline's health was getting worse and many doubted anything could be done for her. It was a race against time. Finally, through advocacy from treating clinicians and other key actors, including KNCV and FHI 360 PMDT experts, a meeting was convened by the NTP with NTP and other experts (KNCV, FHI 360, Doctors without Borders, FGH) to determine a course of action that would help save Caroline.

Already her health condition has improved dramatically and she has gained substantial weight

Through a concerted effort, the experts under the leadership of the NTP devised a course of action that included prescribing an individualized treatment regimen containing the new and potent drugs bedaquiline and delamanid, rapidly training staff and transferring her medications to her province, where she would receive her medications at her local health center with support from the province hospital. This allowed Caroline to stay close to her family and, eventually, continue her studies. This also has prevented her mother from incurring significant costs related to travel and living in Mozambique.
To ensure quality case management and treatment adherence, given the toxicity and side effects of some of the drugs in her regimen, the health center organized a multidisciplinary support team to coordinate the drug supply, patient monthly follow up (smear, culture, laboratory tests, electrocardiogram), psychosocial support and management of adverse events. This was the first experience in managing XDR-TB in Mozambique.

Caroline is five months into her treatment. She has fiercely overcome serious adverse events related to the drugs she takes, while dealing with social and family challenges. Already her health condition has improved dramatically and she has gained substantial weight. She is optimistically looking into the future and fulfilling her dream of completing her studies.

Caroline has been a lesson to treating clinicians on the nature of the programmatic and clinical management of XDR-TB. Mostly, her resilience and positivism, when everything seemed lost, has been a lesson to everybody around her.

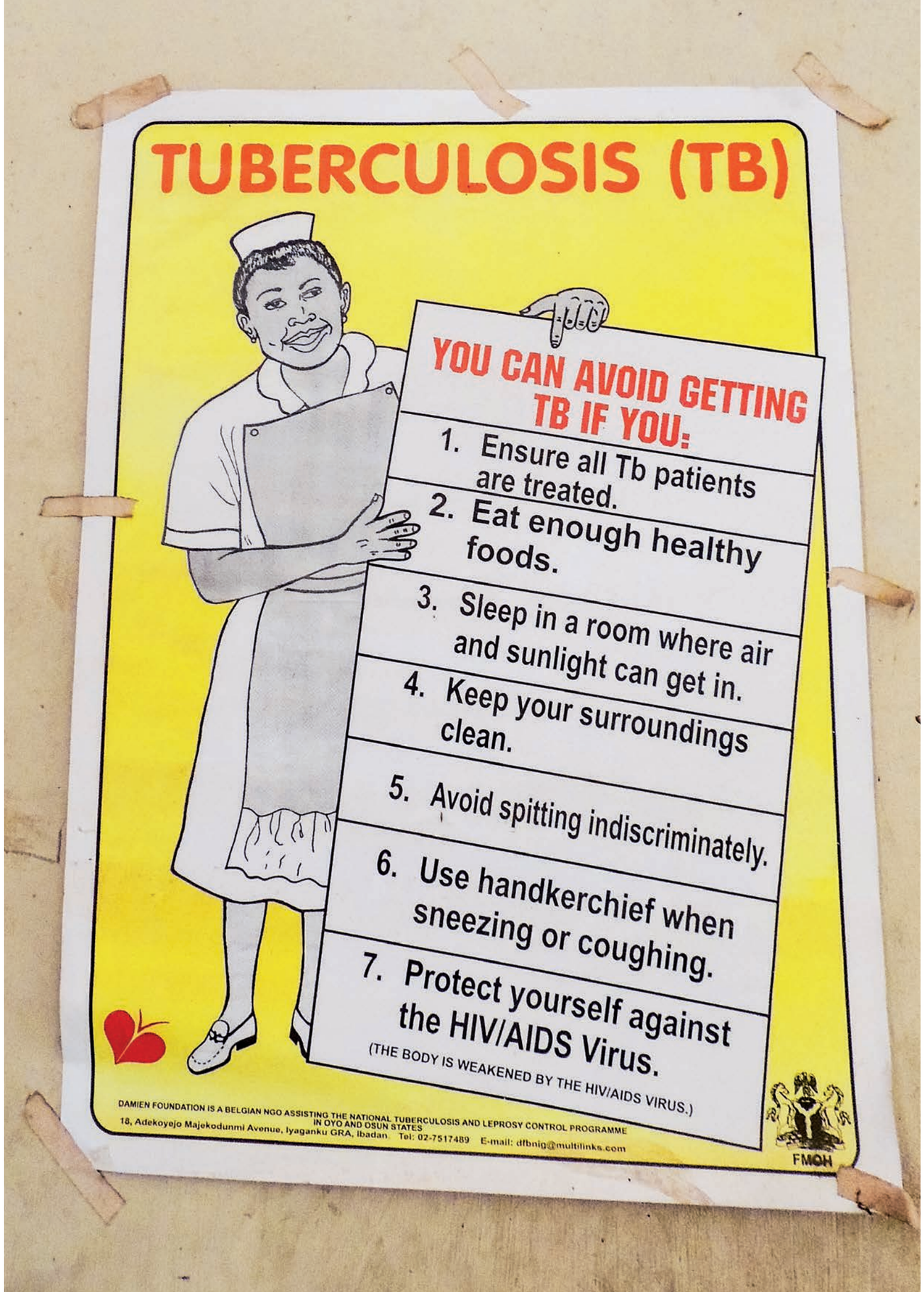
IMPROVING TB PATIENT SUPPORT INTER-VENTIONS

Since the beginning of the 20th century, nurses have played a crucial role in TB control. Initially visiting patients in their own homes, today's public health TB nurses can be found at the various GGDs.

While nursing support's primary focus is the promotion of treatment adherence, the psycho-social and socio-economic consequences of tuberculosis also demand attention. Nursing support also extends to contact investigation as an intervention to avoid and stop further transmission of TB.

Training on the job

With no guidelines and no studies executed in the Netherlands to measure the impact of nursing support interventions, information was scarce. TB nurses were trained on the job and where nursing support was referred to in other guidelines the underlying evidence was weak or absent. Furthermore, the decline in patient numbers in The Netherlands, new policies and patient groups, (e.g. latent tuberculosis infection (LTBI) patients) e-health and other new technologies and organizational issues only further fueled the urgency to evaluate the effectiveness and efficiency of patient support interventions. KNCV Tuberculosis Foundation (KNCV) stepped up to address these issues and in 2016 kick-started and financed the project 'Improving Patient Support Interventions'. The goal of this initiative is to gather evidence on nursing support interventions among TB patients and persons treated for LTBI in the Netherlands as a basis to develop a guideline. The expectation is to also utilize the guideline in other (low incidence) countries among TB patients in the ambulatory phase of treatment.



Systematic review plus survey

The advisory group of this KNCV led project includes TB nurses from the four TB regions in the Netherlands, one patient and representatives from the Dutch Association of TB nurses. The first two studies, completed in 2017 comprised a systematic review plus a survey regarding nursing support in other low incidence countries in Europe. The systematic review included forty articles. We found that although a variety of patient support is implemented in these countries, evidence as to the effectiveness was scarce.

The survey, sent to 24 European countries to gather further information including unpublished data, provided invaluable information. 19 of the 24 countries provided feedback and KNCV were able to produce a nursing support overview for TB patients and persons with LTBI and identify potential best practices. At the end of 2017, articles were submitted with the findings from both studies. In the same year KNCV also began with a descriptive study about the current patient support practices in the Netherlands together with a study of data gathered from the National TB register. These studies are targeted for completion in 2018.

Evidence based nursing care

At the end of 2017, KNCV applied to the V&VN (Dutch Nursing Association) to qualify for a guideline development process. In this process, funded by the Ministry of Health, evidence-based nursing care standards are being developed. This would give us a unique opportunity to improve the quality of nursing care for TB patients.
As mentioned earlier, nurses new to TB received no TB specific formal training. The advised training consists of a mandatory nursing degree plus they can follow the general education for public health nurses (NSPOH). KNCV responded to the needs of those new nurses who have joined the GGD in recent years by developing a basic training course. A six day introductory training course was subsequently delivered over a period of six months to sixteen new TB nurses. Four new TB doctors also participated in the final two days, which focus on contact investigation. The course was evaluated as extremely positive and KNCV is considering the possibility of continuing to provide this training in the future. No-one doubts the necessity to train professionals in low incidence countries, but due to the limited numbers of professionals, we need to determine how to implement this effectively.

‘Focus on strategies and interventions to increase TB diagnosis, notification and treatment’

Gidado Mustapha

MESSAGE FROM OUR CHALLENGE TB DIRECTOR

KNCV as lead partner for USAID funded Challenge TB project provided quality technical assistance in coordination with partners to ensure 90% of all work plans were approved within the slated period in 2017.

The main focus of our activities was on strategies and interventions to increase TB diagnosis, notification and treatment of patients. Emphasis is on diagnostic network expansion, introduction of new drugs and regimens (ND&Rs) for treatment of Multi-Drug Resistant TB and rolling out electronic recording and reporting systems (ERR). We also focus on ‘Finding and Treating the Missing TB Patients’. In 2016, the World Health Organization estimated that close to 40% of TB patients were “missing”, which translates to approximately 4 million people with TB for whom it is not known if they have ever received a diagnosis or appropriate treatment.

We are pleased to announce that by the end of 2017, all the 22 CTB countries have adopted GeneXpert MTB/RIF as a diagnostic tool for TB patients and have an increasing capacity for Second Line Drug (SLD) Sensitivity Testing. The proportion of drug-resistant patients tested for SLD susceptibility in CTB countries reached 57%. 21 countries are now enrolling patients on either ND&R, and countries are at different stages of transitioning to ERR, as well as introducing diagnostic connectivity.

At least 68% (15 CTB countries) are above the global average of 61% for estimated treatment coverage in 2017; CTB countries are increasing case notification at a much higher rate than the rest of the world, the number of TB cases (all forms) notified increased by 9% between 2014 and 2016 in CTB countries compared to a 5% global increment. The number of patients successfully treated among 14 countries of 22 high burden countries increased by 10%, while there was no significant change in overall treatment success rate because of increased case notification from private sector, especially from India.

KNCV/CTB developed an action plan as a response to the external management review of the CTB project. Many of the actions were implemented in 2017 which included mechanisms for quality improvement of work plans, implementation of short term technical assistance, internal and external communication structure, leveraging of consortium partners strength, and strengthening the CTB Monitoring & Evaluation system by the development of database for ease of analysis and reporting.



Gidado Mustapha, MD, PGDM, MPH & MSc-MHPE
Director Challenge TB

KEY FIGURES OF PERFORMANCE OF KNCV COUNTRIES

01 INDONESIA:
- 422% increase of the approved local government budget for TB control program
- 78% improvement of MDR-TB patient notification through rapid expansion of GeneXpert and implementation of new diagnostic algorithm
- 81% increase of MDR-TB treatment adherence in 6 months from 62% in 2016

02 NIGERIA:
- 49,565 people screened for TB: 1,398 were diagnosed with TB through visiting households with TB index cases

03 TANZANIA:
- 11% increase in community contribution to TB case notification
- 99% testing up and 98% ART initiation among co-infected TB/HIV patients

04 BOTSWANA:
- 6,641 Xpert MTB/RIF tests done compared to 1,232 tests in 2016
- 660 TB cases were identified

05 NAMIBIA:
- 70% IPT coverage increase in KNCV supported districts

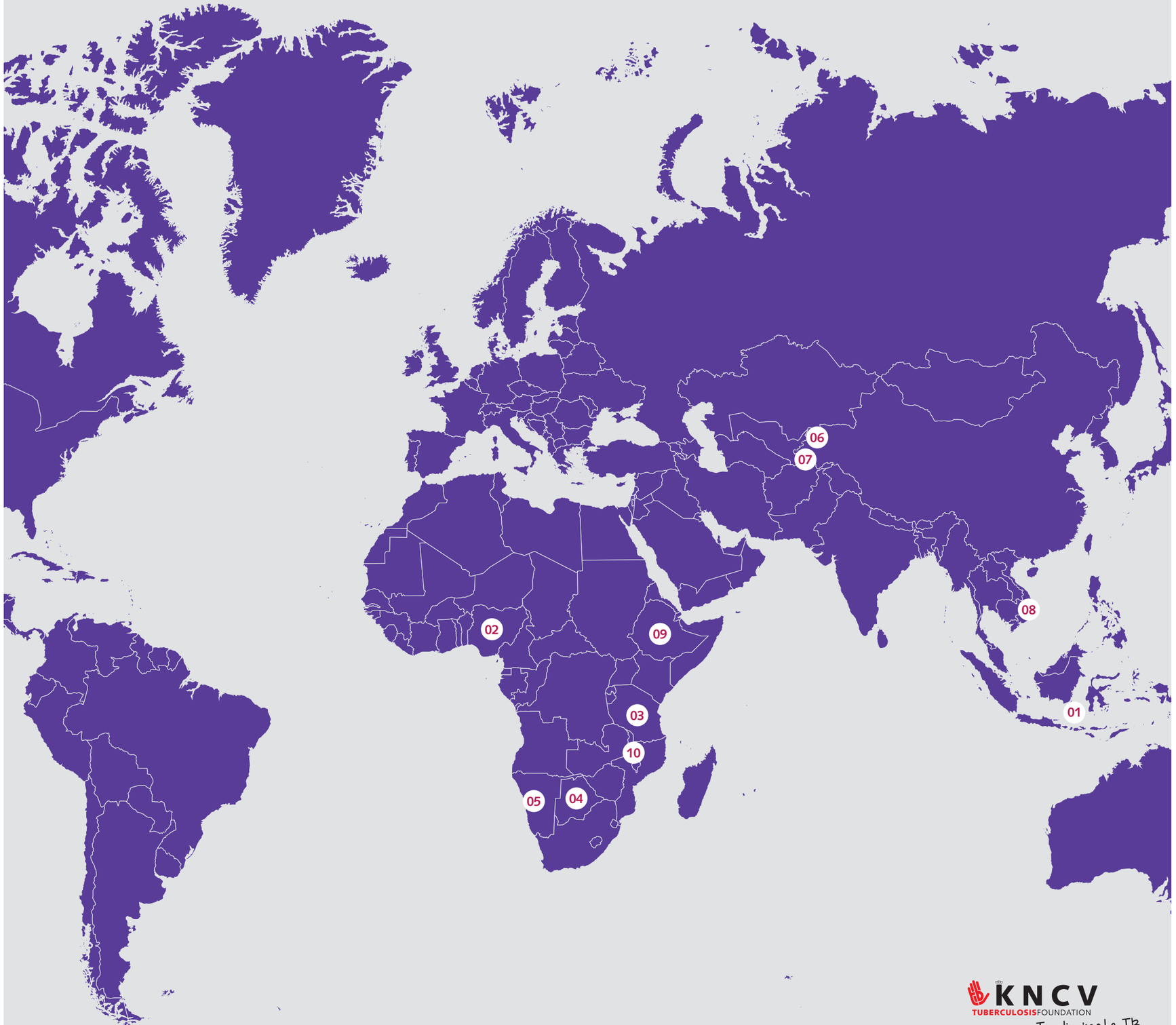
06 KYRGYZSTAN:
- Over 300 patients with multi and extensively drug-resistant tuberculosis enrolled on new, more efficient treatments
- Around 90% adherence rate of patients on new treatments

07 TAJIKISTAN:
- Case detection up from 15% to 29%
- 139 drug resistant patients enrolled on new regimens

08 VIETNAM:
- 65 additional GeneXpert systems introduced
- 99 pre-XDR and XDR-TB patients in three pilot provinces enrolled on BDQ-containing treatment regimens
- 101 approved MDR-TB patients enrolled on shorter regimens

09 ETHIOPIA
- 109,803 drug sensitive TB (DS-TB) and 694 drug resistant TB (DR-TB) cases were notified
- 94% and 75% improvement of treatment success rate (TSR) for DS-TB and DR-TB cases

10 MALAWI:
- 21% increase in the number of children diagnosed with TB



KNCV TUBERCULOSIS FOUNDATION
To eliminate TB

A SUCCESS STORY: HOW INDONESIA ACCELERATES TO END TB

On 16 and 17 November 2017, Indonesia participated in the WHO Global Ministerial Conference "Ending TB in the Era of Sustainable Development: A Multisectoral Response" that was held in Moscow. Under the leadership of host Russia, 80 Ministers of Health, Finance and other sectors underscored the urgency of stepping up to counter the global TB epidemic. Indonesia was represented by the Coordinating Minister for Human Development and Humanity, Puan Maharani and the Minister of Health, Nila Moeloek, besides representatives from the Indonesian National Planning Bureau, the Ministry of Home Affairs and the Ministry of Health. With the Moscow Ministerial Declaration leaders from around the world committed to increasing the response, intensifying R&D and ensuring sustained finance.

Intersectoral collaboration: a mile-stone meeting

Back home, Indonesia showed they were taking things seriously. On the 4th of December 'Moscow' was followed by high level inter-ministerial meeting for "Acceleration towards Indonesia Free of TB: Multisectoral Contribution". Indonesia district mayors in the presence of the Minister of Home Affairs, Tjahjo Kumolo and the Minister of Health, Nila Moeloek, signed their commitment to step up tuberculosis efforts.

A nation's problem

In her opening speech, Nila Moeloek, stressed how strengthening the collaboration between all parties at all levels was necessary. TB is not only "a health sector issue, but the nation's problem", she explained, so all disciplines - including the business sector, communities both religious and professional organizations - must come together and jointly work to end TB. She continued by expressing hope that each of the mayors present and all of those in Indonesia, would "prioritize TB in their agenda and actively support their NTP". The Minister of Home Affairs, Tjahlo Kumolo, comments mirrored those of Moeloek. He mentioned that the community well-being should become the priority of the provinces and districts finance. He appealed to all local governments to place the TB control program in their regional development planning agendas.

Concerted effort

During the meeting the final version of the guide for district action planning for TB elimination was launched and provinces and districts committed to the development of these plans, as a measure to increase sustainability of funding for TB programming for the coming years. While universal health insurance is covering the cost of TB diagnosis, treatment and care, additional TB programming for realization of TB elimination has to be funded by ▶

TB is not only "a health sector issue, but the nation's problem"



district governments, for which the District Action Plans are a prerequisite.

This guide for District Action Plans for TB is the result of the concerted effort by the national TB control program (NTP), the Ministry of Home Affairs and the USAID funded, KNCV led Challenge TB project to develop the relevant legislation in both ministries, develop the methodology and do pilot implementation in 16 districts, significantly increasing the funding available for health and TB programming.

Six new grants received

In 2017 KNCV also contributed to the strategic planning and writing of the Global Fund TB/HIV funding request and during review and grant making. In December 2017 the Global Fund and health partners in Indonesia signed six new grants, totalling more than US$264 million, which will take aim at expanding healthcare programs against HIV, TB and malaria over the next two years. The Indonesian Minister of Health, Dr. Nila Moeloek, stressed yet again the importance of partners and working together for greater impact: "HIV, TB and malaria are not only health issues, they are also development issues involving cross-sectoral ministries, institutions and communities. We will continue to work together to ensure that the resources mobilized through this grant are used accountably and effectively."

Firmly on track

The grants will play an important role catalysing Indonesia achieving their ambitious targets of detecting and treating an additional 1.8 million TB cases, as well as improving treatment success rates of more than 90% for TB patients and 65% – 75% for drug-resistant TB (DR-TB) patients. Realization of these targets will see Indonesia firmly on its way to achieve elimination by 2030, significantly contributing to the Global TB Elimination goals.

Increase in case notification rate

The success story of Indonesia was further illustrated by the latest figures showing the state of notification in 2017 (Figure 1). Until now 458,000 patients have been notified, bringing the case detection rate from 36% in 2016 up to around 46% in 2017. To put this in perspective, it was 36% in 2016 and 32% in 2015.

Ahead in the process

The latest figures also show that the KNCV/CTB supported districts went ahead in the process of increasing notification and are responsible for a more than its proportionate share of notification (increasing from 14% in 2014 to 20% in 2017 on the basis of only 11% of the population) and also of the absolute notification increase (approximately one third of the increase between 2014 - 2017). Measures implemented by KNCV/CTB have been taken on by the country: applying intensified monitoring, followed by action to resolve under-notification in large hospitals; to realize this for the period 2018 – 2020 the new GFATM grant provides funding for an extra data officer in priority districts.

Improving early diagnosis

After 10 years of "flat" notification, the absolute numbers increased with 2% in 2015 (including 1% population growth), 9% in 2016 and 27% in 2017. And the country is only just starting: this 2018 the District Public Private Mix approach will be instrumental in bringing on board even more providers to participate in notification of previously un-reported patients, as well as increasing and improving (early) diagnosis and treatment results.

A unique opportunity to improve the quality of nursing care for TB patients

More good news from Indonesia:

- In 2017, KNCV assisted the development and use of a tool to estimate the incidence of TB at district level, in collaboration with the National Tuberculosis Program (NTP) through Global Fund funding and the London School of Hygiene and Tropical Medicine.

- Following the rapid expansion of Xpert sites and implementation of new diagnostic algorithm with Xpert testing as the primary test for TB, the number of Xpert test reached more than 138,000 in 2017, more than three-fold in 2016. Consequently the notification of multidrug-resistant TB (MDR-TB) patients increased by 78% as compared to 2016.

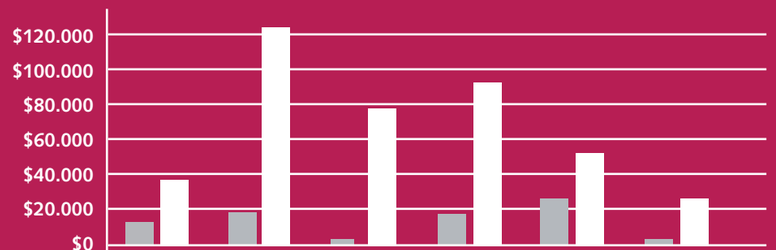
- KNCV and the NTP developed and introduced a benchmarking tool for self-assessment by programmatic management of drug-resistant TB (PMDT) treatment centers. The aim is to improve and standardize quality of care. The NTP decided to use this method throughout Indonesia.

- KNCV intensively supported all steps of introduction of the shorter MDR treatment regimen (STR), including active TB drug-safety monitoring and management (aDSM), with the first patient successfully enrolled early September 2017. In 2017, KNCV introduced monthly interim cohort analysis in 16 districts. Early results are encouraging, resulted in an increase of MDR-TB treatment adherence at 6 months from 62% in 2016 to 81% in 2017.

- The approved local government budget for TB control program in 2018 (in 6 districts) has increased by 422% as compared to 2016.

- In 2017, rapid expansion of Xpert and implementation of new diagnostic algorithm have improved MDR-TB patient notification by 78% as compared to 2016.

Improvement on local government budget allocation for TB control program



	Bogor District	Jember City	Tulugagung District	Jayawijay District	Semerang City	Surakarta City
2016	$21.605	$18.801	$1.062	$17.202	$26.630	$3.759
2018	$36.090	$121.737	$76.413	$91.035	$50.660	$26.314

In 2017, rapid expansion of Xpert and implementation of new diagnostic algorithm have improved MDR-TB patient notification by 78% as compared to 2016.

East Africa Regional: develops childhood TB training for Health Care Workers

At the beginning of 2017, the KNCV led, USAID funded Challenge TB East Africa Regional (CTB EAR) project supported the development of an online childhood TB training for healthcare workers facilitators' guide through The Union. The purpose of this guide is to allow the childhood TB training to be cascaded to a larger target group and for easier facilitation.
Piloting of the online childhood TB training for healthcare workers facilitators guide was conducted in Kampala, Uganda during the year. Ten health care workers were especially trained. These health care workers will help strengthening the knowledge transfer, which is pragmatic and locally relevant, to improve the management and prevention of TB in children. The target audience for the guide are health care workers who manage TB in children.
The CTB EAR project also facilitated a workshop for the development of the laboratory curriculum on rapid diagnostics at the Supra National Reference Lab (SNRL) in Kampala, Uganda. This was followed by another workshop to provide short term technical assistance to the SNRL team to deliver training courses using the standard curriculum that was developed (which will be piloted in February 2018). A total of 25 SNRL health staff underwent both trainings. They will train others in Uganda and in other countries in the region utilizing laboratory tools developed for the introduction of New Drugs and Regimens.
We recently also started working with the Intergovernmental Authority on Development (IGAD) on cross-border TB control in line with the USAID/KEA's Regional Development Cooperation Strategy 2016-2021. IGAD is a regional intergovernmental organization comprising of Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda. KNCV consultants from the project have been providing close and continued input in the development of the TB component of the IGAD TB, HIV and Malaria Strategic Plan 2018-2025. This strategic plan will guide more consistent and coherent implementation of cross border TB control by CTB EA in IGAD member states, and align the work of member countries.



KNCV consultants from the project have been providing close and continued input



Malawi: successfully upgraded the National TB Reference Laboratory

The KNCV led, USAID funded Challenge TB project (CTB) successfully upgraded the National TB Reference Laboratory (NTRL) from a bio-safety level two to a bio-safety level three, in line with WHO recommended requirements. The NTRL is ready to support the processing of over 3000 samples planned for the second national TB drug resistance survey in 2018. Refurbishments included installation of controlled (negative pressure) ventilation system and procurement of key equipment. The quality of the works was approved by the Uganda Supranational Reference Laboratory (SRL) and a USAID consultant. NTRL staff capacity has also been built through international training support by CTB.
With CTB support, the NTP increased the External Quality Assessment (EQA) coverage from 24% (75/312) facilities in the second year of the project, to 96.5% (305/316) facilities in the third year of the project. During this third year 91% (288/316) laboratories demonstrated above 90% performance in blinded rechecking, as per NTP (National Tuberculosis Program) recommendation. Efforts in strengthening EQA program also helped improve the Global Laboratory Initiative microscopy network accreditation standards (increase from 4 to 8 standards). CTB also improved monitoring and maintenance of the GeneXpert platforms.
CTB supported finding missing persons with TB (FTMP) among People Living with HIV (PLHIV), prisoners and children through active screening and contact investigation. FTMP strategies were introduced to 12 health facilities in two urban districts with the highest TB burden in the country. Implementation strategies included focused daily coaching of staff and review meetings with active involvement of health care workers from the antiretroviral therapy (ART) clinics and the outpatient departments. The facilities contributed 63% (1,748/2,776) of annual district notified by January 2017 in Blantyre district and 44% (1,712/3,897) of annual district notification in Lilongwe district.
There was a 21% increase in the number of children diagnosed with TB in 2017, (from October 2015) and a 12% proportion of notified children against the National Strategic Plan target of 15% in the 15 CTB target districts. The proportion of TB cases diagnosed through contact investigation has also increased to 3% in 2017, from 1% in 2016. This occurred because of increased investment in Childhood TB training and contact investigation.



Implementation strategies included focused daily coaching of staff



Nigeria: Patent Medicine Vendors help find missing persons with TB

The KNCV led, USAID funded Challenge TB project in Nigeria has intensified efforts towards finding the missing persons with TB through two community-based approaches.
The engagement with Patent Medicine Vendors (PMVs) has proven to be a useful source in detecting missing persons with TB. The PMVs are typically the first point of care for the majority of Nigerians suffering from respiratory problems. These community based quasi-pharmacists are very popular and well supported due to their easy accessibility and perceived cheaper prices. It is clear to see why these PMVs are playing an instrumental role in the cough to cure pathway and subsequently the control of tuberculosis in Nigeria. 2,367 PMVs have been engaged and trained by the CTB Nigeria team on how to identify potential TB cases and refer them for diagnosis and treatment. 18,979 presumptive patients were referred by the PMVs, while a total of 1,568 of these cases were found to be positive for TB.
More than one thousand TB patients have been diagnosed and put on treatment following home visits to existing TB patients by Contact Investigators. These 338 Contact Investigators are community volunteers, trained to identify the signs and symptoms of TB. Those family members demonstrating TB symptoms are subsequently tested and those with a positive diagnosis are immediately placed on a treatment program. To avoid and prevent further infection transmission within affected families, preventative medication is provided to children under the age of five who live in households with TB patients.
TB case detection is a high priority for Nigeria as currently less than a quarter of estimated TB cases are registered. KNCV has embarked on accelerated TB case finding not only through community based approaches but also via innovative health solutions, including the aggressive roll out of GeneXpert testing for TB diagnosis and the enrollment of new drug-resistant TB patients on shorter treatment regimens.



TB case detection is a high priority for Nigeria



Ethiopia: improving patient-centered care

The USAID funded, Challenge TB (CTB) project in Ethiopia is the major partner supporting the National TB Program (NTP) at national and regional level. In 2017, CTB contributed in the implementation of the NTP's national strategic plan with much success.
CTB has been at the forefront of the national initiative to improve access to new drugs for eligible drug-resistant TB (DR-TB) patients. There are now three treatment centers all providing new drug treatment services, two of which became operational in 2017 via CTB support. CTB facilitated the introduction of bedaquiline through the USAID bedaquiline donation program and procured delamanid and repurposed drugs as part of the support.
Populations considered to be at high risk of TB were mapped and standard operating procedures developed to improve case finding amongst these populations. CTB supported the national program in the development of a national key population strategic framework and operational guide. These high-risk groups were subsequently screened for TB and the resulting number of patients with a positive diagnosis further reinforced the necessity for case finding programs.
With respect to the project's SMART targets: In 2017, 109,803 drug sensitive TB (DS-TB) and 694 drug resistant TB (DR-TB) cases were notified- 102% and 81% achievement of targets respectively. The treatment success rate (TSR) for DS-TB and DR-TB cases improved from 89.4% to 94.2% and 62% to 75% respectively.
Furthermore, CTB assisted in the Ethiopian Public Health Institute's efforts to improve the utilization and service quality of TB diagnostics through, the expansion of LED microscopes (65 added in 2017) and capacity building, marked improvement in external quality assurance of 2,430 TB diagnostic facilities. There was also the expansion of GeneXpert utilization (167 currently in use) whereby over 222,000 presumptive cases were tested and the proportion of DS-TB cases diagnosed by GeneXpert increased from 6% to 18%. Finally CTB provided support to the 6 laboratories and startup of second-line LPA.



Populations considered to be at high risk of TB were mapped



Tanzania: finds the missing persons with TB through multi-pronged interventions

Tanzania has benefited from the USAID funded KNCV led Challenge TB (CTB) project in many ways in 2017. KNCV has provided over several years key technical assistance to develop and implement a state-of-the-art electronic TB surveillance system (eLMIS) that will help the national authorities to better track TB patients countrywide and more accurately report TB statistics. By 2018, this is expected to be rolled out countrywide.

We provided significant support to strengthening the country's capacity to diagnose TB. One area of support was building the capacity of the national TB Reference Laboratory which in turn supports the entire TB laboratory network. The laboratory has advanced to the point that it can apply for international accreditation to a Supranational level from the SADCAS (Southern African Development Community Accreditation Services).

In 2017, KNCV spearheaded further PMDT decentralization and the introduction of new drugs and short treatment regimen (ND/STR) for drug-resistant TB in Tanzania. In order to better understand TB patients drug resistance patterns rapidly and put them on the correct treatment, we supported three zonal laboratories in Dar es Salaam, Kilimanjaro and Mbeya regions to perform the rapid, molecular, second-line HAIN test to gain insights into individual patients' eligibility for the ND/STR.

The country project team has worked with six community-based organizations and volunteers to find the missing persons with TB through multi-pronged interventions including Contact Investigation, targeted Active Case Finding, TB Quality Improvement tool implementation, FAST strategy and sputum specimen referral system. This resulted in the increase in community contribution to TB case notification of 11% compared to 5% in 2016.

CTB contribution to national TB case notification in 2017 was 38%.

CTB continued to support regions and districts to integrate TB and HIV collaborative services with high performance on all key indicators (99% testing up and 98% ART initiation among those co-infected TB patients).

CTB supported the revision of national TB workplace policy that will guide systematic TB screening among healthcare workers (HCWs). This followed a successful introduction of TB screening among HCWs through sensitization and dialogues at different levels of the health system. Over 22,000 HCWs have been screened and 83 confirmed with TB disease and initiated anti-TB treatment.



The laboratory has advanced to the point that it can apply for international accreditation



Botswana: first country to conduct a combined national TB and HIV survey

Since 2013, the number of Xpert MTB/RIF tests carried out by KNCV in Botswana has increased significantly with 6,641 tests done in 2017 alone compared to 1,232 tests in 2016 and 158 tests in 2015. The number of TB cases identified, has shown a slight increase since 2015 with a more significant change experienced from 2016, as a consequence of the change in the diagnostic algorithm (with the adoption of Xpert MTB/RIF as first test for all presumptive TB cases).

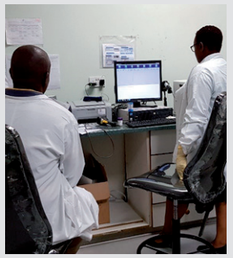
Although the number of tests has shown a significant improvement, the GeneXpert platform is not optimally utilized yet. There is a high down time of GeneXpert machines with about 30% of the modules non-functional by the end of 2017. In order to address above matters, KNCV Botswana has been working with the Ministry of Health to have a service contract in place with Cepheid for the machines to be fixed and serviced timely, for all modules to be functioning.

KNCV technical expertise was leading in the development of a five year strategic plan aligned to the Global End TB strategy. The motivation for this plan came as a result of an earlier external review, also led by KNCV on the integrated TB-HIV-hepatitis program.

KNCV also supported in the development of an accompanying monitoring and evaluation framework.

Botswana will be the first country ever to conduct a combined national TB and HIV survey and KNCV has been providing the necessary technical assistance to develop an integrated survey protocol. The protocol was reviewed by WHO taskforce and CDC IRB and updates have been adopted accordingly. The implementation is planned to start in June 2018.

National Drug Resistant TB (DR-TB) guidelines have been updated and aligned with WHO guidelines. The introduction of shorter treatment regimen and individualized regimen containing the new drugs, bedaquiline and delamanid have been endorsed and the drug regulatory authority has registered and approved the drugs accordingly for importation.



KNCV technical expertise was leading in the development of a five year strategic plan



Namibia: embarks on first ever TB Disease Prevalence Survey

KNCV has been providing TB control support to the Namibian Ministry of Health and Social Services for more than 14 years. KNCV's technical leadership has been pivotal in assisting the National Tuberculosis Program in the development and implementation of three national strategic plans and five successful Global Fund grant applications. In diagnostics, KNCV advocates for universal drug-susceptibility testing and supports the use of a laboratory TB register countrywide. KNCV believes that everyone deserves the most appropriate care with the correct diagnosis using the latest diagnostic tests.

Since 2008, when KNCV first spearheaded the Programmatic Management of Drug-resistant TB (PMDT), more than 3000 patients in Namibia have been treated for drug resistant-TB (DR-TB) and KNCV has been instrumental in the supervision of two nationwide drug resistant surveys.

With regards to the use of new regimens for DR-TB treatment, 36 patients have been treated with bedaquiline through the USAID funded project. KNCV also supported the production of new guidelines for DR-TB, which incorporates the short treatment regimens for treating MDR-TB.

KNCV continues to provide long term technical assistance to the National Tuberculosis and Leprosy Program (NTLP). Via deployment of the technical Programmatic Management of DR-TB Officer, the NTLP were able to access the USAID donation of bedaquiline and treat patients with MDR and XDR-TB. These were patients who had virtually no further treatment options open to them.

In KNCV supported districts, Isoniazid Preventive Therapy (IPT) coverage increased from 30% to 70%. As part of the Continuous Quality Improvement (CQI) training offered to USAID's implementing partners, four KNCV districts were identified as pilot CQI projects. IPT is a public health intervention for the prevention of TB among people living with HIV. Implementation of IPT in Namibia has been limited and this pilot has renewed hope of reinforcing IPT coverage in the future.

Namibia also embarked on the first ever, nationwide TB Disease Prevalence Survey (to be completed in June 2018) with support from KNCV and other partners.



KNCV continues to provide long term technical assistance to the National Tuberculosis and Leprosy Program



Kyrgyz Republic: enrolls patients on new, more efficient treatment regimens

In 2017, KNCV under the USAID funded Challenge TB project helped the Kyrgyz Republic National TB Program (NTP) to enroll patients with multi and extensively drug-resistant tuberculosis on new, more efficient treatment regimens recommended by the World Health Organization (WHO). Patients with first-time multidrug resistant TB are treated with a shorter regimen (nine to twelve months instead of two years), and more complicated cases of MDR-TB and extensively drug-resistant TB are treated with an individualized regimen, tailored for each patient and reinforced with the new drugs Bedaquiline or Delamanid.

These treatments are quickly proving their efficiency: 21 patients have already been cured on the shorter regimen, in half the time, with half the pills and much less long-term side-effects it would have taken with the standard treatment. Patients who had run out of options due to severe drug-resistances are now recovering.

KNCV is providing case managers for all of these patients as well as treatment supporters and psychologists for the patients at risk of interrupting treatment. As a result, the adherence rate to treatments is around 90%, against only 75% on the standard regimen. KNCV continued to reinforce capacity building of the NTP and Primary Health Care centers through regular supportive supervision visits, study tours, mentoring as well as on-job and international trainings. In one year, more than 1,000 NTP and pilot sites healthcare workers were trained in local and international advanced courses on PMDT.

At the end of the year KNCV extended the access to these new treatments from the pilot site to three more regions in the Kyrgyz Republic. KNCV is closely working with the NTP and the Ministry of Health, and by the end of 2018 the Kyrgyz Republic, which has one of the worlds' highest burdens of drug-resistant forms of TB, will shift entirely to these new treatments.



21 patients have already been cured on the shorter regimen, in half the time, with half the pills



Tajikistan: New tools and innovation

The USAID funded, KNCV led Challenge TB Project in Tajikistan focuses on improving the capacity of the healthcare system and the quality of care for drug resistant-TB (DR-TB) patients via the introduction of new tools and innovations. The scaling up of new treatment regimens for DR-TB progresses well and brings hope to those patients with DR-TB. Advanced technologies designed for drug management are now significantly improving patient-centered care in Tajikistan.

The main goal of the USAID funded TB Control Program is more effective and more accessible TB diagnosis and treatment for the whole population, including the most vulnerable, to reduce the burden of TB and drug resistant-TB. The foundations are in place for improved diagnosis and treatment of TB and DR-TB cases. Seven districts, approximating to 27% of the country's population, have been screened resulting in the detection of 29% of the total cases countrywide.

Case detection has almost doubled (from 15% to 29%) due to improvements in accessible diagnosis driven by an effective operational sample transportation system, the introduction of new technologies and methodologies, improved training for health care staff and more involvement by primary health care facilities.

The new drugs and regimens initiative for the treatment of DR-TB has seen more patients enrolled on shorter treatment regimen and on individualized treatment. In 2017, 139 drug resistant TB patients were enrolled with 75 MDR-TB patients on shorter regimens and 64 XDR-patients on individual regimen with bedaquiline. Eight MDR-TB patients successfully completed the shorter regimen treatment and were cured.

A successful scale up of OpenMRS database enabled more training programs at entry points as well as the monitoring and technical support of database operations at all sites, either remotely or on-the-job.

KNCV also supported the Ministry of Health in Tajikistan in strengthening the capacity of TB facilities. Improvements in HR management together with an update of HR policy for TB services promoted better quality of services within the existing resources.



Advanced technologies designed for drug management are now significantly improving patient-centered care



Uzbekistan: improving access to high-quality services

KNCV has been working in Uzbekistan since 2005. As part of the current KNCV led, USAID funded Challenge TB project (CTB), KNCV provides international technical assistance to the National TB Program in Uzbekistan. We collaborate with representatives from the WHO country office, the leading CTB partner in Uzbekistan, on improving access to high-quality patient-centered TB care and drug resistant-TB & TB/HIV services.

KNCV helps the country to implement the shorter regimen and the new drugs for drug-resistant TB treatment including diagnosis and bacterial confirmation of drug resistance, treatment regimen design, monitoring of treatment efficacy and safety, and programmatic evaluation.

To ensure enhanced treatment outcomes and reduce mortality among multidrug-resistant TB (MDR-TB) patients, the Challenge TB partners in Uzbekistan, WHO and KNCV advocated to introduce new drugs and shorter drug regimens for the treatment of MDR-TB and extensively drug-resistant tuberculosis (XDR-TB).

In 2017, KNCV supported the development and finalization of national clinical protocols on the use of new drugs and shorter regimen together with standard operation procedures (SOPs) and aligned with the National Tuberculosis Program (NTP). CTB partners worked intensively with national and international stakeholders to speed up the required approval process so that patients could begin as soon as possible with their treatment and subsequently rapidly scale-up up the program to other regions in Uzbekistan.

The existing diagnostic algorithm was optimized to allow triaging of patients to be enrolled on new regimens for treatment of M/XDR-TB. The KNCV Patient Triage concept is designed to determine the best treatment for patients based on their specific needs and anticipated outcome of care.

We also started the implementation phase with the adaptation of the interim data base (the monitoring tool, based in MS Access) to country specifics. By the end of 2017, the developed data base was tested. NTP staff and TB clinicians from CTB pilots were trained on clinical monitoring, PV/aDSM recording and reporting forms and on use of the interim database.



The KNCV Patient Triage concept is designed to determine the best treatment for patients



Kazakhstan: successful public/ private partnerships in Almaty

Historically, the public healthcare sector in Kazakhstan had always been responsible for providing TB care and primary healthcare. Since 2014 however, the Ministry of Health has been driving the public private partnership initiative due to the increase of public healthcare programs funded by the government through the Guaranteed Volume of Free Medical Care (GVFMC) system. The care package in the framework of the GVFMC includes services related to TB detection, treatment and prevention.
In 2017, this package was introduced into 16 private clinics in Almaty city. KNCV led the way to provide the necessary technical support to these clinics to improve capacity in TB control and succeeded in establishing effective collaboration and communication among the private and public sectors.
To ensure the private clinics delivered a high quality of TB care, KNCV promoted the integration of private clinics into the national TB monitoring and evaluation system.
KNCV also contributed in the plan to involve local NGOs in the provision of TB care. Effective collaboration between local NGOs and public and private healthcare organizations, realized improvements in TB detection and treatment adherence among key populations.
KNCV trained 15 local NGOs representatives on TB care and monitoring and evaluation. Local NGOs were then able to identify those who needed TB screening and refer them for diagnostics and provide psychological and social support to those patients receiving treatment for TB.
To support and sustain this integrated TB care model, KNCV conducted four round tables for key representatives from TB services, private clinics, local NGOs and the department of health.
So far, this model of public-private partnership was established only in Almaty city with support of KNCV.
1,142 people from key populations were screened for tuberculosis in private clinics. 51 patients were referred for TB diagnostics because of presumptive TB and tuberculosis was laboratory confirmed in 16 patients. All of them were enrolled on TB treatment.



Effective collaboration between local NGOs and public and private healthcare organizations realized improvements



Vietnam: scaling-up the GeneXpert platforms

In Vietnam, the KNCV led USAID funded Challenge TB project (CTB) is making a positive difference. The introduction and scale-up of GeneXpert machines is making a significant contribution to the diagnosis of multidrug-resistant TB (MDR-TB) in Vietnam. An additional 65 GeneXpert systems have been introduced in 2017 and Vietnam is the first country to introduce multi-disease testing devices through GeneXpert platforms, namely for TB and HIV testing.
CTB has provided provincial and district level capacity building through the implementation of comprehensive, patient-centered TB/HIV services in Nghe An and Dien Bien provinces.
By providing trainings for National Tuberculosis Program (NTP) staff on HIV testing and counseling for TB patients at provincial and district level, the aim is to achieve the HIV program targets among TB patients. Increasing TB case finding approaches were developed to target high risk groups, such as People Living with HIV (PLHIV), clients attending methadone maintenance clinics (MMT) and underserved populations with an elevated risk for both diseases. These programs were implemented in seven remote mountainous districts in Nghe An, Dien Bien, An Giang and one urban slum district. The preliminary results in An Giang showed high case detection rates in these risk groups.
Progress continues in Vietnam in scaling-up Programmatic Management of Drug-resistant TB (PMDT). Vietnam pioneered the Patient Triage approach for RR-TB patients using SL-LPA as the initial diagnostic test for the detection of fluoroquinolone- and second-line injectable resistance. As of September 30, 2017, the first approved cohort of 99 pre-XDR and XDR-TB patients in three pilot provinces have been triaged and enrolled on bedaquiline-containing treatment regimens. The first approved 101 MDR-TB patients enrolled on the shorter 9 month regimen (using levofloxacin) finished their treatment course in 2017.
CTB has supported the NTP in the development and implementation of the second National TB Prevalence Survey. This survey will provide a precise overview of the current TB burden plus essential information for developing the Vietnam TB elimination strategy as well as estimating funding needs for interventions.
CTB also helped the NTP with developing and successfully negotiating the Global Fund funding request for 2018-2020 for an amount of USD 47,271,094 and the possibility of an additional allocation of USD 29,199,161.





KNCV supported the NTP to develop and negotiate successfully the Global Fund funding request

IMPROVING TB/HIV PREVENTION & CARE: BUILDING MODELS FOR THE FUTURE

The project 'Improving TB/HIV Prevention & Care: Building Models for the Future" focuses on innovative approaches, building effective partnerships and creating sustainable solutions. It's financed by the Dutch Ministry of Foreign Affairs, the Directorate-General for International Cooperation (DGIS) as part of their Global Fund support. In 2017, KNCV was active in five countries: Nigeria, Kazakhstan, the Philippines, Nepal and Swaziland. Throughout 2017 the consortium of project partners KNCV, AFEW International, Hivos and Pharm Access International interacted frequently; drawing on each other's strengths and experiences. The project consists of three pillars. The following highlights some of the major achievements of 2017.

Strengthening engagement of the non-public sector

Pillar I: is implemented in Kazakhstan, Philippines and Nigeria to improve TB and HIV prevention and care by strengthening engagement of the non-public sector (private sector and civil society) through creation of replicable and sustainable partnership models. In 2017, we contributed to significantly higher TB identification and notification and improved treatment adherence. Highlights are:

- In Kazakhstan the project supported a clear interpretation of the legal framework, allowing private service providers to offer ambulatory TB care and draw on government funding to do so.

- In the Philippines a "one-stop-shop approach" for TB/HIV care was established and the percentage of TB patients in the project knowing their HIV status is 48% above the national average (67% vs 19% national average).

- In Nigeria 60 health facilities are successfully engaged in the project with engaged health facilities demonstrate a high level of ISTC (International Standards for Tuberculosis Care) component uptake and a marked quality improvement.

Improving Global Fund implementation

Pillar II: is implemented in Nepal, Swaziland and Indonesia and focused on improving Global Fund implementation through quality Long Term Technical Assistance (LTTA) to NTPs. Highlights are:

- Nepal & Swaziland applied successfully for the upcoming Global Fund funding round and progressed to grant making. Nepal regained its eligibility status. Indonesia retained its full Global Fund TB grant.

- Nepal & Swaziland countries increased their disbursement & implementation rates of Global Fund funding and are now on track.

Optimizing Global Fund Grant performance

In Pillar 3, KNCV continued strengthening the Global Fund in its governance as well as in grant implementation. The first is done through committee leadership of the Audit and Finance Committee with focus on cross-cutting areas like Risk Management, Portfolio Optimization, the Office of the Inspector General and Innovative Finance. In the latter KNCV played a role as technical partner in countries and as member of the NGO developed country delegation in which KNCV provides. ◄



STRATEGIC GOALS REPORT 2020

The progress towards KCNV operational key performance indicators is presented below, based on 2014 and 2016 data from eleven KNCV supported countries.

1) Finding more patients and reducing mortality

Over the period 2014 to 2016 in all KCNV supported countries combined TB notification increased with 7% and bacteriologically confirmed patients was with 5% well over the KNCV average goal of 2% per year. However, figure 1, showing the notified patients and the number of patients bacteriologically confirmed among the notified, clearly illustrates some of the variety between the countries where KNCV works.

While diagnosing and treating hundreds of thousands of TB patients per year, Indonesia, Nigeria and Tanzania are among the countries with the highest numbers of unreported TB patients globally, together "missing" over 1 million TB patients annually. Therefore the increases in patients notified (and treated) in all three countries 2014 – 2017 are important results of interventions to which KNCV contributed. The 2017 data are not yet complete; the current 2016 trends are expected to continue over 2017.

In Indonesia the increases over the past 3 years are due to improvement in the notification system for bacteriologically negative TB and engagement of hospitals, where usually a clinical diagnosis of TB is made. Therefore the significant increases in total notification in 2015, 2016 and 2017 are not matched by a similar increase in bacteriologically confirmed patients. In Nigeria the scale-up of GeneXpert is one of the drivers of the increase in notification, alongside engagement of patent medicine vendors and communities. In Tanzania KNCV focused on intensified case finding in facilities and mobilizing community organization to find the missing persons with TB, resulting in a doubling of the community contribution to national notification.

Figure 1: Total notified patients and those bacteriologically confirmed among notified in KNCV supported countries 2014-2017

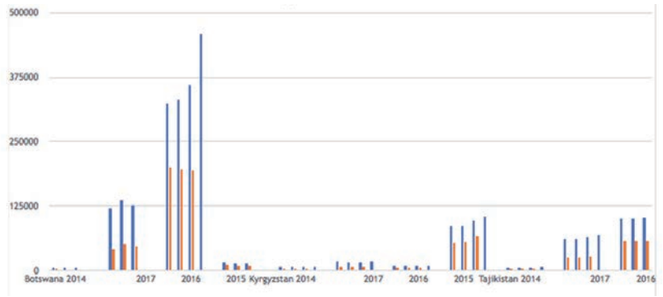
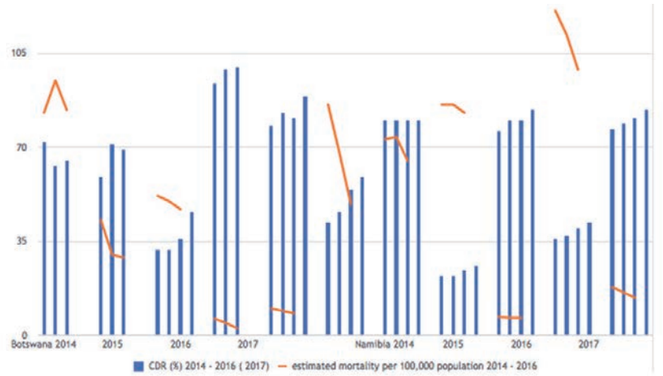


Figure 2: Case detection rate (in%) 2014-2017 and estimated mortality per 100,000 population 2014-2016



Improvement in notification is also shown in figure 2, showing the notification as percentage of the estimated number of TB patients that occur every year (case detection rate, with the target at 90%), alongside the mortality. This provides a better insight in the achievements, also in the countries with lower numbers of patients, which still achieve good results. The countries in Central Asia show very good treatment coverage, with the decreases in mortality mainly due to the introduction and roll out of effective treatment of resistant tuberculosis, in addition to the decline of the overall TB epidemic.

The increase of mortality among patients on treatment shown in figure 3 is due to improvement of the reporting, rather than an actual increase in mortality. Alongside better TB treatment coverage, also increased antiretroviral therapy (ART) provision for TB/HIV patients contribute to the decreased mortality, especially in high HIV burden countries, see for instance Malawi. Of special interest are Ethiopia and Vietnam, which are countries with high absolute numbers of patients (figure 1), and well developed TB programs, as shown by the high notification (figure 2) and low mortality among patients on treatment (figure 3), resulting in low overall mortality as shown in figure 2.

2) Improving treatment completion among drug sensitive TB patients

In Kyrgyzstan and Malawi improvement of reporting and recording resulted in a slight downward correction on the treatment success rates (figure 4) with less treatment outcomes going unreported but also an increase in deaths (figure 3). For example in Malawi frequent on the job mentoring and data quality assessments were conducted in 40% of the facilities by end 2017 in the KNC led, USAID funded Challenge TB supported areas; this methodology has been adopted for nationwide scale-up.
Improving and maintaining treatment success among patients with drug susceptible TB, aiming at 90% continues to be an area of concern. Especially with increasingly diverse and difficult to treat patient populations (based on active case finding and therefore reaching patients living under challenging

Figure 3: Proportion of registered TB patients that died, 2014 & 2015

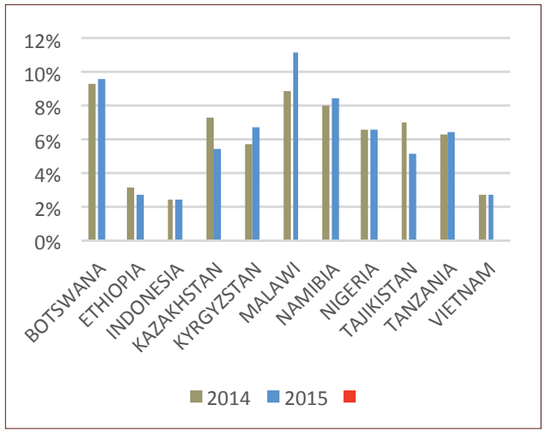
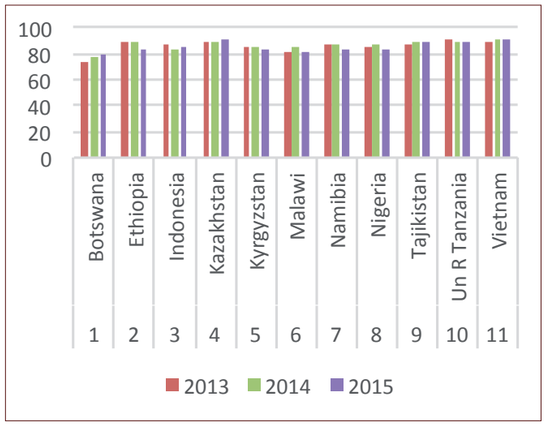


Figure 4: Treatment success rates KNCV supported countries 2014 - 2015 cohorts



social circumstances and /or having co-morbidities) and inclusion of patients treated by a range of non-National Tuberculosis Program (NTP) providers puts pressure on the treatment success rates: while many non-NTP public and private providers do a very good job in diagnosing and treating TB, some follow sub-optimal methods with less good results. While the current trend does not yet show the intended decline of mortality and improved treatment success, the expansion of diagnosis and treatment of MDR and HIV among TB patients is expected to achieve the intended results by 2020.

3) Treatment for all patients diagnosed with drug resistant TB

The scale-up of MDR-TB diagnosis and treatment is shown in figure 5, in blue the number of MDR-TB patients diagnosed and in red the number that started treatment. Kazakhstan has the highest number of patients diagnosed and treated, the decrease in line with the decrease in overall notification. Virtually all patients, including previously untreatable patients now access treatment. This was possible through the introduction of new drugs that can treat the previously untreatable XDR-TB disease, in collaboration with partners. Kyrgyzstan and Tajikistan are expected to follow the same pattern.
Indonesia, Nigeria and Vietnam show remarkable increases in diagnostic and treatment capacity for MDR TB , as a result of a well-planned scale-up of programmatic management of drug resistant TB, including the diagnostic and treatment support capacity. Both Nigeria and Vietnam during scale-up managed to narrow the diagnostic-treatment gap; in Indonesia, despite rapid increase in treatment capacity, this could not match the even more rapid increase in diagnostic capacity, which resulted in patients waiting for treatment. Decentralization of MDR-TB treatment, the introduction of the shorter regimen (in 2017) and close follow-up of treatment enrollment are expected to improve this situation soon.
While PMDT scale-up in these countries is impressive, continued rapid expansion is planned, with estimated incidence of MDR-TB 32,000 in Indonesia, 20,000 in Nigeria, and 8,200 in Vietnam.

Figure 5: Scale-up of MDR-TB diagnosis and treatment in KNCV supported countries 2015 - 2017

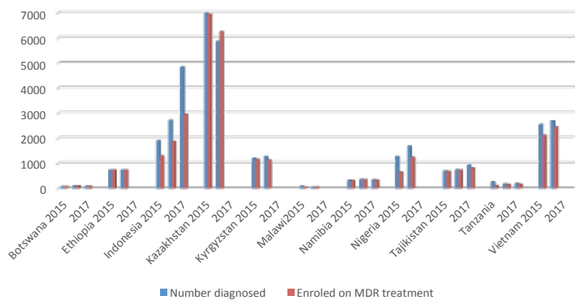
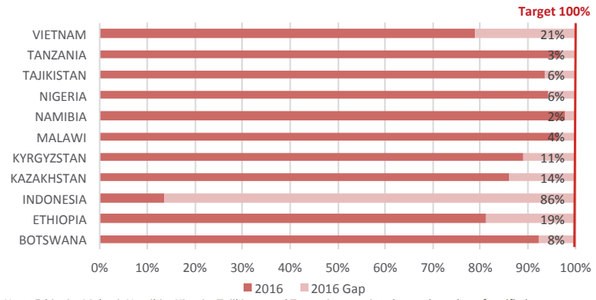
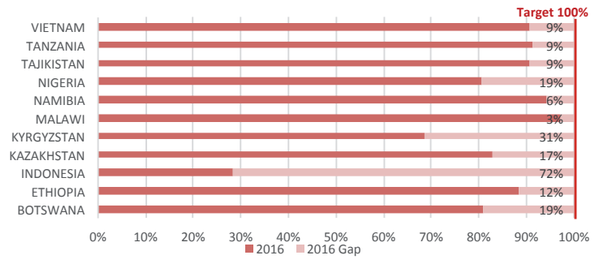


Figure 6: Proportion of TB Patients tested for HIV 2016



Note: Ethiopia, Malawi, Namibia, Nigeria, Tajikistan and Tanzania are using the total number of notified cases (including previously treated patients) as the denominator

Figure 7: Proportion of TB/HIV Patients accessing ARVs 2016



4) Testing of TB patients for HIV and 5) access to antiretroviral treatment

Over the past years increased attention for HIV testing of TB patients has shown results (figure 6), reaching good coverage in the six out of eleven countries. In Vietnam, Kyrgyzstan, Kazakhstan and Ethiopia additional efforts over the coming years are expected to close the gap.
Indonesia is lagging behind, with only 14% of TB patients knowing their HIV status in 2016; in 2016 and 2017 the KNCV led Challenge TB project assisted scale-up of HIV testing capacity in a district, which increased testing coverage 32% in 2015 till 89% in 2017, an approach which is now also used at national level. While stigma of HIV is important, accessibility of HIV testing at TB treatment sites was a more decisive factor in increasing testing rates.
Access to antiretrovirals (ARVs) for TB/HIV patients (figure 7) has improved, with the largest gap in Indonesia, followed by Vietnam. The figures show 2016 data; some improvements are expected to show toward 2017. Over the coming year KNCV continues to work on facilitation and promotion of the scale-up of access to this life-saving treatment.

6) Measuring catastrophic health care expenditures

In 2017 patient cost surveys were completed by Vietnam; in Nigeria the KNCV led Challenge TB project is implementing a patient cost survey. Four other countries are planning to implement such a survey: Ethiopia, Malawi, Indonesia and Namibia. In Kazakhstan, Kyrgyzstan and Tajikistan participation in such a survey is under discussion. No progress was made towards the development of routine surveillance of catastrophic health care expenditures; hiring of staff for this topic did not yet succeed and therefore progress on this indicator was slow. ◀



ORGANIZATIONAL HIGHLIGHTS

CPC RUN HELPS TO FUND STOOL PROJECT

On March 12th, 2017, twenty sponsored KNCV employees participated in the City Pier City Run in The Hague to raise money. By participating KNCV Tuberculosis Foundation (KNCV) wants to raise awareness and funds to initiate and support an effective but underexposed tuberculosis (TB) test that would significantly improve the diagnosis of TB in children. Unfortunately, an estimated 200,000 children worldwide still die of TB every year.

A painless diagnosis for children

"The TB test currently used by doctors in developing countries is focused on cough mucus," says KNCV senior laboratory consultant Petra de Haas: "This method is very drastic for children and often very traumatic for them and their parents. It scares them as well as the doctors off and this is why people are cautious with this child-unfriendly method. As a result, TB in young children is usually only diagnosed on the basis of complaints and symptoms so that this fatal illness is not detected at all or is only diagnosed (too) late."

Alternative

With a research project in Ethiopia, KNCV wants to develop a simple and effective method for the handling of stool samples. From the moment that caregivers collect the sample and hand it in at the aid station, to the simple testing in the laboratory. "We want to use this money from the CPC Run to show that the TB test for faeces can also be done by local laboratories and gives comparable results," says De Haas. "If we can show with this project that TB is easier to detect in children, it has a huge positive impact on TB care. Then doctors can detect, treat and cure many more children with tuberculosis. Not only in Ethiopia, but worldwide."

ROYAL VISIT

The Hague – On the first of June, 2017, her Royal Highness Princess Margriet visited the KNCV head office in The Hague as patroness of KNCV. The princess has been committed to the fight against the 'forgotten disease' tuberculosis in the Netherlands since 2010. On a beautifully sunny day, the princess had lively and in-depth discussions with the worldwide network of country directors and KNCV employees about the latest developments in the field of patient detection, correct diagnosis and new treatments. KNCV employees worldwide feel encouraged in their work by the princess's support.

KNCV Tuberculosis Foundation has a historical link with the royal family. At the beginning of the last century, Queen Emma devoted herself to the fight against tuberculosis, which was then still the number one disease in the Netherlands. She herself lost her sister Sophie to tuberculosis. Queen Wilhelmina and Queen Juliana also joined KNCV Tuberculosis Foundation as patronesses to continue to call attention to the worldwide fight against tuberculosis.

ACTIVE IN SUPPORT: JAKOB & CAROLINA FUND

After establishing the Jakob & Carolina Fund (named fund "under the umbrella of KNCV") in 2016, this year was the first year in which the named fund was active and approachable for requests.

The Jakob & Carolina Fund was initiated by our former chairwoman of the supervisory board Dina Boonstra as a farewell present to KNCV and a tribute to her father (Jakob) and a female patient support group worker (Carolina), both former TB-patients.

Project honored

We were very pleased that a request for co-funding of the so called POP TB project in Indonesia was honored by the Jakob & Carolina Fund. This project initiates and facilitates the creation of local patient support groups in Indonesia.

Two new groups

This co-funding made it possible for KNCV to establish two new local patient support groups. These groups are essential to support and educate TB patients, their relatives, friends, colleagues and family members as well as the general public close to the local community in an enormous country like Indonesia.

Substantial contribution

In December KNCV was also happy to hear that the Hanze Hoogeschool Groningen made a substantial contribution to the Jakob & Carolina Fund on behalf of Dina Boonstra which enables the fund to support even more patient support group workers in the future.



KNCV employees participated in the City Pier City Run to raise money



Dina Boonstra who initiated the Jakob & Carolina Fund



Her Royal Highness Princess Margriet (patroness of KNCV) received the Annual Report 2016 from KNCV executive director Kitty Weekenbeek

KNCV Tuberculosis Foundation has a historical link with the royal family

THE ORGANIZATION IN 2017

Introduction

This chapter provides an insight into the organizational structure of KNCV Tuberculosis Foundation (KNCV) and how this has worked out in 2017. The structure of KNCV is based on three pillars: Technical, Finance and Operations. In addition to these three pillars we have overarching supporting units, namely: the Executive Office, Human Resource Management, Communication and Fundraising, Resource Mobilization, Facilities and IT, and International Policy and Advocacy. This chapter sums up the activities of the Operations Division pillar and the supporting units. The activities of the Technical and Finance pillars are described in separate chapters.

Operations Division: the key to successful project implementation

The main focus of the Operations division is to ensure all KNCV projects are successfully implemented and have achieved the project results we aimed for. All within relevant internal and external rules and regulations and within agreed time lines and budget. Coordination between the different stakeholders, both in the different countries as well as in the office in The Hague is key.

In 2017 KNCV continued to invest in optimizing the collaboration between the different divisions/units. This for example resulted in improvements in the planning processes of all Challenge TB year 4 work plans in terms of internal processes, budgeting as well as quality of the content. KNCV also received positive feedback on this from our main donor USAID.

The Operations Division, in collaboration with the Finance Division, continued working on improving the resource planning system. Individual work plans, team planning overviews and project monitoring reports are now digitally available (Sumatra reporting system), and widely used in the whole organization. A Sumatra working group has been set up to continue working on improvements next year.

Within the Operations Division several additional standard operating procedures (SOPs) and manuals were developed and adjusted. The Travel Policy document has been revised, and we moved to electronic approval of travel requests. In order to further strengthen the capacity in our Country offices, to support them in project management and implementation and equip them with relevant tools, the Country Office Manual has been updated. During the Home week in December 2017 this updated manual was rolled out to all countries.

In both Ethiopia as well as Indonesia, together with the Resource Mobilization Unit, we organized workshops on local resource mobilization.

Related to Safety and Security management KNCV continued to work with a part time Security Advisor through Expat Preventative. Security management was on the agenda during the International Meeting Week focusing on creating awareness, roles and responsibilities and incident management. For all countries the country specific security documents were updated in 2017 and shared within the organization through Sharepoint.

Resource Mobilization: Broadening our funding base

The year 2017 marked the acceleration to intensified strategic resource mobilization efforts in general, and the introduction of country level resource mobilization in particular. In order to maximize outcomes, the coordination between different KNCV disciplines such as advocacy, communications, resource mobilization and technical teams has been intensified in order to ensure optimal planning of focus, timelines and messaging and increase visibility and recognition of its expertise both in the Netherlands and internationally. KNCV is in a process to diversify its funding base. We were a partner in several consortiums that were awarded funding from UNITAID and EDCTP and will introduce or rollout innovative new regimens and prevention methods in Africa and Asia. Furthermore, we received funding from the Bill and Melinda Gates Foundation in the areas of policy advocacy and treatment adherence through digital health solutions.

The strategic decision related to KNCV's ambition to ensure the sustainability of selected country offices in key countries, beyond the Challenge TB project, was taken forward in 2017. KNCV prioritized the sustainability of the country offices through investments in enhanced external communications and institutional fundraising capacity and skills building. Three countries were selected for pilots, and additional capacity and funding was made available for resource mobilization Action plans have been developed in Ethiopia and Indonesia. Where feasible, KNCV registers local entities in order to foster local ownership and to be able to receive funding in-country.

The 'Union World Conference on Lung Health', the global TB gathering which will be held in The Hague in 2018, 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. In 2017 KNCV engaged a broad range of existing and new partners and stakeholders towards the Conference, beyond the already well established TB research and practitioners network in the Netherlands and internationally.

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. In the areas of legacy fundraising and major donors KNCV gained more insight in ways to approach key individuals. A culture of engagement within the organization was further developed and the proposition toward private sector and CSR has been strengthened.

Campaigning and Private Fundraising in the Netherlands

KNCV had a very successful launch and kick-off of the 49th Union World Conference on Lung Health 2018 during the 2017 edition of the Union World Conference in Mexico. KNCV is very proud to co-host the 2018 conference with the City of The Hague. The Netherlands has a unique expertise in TB control and can be proud of its innovational track record in this field; the Union World Conference is the perfect platform to share and exchange that knowledge.

KNCV is working on a redesign of the (international) KNCV website. Website visits are growing, for now 297.076 visits are reached per year. Furthermore, an English Facebook page was introduced with good results. Also, different online messages were tested to learn what works well to engage people and to get to know their Customer Journey.

KNCV managed to improve its private fundraising results compared to 2016, however they were below budget. The main reason for this, is the fact that corporate-income from business partners were missed and there was a lower income on legacies. The Lottery incomes were very good, also because of the extra support we received as a new beneficiary of the Nationale Postcode Loterij. Additional advantages of being at new beneficiary are extra promotion, press and funding possibilities for our international programs.

After an extensive test period, a thorough analysis of the door-to-door income and cost was made. The ROI is low, while the earn back period is too long (>4 years). In 2018, KNCV decided to stop with this form of fundraising. At the end of 2017, 20,514 active donors were counted. The total number of in-active donors in the last two years increased to approximately 2,500. Due to the number of new donors (around 2,200 this year) the number of active donors stayed almost the same.

In 2017 the theme of KNCV's World TB day awareness campaign in The Netherlands was: 'TB is a global health problem'. Stories from TB patients around the world were placed on Facebook. Online people were asked to raise their voice to spur Dutch scientific involvement to stop TB and signatures were collected.

KNCV also worked on a corporate campaign, which has been postponed to 2018. The December campaign on TB in families was successful. Many new email addresses were gained which can be followed-up and hopefully converted to private donors. The campaign was focused on tuberculosis as a family disease, i.e. it focused on the ways in which TB can impact an entire family.

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. Advocacy work is done at three levels: the Netherlands, in-country and at a global level.

In 2017, KNCV stepped up its engagement in advocacy and this has resulted in being awarded grant funding for the coming three years (2018-2020). This allows for capacity expansion for advocacy to 1.5 FTE. The grant's aims are to strengthen the basis for political commitment and Dutch engagement in TB, HIV/AIDS and R&D as well as in the Global Fund. Further aims include contributing to the success of the High-Level Meeting on TB during the UN General Assembly in September 2018, and the global AIDS and Lung Health Conferences in the Netherlands during 2018. ▶

Supported by DGIS, a leadership position is held by KNCV advocacy staff in the Audit and Finance Committee (AFC) and policy influencing occurs through engagement on the NGO delegation to the Global Fund Board.

The 2017 annual plan for advocacy and international policy engagement set out four goals and the following was achieved:

1. In the Netherlands advocacy a round-table on how the Netherlands could deliver its agenda on global health (as expressed by a joint letter to Parliament by the Ministers of Health and Development respectively) was met with enthusiastic response and resolve to bring asks from a multisectoral coalition (from NGOs, the Topsector Life Science & Health, academia and policy makers from Ministries) forward to inform future policy. This resulted in a Clingendael Report "Why the Netherlands should step up its ambitions on Global Health". The report sparked controversy resulting in a health and policy dialogue that aims for an interdepartmental and holistic vision on Dutch Global Health engagement.

2. KNCV, together with partner Aidsfonds, successfully implemented the Capital for Good advocacy grant and was invited for a follow-on grant for 3 years. The grant was awarded towards the end of 2017. It will fund a stepped up advocacy engagement (aims are described above) and enables KNCV to realize the advocacy potential of the 2018 global TB events and Union and IAS conferences in the Netherlands.

3. In 2017, KNCV's Global Fund (GF) advocacy and work on the AFC committee (as co-Chair) focused on country grant absorption and development of strengthened grant facing risk management, which is oriented to addressing risk to mission and impact.

4. Policy engagement in GF Board processes informed the GF hub activities under the Challenge TB and DGIS grants. Policy and operational engagement by KNCV at the GF secretariat was stepped up. KNCV strategies such as "finding the missing persons with TB", stigma and TB modeling were presented aiming to establish regular interactions and dialogue.

5. In-country advocacy capacity building is proceeding in a selected set of CTB countries and is built around preparations towards the Moscow conference (November 2017) and UN HLM in 2018.

6. In September KNCV, WHO, the Dutch and Russian Federation Ministry of Health co-hosted a preparatory briefing at the Dutch Embassy which was very well received, engaged diplomatic missions and contributed to the strong attendance at the WHO Ministerial Conference on Ending TB in de SDG era. The preparations for the policy dialogue event at the Dutch Embassy were started during a high-level retreat hosted by the Honorable Nick Herbert, Member of Parliament in the UK, at Wilton Park.

7. The 2018 conferences: in September the Dutch Minster of Health and the Dutch Ambassador in Mexico played a pronounced role in announcing the 2018 Union World Conference in the Netherlands and at The Union Conference in Mexico respectively. KNCV engagement in the planning group for the AIDS2018 conference in Amsterdam provides opportunities to position TB develop reinforcing links between the two conferences programs towards enhanced advocacy.

IT & Facilities

The focus for the team IT & Facilities is to ensure there is an up to date, reliable and flexible IT system in the office in The Hague. In 2017, the most important IT updates were the following:

- New telephone system: Because Skype for Business was giving regular hiccups, a DECT telephone system was successfully implemented, in combination with Skype for Business.

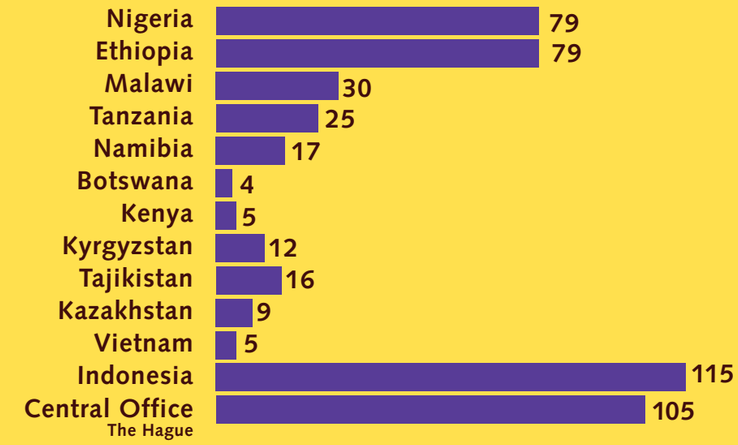
- Computer Operating System: Because the computer operation system Windows 7 was almost at the end of its life cycle and extended support will end in early 2020, all laptops were migrated to Windows 10. This was combined with a new way of managing the laptops and the applications using System Centre Configuration Manager. This enables IT support to automate more tasks and reduce the amount of on premise support tasks.

- CRM Dynamics: CRM Dynamics, the application in use for our strategic relations, was phased out and replaced by Salesforce (the application already in place for our private donors). All actual strategic relations were migrated to this new application.

- Sharepoint: The preparations for the replacement of the Intranet environment took place in 2017. The launch of the new Intranet, based on Sharepoint, will take place early 2018. With this new Intranet, communication, collaboration and exchange of knowledge and information between KNCV employees all over the world will improve a lot.

HRM: SOCIAL REPORT 2017

- STAFFING PER COUNTRY:



- MALE 257, FEMALE 244

- INFLOW/OUTFLOW:

- new staff 173,
- leaving staff 75

- SICK LEAVE AT THE HAGUE OFFICE

was 5.4 percent in 2017 versus 5.4 percent in 2016.

BOARD OF TRUSTEES REPORT

A changing environment

In 2017, KNCV Tuberculosis Foundation was operating in a changing and challenging environment, which provided lots of opportunities for the organization. The technical environment is changing due to new drugs, new diagnostics and individualized treatments. For the digital environment, there are new opportunities for KNCV by using big data. With the use of SMS services and video observed treatment in the field of TB control, KNCV currently works on innovating digital technologies through various projects and initiatives. Current actions and investments unfortunately are falling far short to end TB. To meet the WHO and SDG End TB targets, acceleration on a global scale is needed.

Organizational adjustments

In order to improve the quality and speed of decision making and KNCV's international profile, the Board of Trustees has decided to endorse an adjustment to the organizational structure. A Deputy Director without statutory powers is added and Lucian Roeters will fulfill this position next to her role as Director Finance. The Board of Trustees congratulates Lucian with her new responsibilities. Signing and decision making authority in case of multi day absence of the Executive Director is now delegated to the Deputy Director as well as managerial oversight on various internal projects. This gives the Executive Director more opportunities to focus on relationship management and external representation. After agreement by the Works Council, the new structure was implemented on 1 April 2017. During the year, the Board of Trustees has monitored the implementation of the new structure and has concluded in an interim evaluation in December that the adjustment works out very well.

Changes in the Board of Trustees

In 2017 Dirk Dotinga, former Chair of the Audit Committee and Vice-Chair, stepped down as a member of the Board of Trustees after five years of service. We express our gratitude for Dirk Dotinga's valuable contributions to the organization and as a well-respected colleague in the Board of Trustees. The General Assembly appointed two new members: Rolph van der Hoeven, emeritus professor on employment and development economic at the International Institute of Social Studies in The Hague, and Johan van 't Hag, Chief Financial Officer at Arts en Zorg, who is also appointed as a member of the Audit Committee. They both started their membership of the Board of Trustees with an introduction program to the various aspects of the organization. Mirella Visser, Vice-Chair, was appointed as the new Chair of the Board of Trustees, succeeding Ton van Dijk, who was appointed as the new Vice-Chair. The Board of Trustees wishes to thank Ton van Dijk for the considerate way he fulfilled the position as Interim Chair for 1,5 years. The annual self-assessment of the Board of Trustees has been moved to September 2018 because of all the changes in the Board of Trustees.

In preparation for the upcoming years

In July 2017, an annual retreat with the Board of Trustees and senior KNCV management took place to discuss the strategic direction of the organization. The retreat focused on possibilities for future scenarios, including rethinking and broadening partnerships and a franchise approach at country level. The importance of the USAID funded Challenge TB program for the future of KNCV is fundamental, therefore an effective international communication of the many CTB results is a main priority.

The Board of Trustees has decided on a preferred scenario for the coming ten years in which KNCV remains a global player in global policy development, evidence generation and a preferred Technical Assistance (TA) provider. As both an implementer and a delivery organization with an excellent reputation and track record, KNCV's place is on the leading edge of change.

Diversification of multi-year and multi-country funding and resource mobilization remains a challenge and continues to be a point of focus for the Board of Trustees.

Mapping towards a digitalized future

Digital innovation is an important strategic subject for the Board of Trustees. During the annual retreat, Mirella Visser gave a presentation on the impact of digital innovation. The digital revolution does not only have economic consequences but will also have impact on the medical environment, with for example artificial intelligence (AI) and the use of apps and SMS services in the health care field. The Board of Trustees fully supports the development of KNCV's Digital Health Assessment Tool, applying digital health in three areas of work: diagnosis, care and treatment support, surveillance and monitoring.

Royal visit

On Thursday June 1st, Her Royal Highness Princess Margriet honored KNCV with a working visit to the central office. She is the patroness of KNCV and met with the employees to get familiarized with the organization and KNCV's mission. Ton van Dijk, in his capacity as Board of Trustees Chair, was also present at this important visit.

2018: KNCV on stage

With two upcoming global TB events: the UN High Level Meeting on Tuberculosis (New York, September) and the Union World Conference on Lung Health (The Hague, October), the year 2018 will be a very important one for KNCV to improve political awareness and accelerate fundraising possibilities to end TB. We are looking forward to it!

Board of Trustees,

Chair
Mirella Visser

Vice-Chair
Ton van Dijk

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 an association according to Dutch law. The central office is based in The Hague, the Netherlands. The latest version of the Articles of Association passed the notary deed on 23 August 2012 and can be found on our website. For an overview of all KNCV country offices worldwide, please see the contact list for KNCV country offices in the annex page **XX**.

General Assembly

In 2017, the General Assembly was held on 10 May. The objective of the General Assembly is to ensure that the efforts of KNCV make an optimum contribution to the statutory mission. The General Assembly has an advisory role in this respect. The members are associations and foundations which have TB control as their mission or area of work. The primary responsibility of the General Assembly is supervisory governance, in accordance with the Good Governance Code.

The members are:

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

The General Assembly is authorized to:

- Approve the annual accounts;
- Grant annual discharge from liability to the Executive Director;
- Grant annual discharge from liability to the Board of Trustees for supervisory governance;
- Appoint, suspend and dismiss the Board of Trustees and its members;
- Appoint the auditor;
- Change the Articles of Association;
- Dissolve KNCV.

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 Dutch legal provisions and the Code of Good Governance for charity organizations ('SBF-code Goed Bestuur van de Samenwerkende Brancheorganisaties Filantropie'). Board of Trustees members are recruited through co-optation and are appointed by the General Assembly for a term of four years upon nomination by the Board of Trustees. The Board of Trustees appoint a Chair and Vice-Chair from its Members. Members of the Board of Trustees donate their time and expertise and do not receive any 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 meets four times a year. In addition, 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 Committee, consisting of Chair and Vice-Chair, to prepare the board agenda, in consultation with the Executive Director;
- An Audit Committee to assess in detail the annual plan, annual report, and the findings of the independent auditor;
- A Remuneration and Assessment committee, consisting of Chair and Vice-Chair, to assess the performance of the Executive Director.

Depending on ongoing developments, temporary committees can be established on an ad hoc basis. In 2017, a Nomination Committee consisting of Ton van Dijk, Maria van der Sluijs-Plantz and Mirella Visser was set up in order to select and recruit two new members for the Board of Trustees.

MEMBER	APPOINTED	EXPIRING
Mirella Visser (Chair)	May 2015 (1st term)	2019, ELIGIBLE FOR 2ND TERM
Ton van Dijk (Vice-Chair)	May 2017 (2st term)	2021
Maria van der Sluijs-Plantz	May 2015 (1st term)	2018, ELIGIBLE FOR 2ND TERM
(Chair Audit Committee)	--	
Jan Hendrik Richardus	May 2015 (1st term)	2018, ELIGIBLE FOR 2ND TERM
Wieneke Meijer	December 2016 (1st term)	2020, ELIGIBLE FOR 2ND TERM
Rolph van der Hoeven	July 2017 (1st term)	2021, ELIGIBLE FOR 2ND TERM
Johan van 't Hag	July 2017 (1st term)	2021, ELIGIBLE FOR 2ND TERM
(Member Audit Committee)	--	

Supervisory Governance during 2017

For an extensive description on the supervisory governance during 2017, please see the Board of Trustees Report directly prior to this chapter.

At the annual General Assembly meeting on 10 May 2017, KNCV Tuberculosis Foundation said goodbye to Dirk Dotinga, who served the organization over five years of service on the Board of Trustees. Rolph van der Hoeven and Johan van 't Hag were appointed by the General Assembly as new Members of the Board of Trustees on 3 July. Ton van Dijk was appointed for a second term at the General Assembly. In December, Vice-Chair Mirella Visser was appointed as Chair of the Board of Trustees and Chair Ton van Dijk as the new Vice-Chair.

In 2017 the Board of Trustees meetings were held on the following dates: 19 February, 25 April, 19 September and 7 December. The Audit Committee meetings were held on 11 April and 4 December. The annual retreat with senior KNCV management took place on 4 July.

The members of the Board of Trustees have the following relevant other positions that are listed below. The members of the Board of Trustees have signed an annual statement from the CBF regarding the avoidance of conflicts of interests with their other positions.

MEMBER	POSITIONS
Mirella Visser	Founder and Director of Center for Inclusive Leadership; Member European Integration Committee (CEI) of the Advisory Council on International Affairs (AIV) of the Netherlands (by Royal Decree); Chair Board of Directors of Population Services International (PSI) Europe; Vice-Chair Supervisory Board Media Pensioen Diensten (MPD)
Ton van Dijk	Director of public health (region Haaglanden) and director of medical disaster management (region Haaglanden)
Maria van der Sluijs-Plantz	Supervisory Board Member of Zuidweg & Partners B.V.; Non-Executive Board Member of Kidsfoundation B.V.; Non-Executive Board Member TMF Orange Holding B.V; Non-Executive Board Member Telefonica Europe B.V; Member of the Board of Financial Supervision Curacao and Saint Martin (nominated by Saint Martin)
Jan Hendrik Richardus	Professor Infectious Deceases and Public Health at the Erasmus University Medical Center and the Municipal Public Health Service Rotterdam; Member of the following scientific committees and professional societies: Chair Scientific Advisory Board, Leonard Wood Memorial Hospital, Cebu, Philippines; Chair IDEAL consortium (Initiative for Diagnostic and Epidemiological Assays for Leprosy); Member WHO Technical Advisory Group Leprosy; Member Steering Committee National Hepatitis Plan; Member Programme Committee Rotterdam Global Health Initiative (RGHI); Member Programmacommissie Infectieziektebestrijding, NSPOH opleiding Infectieziekte-bestrijding; Member Board National Academic Workplace 'Medische Milieukunde'; Member TLM International Research Committee; Member Netherlands Leprosy Expertise Center; Member Werkgroep "Lepra in Nederland"; Member Steering Group The PEP++ Project Stop the transmission of leprosy; Member Steering Group TENLEP; Member Steering Group LPEP; Member Steering Group ILEP Research Strategy; Member: Board of the Q.M. Gastmann-Wichers Stichting, (NL); Editorial Board member Leprosy Review, London (UK)
Rolph van der Hoeven	Professor Emeritus International Institute of Social Studies (ISS), Erasmus University (EUR); Member Committee Development Corporation (COS) of the Advisory Council on International Affairs (AIV) of the Netherlands
Johan van 't Hag	Chief Financial Officer (CFO) with Arts en Zorg

Executive Director

KNCV Tuberculosis Foundation is led by an Executive Director who holds statuary powers.

EXECUTIVE DIRECTOR	APPOINTED
C.S.B. van Weezenbeek, MD, PhD, MPH, Executive Director	1 September 2013

The Executive Director is supported in decision-making by the Management Team. The Management Team consists of the three division directors of KNCV (Technical Division, Finance Division, and the Operations Division). The organizational structure of KNCV includes a non-statutory Deputy Director who is part of the Management Team. The Director Finance Lucian Roeters holds the position of Deputy Director as of 1 April 2017.

The performance of the Executive Director is assessed by the Remuneration and Assessment committee of the Board of Trustees. The committee reports their findings to the full Board of Trustees.

The Executive Director held during 2017 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
The Lancet	Commisioner	QQ	2017 – 2018

Works Council

The report of the Works Council for the year 2017 is as follows: "2017 was a busy year for us. Not only because of all the topics we were involved in, but it was also an election year. As two of our members left the Works Council this resulted in having two vacancies. In October elections were held and we warmly welcomed our two new members, Stephanie Borsboom and Harmen Bijster.

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.

This year we gave advice on the new board structure and consent on the updated Employee Conditions.

Other topics that were discussed during 2017 were: sick leave report, restructuring office space, role of the occupational health doctor, travel policy and the organizational changes in the Technical Division. An always important subject is the workload for KNCV staff an how this is experienced.

The Works Council ensures this will also be on the agenda in 2018."

At the end of December 2017, the Works Council members were:

MEMBER	APPOINTED	EXPIRING
I. HUITEMA (CHAIR)	2014 (2ND TERM)	2018, ELIGIBLE FOR 3RD TERM
J. VAN REST (VICE-CHAIR)	2016 (2ND TERM)	2020, ELIGIBLE FOR 3RD TERM
E. TIEMERSMA	2014 (2ND TERM)	2018, ELIGIBLE FOR 3RD TERM
S. BORSBOOM	2017 (1ST TERM)	2021, ELIGIBLE FOR 2RD TERM
H. BIJSTER	2017 (1ST TERM)	2021, ELIGIBLE FOR 2RD TERM

Quality Control

KNCV considers quality an essential hallmark of all the work we do. In 2017, 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 "innovation 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 Director, 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, Goede Doelen Nederland (GDN).

Risk Management

We are aware of the fact that as an organization we are exposed to risks. 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 2017 the risk analysis was discussed with all KNCV Country directors during a home week in The Hague. Country Directors identified the following three main risks for their local organization:

- Staff insecurity related to uncertainty about future funding;
- Coordination issues and different priorities with National TB programs resulting in delayed implementation;
- Physical safety related to accidents, crime of natural disasters.

Mitigating actions per country were discussed and will be implemented in 2018.

In the risk analysis the following risk areas are identified:

1. Risks related to primary tasks;
2. Risks related to image and reputation;
3. Risks related to financing and the financial structure;
4. Administrative risks;
5. General legal risks;
6. Risks related to employment practices;
7. IT risks (information security);
8. Risks related to other facilities.

Information Security

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. On May 25 2018 the new law "Europese Algemene verordening gegevensbescherming (AVG)" comes into place.

KNCV has developed a data security policy and a procedure on how to report data leaks. This includes an inventory of types of sensitive information within KNCV, drafting of 'bewerkersovereenkomsten' with suppliers and preparing a checklist with action points. KNCV has appointed a data security officer. In 2017, the security policy has been updated and all staff will be trained on data security in 2018.

In 2017 two incidents have been evaluated. After evaluation no report was made to the Autoriteit Persoonsbeveiliging, because the incidents were not considered data leaks. The incidents have helped us in developing our policy and will be included in training materials for all staff.

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;
- Code of Conduct for the use of e-mail, social media, internet and telephone facilities;
- Policy and protocol for undesirable behavior at work;
- Policy on fraud, money laundering and trafficking in persons (2018);
- Whistle-blower policy.

In 2017 no incidents have been reported to the external confidential counsellor related to undesirable behavior of others. Also no reports have been made in 2017 to the confidential advisor whistleblower procedure.

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.

Figure 8: Sustainable Development Goals



Social Responsibility and sustainable development goals

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 black and white printing as much as possible, we use environment friendly printing toner. Obviously, an important side effect of our work in southern countries is the emission of CO_2 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.

External Quality Hallmarks

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. A new evaluation will take place in 2018.

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.

Summary of the CBF accountability requirements

Any fundraising organization who has been acknowledged as a CBF recognized charity has to demonstrate that it adheres to a list of predefined norms and standards in seven categories:

1. Mission/social value
2. Means
3. Activities/organization
4. Realization of goals
5. Governance
6. Accountability
7. Stakeholders

The norms define how the 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.

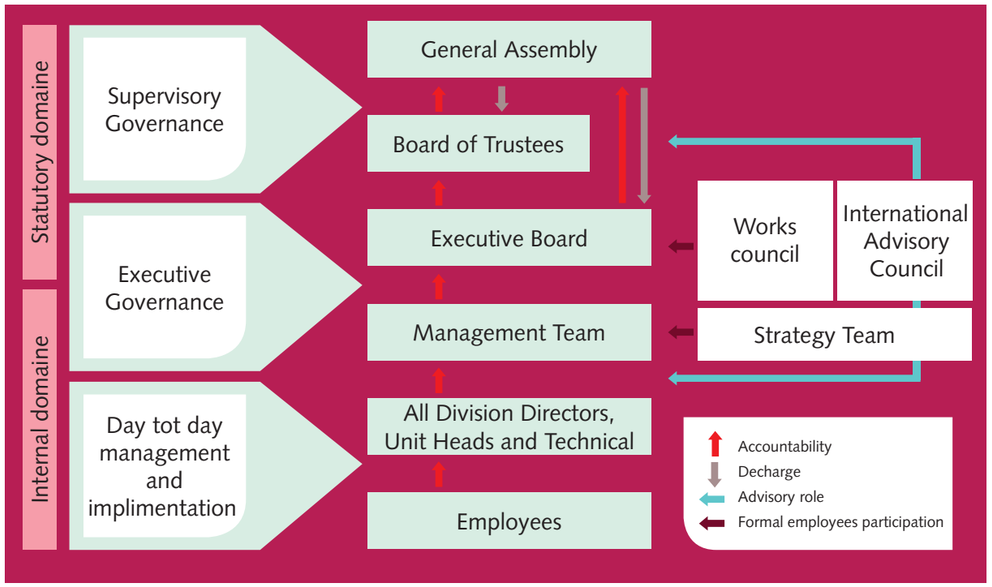
This Annual Report contains a summary of the accountability report.

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 9** a schematic overview of the governance structure is explained.

Figure 9: Overview of the Governance Structure



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 Director;
- Rules and Regulations for the Management Team;
- Rules and regulations with regard to the relation between the Works Council and the Executive Director.

[1] *The full set of mandatory and non-mandatory norms can be retrieved from the CBF website*

Ad2. The continuous improvement of efficiency and effectiveness in mission related activities

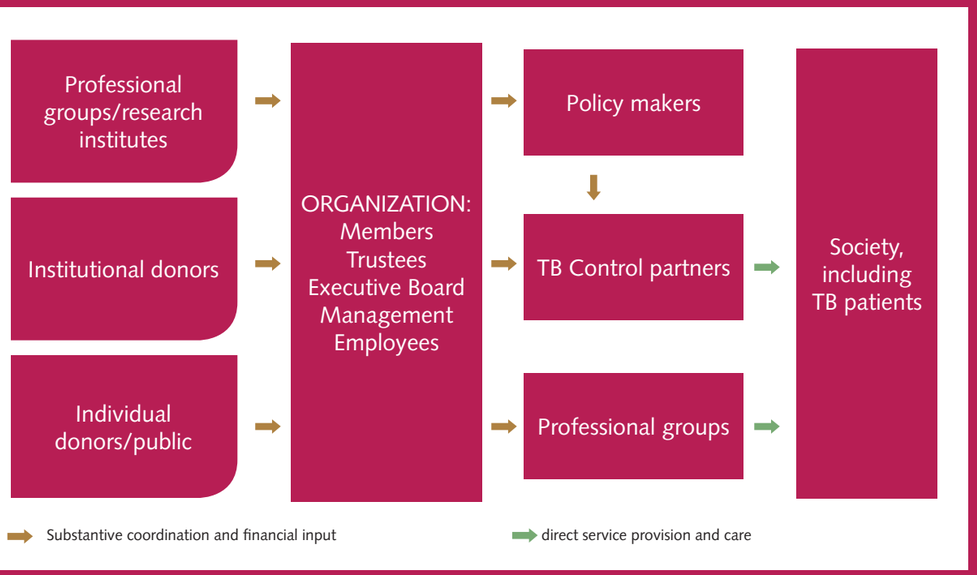
KNCV has developed and implemented a set of mechanisms to continuously and coherently strive for improvement in its operations, especially in terms of efficiency and effectiveness. These include:

- 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. The structure and composition of our network is outlined in the below figure.

Figure 10: KNCV Partner Network



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 International Advisory Counsil 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.

FINANCIAL INDICATORS AND MONITORING DATA

The financial results for 2017 show a positive development. The income grew substantially compared to 2016, mainly because of increased government grants. An increase is also shown in the income from lotteries and the income from companies. The total expenses in 2017 increased compared to 2016, although slightly less than planned .

KNCV Tuberculosis Foundation is pleased with the increase in income from lotteries. In 2017 we became beneficiary of Nationale Postcode Loterij with an annual contribution of € 900,000 for five years. Until 2016 we were beneficiary of Vriendenloterij and we will continue to receive contributions from Vriendenloterij for lottery tickets that were sold earmarked for KNCV. We are very grateful to Vriendeloterij for their support to our mission in the past years and we look forward to working together with Nationale Postcode Loterij in the future. The lottery contribution is invaluable as unearmarked funding in achieving our mission and goals.

Income from legacies is highly unpredictable and showed a decrease in 2017 compared to 2016. Income from endowment funds increased in 2017 due to an additional grant to develop our core funding strategy that continued in 2017. Income from corporate partners increased again 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.

Income from companies shows and increase and includes an in kind contribution from Sanofi and Qiagen for a Prevention study under Challenge TB.

Income from government grants showed a significant increase again compared to last year. This is mainly related to the fact that activities for the 5-year USAID-funded Challenge TB project have again accelerated. 2017 was also the third year of activities for the five year DGIS grant, that counts as cost share towards the Challenge TB project.

Income from investments increased due to positive stock market developments in 2017, which resulted in a realized exchange gain.

Total expenses in 2017 increased from € 72,8 million to € 93,4 million.

Expenses for TB control in low prevalence countries (mainly The Netherlands) have increased compared to the level of 2016 and include, besides an annual project grant from the Ministry of health, 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.

Expenses for education and awareness increased in 2017 as was planned.

Expenses for private fundraising increased in 2017 because of investments in door to door fundraising.

Expenses for administration and control are higher than last year and also higher than planned because of long term sick leave, which was covered by temporary staff.

A proposal for allocation of the result 2017 is presented on **page 110**.

Financial data 2013-2018

Since 2016 the financial statements are prepared in accordance with the revised Dutch Accounting Standard for Fundraising Institutions (RJ650) introduced in 2016. 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 1:

Table 1: Financial monitoring data compared to standards

Monitoring data	Standard	Actual 2013	Actual 2014	Actual 2015	Actual 2016	Actual 2017	Budget 2018	Average 2015-2017
Spent on the mission compared to total expenses	Not applicable	96,7%	95,7%	95,9%	97,4%	97,2%	97,0%	97,0%
Spent on the mission compared to total income	Not applicable	96,0%	95,2%	94,6%	96,9%	97,9%	97,7%	96,8%
Spent on private fundraising compared to private fundraising income (income from individuals and companies) [2]	Max. 25%	17,4%	24,6%	28,5%	15,4%	20,3%	34,7%	20,4%
Spent on administration and control compared to total expenses	2.5-5%	2,0%	2,5%	2,5%	1,6%	1,6%	1,4%	1,8%
Spent on administration and control compared to total expenses excluding TBCTA coalition share in activities [3]	2.5-5%	5,1%	5,0%	5,0%	3,2%	3,1%	2,6%	4,6%

In total KNCV Tuberculosis Foundation generated less income in 2017 (€ 92,8 million) than was planned (€ 95,1 million), but more than 2016 (€ 73,2 million).

Total expenditures in 2016 were € 93,4 million, which is € 2,7 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 an increase compared to budget (mainly expenses for government grants) and expenses for "administration and control" showed an increase compared to budget, due to temporary replacement of long term sick leave.

Expenditures on the mission (R7)

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 last year the percentage decreased from 97,4% to 97,2%. 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 (R8)

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 (individuals and companies). 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. Because of the unpredictability of legacy income the percentage fluctuates over the years. Expenses in 2017 are 20,3% of the income from own fundraising activities from individuals and companies, well below the 25% maximum. The 3-year average is 20,4%. The three-year average based on 2016, 2017 and the budget for 2018 is 23,5%. The budget for 2018 is higher than average due to planned expenditures for the upcoming 49th World Conference on Lung health in The Hague in October 2018. In the past, this percentage was calculated as a percentage of all fundraising income. Because income in the new RJ650 guideline, which KNCV is following since 2016, is broken down in various income sources (individuals, companies, and other non-profit organizations) this percentage is now calculated based on income from individuals and companies only.

[2] *Private fundraising income only includes income from individuals and companies, whereas in the past also income from other non-profit organizations was included.*

[3] *Challenge TB is partly implemented by partners in the Tuberculosis Coalition for Technical Assistance (TBCTA)*

KNCV's policy for administration and control costs (R9)

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 from 5-10%, because the volume of activities has increased due to the five-year Challenge TB award, allowing for an overall percentage reduction. In 2017, the percentage of 1.6% is equal to 2016 but lower than what was budgeted for (2.2%) due to an increase in expenses to mission related goals were not matched with an equal increase in costs for monitoring and control.

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 2017, a total number of 15.407 project days were planned and 16.467 were realized, which is 107% of the planned days. In 2016, this was 98%. 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 2017, the planned percentage of indirect costs on direct costs was 82.80%, and realized is 78.68%. The decrease in 2017 compared to the budget is due to a higher 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 2017 is 66.31%, while 64.71% was planned. In 2016, the percentage was 59.84%.

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

The results of our internal key performance data show an increase in indirect cost rate, which was partly planned, but negatively affected by expenses related to temporary replacement of long term sick leave.

Budget 2018 and possible risks

The full budget for 2018 is shown in the Statements of Income and Expenditure. The total income is budgeted on a consolidated level of € 98,3 million. Of that amount, € 46,7 million is compensation for implemented activities by the coalition partners of Challenge TB. Therefore, excluding consolidation, the total income is budgeted at € 51,6 million, which is € 3 million higher than the actual for 2017.

Income from government grants is budgeted to increase, related to the plans for activities in the fourth year of Challenge TB. Income from our share in third parties' activities (e.g., lottery income) is budgeted to increase slightly as well. Of the total amount of Lotto income 90% will be contributed to an overall health campaign in the Netherlands through Samenwerkende Gezondheidsfondsen aimed at creating the healthiest generation ever. Investment income is budgeted conservatively at a slightly increased level from the budget for 2017. No unrealized gains and losses on investments are budgeted.

The total level of consolidated expenditures amounts to € 99,0 million. Excluding the partners' activities in Challenge TB, this leads to a total budgeted cost level of € 52,3 million, which is € 3,1 million higher than the actual for 2017. TB control in high prevalence countries is increasing compared to 2017, related to the activities in the fourth 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 USD 1.20 against EUR 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 USD. Balances held in other currencies than the euro or US dollar are as much as needed exchanged into US dollar. The majority of our income is in euro and in US Dollar. Foreign currency needed in our project countries is as much as possible purchased centrally while balances are kept to a minimum.
- Not all obligations for approved workplans for the period October 2017 – September 2018 for Challenge TB were received in modifications to the cooperative agreement as at 31 December 2017. This is being closely monitored. In no way can expenses be incurred above the total amount of obligation received. On average a buffer amount of obligation of one quarter of expenditures is available.
- 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, although not in 2017, 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 fall backs or to react to valuable opportunities.

Long-term financial plan

An indication of a longer term financial plan is depicted in Table 2. 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 2: Long-term Financial Plan 2018-2021

Profit & Loss account	Budget 2018 In € 1 mln	Longterm forecast 2019 In € 1 mln	Longterm forecast 2020 In € 1 mln	Longterm forecast 2021 In € 1 mln
Organizational costs				
Personnel related costs	12,77	13,03	13,29	9,00
Other indirect costs	1,95	1,99	2,03	1,50
Subtotal organizational costs	14,72	15,01	15,31	10,50
Charged to projects	-14,37	-14,65	-14,95	-9,00
Total organizational costs not charged to projects	0,35	0,36	0,37	1,50
Investment and general income	0,11	0,11	0,11	0,11
Net result organizational costs	**-0,24**	**-0,24**	**-0,26**	**-1,39**
Activity costs				
Costs for fundraising	0,44	0,44	0,44	0,45
Other activity costs	0,10	0,10	0,10	0,10
Total Activity costs	0,55	0,55	0,54	0,55
Activity income				
Own fundraising	1,71	1,00	1,00	1,00
Lotteries	1,30	1,30	1,30	1,30
Total Activity income	3,01	2,30	2,30	2,30
Net result Activities	**2,46**	**1,75**	**1,76**	**1,75**
Project costs				
Charges organizational costs	14,37	14,65	14,95	9,00
Travel and accommodation	8,73	8,90	9,08	5,50
Material costs	28,34	25,00	25,00	15,00
Expenses coalition partners Challenge TB	46,70	50,00	50,00	-
Total Project costs	98,13	98,55	99,02	29,50
Project income				
Funding donors - fee	11,94	12,70	13,05	8,00
Funding donors - travel and accommodation	8,65	8,82	8,99	5,00
Funding donors - other direct project costs	27,47	24,60	24,60	15,00
Endowment funds contribution	0,50	0,30	0,30	0,30
Other income for projects	0,01	0,01	0,01	-
Income coalition partners Challenge TB	46,70	50,00	50,00	-
Total Project income	95,26	96,42	96,95	28,30
Net result Projects	-2,87	-2,13	-2,07	-1,20
General Result (minus is a deficit)	**-0,66**	**-0,63**	**-0,57**	**-0,84**
Covered by earmarked reserves / donated to earmarked reserves	**-0,64**	**-0,55**	**-0,55**	**-0,55**
Influence on/movements other reserves	**-0,02**	**-0,08**	**-0,02**	**-0,29**



FINANCIAL STATEMENTS 2017

BALANCE SHEET
KNCV TUBERCULOSIS FOUNDATION PER 31 DECEMBER 2017
In Euro, after result appropriation

Assets

		31-12-2017		31-12-2016	
Immaterial fixed assets			-		-
Tangible fixed assets	B1		461.617		502.824
Accounts Receivable	B2				
Investments	B3	29.853.190		75.402.547	
-Shares		1.740.803		1.713.137	
-Bonds		3.665.091		3.318.398	
-Alternatives		720.186		666.628	
Cash and Banks	B4	12.470.575		13.988.192	
Current Assets			48.449.845		95.088.902
Total			**48.911.462**		**95.591.726**

Liabilities

		31-12-2017		31-12-2016	
Reserves	B5				
- Reserves					
Continuity reserve		8.381.096		8.267.913	
Decentralization reserve		997.394		1.052.159	
Earmarked project reserves		1.430.709		1.835.577	
Unrealized exchange differences on investments		526.039		492.777	
Fixed Assets reserve		461.617		502.824	
			11.796.855		12.151.250
- Funds	B6				
Earmarked by third parties		423.975		425.604	
			423.975		425.604
Various short-term liabilities	B7				
-Taxes and social premiums		691.348		675.212	
-Accounts payable		751.054		792.997	
-Other liabilities and accrued expenses		35.248.229		81.546.663	
			36.690.631		83.014.872
Total			**48.911.462**		**95.591.726**

STATEMENT OF INCOME AND EXPENDITURE
KNCV TUBERCULOSIS FOUNDATION 2017 (in euro)

Income

		Budget for the year ended 31 December 2018	Budget for the year ended 31 December 2017	Actual for the year ended 31 December 2017	Actual for the year ended 31 December 2016
- Income from individuals	R1	1.269.600	1.162.000	966.765	1.125.626
- Income from companies	R2	437.000	69.500	794.124	375.803
- Income from lotteries	R3	1.300.000	1.070.000	1.273.916	1.144.439
- Income from government grants	R4	94.518.500	90.736.300	88.389.252	69.550.163
- Income from allied non-profit organizations	R5	502.400	452.400	488.625	348.250
- Income from other non-profit organizations	R6	230.000	1.583.800	837.842	576.993
Total fundraising income		**98.257.500**	**95.074.000**	**92.750.524**	**73.121.274**
- Income for supply of services	R7	11.000	23.000	18.803	25.291
- Other income	R8	12.400	13.400	9.901	8.442
Total income		**98.280.900**	**95.110.400**	**92.779.228**	**73.155.007**

Expenses

Expenses to mission related goals	R9				
- TB control in low prevalence countries		830.000	960.800	1.065.021	872.219
- TB control in high prevalence countries		92.047.500	90.503.600	82.933.547	67.824.500
- Research		1.451.400	1.362.500	5.644.999	1.326.022
- Education and awareness		1.709.200	1.152.800	1.154.097	857.159
		96.038.100	**93.979.700**	**90.797.664**	**70.879.900**
Expenses to fundraising					
- Expenses private fundraising		592.600	416.600	359.067	230.609
- Expenses share in fundraising with third parties		321.700	40.100	51.111	49.652
- Expenses government grants		697.700	524.300	667.228	450.677
		1.612.000	**981.000**	**1.077.406**	**730.938**
Administration and control					
- Expenses administration and control		1.352.500	1.113.000	1.533.118	1.161.406
Total Expenses		**99.002.600**	**96.073.700**	**93.408.188**	**72.772.244**
- Net investment income	R10	86.000	61.900	219.111	121.681
Surplus / Deficit		**-635.700**	**-901.400**	**-409.849**	**504.444**
Spent on mission compared to total expenses		97,0%	95,9%	97,2%	97,4%
Spent on mission compared to total income		97,7%	98,8%	97,9%	96,9%
Spent on private fundraising compared to income		1,6%	1,0%	1,2%	1,0%
Spent on administration and control compared to total expenses		1,4%	2,2%	1,6%	1,6%

Result appropriation

Surplus / Deficit appropriated as follow				
Continuity reserve	1.300	47.800	113.183	573.717
Decentralization reserve	-150.000	-150.000	-54.765	-10.978
Earmarked project reserves	-334.400	-749.300	-404.868	191.497
Unrealized differences on investments	-	-	-20.563	-157.297
Fixed Assets reserve	-152.600	-49.900	-41.207	-86.590
Earmarked by third parties	-	-	-1.629	-5.905
Total	**-635.700**	**-901.400**	**-409.849**	**504.444**

EXPENSE ALLOCATION
KNCV TUBERCULOSIS FOUNDATION 2017 (in euro)

Expenses

	Budget for the year ended 31 December 2018	Budget for the year ended 31 December 2017	Actual for the year ended 31 December 2017	Actual for the year ended 31 December 2016
Grants and contributions	23.000	28.000	14.849	17.016
Contributions to allied organisations	46.700.000	51.872.000	44.622.476	36.034.875
Purchases and acquisitions	11.268.800	22.264.600	11.087.332	9.082.808
Outsourced activities	7.111.800	845.700	7.604.580	3.054.953
Publicity and communication	864.600	871.500	882.198	530.546
Personnel	21.841.800	16.398.600	21.575.917	17.639.875
Housing	302.600	297.800	284.350	281.586
Office and general expenses[1)]	10.594.200	3.222.500	7.129.506	5.916.221
Depreciation and interest	295.800	273.000	206.981	214.363
Total	**99.002.600**	**96.073.700**	**93.408.188**	**72.772.244**

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
Actual for the year ended 31 December 2017

	Related to the mission goals			
	Low prevalence countries	High prevalence countries	Research	Education and Awareness
Grants and contributions	13.849	500	500	-
Contributions to allied organizations	-	44.622.476	-	-
Purchases and acquisitions	204.604	6.330.781	4.484.694	-
Outsourced activities	73.337	7.531.243	-	-
Publicity and communication	-	28	-	628.051
Personnel	635.938	17.375.412	1.089.917	492.278
Housing	15.962	189.918	23.348	11.321
Office and general expenses	109.595	6.745.642	29.372	14.124
Depreciation and interest	11.736	137.549	17.167	8.324
Total allocated	**1.065.021**	**82.933.547**	**5.644.999**	**1.154.097**

Allocation to destination
Actual for the year ended 31 December 2017

	Income fundraising			Administration & Control
	Private fundraising	Share in third parties activities	Grants	
Grants and contributions	-	-	-	-
Contributions to allied organisations	-	-	-	-
Purchases and acquisitions	-	33.000	34.253	-
Outsourced activities	-	-	-	-
Publicity and communication	235.623	-	-	18.495
Personnel	95.454	17.111	586.605	1.283.201
Housing	2.865	336	15.571	25.030
Office and general expenses	23.019	417	19.349	187.988
Depreciation and interest	2.106	247	11.449	18.403
Total allocated	**359.067**	**51.111**	**667.228**	**1.533.118**

CASH FLOW STATEMENT KNCV TUBERCULOSIS FOUNDATION 2017
in euro

	Actual 2017		Actual 2016	
Surplus excl interest	-430.275		474.273	
Interest paid/ received	20.426		23.070	
Total surplus	-409.849		497.343	
Depreciation - Fixed Assets	205.117		214.628	
Cash Flow from income and expenditure		-204.732		711.971
Investments	-374.092		-498.491	
Accounts receivable	45.549.357		-15.491.398	
Non-current liabilities	-		-	
Current liabilities	-46.324.241		13.522.623	
Increase/ (Decrease) net working capital		-1.148.976		-2.467.266
Cash flow from operational activities		-1.353.707		-1.755.295
Disinvestments fixed assets	1.812		6.128	
Investments fixed assets	-165.722		-134.165	
Cash flow from investments fixed assets		-163.910		-128.037
Net cash flow		-1.517.617		-1.883.332
Cash and banks as at 1 January	13.988.192		15.871.523	
Cash and banks as at 31 December	12.470.575		13.988.192	
Increase/ (Decrease) Cash on hand	**-1.517.617**		**-1.883.332**	

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 valuation principles and method of determining the result are the same as those used in the previous year, with the exception of the changes in accounting policies as set out below and in the relevant sections.

From 2017 KNCV will value its bonds at market value, as per the new RJ 650 guidelines. The effect of this adjustment on the balance sheet per 31 December 2016 has been added to the reserve for unrealized revaluation of investment prices.

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.

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 2017.

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 Investments in bonds and 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 values its bonds at market value.

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 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 2017, 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.

Income from individuals and companies

Income from individuals and companies is recognized as income in the financial year the income or in kind contribution is received.

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 2017, 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.

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 2017 was 101.1%, which is an improvement compared to 2016. 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%.

Prepaid contributions are recognized as deferred assets if these lead to a refund or reduction of future payments. Contributions that are due but have not yet been paid are presented as liabilities.

Operational lease

The company may have lease contracts whereby a large part of the risks and rewards associated with ownership are not for the benefit of nor incurred by the company. The lease contracts are recognized as operational leasing. Lease payments are recorded on a straight-line basis, taking into account reimbursements received from the lessor, in the income statement for the duration of the contract.

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.

Allocation expenditure

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

Organizational unit	Charge argument
Netherlands, low prevalence	All expenses charged on 'TB control in low prevalence countries'
Other countries, high prevalence	3% of staff expenses charged on 'Expenses government grants' All other expenses charged on 'TB control in high prevalence countries'
Project management	3% of staff expenses charged on 'Expenses government grants' All other expenses charged on 'TB control in high prevalence countries'
Research	3% of staff expenses charged on 'Expenses government grants' All other expenses charged on 'Research'
Communication	All expenses charged on 'Information, education and awareness'
Fundraising	Absolute expenses charged on 'Expenses actions from third parties' Staff expenses charged on 'Information, education and awareness' (33%) and 'Expenses private fundraising' (67%) based on timewriting. 40% of all other expenses charged on 'Information, education and awareness' 60% of all other expenses charged on 'Expenses private fundraising'
Directors office	Grants to third parties for scientific research charged on 'Research' Expenses for public affairs charged on 'Information, education and awareness' 2% of staff expenses charged on 'Expenses fundraising third parties' 3% of staff expenses charged on 'Expenses government grants' 3% of staff expenses charged on 'Expenses financial assets' All other expenses charged on 'Expenses administration and control'
Human resource management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Facility management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Finance Planning & Control	Staff exclusively working for project finance is charged to the objective-categories All other expenses charged on 'Expenses administration and control'

Materials used for supporting the fundraising message (for examples letters to 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.

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. In the new RJ 650 guideline valuation of bonds against amortized cost price is no longer allowed. From 2017 KNCV values its bonds at market value. The effect of this valuation change has been added to the reserve for unrealized revaluation of investment prices (€ 53,825). In the following notes the composition of the Balance Sheet is analyzed and commented. Furthermore, significant deviations between the 2017 results and budget and between 2017 and 2016 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 30 September 2014 up to 29 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 2017 - Assets

Fixed Assets (B1)

Movements in the tangible fixed assets are as follows:

	Office reconstruction work	Office inventory	Computers (including regional office)	Total
as at 1 January, 2017				
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**
Increase / (Decrease) 2017				
Acquisitions	16.899	19.694	129.129	165.722
Disinvestments	-	-	-221.938	-221.938
Depreciation on disinvestments	-	-	220.126	220.126
Depreciation	-59.016	-14.076	-132.025	-205.117
	-42.117	**5.618**	**-4.708**	**-41.207**
as at 31 December, 2017				
Cost / Actual value	361.431	269.921	848.310	1.479.662
Accumulated depreciation	-226.689	-169.223	-622.133	-1.018.045
Book value	**134.742**	**100.698**	**226.177**	**461.617**

The book value of fixed assets ultimo 2017 amounts to € 461,617, which is lower than 2016. 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 2017 amounting to € 165,722 were mainly for ICT equipment. Total depreciation is calculated at € 205,117. Assets that are no longer in use have been divested for an amount of € 221,938. The part of their book value that was not depreciated yet is included in the depreciation for 2017.

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 € 29,9 million, which is € 45,5 million lower than in 2016.

The bulk of the receivables amount consists of current account balances with projects, accounts receivables from donors, and the financial contractual relation with coalition partners. Overall, the annual level of activities executed influences this balance significantly. Acquiring more or less grants from institutional donors can lead to a structural and significant decrease or increase of the amount.

The significant decrease in 2017 is caused by the fact that most obligations for Challenge TB year 4 have not been released yet. This is partly related to e general trend to want to reduce project pipelines, but is also related to delayed approval of country operational plans fiscal year 2017 by USAID in Washington. The current pipeline reflects approximately three months of spending.

B2 Accounts Receivable	31/12/2017	31/12/2016
Interest (on bonds)	18.018	22.146
Lotteries	516.970	303.220
Current Accounts project countries	646	115
Debtors	217.415	160.194
Payments in advance general	910.104	586.567
Payments in advance projects	461.742	77.009
Legacies in process	439.802	339.902
Other receivables	31.018	171.961
Receivable USAID Challenge TB	363.716	310.203
Current account USAID	-	1.728.638
Accounts receivable USAID based on agreement	26.792.899	71.702.592
Receivables other donors	100.860	-
	29.853.190	**75.402.547**

The total account receivable from USAID for the Challenge TB project, based on approved project work plans, decreased from € 71,7 million to € 26,8 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.

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 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.

Controversial activities to be addressed are:
- Animal welfare;
- Factory farming;
- Animal testing and
- GMOs.

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.

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 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: CO_2 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).

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 10 to 13. As far as is relevant a comparison with 2016 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 2017, € 10,9 million was available and as per 1 January 2018, € 10,6 million. The market value (€ 6,1 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 4 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 2017, this amount increased due to sale of bonds and stocks. Ultimo 2017 bonds are slightly underweighted 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	Alternatives	Total
Balance as at 1 January, 2017	1.713.137	3.372.223	666.628	5.751.988
Purchases and sales	-155.879	291.012	65.343	200.476
Redemption of bonds	-	-	-	-
Realized stock exchange result	216.264	14.260	-	230.524
Unrealized stock exchange result	-32.719	-12.404	-11.785	-56.908
Amortization	-	-	-	-
Balance as at 31 December, 2017	**1.740.803**	**3.665.091**	**720.186**	**6.126.080**

The effect of changing the valuation of bonds to market value on the portfolio as at 31 December 2016 has been added to the opening balance of the bond balance (€ 53,825).

Table 3: Composition of the investment portfolio and historical values

Fund	Interest %	Nominal value 1/1 2017	Historic purchase value 1/1 2017	Value in balance sheet 1/1 2017	Transactions in reporting year nominal: Purchased	Sold	Redemption of bonds	Transactions in reporting year in actual prices: Purchased	Sold	Redemption of bonds	Nominal value 31/12 2017	Historic purchase value 31/12 2017	Value in balance sheet 31/12 2017
Shares													
AA Eden Tree European	-	-	-	-	-	-	-	191.483	20.929	-	-	172.083	181.538
AA Parnassus US Sustain			-	-	-	-	-	121.500	19.881	-	-	101.900	103.520
ABN Amro Global Sust Equity E	-	-	148.267	181.853	-	-	-	-	78.311	-	-	96.828	117.278
ASN Duurzaam Fund 3	-	-	100.341	133.409	-	-	-	2.227	25.763	-	-	88.572	123.075
ASN Milieu en Waterfonds	-	-	60.673	104.372	-	-	-	19.379	10.123	-	-	75.745	124.070
Liontrust (vh Luxellence) Sustain	-	-	121.678	170.502	-	-	-	54.166	74.035	-	-	141.530	172.002
Calvert Internat equity I dis	-	-	104.403	123.234	-	-	-	-	123.141	-	-	-	-
Calvert Equity I dis	-	-	114.242	139.416	-	-	-	-	71.901	-	-	60.402	74.627
Celsius Sust Emerging Markets	-	-	160.745	167.645	-	-	-	69.386	63.685	-	-	176.726	207.097
F C Responsible Global equity	-	-	100.375	148.713	-	-	-	-	55.991	-	-	75.596	108.172
Janus Henderson Global Care	-	-	110.512	151.145	-	-	-	-	44.858	-	-	88.564	125.727
Kempen Sust small cap	-	-	80.046	120.410	-	-	-	31.275	22.259	-	-	99.997	140.866
Pictet eur Sustainable	-	-	127.441	133.160	-	-	-	12.763	9.436	-	-	131.583	150.228
Triodos Sust. Equity Fund dis	-	-	111.148	139.279	-	-	-	687	38.430	-	-	90.731	112.604
Subtotal shares		**-**	**1.339.872**	**1.713.138**	**-**	**-**	**-**	**502.866**	**658.743**	**-**	**-**	**1.400.257**	**1.740.804**
Real estate/Alternatives													
Previum Sustainable Alternatives	-	-	622.900	666.628	-	-	-	65.344	-	-	-	688.244	720.186
Subtotal real estate/altern.		**-**	**622.900**	**666.628**	**-**	**-**	**-**	**65.344**	**-**	**-**	**-**	**688.244**	**720.186**
Bonds													
Duitsland 09-20	1,750	236.000	284.549	284.549	15.000	27.000	-	18.327	32.594	-	224.000	304.489	301.089
Ierland T bond 13-23	3,900	194.000	232.784	232.784	-	-	-	-	-	-	194.000	242.255	232.568
Ierland T bond 14-24	3,400	200.000	237.352	237.352	25.000	22.000	-	30.073	26.348	-	203.000	246.065	242.483
European Inv bank 14-26	1,250	168.000	180.857	180.857	-	15.000	-	-	15.963	-	153.000	166.007	164.024
Kredit Wiederaufbau 17-25	0,250	-	-	-	200.000	-	-	199.200	-	-	200.000	199.200	199.890
SSGA euro sustainable corp bonds	perp	1.595.728	2.239.848	2.382.856	-	-	-	321.421	203.104	-	2.561.269	2.372.176	2.525.037
Subtotal bonds		**2.393.728**	**3.175.390**	**3.318.398**	**240.000**	**64.000**	**-**	**569.021**	**278.009**	**-**	**3.535.269**	**3.530.192**	**3.665.091**
Total		**2.393.728**	**5.138.162**	**5.698.164**	**240.000**	**64.000**	**-**	**1.137.231**	**936.752**	**-**	**3.535.269**	**5.618.693**	**6.126.080**

Table 4: Asset allocation ultimo 2017 compared to the policy (source: Quarterly report ABN AMRO/MeesPierson)

Investment	Investment policy		31 December 2016		31 December 2017	
	Range	Target	In € million	%	In € million	%
Bonds	40-80%	70%	3,30	45,2%	3,66	50,2%
Shares/Real Estate/Alternatives	0-50%	30%	2,40	32,9%	2,46	33,7%
Liquidities		0%	1,60	21,9%	1,17	16,0%
Total			**7,30**	**100,0%**	**7,29**	**100,0%**

Bonds are mostly consisting of an investment in a bond portfolio fund (SSGA) and from Northern European national governments 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 5.

Table 5: Maturity of bonds

Running period remaining	2015	2016	2017
0 to 2 years	0%	0%	0%
2 to 5 years	0%	9%	8%
5 to 8 years	22%	15%	18%
>8 years	0%	5%	5%
Bond funds	78%	71%	69%

An overall result of 3.03% (benchmark: 2.05%; 2016: 3.6%) is realized. Below, a comparison between our 2017 portfolio, the benchmark and the results for 2016 is shown per asset category:

- Bonds; 2017 1.51%, benchmark 0.28%, 2016 3.6%
- Shares; 2017 11.39%, benchmark 9.88%, 2016 2.6%.
- Real estate/alternative assets; 2017 0.02%, benchmark -0.77%, 2016 1.7%.
- Liquidity available for investments; 2017 -2.11% (includes investment expenses), benchmark 0%, 2016 0.8%.

In absolute terms and in comparison with the long-term expected result of 5% the portfolio underperformed. Compared to the benchmark it outperformed, mostly due to the sector allocation of shares. The energy sector, the sector with the worst performance in 2017, 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.

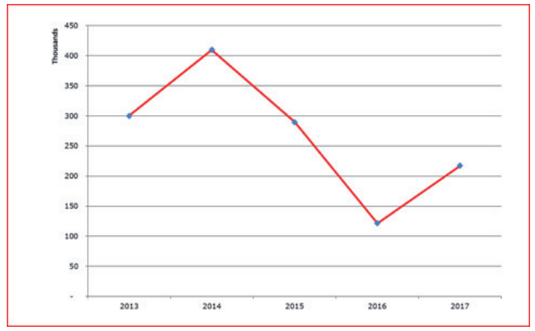
In Table 6 and Figure 11, as required by the sector organization for charities, Goede Doelen Nederland, the investment results over a 5-year period are depicted. The figure also shows the accumulated result over the years.

Table 6: Investment results 2013-2017

Description	2013	2014	2015	2016	2017	5 year average
Bond income	109.447	78.764	64.538	33.687	51.010	67.489
Depreciation of amortization	-35.906	-26.842	-17.128	-	-	-15.975
Dividend	28.435	44.986	48.736	46.248	26.461	38.973
Realized exchange results	-6.075	226.913	246.851	152.180	230.524	170.079
Unrealized exchange results	250.743	145.253	7.735	-84.166	-56.908	52.531
Interest on cash on hand and deposits	16.676	11.485	18.985	23.070	20.426	18.128
Gross investment income	363.320	480.559	369.717	171.019	271.513	331.226
Investment expenses	63.108	70.759	80.083	49.338	54.202	63.498
Net investment income	300.212	409.800	289.634	121.681	217.311	267.728

Investment expenses include allocated organizational expenses.

Figure 11: Net investment income 2013-2017



The Executive Director confirms that all transactions in 2017 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.

Transaction costs are expensed in the income statement if these are related to financial assets carried at fair value through profit or loss. The equity instruments are quoted in an open market.

Cash and banks (B4)

The balance of cash and banks decreased compared to 2016, with € 1,5 million to a level of € 12,5 million. Main reason is the aim to keep low buffer balances for coalition partners through careful cash planning. Ultimo 2017 no deposits were available, because interest rates on deposits during 2017 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.

B4 Cash and banks	31/12/2017	31/12/2016
Immediately available		
Petty cash	7.569	18.400
ING	79.257	195.045
ABN AMRO bank	2.581.763	1.328.435
ABN AMRO (USD account)	6.285.843	7.454.633
ABN AMRO investment account	1.169.781	1.622.788
ABN AMRO Challenge TB	675.825	1.379.336
Bank accounts country offices	1.670.537	1.989.555
	12.470.575	**13.988.192**

[4] *BofA Merril Lynch Euro Government 1-10 year*

[5] *50% MSCI Europe, 40% MSCI World ex-Europe, 10% MSCI Emerging Markets*

[6] *50% GPR-250 Property, 50% Euribor + 2%.*

[7] *Euribor I month.*

Balance sheet per 31 December 2017 - 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 2018 for organizational costs (€ 33.0 million) the continuity reserve's maximum is € 33.0 to € 49.5 million. The reserve ultimo 2017, € 8.4 million, stays well within the maximum (0.25 times the budget for organizational costs in 2018). 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 1/1/2017	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2017
Continuity reserve	8.267.913	-	-	113.183	8.381.096

- 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 2017, an amount of € 404,868 has been withdrawn from the earmarked project reserves for these kinds of activities. The budget had an amount of € 749,300 planned to be deducted from the earmarked reserves. Due to prioritization of Challenge TB activities the actual deduction was lower. For 2018 € 334,400 is budgeted to be used.

	Balance as at 1/1/2017	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2017
Reserve national policy planning	157.573	-	-	-40.284	117.289
Reserve international policy planning	232.966	-	-	-65.651	167.315
Reserve research policy planning	163.566	-	-	-18.265	145.301
Reserve special needs	131.077	-	-	-	131.077
Reserve innovations	87.972	-	-	-87.972	-
Reserve capacity building	255.810	-	-	-146.115	109.695
Reserve monitoring tools	170.000	-	-	-5.072	164.928
Reserve advocacy	133.484	-	-	-28.808	104.676
Reserve childhood TB	3.129	-	-	-3.129	-
Reserve education center	500.000	-	-	-9.572	490.428
Total earmarked by the board	**1.835.577**	**-**	**-**	**-404.868**	**1.430.709**

The reserves for policy planning are intended for national and international projects that have a policy development component. The special needs reserve is intended for patient support. The capacity building reserve is intended for training of KNCV staff on new developments in TB control. The reserve for monitoring tools is intended for investment in improving monitoring tools. The advocacy reserve is allocated for advocacy and awareness creation related to the 2018 World conference on Lung Health in The Hague. The reserve for an educational center is allocated for activities related to setting up KNCV educational activities.

- 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 organizational tasks, focusing on decentralized resource mobilization.

In 2017, the decentralization reserve was allocated towards expenses to be incurred for the capacity building of country office staff in the years 2014-2017. In 2017, the amount of € 54,765 was withdrawn from this reserve. For 2018, an amount of € 150,000 is planned to be withdrawn.

	Balance as at 1/1/2017	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2017
Decentralization reserve	1.052.159	-	-	-54.765	997.394

- 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 2017 the reserve contains € 526,039. The effect of changing the valuation of bonds to market value on the portfolio as at 31 December 2016 has been added to the opening balance of this reserve (€ 53,825). The movement in the reserve is as follows:

	Balance as at 1/1/2017	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2017
Total revaluation reserve	546.602			-20.563	526.039

- Fixed Assets reserve

KNCV Tuberculosis Foundation separates equity, needed to finance the remaining value of fixed assets, which is allowed by Guideline 650. In 2017, the reserve decreased to an amount of €€461,617.

	Balance as at 1/1/2017	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2017
Total revaluation reserve	502.824			-41.207	461.617

Funds (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 2017, an amount of € 12,704 is used and an additional € 11,075 was added to the Jakob and Carolina funds by fund founder and former Board of trustees chair Dina Boonstra.

	Balance as at 1/1/2017	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2017
Fund TSRU	145.670	-	-	-8.897	136.773
Fund Special Needs	255.610	-	-	-	255.610
Jakob and Carolina fund	5.670	-	-	7.268	12.938
Young Talent Scolarship	18.654	-	-	-	18.654
	425.604	**-**	**-**	**-1.629**	**423.975**

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 withdrawal in 2017 of € 8,897 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.

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 decreased from € 81.5 million in 2016 to € 35,2 million in 2017 and includes under Other liabilities € 8.4 million of contractual committed projects still to be executed for USAID and € 19.5 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 2017 is € 555,170, which is higher than the amount in 2016, because some staff members have not taken their entitled leave in 2017.

B7 Various short-term liabilities

	31/12/2017	31/12/2016
Taxes and social premiums		
Income tax and VAT	526.261	456.395
Social premiums	74.142	43.291
Pension premiums	90.945	175.526
	691.348	**675.212**
Accounts payable	751.054	792.997
Other liabilities and accrued expenses		
Provision for holiday pay	348.291	333.585
Provision for annual leave	555.170	448.710
Declarations from staff	54.995	21.219
Audit fees	64.478	52.368
Current Accounts project countries	191.768	251.265
Current accounts sub awardees	671.630	340.964
Payable WHO	-	4.182
Current account - Dutch Ministeries	1.147.483	1.287.112
Other donors	1.174.313	2.416.505
Other liabilities	190.514	207.743
Project payables KNCV country offices	1.255.910	1.017.948
Current account USAID	1.170.041	-
KNCV projects to be executed	-	729.305
Dr. C. de Langen stichting	45.539	81.439
Other	376	404
Accruals TBCTA partners balance	504.715	1.285.518
Projects to be executed under Challenge TB	8.353.438	33.977.499
Accounts payable TBCTA coalition partners	19.519.568	39.090.897
	35.248.229	**81.546.663**

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 lessor for offices on Benoordenhoutseweg 46 in the Hague (Van Bylandthuis). The rental contract is for 5 years, ending on 31 May 2020, with an option to extent for 5 years. The annual rent is € 248.369 including maintenance fee and VAT. A € 62.092 bank guarantee has been issued in favor of the lessor.

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 and a cost share of US$ 36,732,815. Until 31 December 2017 the declared cost share is US$ 31,217,251.

The audit according to the USAID guidelines of the 3rd year of Challenge TB still has 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 2017. 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 5 year grant from DGIS (Dutch Ministry of foreign affairs) of EUR 7,500,000 as cost share towards the USAID Challenge TB award.

Multi-year contracts

We entered into several multi-year contracts with institutional donors, including:

- a grant agreement for USD 690,726 with Bill and Melinda Gates Foundation for the period October 2017 – October 2019 (Adherence);
- a grant agreement for EUR 901,143 with EDCTP for the period October 2017 – October 2021 (Treat);
- a grant agreement with the EU for EUR 493,838 for the period January 2017 – December 2019 (Impact TB);
- a service agreement with Swaziland Ministry of Health for USD 559,718 for the period 2017-2018 (TB prevalence survey);
- a subgrant agreement with the Aurum institute for UNITAID funding for USD 7,341,367 for the period December 2017 – October 2021 (Impaact4tb);
- a statement of work with TB Alliance for USD 642,817 for the period October 2017 – September 2019 (value proposition study);
- a collaboration agreement with London School of Hygiene & Tropical Medicine for USD 55,000 for the period January 2017 to December 2019 (TB MAC).

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 2017 (€ 92,8 million), compared to 2016 (€ 73,2 million).

In Table 7 the total income for 2017 is compared with the budget and with 2016. In the tables that follow, each income category is further clarified.

Table 7: Total income

Total income	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
Own share	43,24	48,16	37,13	11%	23%
Coalition partners share	51,87	44,62	36,03	-14%	19%
Total	**95,11**	**92,78**	**73,16**	**-2%**	**21%**

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

Table 8: Income from individuals (R1)

Income from individuals	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	1,16	0,96	1,13	-17%	-18%

Income from individuals was 17% lower than planned and 18% lower than last year, mostly due to lower legacy income.

R1 Income from individuals	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Donations and gifts				
Direct marketing activities	869.600	662.000	619.559	563.797
Gifts- other	-	100.000	19.089	5.548
Total donations and gifts	**869.600**	**762.000**	**638.648**	**569.345**
Contributions by association members	-	-	-	370
Legacies and endowments	400.000	400.000	328.117	555.911
Total income from individuals	**1.269.600**	**1.162.000**	**966.765**	**1.125.626**

Table 9: Income from companies (R2)

Income from companies	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	0,70	0,79	0,38	13%	52%

Income from companies increased compared to 2016 due to more activities for Cepheid in 2017 and a substantial in kind contribution from Sanofi and Qiagen for a prevention study, represented under sponsoring.

R2 Income from companies	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Various through fundraising campaigns	-	20.000	38.224	17.082
Cepheid	-	49.500	358.389	139.800
Sponsoring	437.000	-	397.511	218.921
Total income from companies	**437.000**	**69.500**	**794.124**	**375.803**

Table 10: Income from lotteries

Income from lotteries	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	1,07	1,27	1,14	19%	10%

Income from lotteries increased by 19% compared to budget, and 10% compared to 2016 due to a contribution received from the Nationale Postcode loterij as a new beneficiary. This is the result of a move from Vriendenloterij to Nationale Postcode Loterij. We will continue to receive income from sale of earmarked lottery tickets from Vriendenloterij.

The income from third party campaigns consists of contributions from two three Dutch lottery organizations: **The Nationale Postcode Loterij**, **VriendenLoterij** and **De Lotto**. The amount consists of general participation in the lotteries, earmarked lottery tickets sold 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. Income from the lotteries is recognized at the time of the allocation. The proceeds from the lotteries are based on multi-year contracts.

R3 Income from lotteries

		Budget 2018	Budget 2017	Actual 2017	Actual 2016
Settlement previous years		-	-	-38.995	85.723
Vriendenloterij	earmarked lottery tickets	-	770.000	98.511	95.959
Vriendenloterij	non-earmarked tickets	100.000	-	-	640.257
Nationale Postcode Loterij		900.000	-	900.000	-
De Lotto		300.000	300.000	314.400	322.500
Total from fundraising third parties		**1.300.000**	**1.070.000**	**1.273.916**	**1.144.439**

Table 11: Income from government grants (R4)

Government grants	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
Own share	38,87	43,77	33,57	13%	23%
Coalition partners share	51,87	44,62	36,03	-14%	19%
Total	**90,74**	**88,39**	**69,60**	**-3%**	**21%**

KNCV's 2017 share in the USAID-funded **Challenge TB project**, with € 83,9 million, amounts to 95% of the total figure for government grants. The DGIS income for 2017 was € 2.7 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, but includes project subsidy for the biannual Wolfheze conference in 2017, which explains the increase.

From a large group of other government donors, a total of € 1.3 million was received, which is lower than the budgeted amount. For 2017, government grants determined 95% of KNCV's budget.

R4 Government grants

	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Center for disease control	460.000	596.400	562.187	512.510
DGIS	2.320.000	3.125.900	2.663.029	1.479.638
USAID	42.600.000	33.531.300	39.397.640	31.394.487
WHO	} 2.438.500	} 136.900	50.902	93.446
Global Fund/GFATM			421.816	467.983
Other Donors		1.473.800	808.552	987.218
Subtotal	**47.818.500**	**38.864.300**	**43.904.126**	**34.935.282**
USAID grants coalition partners	46.700.000	51.872.000	44.485.126	34.614.881
Total government grants	**94.518.500**	**90.736.300**	**88.389.252**	**69.550.163**

Table 12: Income from allied non-profit organizations

Income from allied non-profit organizations	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	0,45	0,49	0,35	9%	29%

Income from allied non-profit organizations increased compared to 2016, because of an additional contribution for a core funding strategy from Dr. C. de Langen Foundation. Also part of the allocated funds for 2016 were not spent in 2016 and activities were transferred to 2017.

R5 Income from allied non-profit organizations

	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Contributions by association members	400	400	364	-
Sonnevanck Foundation	22.000	22.000	22.000	22.000
Mr. Willem Bakhuijs Roozeboom Foundation	10.000	10.000	10.000	10.000
Dr. C. de Langen Foundation for global Tuberculosis	360.000	360.000	396.261	256.250
's-Gravenhaagse stichting tot steun aan de bestrijding der tuberculose	110.000	60.000	60.000	60.000
Total income from allied non-profit organizations	**502.400**	**452.400**	**488.625**	**348.250**

Table 13: Income from other non-profit organizations (R6)

Income from other non-profit organizations	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	1,58	0,84	0,58	-47%	31%

Income from other non-profit organizations increased compared to 2016 and includes contributions from Eli Lilly Foundation, Bill and Melinda gates Foundation and Capital for Goods.

Table 14: Income for supply of services

Income for supply of services	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	0,23	0,19	0,25	-17%	-32%

Income for supply of services decreased due to less income from fees for trainings in The Netherlands.

R7 Income for supply of services	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Endowment funds fee on administration & control costs	7.000	3.000	4.132	2.479
Trainings	4.000	20.000	14.671	22.812
Total income for supply of services	**11.000**	**23.000**	**18.803**	**25.291**

R8 Other Income	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Miscellaneous	12.400	13.400	9.901	8.442
Total Other Income	**12.400**	**13.400**	**9.901**	**8.442**

Expenditure

Total expenditures in 2017 were € 93.4 million, which is € 2.7 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 an increase compared to budget.

In Table 15 the total expenses for 2017 are compared with the budget and with 2016. In the tables that follow each income category is further clarified.

Table 15: Total expenditure

Total expenditure	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
Own share	44,20	48,79	36,77	10%	25%
Coalition partners share	51,87	44,62	36,03	-14%	19%
Total	**96,07**	**93,41**	**72,80**	**-3%**	**22%**

The increase of € 20.6 million compared to 2016 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 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
Own share	42,11	46,18	34,85	10%	25%
Coalition partners share	51,87	44,62	36,03	-14%	19%
Total	**93,98**	**90,80**	**70,88**	**-3%**	**22%**

In 2017, 97% of all expenses were spent on mission related activities. This is the same level as 2016. The activities in low prevalence countries took 1% of the total amount, high prevalence countries 91%, research activities 7% and education/awareness 1%.

R 9 Expenses to mission related goals	Budget 2018	Budget 2017	Actual 2017	Actual 2016
- TB control in low prevalence countries	830.000	960.800	1.065.021	872.219
- TB control in high prevalence countries				
-- executed by KNCV	45.347.500	38.631.600	38.448.421	32.709.990
-- executed by CTB coalition partners	46.700.000	51.872.000	44.485.126	35.114.510
- Research	1.451.400	1.362.500	5.644.999	1.326.022
- Education and awareness	1.709.200	1.152.800	1.154.097	857.159
Total expenses to the mission	**96.038.100**	**93.979.700**	**90.797.664**	**70.879.900**

Specification - per country, independent from nature of the project

	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Netherlands	872.900	1.036.700	1.085.282	958.850
Africa				
- Botswana	750.500	580.000	547.003	630.185
- Congo	34.100	-	11.837	93.841
- Ethiopia	5.204.100	6.528.700	5.853.295	3.534.931
- Ghana	16.900	-	33.003	-
- Kenya	-	1.431.960	635.126	675.394
- Malawi	2.388.900	3.035.100	2.911.389	3.772.567
- Mozambique	-	401.000	334.805	160.351
- Namibia	1.223.400	1.645.400	1.534.827	1.950.369
- Nigeria	10.445.000	4.379.600	8.681.479	7.769.980
- South Africa	5.049.900	-	-	-
- South Sudan	-	-	-	1.186
- Swaziland	361.600	448.600	543.695	323.822
- Tanzania	3.559.600	2.618.800	2.936.276	2.671.398
- Zambia	106.900	-	181.369	9.353
- Zimbabwe	-	35.300	69.274	52.862
Subtotal Africa	**29.140.900**	**21.104.460**	**24.273.378**	**21.646.239**
Asia				
- Afghanistan	-	-	-	908
- Bangladesh	48.000	217.400	92.354	321.625
- Cambodia	22.200	110.200	51.227	58.658
- India	33.600	1.570.400	1.150.131	284.453
- Indonesia	5.744.800	5.743.500	4.885.342	3.531.909
- Myanmar	39.300	278.100	153.400	163.760
- Nepal	170.600	-	432.746	142.901
- Papua New Guinea	-	-	-	10.049
- Philipinnes	41.700	-	363.165	238.722
- Vietnam	420.800	557.600	822.260	762.209
Subtotal Asia	**6.521.000**	**8.477.200**	**7.950.625**	**5.515.194**
Eastern Europe				
- Regional office	230.600	-	58.653	66.672
- Kazakhstan	115.800	-	543.341	264.598
- Kyrgyzstan	1.138.300	754.100	745.237	339.033
- Ukraine	135.500	302.500	121.947	118.954
- Uzbekistan	183.700	164.100	118.741	135.865
- Tajikistan	741.300	787.000	970.358	1.048.474
- Turkmenistan	-	-	5.268	-
Subtotal Eastern Europe	**2.545.200**	**2.007.700**	**2.563.545**	**1.973.596**
Non-country or region related projects	12.577.400	9.010.888	11.893.092	6.978.427
Challenge TB coalition partners	46.700.000	51.872.000	44.485.126	35.114.510
Expenses charged to other expenditure categories 3)	-2.319.300	470.752	-1.453.384	-1.306.916
Total expenses to the mission	**96.038.100**	**93.979.700**	**90.797.664**	**70.879.900**

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.

Currency exchange effects

We work with multiple currencies on a daily basis. Income is realized in euro and US dollar, while our expenditures are largely in euro and several project country currencies. Balances held in other currencies than the euro or US dollar are as much as needed exchanged into US dollar. The majority of our income is in euro and in US Dollar. Foreign currency needed in our project countries is as much as possible purchased centrally while balances are kept to a minimum. In 2017 KNCV did not use financial instruments to control currency risk on various foreign currencies.

Table 17: Expenses to fundraising

Expenses to fundraising	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	0,98	1,08	0,73	10%	32%

In all categories of fundraising and acquisition activities, including those for private fundraising,

€ 1.08 million was spent. This was higher than the budget, due to responses to many requests for proposals in 2017. For income from fundraising from individual private and company donors a percentage of 20.3% of the income has been spent as costs. This is below the CBF maximum percentage.

Table 18: Expenses administration and control

Expenses to Administration and control	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	1,11	1,53	1,16	38%	24%

Costs for administration and control were higher than planned, due to the fact that some long term sick leave was covered by temporary staff.

Personnel expenses

	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Salaries	9.605.000	8.673.900	9.044.737	8.033.204
Accrued annual leave	60.000	60.000	131.209	104.255
Social security premiums	930.600	841.500	852.848	762.414
Pension premiums	957.400	836.400	687.140	615.311
External staff/temporary staff	185.000	250.000	768.482	400.720
Expenses regional offices	227.000	228.000	30.437	55.810
Capacity building decentralization	-	-	933	2.445
Sub total	**11.965.000**	**10.889.800**	**11.515.786**	**9.974.159**
Salaries KNCV country offices	8.892.500	4.709.000	9.234.977	6.949.729
Sub total	**20.857.500**	**15.598.800**	**20.750.763**	**16.923.888**
Additional staff expenses				
Commuting allowances	137.000	110.500	131.615	135.500
Representation	4.500	3.000	2.300	3.455
Social event	7.200	6.600	33.362	13.661
Congresses and conferences	33.000	63.000	36.882	42.816
International contacts	58.000	52.100	46.733	53.542
Training & Education	192.200	173.700	151.613	117.090
Recruitment	25.000	25.000	76.581	53.237
Insurance personnel	46.000	22.000	39.618	19.162
Catering	26.000	25.000	23.539	21.598
Works council	23.500	22.500	12.064	34.223
Expenses regional offices	8.000	8.800	22.449	11.009
Other	339.700	216.500	192.842	171.809
Allocated to investment income	-	-13.400	-16.582	-18.640
Sub total	900.100	715.300	753.016	658.462
Other human resource management costs				
Development of tools	20.000	20.000	3.783	12.988
Safety training	64.200	64.500	68.355	44.537
Sub total	**84.200**	**84.500**	**72.138**	**57.525**
Total personnel expenses	**21.841.800**	**16.398.600**	**21.575.917**	**17.639.875**
Average number of fte's The Hague			105,0	100,0
Average number of fte's country offices			396,0	325,0

Housing expenses

	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Rent	160.000	160.000	166.472	155.586
Repairs and maintenance	7.000	5.000	5.657	8.202
Cleaning expenses	34.000	36.000	33.218	32.388
Utilities	65.000	66.000	59.645	63.391
Insurance and taxes	4.000	2.000	5.213	1.463
Plants and decorations	12.500	12.400	11.230	12.802
Housing expenses regional offices	20.100	16.400	2.915	7.754
Total housing expenses	**302.600**	**297.800**	**284.350**	**281.586**

Office and general expenses

General office supplies	14.000	14.000	12.404	11.799
Telephone	33.000	40.400	32.581	33.841
Postage	8.000	8.000	7.847	6.718
Copying expenses	16.000	23.000	15.976	18.503
Maintenance - machines, furniture	1.000	1.000	-89	89
Professional documentation	3.000	4.000	1.347	3.129
IT costs	215.000	204.000	248.437	189.533
Audit fees	100.000	90.000	117.790	90.955
Board of Trustees	7.500	10.000	4.977	6.925
Consultancy	130.700	45.000	36.213	68.365
Bank charges	30.000	20.000	41.667	30.661
Other	9.996.500	161.800	11.676	58.436
Office and general expenses regional and country offices	39.500	2.601.300	6.598.680	5.397.267
Total office and general expenses	**10.594.200**	**3.222.500**	**7.129.506**	**5.916.221**

Depreciation and interest

Office reconstruction work	59.100	55.000	59.016	57.085
Office inventory	19.000	40.700	14.076	11.315
Computers	217.200	203.000	133.838	145.499
Regional offices	500	1.000	290	729
Allocated to investment income	-	-26.700	-239	-265
Total depreciation and interest	**295.800**	**273.000**	**206.981**	**214.363**

The audit expenses at KNCV headquarters can be broken down in various categories:

Audit costs

	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Audit of the annual accounts	100.000	90.000	114.159	86.489
Project audits	60.000	60.000	64.699	71.348
Other audit assignments	-	-	-	-
Tax advice	-	-	-	-
Costs related to previous years	-	-		4.466
Total	**160.000**	**150.000**	**178.858**	**162.303**

Audit costs are charged to the year to which they relate. Project audit costs, when allowable under donor conditions, are reported under expenses to mission related goals.

Net investment income

Table 19: Net investment income (R10

Net investment income	Budget 2017 in € million	Actual 2017 in € million	Actual 2016 in € million	% difference budget	% difference last year
	0,06	0,22	0,12	267%	45%

With the investment portfolio and interest on bank balances we earned an amount of € 0.223 million as realized income and made a loss of € 0.06 million as unrealized exchange differences. The exchange differences were not budgeted for, which explains the difference with the budget. In 2016, the unrealized exchange differences were a loss of € 0.08 million. The increase in total investment income compared to 2016 is caused by the positive stock market developments in 2017.

R10 Investment income

	Budget 2018	Budget 2017	Actual 2017	Actual 2016
Dividends	50.000	36.000	26.461	46.248
Bond earnings	40.000	64.000	33.010	15.687
Bond earnings on behalf of Fund Special Needs	18.000	18.000	18.000	18.000
Realized exchange gains	-	-	230.524	152.180
Unrealized exchange results	-	-	-56.908	-84.166
Interest on cash on hand and deposits	25.000	25.000	20.426	23.070
Depreciation of amortization of bond value	-	-15.000	-	-
Total from investments	**133.000**	**128.000**	**271.513**	**171.019**
Total out of pocket costs investments	35.000	26.000	34.853	29.737
Allocated costs	12.000	40.100	17.549	19.601
Net investment income	**86.000**	**61.900**	**219.111**	**121.681**

In line with the new guideline 650 investment income is presented after deduction of investment costs. Since 2017 bonds are valued at market value. The effect of this change in valuation has been added to the opening balance of the reserve for unrealized exchange differences on investments (EUR 53,825) and the comparing figures for 2016 have been adjusted.

Operating result

The balance between income and costs is a deficit of € 0.41 million, while a deficit of € 0.9 million was planned. The main causes of the difference with the budgeted figures are incidental: higher income from investments and lotteries and fewer expenses for projects to be covered from earmarked reserves. Also negative currency exchange gains were realized for € 0.45 million and a contingency amount in the budget of € 0.2 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 110.

Cash flow statement

The decrease in cash and banks in 2017 is caused by a negative 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 less funds are kept as buffer for payments to partners, due to careful cash flow planning. This results in a negative cash flow from operational activities and a negative cash flow from tangible fixed assets (investments).

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		
Gross salary	112.613	
Holiday allowance	9.259	
Extra month	9.384	
Variable/performance allowance	-	
Subtotal		131.256
Social securities, employers part	9.367	
Taxable allowances	-	
Pension premium, employers part	11.012	
Pension compenzation	-	
Other allowance, long-term	6.816	
Payment in relation to beginning of end of contract	-	
		27.195
Total remuneration 2017		**158.451**
Total remuneration 2016		**154.996**

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 2017. 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[8], 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 580 points (K) and a maximum annual remuneration of 100% of € 146,000 for 1 FTE in 12 months for the statutory director.

In 2017, the actual incomes of management for the purposes of assessment of compliance with Goede Doelen Nederland's maximum annual remuneration were as follows:

C.S.B. van Weezenbeek € 131,256 (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 € 146,000/12 months according to the Regeling beloning directeuren van goede doelen ten behoeve van besturen en raden van toezicht. The total remuneration 2017 (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.

[8] Advisory scheme for remuneration of directors, Goede Doelen Nederland

OTHER INFORMATION

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 17 April 2018 and 16 May 2018, we propose to appropriate the surplus of 2017 according to the following division:

	In €
Continuity reserve, contribution	113,183
Decentralization reserve, withdrawal	-54,765
Earmarked project reserves, contribution	50,000
Earmarked project reserves, withdrawal	-454,868
Unrealized exchange differences on investments, withdrawal	-20,563
Fixed asset fund, withdrawal	-41,207
Third party earmarked funds, contribution	11,075
Third party earmarked funds, withdrawal	-12,704
	-409,849

The withdrawals are specified on pages 92 and 93 of the financial statements. KNCV Tuberculosis Foundation's policy towards reserves and funds is clarified in chapter Accounting policies.

Mirella Visser
Chair of the Board of Trustees

Ton van Dijk
Vice chair of the Board of Trustees

Kitty van Weezenbeek
Executive Director



Actrice Imanuelle Grives zet zich als ambassadeur graag in voor de missie van KNCV

Independent auditor's report

To: the board of trustees of KNCV Tuberculosis Foundation

Report on the financial statements 2017

Our opinion

In our opinion KNCV Tuberculosis Foundation's financial statements give a true and fair view of the financial position of the KNCV Tuberculosis Foundation as at 31 December 2017, 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 2017 of KNCV Tuberculosis Foundation, The Hague ('the Foundation').

The financial statements comprise:

- the balance sheet as at 31 December 2017;
- the income statement for the year then ended; and
- 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.

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

Z734SM5KTPQK-180515272-34

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Independence

We are independent of KNCV Tuberculosis Foundation in accordance with the 'Wet toezicht accountantsorganisaties' (Wta, Audit firms supervision act), the 'Verordening inzake de onafhankelijkheid van accountants bij assuranceopdrachten' (ViO – Code of Ethics for Professional Accountants, a regulation with respect to independence) and other relevant independence requirements in the Netherlands. Furthermore, we have complied with the 'Verordening gedrags- en beroepsregels accountants' (VGBA – Code of Ethics for Professional Accountants, a regulation with respect to rules of professional conduct).

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 2017 - Innovating for impact & Points of progress in country offices 2017;
- organizational highlights in 2017;
- 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 the 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, 14 May 2018

PricewaterhouseCoopers Accountants N.V.

Original has been signed by M. van Ginkel RA

Appendix to our auditor's report on the financial statements 2017 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 2017

In 2017, 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; Global Task Force on TB Research; Global Task Force on New TB Drugs and Regimens;

- 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); WHO- Euro Childhood TB Task Force;

- 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); Chilhood TB Core Group;

- The Union: Europe Region Executive Committee; HIV Working Group;

- 49th Union World Conference on Lung Health 2018 in The Hague: Coordinating Committee of Scientific Activities (CCSA); Conference Organizing Committee (COC);

- Global Fund: TRP (Technical Review Panel); Global Fund Board's Audit and Finance Committee (AFC); TB/HIV working group; NGO Developed Countries Delegation, Board; CCM (Country Coordinating Mechanism) of Kazakhstan;

- 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; Social Protection Action Research Knowledge Sharing (SPARKS) network;

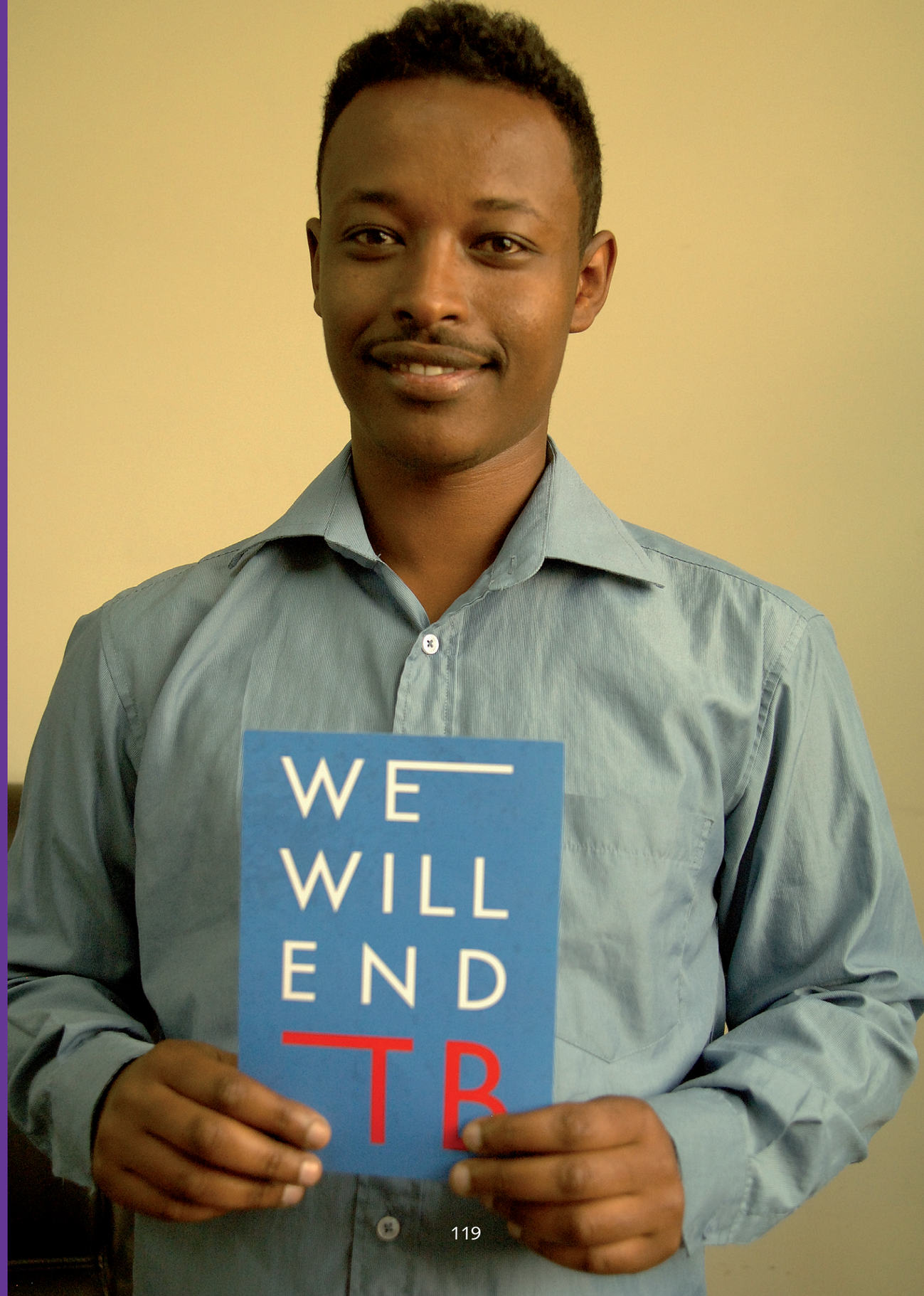
- Wolfheze: Program Committee; Working Groups (Collaborative TB/HIV activities; New drugs and regimens);

- 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; 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);

- The Lancet: Commission on Tuberculosis;

KNCV staff were also on the Editorial Board of:
- IJTLD (International Journal of Tuberculosis and Lung Disease);
- Periodical "Tegen de Tuberculose" (Against Tuberculosis).



KNCV PARTNERS IN 2017

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

In the Netherlands:
Academic Medical Centre Amsterdam (AMC)
AFEW International
Aidsfonds
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
Coördinatiecentrum Expertise Arbeidsomstandigheden en Gezondheid (CEAG), Ministry of Defense;
Delft Imaging Systems BV
Dr. C. de Langen Stichting voor Mondiale Tuberculosebestrijding SMT)
Erasmus University Rotterdam
Goede Doelen Nederland
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
Maasttricht University
Madurodam Support Fund (Stichting Madurodam Steunfonds)
Medical Committee Netherlands-Vietnam
Ministry of Foreign Affairs
Minsitry of Health, Welfare and Sports
Ministry of Security and Justice - Penitentiary Services (Ministerie van Veiligheid en Justitie - Dienst Justitiële Inrichtingen)
Mr. Willem Bakhuys Roozeboomstichting
Municipal Public Health Services in the Netherlands (GGD)
Nederlandse Vereniging van Artsen voor Longziekten en Tuberculose
Nederlandse Vereniging voor Medische Microbiologie
Netherlands Ministry of Foreign Affairs/Development Cooperation (DGIS)
Netherlands Ministry of Health, Welfare and Sport (VWS)
Netherlands School of Public and Occupational Health (NSPOH)
NWO-WOTRO
OGD
Our private donors
PharmAccess Foundation
Pharos
Radboud University Nijmegen
Royal Tropical Institute (KIT)
Stichting Loterijacties Volksgezondheid (SLV)
Stichting Suppletiefonds Sonnevanck
Stop Aids Now!
Taskforce Health Care
Topsector Life Sciences and Health
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
AFEW International 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 Amis 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 (EDCTP)
European Union (EU)
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)
John Hopkins University School of Medicine
Karolinska Institute, Sweden
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 nationale contre la lèpre et la tuberculose du Congo (LNAC)
Liverpool School of Tropical Medicine (LSTM)
London School of Hygiene and Tropical Medicine (LSHTM)
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
Nationale Postcode Loterij
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)
Qiagen
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
Sanofi
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)
UNITAID
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…



ABBREVIATIONS

99DOTS A mobile phone technology for monitoring and improving TB medication adherence
aDSM Active TB Drug-safety Monitoring and Management
AFEW AIDS Foundation East-West
AIDS Acquired Immune Deficiency Syndrome
ART Antiretroviral Therapy
ARV Antiretroviral
BSD "Basis Score voor Directiefuncties" - Basic Score for Management positions
CBF Centraal Bureau Fondsenwerving (Central Bureau for Fundraising in the Netherlands)
CDC IRB Centers for Disease Control and Prevention International Review Board
CIb Centrum Infectieziektebestrijding (Center for Infectious Disease Control)
CQI Continuous Quality Improvement
CTB Challenge TB, the global mechanism for implementing USAID's TB strategy and TB/HIV activities under PEPFAR
CTB EAR CTB East Africa Regional
DGIS Directoraat-Generaal Internationale Samenwerking (Netherlands Ministry of Foreign Affairs)
DOT(S) Directly Observed Treatment (Short-course)
DR-TB Drug Resistant Tuberculosis
EDCTP European and Developing Countries Clinical Trials Partnerships
eLMIS Electroning TB Surveillance System
EQA External Qualiy Assessment
ERR Electronic Recording and Reporting Systems
EURO European regional office WHO TB Technical Advisory Groups
FAST-strategy Finding, Actively, Separating, Treating
FGH Friends in Global Health
FTE Full-time equivalent
GDI Global Drug resistant TB Initiative
GeneXpert® (See Xpert MTB/RIF assay, below)
GFATM Global Fund to Fight Aids Tuberculosis and Malaria
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
GLI Global Laboratory Initiative
HCWs Health Care Workers
HIV Human Immunodeficiency Virus
HRM Human Resource Management
ICT Information and Communication Technology
IGAD Intergovernmental Authority on Development
IJTLD International Journal of Tuberculosis and Lung Disease
IPT Isoniazid Preventive Therapy
ISTC International Standards for Tuberculosis Care
KEA Kenya and East Africa
KNCV Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose (Royal Netherlands Tuberculosis Association)
LTBI Latent Tuberculosis Infection
LTTA Long Term Technical Assistance
M&E Monitoring and Evaluation
MDR Multidrug-Resistant
MDR-TB Multidrug-resistant Tuberculosis
MERMS Medication Event Reminder Monitoring Systems
MMT Methadone Maintenance Clinics
MPH Master of Public Health
MSH Management Science in Health
MTB Mycobacterium Tuberculosis
MTMBeVE Medisch Technisch Medewerkers Beroepsvertegenwoordiging (Professional Association of Medical Technical Assistants)
ND&RS New Drugs and Regimens
ND/STR New Drugs and Short Treatment Regimen
NGO Non-Governmental Organization
NIH National Institutes for Health
NTP National Tuberculosis Program
NTLP National Tuberculosis and Leprosy Program
NTRL National TB Reference Laboratory
OpenMRS Open source project to develop software to support the delivery of health care in developing countries
PEPFAR U.S. President's Emergency Plan for AIDS Relief
PFZW Pensioenfonds Zorg en Welzijn (Pension fund for health care)
PhD Doctor of Philosophy
PLHIV People Living with HIV
PMDT Programmatic Management of Drug-Resistant TB
PMU Project Management Unit
PMV Patient Medicine Vendor
POP TB National association of patient-support groups in Indonesia
Pre-XDR-TB MDR-TB with resistance to either any fluoroquinolone or at least one second-line injectable
VQQ Qualitate Qua
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)
R&D Research & Development
SADCAS Southern African Development Community Accreditations Services
SDG Social Development Goals from the United Nations
SEARO WHO TB South-East Asia Regional Office
SL-LPA Second-Line Line Probe Assays
SLD Second Line Drugs
SMT Dr. C. de Langen Stichting voor Mondiale Tbc-Bestrijding/Stichting Mondiale Tuberculose-bestrijding (Dr. C. de Langen Foundation for Global TB Control)
SOP Standard Operation Procedure
SRL Supranational Reference Laboratory
STAG/STAG-TB Strategic and Technical Advisory Group
TAG-TB Technical Advisory Group on TB Control
STR Shorter MDR Treatment Regimen
TA Technical Assistance
TB Tuberculosis
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
TSRU Tuberculosis Surveillance and Research Unit
UN United Nations
UNGA United Nations General Assembly
UNHLM United Nations High Level Meeting
UNION International Union Against Tuberculosis and Lung Disease
US United States
USAID United States Agency for International Development
USD US Dollar
US$ US Dollar
V&VN/OGZ Verpleegkundigen Openbare GezondheidsZorg (Professional Association of Nurses)
VIDEO DOT Video Observed Therapy
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) ◂

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TUBERCULOSISFOUNDATION

To eliminate TB