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KNCV
TUBERCULOSIS FOUNDATION
To eliminate TB

STRATEGIC PLAN
2015-2020

KNCV
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To eliminate TB

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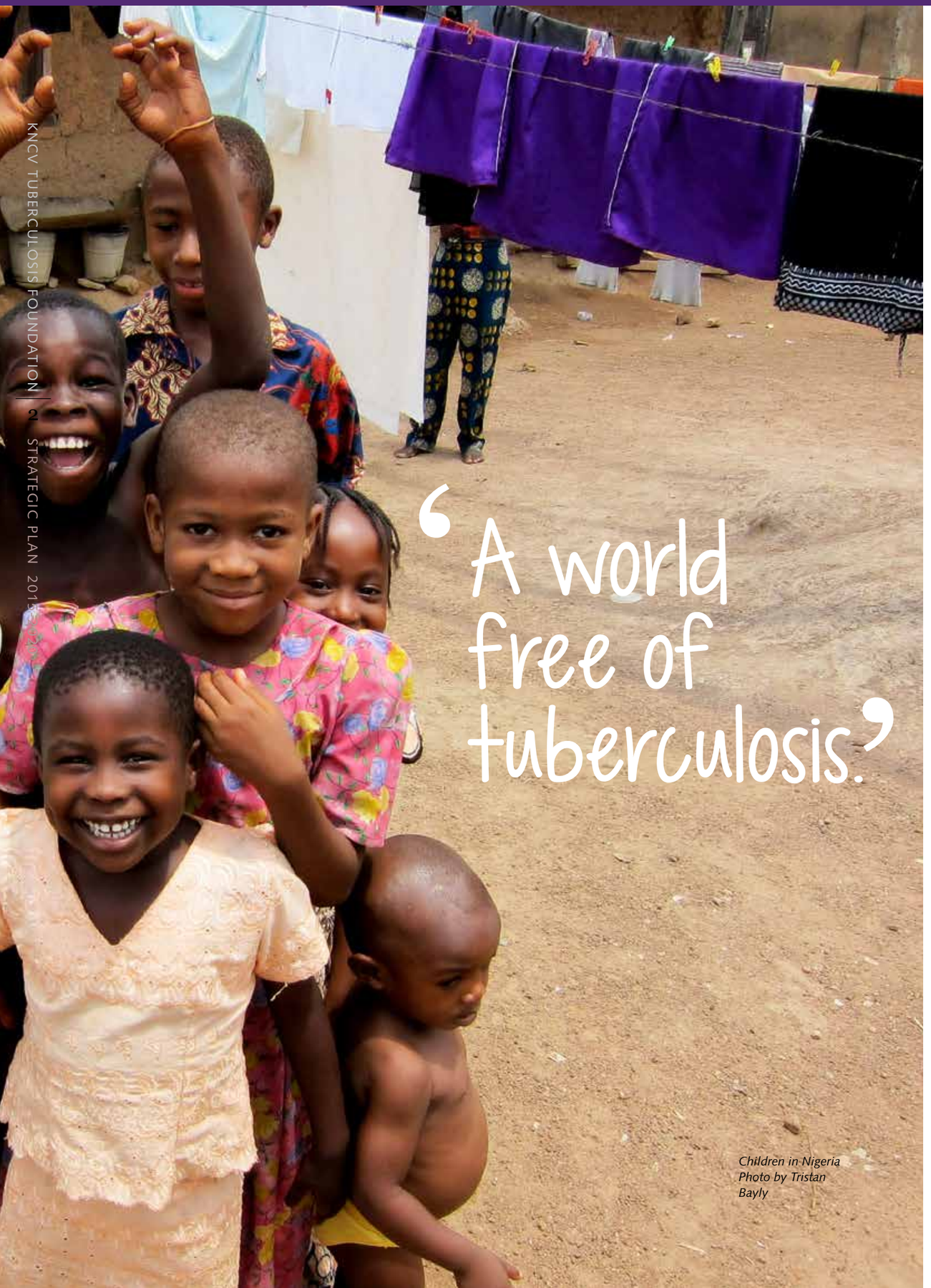

Children in Nigeria
Photo by Tristan Bayly

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1. FOREWORD

by our patroness H.R.M. Princess Margriet

HET LOO

Het Loo, 2015

When I was asked to become the patroness of KNCV Tuberculosis Foundation a few years ago, I didn't hesitate to answer 'Yes', because I am especially motivated to help in the fight against tuberculosis.

That is because tuberculosis is anything but a 'forgotten' disease; in 2015 it poses an all-too-real threat: a devastating infectious disease, the second-most deadly infectious disease in the world, which costs the lives of more than 4,000 people every day. Each year, nine million people fall ill with tuberculosis and one third of them are unable to receive adequate treatment.

It is therefore vital that we understand that, and that we inform as many people as possible that we must do everything we can to eliminate the disease.

That is a realistic goal, if we have the desire and are willing to devote the necessary financial resources. We will have to combine our efforts in order to reduce the suffering of the most vulnerable groups of people in the most affected countries such as India, Nigeria and Indonesia, but also to protect the many nurses and health workers who face the ever-present risk of becoming infected as they do their jobs. If the disease is detected in time and the patients receive proper treatment, then the disease is curable.

KNCV has been active in the fight against tuberculosis for more than 110 years, and strives to eventually eliminate the disease from the world. KNCV is an important center of expertise and pioneer in the global fight against tuberculosis. With the TB CARE I program, which was led by KNCV and financed by USAID, more than four million lives have been saved over the past five years.
Over the next five years, the organization will continue to work towards a structured, sustainable approach in the most affected countries. An international approach in line with the World Health Organization's strategy is crucial. But we in the Netherlands must also remain vigilant to ensure that TB does not regain a foothold here as well. Even here, drug-resistant variants of TB pose a threat to public health.

The strategy for the next few years is based on: ensuring that everyone infected with TB is identified, diagnosed and treated; gathering and sharing knowledge of the most effective treatment methods; and reinforcing the local infrastructure in cooperation with governments, social partners and private parties.

I am proud of our KNCV, which in drawing up and implementing this Strategic Plan 2015-2020 will make an important contribution to 'a world without tuberculosis'.

2. EXECUTIVE SUMMARY

KNCV Tuberculosis Foundation (KNCV) is an international non-profit organization, committed to fighting and preventing tuberculosis worldwide. Our ultimate goal is a world without tuberculosis.

Our strategic objectives for 2015-2020 are:

1. Improve **access** to early TB prevention and care for patients with all forms of tuberculosis and achieve better individual outcomes and public health impact (Access).
1. Generate a solid **evidence** base for new and new and existing tools and interventions (Evidence).
1. Bolster the governance and management capacity of the National TB Programs (NTPs) to ensure robust, responsive and inclusive national TB Control systems (**supportive systems**).

We intend to reach those objectives by:

Access: developing and delivering a comprehensive country-specific package of interventions for prevention of transmission, prevention of progression from infection to disease, early diagnosis and effective treatment of TB disease, and overcoming barriers for special patient groups.

Evidence: generating evidence about the TB epidemic, the control response and specific interventions through implementation research, operational research, population epidemiology and building research capacity in these areas.

Supportive systems: developing and delivering comprehensive, needs-based, country-specific managerial assistance packages that cover strategic and operational planning, resource mobilization, engagement and coordination of other sectors and partners and monitoring and evaluation.

Our organizational goals for 2015-2020 are linked to our three strategic objectives:

1. Access: To have contributed to TB case-finding and treatment outcomes, as indicated by country-specific data on different types of TB in different sub-populations.
2. Evidence: To be among the top-3 leading groups in each of the four key results areas, as indicated by impact on policy, research output and successful collaborations.
3. Supportive systems: To be recognized as a technical agency that excels in both technical and managerial assistance, as indicated by managerial indicators such as GF performance, stakeholder involvement, and the quality and robustness of M&E.

3. VISION, MISSION AND PRINCIPLES

KNCV Tuberculosis Foundation is an international non-profit organization dedicated to the fight against tuberculosis. TB is still the second most deadly infectious disease in the world. In 2013 there were 9 million TB patients worldwide, and the WHO estimates that about 3 million people who become ill with TB remain without effective treatment. Each year, 1.5 million people die from TB, leaving families behind in despair and poverty. Treatment is often long, difficult and expensive, especially for MDR-TB.

KNCV has been fighting TB since its establishment in 1903 as a collaborative effort by several private local TB control initiatives in the Netherlands. Over the past 110 years, the organization has acquired indispensable knowledge and experience in the field effective TB control, resulting in the Netherlands' program currently being one of the front runners for eliminating the disease. In 2001, KNCV was one of the founders of the Stop TB Partnership, joining forces with the WHO and many local and international organizations to implement a global approach to TB control. KNCV has contributed significantly to the realization of the global Stop TB strategy 2006-2015 by leading the Coalition for Technical Assistance, which implements TB control programs in countries throughout the world.

In the short term, KNCV aims to save lives and alleviate human suffering due to TB, to curb the TB epidemic and to prevent the further spread of drug-resistant tuberculosis.
In the medium term, our goal is to reach the targets for TB prevention and control set by the international community and guided by the WHO Global Strategy, which aims for a 95% reduction in deaths and a reduction in the global incidence of TB to less than 10 cases per 100.000 population, all by 2035. For the Netherlands, by 2035 we aim to reduce the rate of TB incidence to reach the elimination target of less than one case per million population. In the long term, KNCV strives for the complete elimination of TB worldwide.

KNCV contributes to these goals by

- **Helping countries to build and implement**
- **their TB fighting strategies**
  We provide technical advice and knowledge to support countries in the process of developing and implementing solid national strategic- and annual working plans that adhere to international guiding principles. By working together, we aim to build local capacity, thereby increasing the ability of people and systems to develop and become self-sustaining

- **Generating, applying and sharing knowledge**
  We are a worldwide expertise center for TB control that generates a solid evidence base for new and existing tools and interventions, helping countries to apply them and facilitate the sharing of knowledge and ideas.

- **playing a pivotal role in international TB policy development and advocacy**
  KNCV participates in and regularly facilitates the development of policies, guidelines and tools, in cooperation with the WHO, Stop TB Partnership or TBCTA partners. By working together with governments, public and private health companies, research institutes and civil society organizations worldwide we keep TB on the global agenda and help mobilize resources.

Our vision is: A world free of tuberculosis.

Our mission is: The global elimination of tuberculosis through the development and implementation of effective, efficient and sustainable TB control strategies and interventions.

KNCV guiding principles

In our work we are guided by six principles:

1. Base the KNCV strategy on the Universal Health Coverage[1] agenda;
2. Consider the legal and ethical issues of TB care and a human rights-based approach;
3. Identify the greatest impact at the lowest cost and least effort;
4. Ensure country ownership and country-specific design of interventions;
5. Value and build partnerships at all levels;
6. Ensure transfer of knowledge as an integral part of our technical assistance.

KNCV Core values

These are the values that make us proud to be part of KNCV:

- Humanitarian focus
- Delivering results
- Reliability
- Flexibility to respond to changing challenges and opportunities

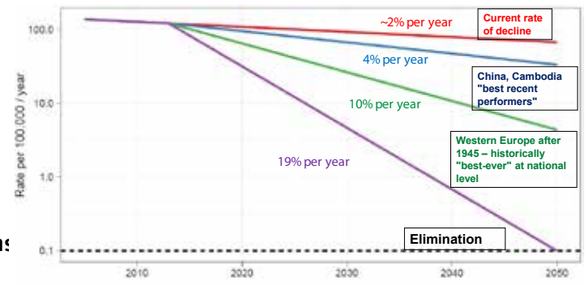
[1] *The goal of universal health coverage (UHC) is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. UHC is the overarching agenda of the WHO as embraced by the World Health Assembly for the Post-2015 Sustainable Development Goals.*

4. STATE OF TB CONTROL IN 2014

The TB epidemic is generally in slow retreat. Although the Millennium Development Goals (MDGs) targets for decline of prevalence and mortality will be met by 2015, the decline of incidence still lags far behind by an average of only 2% per year. Even the "best performing" countries have a rate of decline that falls short of what has been achieved historically in Western Europe (graph). Clearly, the current approach based on passive detection of TB patients and treating them with existing drug regimens remains insufficient to stop transmission and reduce mortality. Although TB control efforts have saved an estimated 37 million lives since 2000, new approaches are badly needed if we are to reach the goal of TB elimination by 2050. These approaches need to address important new challenges such as drug resistance and TB/HIV co-infection.

What is needed to reach TB elimination by 2050?

(<1 case per million population)



Multi-Drug Resistant TB (MDR-TB) is a serious problem in all countries from a humanitarian perspective, and in several countries it is also a serious public health hazard, with increasing rates of MDR-TB, Extensively Drug Resistant TB (XDR-TB), and even Totally Drug Resistant TB (TDR, resistance to all available TB drugs). Although case detection of MDR-TB is increasing with the rollout of rapid resistance testing, it is still low (only 28% of the estimated 480,000 MDR patients diagnosed around the world in 2013). This is due to weak laboratory systems, insufficient training for clinicians and lack of attractive treatment options. The current second-line treatment, which lasts 18-24 months and involves severe toxicities, poses serious challenges to health systems and patients, including catastrophic expenditures for patients' households. Treatment outcomes for MDR-TB are very low (global average is 50%, while the target is 75%). This is a testimony to the poor scalability of these treatment regimens. Newly available drugs such as bedaquiline and delamanid hold promise for simplifying and shortening MDR-TB treatment, but it will be several years before regimens based on these drugs will have been tested for their effectiveness and safety.

The epidemic of HIV-associated TB appears to be on the retreat in sub-Saharan Africa, where various countries have achieved high coverage of testing TB patients for HIV and high overall coverage of anti-retroviral treatment, as well as a slow decline of HIV prevalence in the general population. Yet many high-burden countries are still far from reaching the target of (100%) universal HIV testing and counseling and anti-retroviral treatment. Mortality from TB among people living with HIV is still considered very high, at around 25%. While HIV prevalence in the general population has stabilized or is decreasing in many high-burden countries, Eastern-European countries are still experiencing a steady increase of HIV in concentrated epidemics among intravenous drug users, sex workers, and marginalized populations such as in prison populations, which are also populations at higher risk for MDR-TB. This requires a combined response by national TB and HIV programs. A similar situation exists in South and East Asia, although the MDR-TB prevalence is generally much lower there.

Lastly, the TB epidemic tends to concentrate in vulnerable groups, such as the elderly, children, migrants, slum dwellers and prisoners, who often face barriers to access diagnosis and care. This applies to all settings, although different sub-populations may be involved. Elimination of TB will require appropriate mechanisms to reach these groups and to stop transmission and unnecessary suffering through targeted and tailored programs.

Funding for TB control

International donors are the main funding source for TB control, and the majority of the funding is channeled through the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM/ Global Fund). This important funding mechanism struggles to acquire sufficient donor contributions to meet the financial gap in the fight against these three diseases. The GFATM is under close scrutiny by donors for effective, efficient and accountable use of its funds. Countries must demonstrate increasing and significant government commitment in order to make the Global Fund investments sustainable and the countries less donor-dependent. Also they must meet increasingly stringent criteria for receiving grants. The demand for specialized technical assistance to help countries apply and implement these grants has exploded, presenting a challenge to all technical agencies. Ensuring the success of Global Fund grants in countries by showing the impact of Global Fund investments generates critical evidence to convince donors that their investments are well spent and should be continued.

USAID is the largest single Global Fund donor for TB control. Its global funding mechanisms and its bilateral grants at the country level are highly sought after by a vast number of international technical agencies. At the country level, bilateral funding is given more emphasis with national organizations as the lead partner.

In the Netherlands, TB control funding is acquired through municipal funding streams. Program governance is financially supported through RIVM and the Dutch Friends Lottery's support to KNCV. The Dutch Ministry of Foreign Affairs has recently stepped up its funding of international TB control by allocating a modest amount to support technical assistance to countries in support of Global Fund TB and TB/HIV grant implementation.

Research into new diagnostics, new drugs and vaccines is largely funded by the US National Institutes of Health, the Bill and Melinda Gates Foundation and the European Union. The available funding is considered by many stakeholders as too low to produce a technical revolution in TB control in the near future, such as a point-of-care test for active TB, a completely new and shorter regimen that treats all forms of TB (including MDR-TB), an easy and affordable diagnostic test for latent TB infection, short and affordable preventive therapy, or a safe vaccine that can prevent adult pulmonary TB and cut TB transmission. In the light of this reality, in order to drive the epidemic down at a much faster rate than currently observed, TB control programs must better utilize the current and newly available tools. Funding agencies do recognize this need and are increasing investments in implementation research aimed at increasing these tools' (cost-) effectiveness and feasibility.

5. KNCV'S POSITION IN A CHANGING GLOBAL ENVIRONMENT

There are various external developments, trends and challenges that influence our work and should be taken into account to make our strategic interventions truly effective. The main challenges that KNCV sees in relation to effective TB Control worldwide stem from macro developments in the political, economic, social, technological and legal sphere.

Political

- Due to the economic crisis in many countries, including The Netherlands, budgets have been reduced and Government priorities have shifted away from tuberculosis and health in general. However, donors such as USAID express continued strong commitment to address the TB pandemic, and administer political pressure to strengthen the global TB control effort as an important health priority on their foreign policy agenda.
- On 19 May 2014, the 67th World Health Assembly adopted the Post 2015 Global Strategy for TB Prevention, Care and Control. This should lead to increased commitment from the participating countries.
- The 2015 Millennium Development Goal (MDG) of halting and reversing TB incidence has been achieved globally, but progress has been uneven within and across countries and regions. Although health will remain an important component of the post-2015 development agenda, transformational changes towards universal access are foreseen for health in general. Nonetheless, the new Sustainable Development Goals are expected to address important underlying determinants of the tuberculosis epidemic, including poverty, food security, adverse effects of population movements and complex emergencies. TB prevention and control will benefit from general economic growth, poverty reduction, improved nutrition, better living and working conditions as well as strategies that mitigate the impact of migration, population ageing and chronic diseases such as diabetes, which are all risk factors for TB.

Economic/financial

- The WHO estimates that although there has been substantial increase in global financing for TB control, from less than 2 billion US$ in 2002 to 6 billion US$ in 2013, there is still a gap of 2 billion dollars per year needed to ensure an effective global response to the TB epidemic. This excludes the necessary resources for research and development of new diagnostics, drugs and vaccines, estimated at another $ 2 billion a year.
- While domestic contributions towards TB control efforts have generally increased over the past decade, in the African region (excluding South Africa), donors still provide more than 50% of the funding, frequently supporting the critical operational components (HR, drugs, supervision etc.). This jeopardizes the sustainability of core interventions.
- A more prominent role is expected from the rising economic powers Brazil, Russia, India, China and South Africa (BRICS), which account for more than 55% of TB notifications and more than 60% of all MDR-TB. They have the capacity to finance the majority of their own domestic programs and are increasing their technical (assistance) capacity rapidly. The discovery and/or development of new tools and technologies might very well come from one of these countries.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria has introduced its new funding model, placing stronger emphasis on a comprehensive approach. This reaffirms the KNCV working methods.

Social

- At this moment, more than half of the world population lives in an urban area. In mid-2014, the United Nations reported that an additional 2.5 billion people are predicted to live in urban areas by 2050, making up almost 70% of the total world population. This is having, and will continue to have, a major impact on the way TB will spread and on the way we will need to organize urban TB control.
- The gap between the haves and the have nots is growing. Poor people not only have limited access to health care, they are also disproportionally burdened with the extra costs or loss of income associated with following TB treatment. Recent KNCV studies on out of pocket expenditures illustrate that free treatment alone is not enough to take away barriers for the poor.
- Focus is shifting from government responsibility to self-organization, and from consumerism to a sharing economy. The vigor and potency of community organizations is gaining recognition.

Technological

- The advent of new drugs and diagnostics represents the most important development in contemporary TB control, marking a dynamic and crucial phase in the history of the fight against TB. At the same time, uncontrolled use, especially of new drugs, may have dramatic consequences for their effectiveness in the longer term. KNCV can play an important role in generating, applying and sharing the evidence needed to scale up new tools and regimes.
- Technological advances in microbiology are rapidly resulting in lab technologies currently used in research settings feasible for routine use in clinical and public health labs. In particular, DNA sequencing, including whole-genome sequencing, is becoming available to provide detailed information about drug resistance patterns and even transmission chains.
- The rapid development of internet and mobile phone systems in the low- and middle-income countries opens up opportunities to implement nationwide electronic surveillance systems which can change the landscape of reliable recording and reporting for any form of TB, as well as laboratory data systems important for quick feedback of diagnostic test results to clinicians. These technologies also pave the way for innovations that improve access to care (e.g. payment systems) and adherence to treatment, as well as keeping health care workers updated on new developments.

Legal

- Illegal immigration is a growing problem in many countries, which often do not allow patients without documentation to be diagnosed and treated. This is true between the global South and the North, but also within the South (e.g. cross-border migration within Africa). Ethical and legal dilemmas also arise when XDR/TDR patients are beyond treatment but still infectious.
- To optimize resource mobilization, KNCV may occasionally benefit from competition for local funding opportunities, but governments posing restrictions on foreign NGOs doing so often hinders the organization.

6. SWOT ANALYSIS

Strengths

Strong track record in technical assistance at the country level. KNCV has an internationally recognized track record in country programs and implementation of TB control, as well as strong personal relations with NTPs.

Strong generalist reputation in TB control. KNCV has a large consultant base with broad technical expertise, combining a variety of consultancy skills by experts with extensive working experience in a large number countries, and is represented in a wide array of TB policy forums.

Combination of program-based support and research. KNCV is probably the only technical agency that provides an integrated approach of programming and implementation with research to map the epidemic and address operational issues.

Strong track record in surveillance. KNCV has widely recognized expertise in the design, implementation and data analysis for TB recording and reporting systems, as well as for surveys of TB prevalence, TB drug resistance and latent TB infection. It also has a wealth of experience in operational research in various countries and types of health systems.

Successful models and tools. KNCV has created successful models for TB control (e.g. for capacity building and social mobilization), and gained broad experience in applying and adapting these models in various settings.

Weaknesses

Low brand recognition: KNCV has created many successful models and tools, but the organization should make a greater effort at branding these as such, as this would help to position and bolster KNCV's image as a pro-active and innovative agency.

Inconsistent quality monitoring: KNCV is a technical agency and our success greatly depends on the technical quality we offer. While much of KNCV's output has been of excellent quality, we must be even more rigorous in monitoring our technical quality in order to ensure that KNCV upholds its reputation as a pioneer in quality TB control programs and research.

Vulnerable funding base. The number of donors for global TB control is decreasing. This makes KNCV, as a technical agency specializing in TB, vulnerable to changes in the funding landscape. KNCV must mitigate this risk by diversifying its funding base and protecting its competitive advantage.

Insufficient young talent. TB control requires new young talent, and KNCV should increase its efforts to attract young talent to foster the next generation of TB control experts by offering scientific career opportunities in the organization, for example, but also by increasing opportunities to specialize in certain expertise outside of classic TB control.

Limited focus on research potential. KNCV's research is now largely driven by capacity building motives, which should be balanced more with scientific relevance. This could be done by focusing on research that has a high potential for innovation and by collaborating with academic groups, while continuing to strengthen research capacity in the countries where we work.

Opportunities

Growing need for technical assistance. There is a growing need for technical assistance for TB control with growing availability of funds, in particular from the Global Fund, but also from other donors and countries.

Technological developments. Technical developments for TB (new diagnostics, new drugs) as well as for health in general (m-health, e-health) are enabling innovations in TB control.

Increasing call for evidence and impact. Governments, international donors and end-users increasingly require that interventions and policies are evidence-based/evidence-informed and cost-effective, and that control programs and projects show the impact of their efforts on patient's health, on their livelihoods and on the TB epidemic.

Growth of private health care and corporate sector. Low- and lower-middle income countries are seeing a rapid expansion of the private health care sector and corporate interest in health financing, including insurance policies. While in the past this has been regarded as a threat to TB control, it also offers opportunities for developing new models of public-private collaboration and equitable access to TB diagnosis and care.

Threats

Fragmentation of technical assistance. There is increasing demand for specialized technical assistance, and donors increasingly focus on quick results, e.g. in small pilots. This poses the risk of fragmentation and of reduced demand for the more generalist expertise and long-term approach that KNCV offers.

Fewer global contracts. Increasingly, calls for technical assistance are bi-lateral rather than part of a multi-country call. Responding to multiple calls requires increased mobilization of resources.

Competition on financial grounds. Free-lance consultants with relatively low salaries and overheads are increasingly successful in acquiring TA contracts, posing the risk of the KNCV of being outcompeted on financial grounds.

7. EXTERNAL STAKEHOLDERS

KNCV operates in a complex client system with a diverse group of stakeholders that have different interests and expectations. We believe that sustainability and partnerships are crucial to reach our goals of alleviating suffering, saving lives, and eliminating TB. That is why we strive to be a strong partner in relevant and occasionally unorthodox local and international alliances, and to share and exchange knowledge in order to build local capacity.

Partners
- Technical agencies
- Civil society organizations
- Research institutes
- Development NGOs
- Professional associates

Beneficia
- ries
- National TB programs
- Health care workers
- Patients

Influencers
- Media
- Advocacy groups

Donors
- USAID
- Global Fund
- Dutch government
- Other (research) funders
- Dutch TB foundations
- Dutch lotteries
- Private donors
- Unidentified possible donors

Policy makers
- WHO
- Stop TB Partnership
- Governments
- Multi-lateral organizations and institutes
- Product Development Partnerships

Private sector
- Health insurance companies
- Manufacturers
- Private health providers

Beneficiaries

KNCV aims to eliminate TB by the development and implementation of TB strategies and interventions at the country level. Our main direct beneficiary is the country's National Tuberculosis Control (NTC) effort, and through them health care workers and, eventually, patients. The NTC is almost always a multi-stakeholder initiative led by the Ministry of Health's National TB Program, with the objective reducing TB as a public health problem in the country. They need and expect professional knowledge and experience, tailor made to their specific situation. Also KNCV's capacity building approach is important to countries in order to enhance the self-sustaining and developing ability of their people and systems.

Partners
KNCV works in a broad network of international and local technical partners, civil society organizations and research institutes, but also local and international development NGOs and professional organizations. We share our knowledge and experience with them, but we also learn from them while working to realize the countries' TB control missions and strategies.

Donors
Donors (USAID, Global Fund, Netherlands Government and other [research] funders) are important partners, as they fund the KNCV's consultancy services and research activities. In addition to expecting quality expertise and deliveries they also expect to work in tandem, aligning efforts to get the most results. KNCV has an important role in linking donor demands with national TB control requirements in an optimal manner. Donors are increasingly becoming our direct beneficiaries, as our work contributes to their national and international positioning and recognition. In many settings, KNCV contributes to strengthening the capacity of local donor staff, providing the appropriate feedback with the aim of adapting the donor funding strategy to the local needs. In addition KNCV is itself beneficiary of private donations, directly or indirectly through lotteries (Vriendenloterij, LOTTO) and Dutch TB foundations ("doelaanwijzers"). These expect KNCV to maximize the yield of their contributions, in terms of TB control achievements, to do so in a responsible and transparent manner, and to make those achievements visible.

Policy makers
KNCV must respond to policies set forth by national governments, the WHO and other multi-lateral organizations and institutes. At the same time KNCV attempts to influence those policies based on its technical expertise and evidence gathered regarding TB burden, TB control performance and new interventions. Organizations such as the Stop TB Partnership, but also Product Development Partnerships through their stakeholder associations (for new drugs, diagnostics and vaccines), are important channels through which KNCV can exert such policy influence.

Influencers
With regard to policy influence KNCV operates in a broader landscape in which advocacy groups have become powerful players. Alliances with groups advocating for better TB control (politically, financially, technically) are valued elements of achieving KNCV's mission. At the same time, we are aware that at the country level, the advantages of such alliances need to be weighed against the potential disadvantages.
Public media are similarly powerful players. These expect KNCV to publish its achievements and approach in a transparent manner. We welcome this, as it provides opportunities to keep the global TB problem on the public and political agenda.

Private sector
Historically regarded as part of the problem (e.g. emergence of drug resistance through TB treatment by private providers), the for-profit private sector is increasingly seen as an important contributor to the solution. This is true for for-profit health care providers, who as increasingly important players in diagnosis and treatment in many countries must be engaged as part of countries' national tuberculosis control efforts. Other important contributors can be health insurance companies in the context of Universal Health Coverage, as well as manufacturers of drugs, diagnostics and vaccines. KNCV must develop partnerships with these players, building on previous public-private partnership successes in Indonesia, Vietnam and The Netherlands. When these parties realize that KNCV will acknowledge their profit objectives, business models can be developed in which this aim is aligned with KNCV's TB control and elimination mission.

8. KNCV STRATEGIC RESPONSE

During the period 2015-2020 KNCV will work towards achieving its mission of eliminating TB in three focus areas: access, evidence and supportive systems.

The **access** focus area encompasses the deliverables needed to alleviate suffering, prevent deaths, and curb the epidemic by reducing transmission of drug-susceptible and drug-resistant TB. Here KNCV's strategic objective is **to improve access to early TB prevention and quality care for patients with all forms of tuberculosis, and achieve better individual outcomes and public health impact.** This objective puts access to prevention and care at the center of our efforts to eliminate TB, acknowledging the profound disparities (socio-economic, co-morbidities, living and working conditions) that exist with regard to risk for TB and access to quality care. It also acknowledges the importance of smear-negative and extra-pulmonary TB, pediatric TB and drug-resistant forms of the disease, in addition to adult, drug-susceptible smear-positive pulmonary TB that has historically been the focus of National TB Programs. We have defined four key result areas (prevention of transmission, prevention of progression from infection to disease, early diagnosis and effective treatment of TB disease and overcoming barriers for special patient groups) covering the entire chain of TB control that needs to be addressed in order to achieve our mission.

The **evidence** focus area supports KNCV's mission by providing the knowledge required to maximize the outputs and outcomes to improve access. The strategic objective here is **to generate a solid evidence base for new and existing tools and interventions.** This objective responds to the need for new interventions and approaches for TB control and the opportunities offered by technological innovations, while acknowledging the importance of producing the evidence to support their scale-up. It aims to identify in a methodologically rigorous way the most effective means (diagnostics, drugs, potentially vaccines) and interventions, as well as the target populations and modes of delivery with an optimal value for money. The key results areas for this objective include evaluation of new interventions (implementation research), optimizing performance of TB programs (operational research), and quantifying the problem to be addressed and identifying target populations (population epidemiology), as well as building the capacity to plan and conduct these types of research.

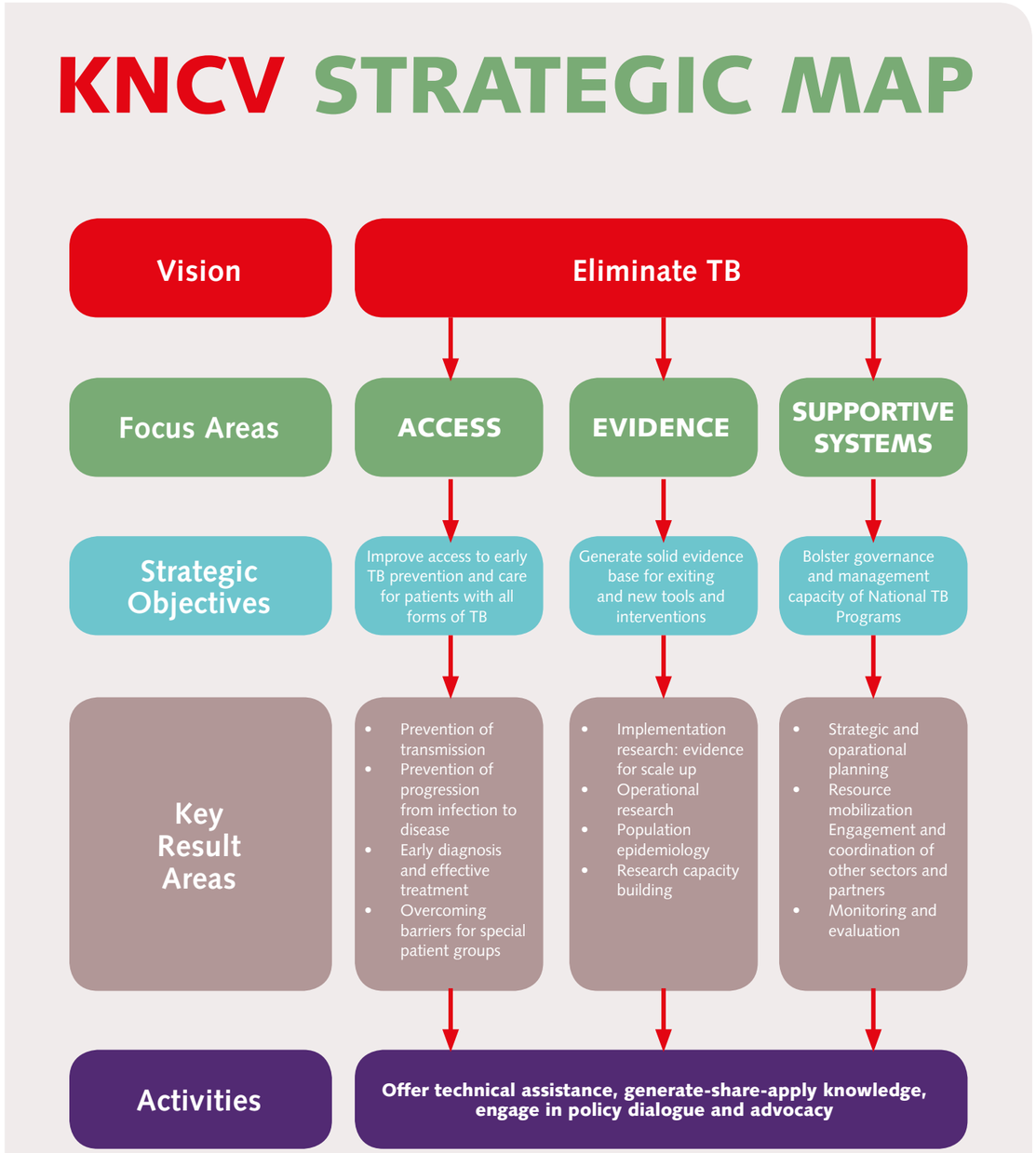
The **supportive systems** focus area further supports KNCV's mission by optimizing the conditions for realizing the outputs and outcomes to improve access. The strategic objective is **to support management systems that ensure efficient use of human and financial resources.** It acknowledges that maximizing equitable access requires technological and managerial solutions that take a holistic view of TB control as being embedded in health systems and supported by various actors. The key result areas to reach this objective are strategic and include: operational planning for national TB control efforts, mobilizing resources for TB control (at the country level as well as globally), engagement and coordination of other sectors and partners (including the private sector, for example), and monitoring and evaluation of the outputs, outcomes and impact of TB control activities.

In each of these there focus areas KNCV will achieve its results through three types of activities: technical assistance, knowledge center functions, and policy dialogue and advocacy.

KNCV will offer technical assistance through an effective mix of long term in-country technical assistance and short term consultancies by highly specialized experts. We will build local capacity through local offices and country teams, while ensuring that the latest developments are shared.

KNCV aims to be a knowledge center by generating, sharing and applying experiences, expertise and evidence for TB control. We will gather experiences with various approaches through our assistance work in countries, share these as best practices with clients, partners and policy makers, and apply them in other countries where we work. We will build expertise in assessments and studies that we will share in policy arenas and trainings, and apply them to develop new effective ways to control TB. The evidence we generate in our research projects will be shared through scientific publications, conferences and policy briefs, and of course will guide our interventions.

Finally, KNCV will be actively engaged in policy dialogue and advocacy, both at the country level and internationally. We will call on all of our experience, expertise and evidence to help generate policy recommendations and guidelines for various aspects of TB control, to share the policy insights, and to build the political support among governments, multilateral organizations and donors by informing and shaping policy dialogue and advocacy towards effective TB control with the required policies, legislation and finance.



8.1 Focus area and strategic objective 1:

ACCESS

Strategic Objective

Improve access to early TB prevention and care for patients with all forms of tuberculosis and achieve better individual outcomes and public health impact.

Strategic Approach

Eliminating TB requires blocking the cycle of transmission and disease. KNCV's strategic approach is to impact all three crucial components of this cycle: prevention of transmission; prevention of progression from infection to disease; and early effective treatment of patients with TB. Decades ago KNCV shifted from its historical focus on passive case-finding of sputum-smear positive pulmonary TB to a more comprehensive set of interventions, including TB infection control, diagnosis and treatment of latent TB infection, and a rational mix of passive and active case-finding strategies followed by prompt and effective treatment. Today KNCV brings a wealth of experience in all three intervention areas, ranging from the introduction of IC worldwide and decades of LTBI treatment in The Netherlands, to scale-up and decentralization of PMDT in many parts of the world. In addition, we were the first organization in the industrialized world to develop and help implement national guidelines for TB control among high-risk groups such as (illegal) immigrants, prisoners and substance abusers (1995). We build on that successful experience to design custom-tailored services for key affected populations for all types of TB, wherever we work.

We strongly feel that these experiences are of great relevance to high-prevalence countries which are now upgrading their programs to include IC, LTBI management, PMDT scale-up and active case finding among key affected populations. At the same time, we acknowledge that introduction of new interventions requires robust basic general TB control systems. Therefore KNCV will follow a rational step-by-step approach to introducing and scaling up additional and more resource-intensive interventions, while taking into account the national context and preserving any advances already achieved. Technical assistance in this field will be delivered by country offices, supported by complimentary expert advice from KNCV central office.

Key results areas

KNCV strives to deliver a comprehensive country specific package of interventions in the following 4 key areas:

1. Prevention of transmission
2. Prevention of progression from infection to disease
3. Early diagnosis and effective treatment of TB disease
4. Overcoming barriers for special patient groups

The comprehensive approach proposed above requires setting rational country-specific priorities and buy-in from relevant stakeholders and care providers to be successful (see also Strategic Objective 3). KNCV recognizes that many interventions under Strategic Objective 2 are under development or in the pilot phase, whereas others are based on decades of experience. KNCV is in the perfect position to blend proven and novel interventions by mixing decades of program-based experience with our research findings (Strategic Objective 2). This applies particularly to the introduction and scale-up of new tools.

Key result area 1: Prevention of transmission

Transmission of TB infection in health care, community and household settings is a well-documented problem, but international standards and guidelines on TB Infection Control (TB-IC) have had very limited uptake in high prevalence countries. This became acutely clear in 2007, when the world realized that MDR-TB patients – particularly in high HIV prevalence countries and settings such as South Africa – posed a serious risk for nosocomial transmission with unprecedented high TB mortality among co-admitted patients and health care workers. KNCV played a prominent role in the development of standards and guidelines for TB infection control and their adoption and adaptation in many countries. Health care workers are the most precious resource of any health system and need a safe and caring working environment as they execute their call to look after the sick. KNCV will continue to support countries in scaling up quality-assured, prioritized and appropriate, cost-effective and evidence-based TB-IC interventions. While working to improve such conditions for patients who cannot go without hospital admission, KNCV will continue supporting implementation of ambulatory treatment strategies when and where possible, ensuring that clinical management, patient support and follow-up is combined with TB-infection control measures in the household/community. Occupational care programs for health care workers will be supported with the introduction of routine screening for TB disease and infection (where appropriate and feasible), in combination with HIV care and prevention and other relevant diseases. However, in order to scale-up and sustain TB-IC it must be integrated into general Infection Control and Prevention programs. KNCV will continue supporting initiatives towards achieving this full integration. Information, Education and Communication (IEC) interventions for individual patients and communities at risk are essential interventions for achieving effective health-seeking behavior, contributing to early diagnosis and treatment, and the reduction of transmission and TB morbidity and mortality. KNCV has long experience in this area, both in our own country as well as in high-burden countries, and will continue to apply this expertise in its country projects. KNCV will continue to support efforts towards building more and better evidence on the effectiveness of TB-IC interventions, through targeted monitoring and

evaluation, impact evaluation and development of innovative practical methods of measurement.

Key result area 2: Prevention of progression from infection to disease

LTBI diagnosis and treatment is a routine intervention in industrialized countries such as the Netherlands, where KNCV has been supporting policy and strategy development and monitoring and evaluation of its implementation for several decades. KNCV recognizes the need to scale-up LTBI management (diagnosis and treatment) in high prevalence countries, taking into account rational setting-specific priorities. Obvious target groups include the household contacts of infectious TB index patients and HIV infected individuals, but other key affected populations may also benefit from LTBI management. Ideally, countries should develop national LTBI strategies which define target groups, diagnostic methods and treatment regimens. KNCV is in a perfect position to assist countries in developing, piloting, evaluating and scaling up LTBI related interventions. Operational research will be important in this context, as LTBI diagnosis, IEC, and treatment adherence pose significant challenges under routine program conditions. KNCV therefore offers a comprehensive technical assistance package, covering the full progression from policy-development to service delivery, evaluation and possible scale-up.

Key result area 3: Early diagnosis and effective treatment of TB disease

Early diagnosis and appropriate treatment with a standardized and effective regimen is the cornerstone of TB control. KNCV has extensive experience with successful implementation of this approach in low-, mid- and high TB prevalence countries. Despite all of the progress made so far, it is estimated that 3 million of 9 million incident patients each year remain undiagnosed and/or un-notified. Although some of these missing patients might have received treatment (of unknown quality) in the private sector, many others cannot access TB diagnosis and treatment for a variety of reasons. For instance, several studies have shown that TB patients in low resource settings still face significant out of pocket expenditures to access TB care and/or are unable to cope with the long treatment regimens. This is especially true for, but not limited to, patients with drug-resistant TB. In addition, prevalence studies show that current diagnostic algorithms fail to diagnose a significant proportion of bacteriologically confirmed TB, especially in the elderly. Clearly, new case-finding strategies are necessary to find and treat more TB cases. This will require the introduction of new technologies, including X-ray, targeted active case-finding and patient centered treatment delivery including use of e- and m-health technologies. KNCV brings ample experience with all of the approaches listed above, as well with the design and implementation of prevalence surveys. We are committed to using our expertise and experience to assist countries in upgrading their diagnostic services and introducing and scaling up new shorter regimens to improve treatment outcomes. KNCV recognizes the importance of strong laboratory systems for diagnosis of (MDR-) TB, proper case-management and surveillance of drug resistance. KNCV will continue to invest in laboratory technical assistance capacity as the demand and need in this highly specialized area is still unmet.

Key result area 4: Overcoming barriers for vulnerable patients

Recent prevalence surveys in high burden countries and a vast amount of evidence gathered over the past few years have that particular patient populations do not access, or have difficulties accessing, regular health care, or more specifically, HIV and TB care services. This applies to the elderly (especially in remote areas), but also to specific groups that may not be large in size, but bring a relatively high risk of TB. It is important to note that a country-specific analysis is required in order to identify which groups need tailored interventions, as situations differ significantly. However, in many countries these include the following groups: persons using drugs (PUDs), injecting drug users (IDUs), prisoners, mine workers (particularly underground miners and in combination with silicosis), and (illegal) internal or foreign migrants. While these groups are often marginalized and/or stigmatized, with the associated socio-economical and legal complexities, other (mostly clinical) risk-groups may require special attention as well. For instance, the global increase of diabetes mellitus will have consequences that we must begin addressing today. KNCV will expand ongoing efforts to identify and target these special patient populations by designing, implementing and evaluating custom-tailored diagnostic and treatment modalities that fit the special needs of these vulnerable patients. This may include epidemiological analysis; creating an enabling environment for care; inclusion of TB in insurance schemes and mobile-phone based money transfer and microfinancing services; supportive regulations for migrants and immigrants; culturally sensitive IEC and community support; workplace treatment delivery and targeted case-finding.

Organizational goal I

Our organizational goal for this focus area is to have contributed to TB case-finding and treatment outcomes as indicated by country-specific data on different types of TB in different sub-populations.

8.2 Focus area and strategic objective 2:

EVIDENCE

Strategic Objective

To generate a solid evidence base for new and existing tools and interventions.

Strategic approach

The elimination of TB will not be possible without new technologies (diagnostics, drugs, vaccines) and approaches to enhance their access and uptake. This will require biomedical research and development, as well as insight into drivers and hurdles for access and uptake of new technologies in various settings. At the same time, there is increasing demand for evidence that new and existing health interventions are effective and bring value for money. This is particularly true for TB, which has traditionally been an area of public health and, due to its strong association with poverty, of donor financial support. There is also an increasing need for more in-depth understanding of the burden of TB, latent TB infection (LTBI) and anti-TB drug resistance in various populations and risk groups, and of the factors that drive variations between them.

KNCV has for long linked operational and epidemiological research to technical assistance for TB control programs, and its niche in TB research is determined by its comparative advantages in this field. KNCV's strength lies in the close link between its research and TB program implementation, as well as in its widely recognized experience in operational research to support TB control activities and in research to measure their epidemiological impact in all regions of the world. Its primary research niche is therefore in three partially overlapping key result areas: implementation research, operational research and population epidemiology. In addition, research capacity building in the countries where we work will remain an important area of focus for KNCV.

Key results areas

KNCV strives to generate evidence about the TB epidemic, the control response and specific interventions in the following four results areas:

1. Implementation research: evidence for scale-up
2. Operational research
3. Population epidemiology
4. Research capacity building in these areas

Key result area 1. Implementation research: evidence for scale-up

KNCV's implementation research focuses on helping translate innovations in TB control into policy and practice by gathering evidence about new interventions for their implementation at the program scale in a systematic and scientifically robust manner. Its product is "evidence for scale-up", as needed by governments, donors and other policy makers to take decisions about rolling out particular interventions, primarily concerning effectiveness (patient-important outcomes; epidemiological impact), feasibility (adaption to local situations, optimized access, uptake and adherence; acceptability) and economic aspects (cost-effectiveness; affordability; patient cost, in particular impact on catastrophic expenditures). We will look at control strategies (e.g. diagnostic algorithms) rather than at the technologies as such.

One consequence of this implementation focus in its research is that KNCV focuses on demonstration studies pre- and post-WHO endorsement but does not prioritize more upstream research such as diagnostic proof-of-concept studies and clinical trials of new drugs – even though collaborations in such areas (such as support to collaborating clinics or labs to be involved in clinical trials) may be pursued when strategically relevant.

Under this comprehensive implementation research umbrella KNCV will undertake studies of a broad range of types and designs depending on the need, the geographical scope and available conditions and funding. Effectiveness evaluations may take the shape of pragmatic trials (e.g. community-randomized and stepped wedge designs) as well as more limited parallel or before-after comparisons. Epidemiological impact measurement may be based on repeated surveys (e.g. TB prevalence, drug resistance) and on longitudinal analysis of surveillance data. Evaluations of feasibility may combine larger systematic data collections with targeted root cause analysis approaches, and quantitative with qualitative research approaches. Economic evaluations may include decision analytical modeling and empirical costing data collection, including patients' costs.

Key result area 2. Operational research

Operational research has been defined in many different ways. KNCV's pragmatic definition[2] is observational studies to assess deficiencies in TB control, and to identify causes that are amenable to improvement using technical or managerial interventions. Operational research is intended to provide locally relevant solutions to locally defined problems (but may yield results that are useful to similar settings elsewhere), with priorities that are generally also locally defined. KNCV has a longstanding track record in operational research in support of TB control programs, and aims to continue this work. However, it does recognize that scope and applicability of previous work (in terms of relevance outside the setting in which the studies were done) has sometimes been limited, and that the results have not always been translatable into policy due to the lack of actionable outcomes. Therefore KNCV will steer the operational research projects that it supports towards increased policy relevance and applicability to other settings.

Operational and implementation research clearly have overlaps, in particular with regard to evaluations of feasibility. In addition, KNCV recognizes the need to shift the direction of its operational and implementation research from a TB-unique focus to one

[2] For KNCV's purposes, this classical notion of operational research in TB control is separated from implementation research due to its non-intervention nature.

that includes the health systems context. Interventions will only bring about better TB control if health services are available and of acceptable quality, and if patients seek diagnosis and care for their disease and adhere to advice and treatment. These conditions depend on health care financing and costs to patients, and must be studied in order to develop interventions on both the supply and demand side in order to improve them. Such interventions should then also be evaluated with regard to their scalability. Therefore, KNCV will seek to include the broader health systems context in its operational and implementation research whenever relevant. This will require putting more emphasis on qualitative research methods and involvement of health economics and finance expertise.

Key result area 3. Population epidemiology

Over the years KNCV has acquired a wealth of expertise in surveys and surveillance to measure the extent and course of the TB epidemic and its aspects at the population level in a variety of settings. This includes technical assistance to building surveillance systems and analyzing surveillance data, as well as designing, conducting and analyzing TB prevalence surveys, surveys of LTBI in children, and drug resistance surveys. This work is becoming increasingly important for a number of reasons. Indicators of TB control must be measured against targets set by the global TB community. There is an increasing demand for understanding the TB burden among specific risk groups ("know your epidemic"), primarily to target interventions under the Global Fund New Funding Model. Increasing attention to treatment of LTBI as a way of reducing incidence requires mapping of (recent) LTBI prevalence in various population segments. The advent of new drug regimens using existing or repurposed drugs (such as pyrazinamide and moxifloxacin) require detailed insight into the population distribution of resistance to these drugs and its course over time. And finally, new interventions ultimately need to be evaluated for their epidemiological impact, requiring the monitoring of trends in various indicators.

There is also a need for methodological innovations in this field, which KNCV is well positioned to address. These include novel sampling approaches for TB prevalence surveys, especially for hard-to-reach groups (e.g. respondent-driven sampling), and for drug resistance measurement; use of IT solutions in surveillance and surveys; molecular testing in prevalence surveys; including detailed patients costing in surveys to measure "catastrophic expenditures"; sequencing-based drug resistance surveys and surveillance; real-time analysis of drug resistance data to identify emerging outbreaks of multidrug-resistant TB; and novel approaches to testing for LTBI.

Key result area 4: Research capacity building

For many years, KNCV has aimed to build capacity for operational research and population epidemiology in the countries where we work. Experience has led to a model of networks in which national TB control programs collaborate with local academic or other research institutes based on a research agenda developed with stakeholders. In this model, the NTP's role is to steer and coordinate research activities rather than to implement these itself, while KNCV's role is to provide technical assistance for the various steps in this process (agenda development, design of studies, study implementation, data analysis and dissemination of results), while training NTP staff and local researchers through short courses, learning-by-doing and PhD programs. In countries where this model has been fully implemented, it has proven successful, but it requires long-term political, organizational and financial commitment, solid embedding in program implementation and planning, and therefore strong links with other KNCV technical assistance. We will continue to build capacity through this comprehensive model, prioritizing countries where these conditions can be met. Short-term and isolated capacity building activities, such as operational research courses in countries where KNCV does not provide other TA, have had limited yield and impact and will therefore not be prioritized.

The training activities for research capacity building will continue and be strengthened. The KNCV-developed short course in operational research, which includes follow-up with study protocols, study implementation and data analysis, will be reviewed for its short- and long-term effectiveness and impact. PhD projects linked to larger studies will be encouraged insofar that they support the conduct, analysis and dissemination of these studies. In addition KNCV will explore options for MSc training programs in operational and implementation research, in order to fill the gap between the short course providing basic knowledge and skills and PhD programs that are aimed at creating independent senior scientists. NTPs in particular could benefit from such MSc trainees. Options include linking to existing initiatives for TB operational research (e.g. that conducted by The Union/MSF) and supporting modular MSc courses provided by (networks of) regional training centers such as Schools of Public Health.

A caveat to KNCV's strategy as it has developed over the years is that capacity building had become the overriding objective for its research activities. The consequence of that choice is that local research capacity and local needs are decisive for any research activity undertaken, resulting in the often limited scope of the studies, long delays in publication and limited visibility of KNCV's efforts in publications. This may jeopardize efforts to produce high-quality implementation and epidemiology research, and to acquire grants for doing so. Therefore, capacity building will be a stated objective for selected projects or country support activities rather than the primary objective for all of KNCV's research.

This means that the capacity building objectives for each project will need to be clearly defined, and that KNCV may conduct or support research projects that have no such objective.

Organizational goal

Our organizational goal for this focus area is to be among the top-3 leading groups in the 4 key results areas, as indicated by impact on policy, research output and successful collaborations.

8.3 Focus area and strategic objective 3:

SUPPORTIVE SYSTEMS

Strategic Objective

Bolster the governance and management capacity of the National TB Programs (NTPs) to ensure robust, responsive and inclusive national TB Control systems.

Strategic approach

Effective TB Control at the country level requires strong technical and managerial leadership to ensure sound TB control, respond to opportunities and overcome challenges. In reality, many NTPs struggle to develop and implement strategic plans, to access domestic funding, to comply with international donor requirements and cross the familiar Ministry of Health (MOH) boundaries to engage with other sectors and health systems developments. For instance, TB control could benefit from political agendas, such as Anti-Microbial Resistance (AMR) and Universal Health Coverage (UHC), and related initiatives such as health insurance schemes. At the same time, the integration of TB surveillance or supply chain mechanisms in broader national data-management systems may easily turn from opportunity to threat if not well managed. All in all, NTPs operate in an increasingly complicated environment, facing a great number of opportunities, challenges and expectations that require strong leadership and management skills.

Therefore, KNCV considers managerial support an essential component of contemporary TB technical assistance. KNCV aims for empowerment of NTP central units to design, manage and report on inclusive TB control programs, which are not limited to MOH run operations only. We embrace a holistic approach that ensures optimal use of resources in the community, both financial and human, to support TB control. Ideally, all stakeholders in the public and private sector contribute to one comprehensive national TB control strategy. This approach contributes to better outcomes and prevents fragmentation and/or diverging policies. This vision is ideally suited to KNCV's history of providing technical assistance by working with and through governments, while at the same time linking up with private and public sector partners beyond the MoH, such as civil society organizations, relevant other ministries, academia and medical associations.

KNCV will further strengthen its systems support through a comprehensive set of interventions in countries with KNCV offices, whereas KNCV country portfolio managers in the central office will pursue the same approach for all countries funded under the USAID funded Challenge TB project.

Key results areas

KNCV strives for delivering a comprehensive country specific package of interventions in the following 4 key areas:

1. **Strategic and operational planning**
2. Resource mobilization
3. Engagement and coordination of other sectors and partners
4. Monitoring and evaluation

KNCV will develop comprehensive needs-based managerial assistance packages (MAPs) for each country, which will contribute to sustainable, accountable and responsive National TB Programs. These will be based on a stakeholder analysis and a country-specific scan of national health systems developments, program performance and human and financial resource capacities. KNCV MAPs are built on more than 30 years of long-term country support and facilitate the sharing of best practices between settings.

Key result area 1: Strategic and operational planning

Technically sound, prioritized and budgeted national strategic plans (NSPs) form the basis of any successful program and are a requirement for key donors such as the Global Fund. KNCV will continue to support the development of such plans and GF Concept Notes in an interactive TA process, aiming for both concrete TA outputs (sound plans) and country ownership. KNCV realizes that transfer of knowledge in the field of planning, budgeting and operational management requires an effective mix of generic guidance (training, tools) and country-specific products that match needs, culture and capacity. KNCV country offices will play an important role in this respect. We recognize the importance of aligning TB-specific plans with approved broader national health plans and health systems developments, such as national directives to harmonize procurement and distribution of drugs or regulations in the field of staff transfers and retention. KNCV will not limit itself to national plans, but also provide smaller-scale operational guidance. For instance, new tools only translate to improved patient outcomes if systems are ready to use them properly. This requires he early identification of systems requirements and timely preparatory interventions to meet these, such as adaptation of procurement and supply chain management, regulatory approval, or accreditation mechanisms. For instance, the introduction of rapid diagnostics, such as line-probe assays, only translate into rapid treatment initiation if referral and data feedback mechanisms are adjusted and clinicians demand the test and utilize the results. Key result area 1 also includes support in the field of staffing, ranging from HRD plans to guidance on HRD consequences of new interventions and tools.

Key result area 2: Resource mobilization

Although domestic funding for TB control has been increasing globally, many countries still depend on international funding for basic and/or advanced TB control interventions, especially the introduction of new tools. TB elimination will require increased long-term global investments in new tool development and sustainable funding at national levels to implement state-of-the-art TB control. Therefore, KNCV acknowledges its responsibility to support access to domestic and international funding sources, distinguishing country-based support and global advocacy. KNCV's country-based support includes a wide array of interventions, ranging from donor identification and application processes to involvement of private and corporate sector in service delivery. KNCV will closely monitor health systems opportunities that may benefit TB control, such as the UHC and AMR political agenda. KNCV research activities may contribute to building "the national and global TB business case". Given the complexity of the subject, KNCV central office will work in tandem with country office staff and partners to ensure multidisciplinary approaches to policy dialogue, political advocacy and resource mobilization. At the international level KNCV will strengthen its role as TB advocate through better communication of compelling data and results, and active participation in and contribution to relevant global TB and non-TB fora.

Key result area 3: Engagement and coordination of other sectors and partners

The history of KNCV in the Netherlands is illustrative for the important role that communities, NGOs and private sector stakeholders can play in mobilizing demand, resources and realizing private care modalities for TB control. Even countries with strong public TB services face a shift from public to private sector utilization by all layers of society, including the poor. For instance in the Philippines and Indonesia, private sector TB drug sales match the amount provided for free by the government, indicating the level of under-notification of TB to the NTP and the high risk of poor treatment outcomes and acquired MDR-TB when patients do not adhere to the prescribed treatment regimen because of high out-of-pocket expenditures. KNCV recognizes this reality and prefers to handle it as an opportunity rather than a threat, by building referral and quality assurance mechanisms for private sector providers in TB control. In addition, KNCV aims at improving the engagement of relevant government structures and broadening the political and administrative basis for effective TB control. National TB programs traditionally tend to operate within MoH boundaries, with limited outreach to relevant ministries such as Justice, Finance, Social Affairs, Labor, Education, Immigration and the Military. Yet their involvement is crucial for reaching vulnerable groups, developing and enforcing laws and regulations, registration of new tools, ensuring sufficient staffing levels and facilitating public-public and public-private collaboration. KNCV considers the engagement of all relevant stakeholders within the context of a comprehensive national framework for TB control of crucial importance for the future of TB control. Therefore, KNCV will play a pro-active role in engaging communities, private providers, academia, and relevant stakeholders, while respecting and promoting the leadership and coordinating role of National TB Programs. The focus of KNCV activities will differ per country, and may range from community engagement to accreditation of private providers or engagement of local NGOs. Efforts will be based on country-specific MAPs. At the same time, KNCV also recognizes the need for better coordination of technical partners and donors. The USAID-funded Challenge TB project, led by KNCV, offers an excellent opportunity for KNCV to further improve joint TA planning and rational use of TA capacities.

Key result area 4: Monitoring and evaluation

Monitoring and evaluation (M&E) is a crucial, yet often neglected component of TB control. KNCV has a decades long history in the field of M&E design and implementation, both for epidemiological and program management purposes. Lack of (reliable) M&E data keep countries from assessing the TB problem, designing appropriate policies and interventions, monitoring program performance and ensuring effective supply chain management. In addition, donor requirements (accountability) and health system developments have led to increased interest among countries in strengthening, extending and modernizing their TB M&E systems. New technologies, such as e- and m-health, offer major opportunities, whereas linkage with national information systems poses significant challenges. KNCV has been at the forefront of supporting countries in this field and aims at delivering a complete package of M&E support that includes the full range of related components, such as design (content and technology), and capacity building to analyze, interpret and translate collected data into appropriate actions. KNCV notes that in most countries, data are underutilized and supportive supervision in the field is weak. KNCV will address these issues and seeks for country-specific approaches, while ensuring compliance with WHO data collection guidance.

Organizational goal

Our organizational goal for this focus area is to be recognized as a technical agency that excels in both technical and managerial assistance, as indicated by managerial indicators such as GF performance, stakeholder involvement, and the quality and robustness of M&E.

8.4 The Netherlands

KNCV is the overarching national private organization dealing with TB control in the Netherlands. We support evidence-based policy and guideline development by organizing the Committee for Practical TB Control (CPT), and, working together with the Centre for Disease Control (Centrum Infectieziektebestrijding RIVM), to coordinate TB control in The Netherlands.

As a private organization, KNCV provides information and education to patients and the public in general, organizes financial support to vulnerable patients and their families, lends scientific support to TB professionals to conduct (operational) research and organizes training programs for TB doctors, nurses and medical-technical assistants. KNCV also plays a key role in identifying and addressing bottlenecks in TB control (advocacy).

KNCV receives subsidy from the Dutch government for policy and guideline development, the coordination of national TB activities, the monitoring and regular evaluation of TB intervention (such as the screening of immigrants and asylum seekers and source- and contact tracing) and the monitoring of TB transmission through the national DNA fingerprinting program.

8.5 Target countries

For the period 2015-2020 KNCV will define **three to five priority countries**. Here KNCV will implement a comprehensive strategic approach, meaning work on all three strategic pillars, tailor-made to local needs and context. We will strive to optimize our efforts to illustrate the feasibility of our mission of eliminating TB. We will also actively mobilize the resources necessary to achieve this goal.

Our secondary focus will be on the other **Challenge TB countries in which KNCV plays a leading role**. Here also we will work on implementing strategy not included in Challenge TB and in so far it strengthens Challenge TB efforts. To achieve this goal, we will actively work on resource mobilization to supplement USAID funding.

We will also offer support to all **other countries** in the form of technical advice for specific access, evidence or systems support, but we will not implement an active strategic approach. We will act only upon request, and only if doing so strengthens our strategy and if capacity is available.

9. RESOURCE MOBILIZATION

KNCV operates in a rapidly changing TB Control funding landscape that is increasingly becoming the domain of a small group of financiers, with the Global Fund as the single largest donor, accounting for 60% of total TB assistance, followed by the U.S.A., which provided 21%. Together the Global Fund and the U.S.A. were present in a combined total of 105 of the 109 countries, and accounted for more than 75% of assistance in every region. This suggests potential vulnerabilities should the scope and/or magnitude of funding commitments from these key donors change in the future[3].

In the new strategic period, KNCV will therefore ensure that it is ready to adequately respond to these resource mobilization challenges. We will aim not only to strengthen and diversify our funding base, but also strengthen our partnerships by pro-actively seeking strategic partnerships in and outside the TB sector: with other NGO's and technical agencies, but also with financiers and the private sector. In addition, we will build our local partnership base and strengthen their capacity to mobilize resources to stimulate sustainable TB control systems.

Lastly, KNCV also aims to develop new and innovative ways of financing Tuberculosis Control. Depending on the setting, we will seek to work with other stakeholders in the field of sustainable health financing.

KNCV will step up its efforts to diversify and sustain its funding base in the strategic period 2015-2020 by:

1. Maintaining relations with current donors
2. Building relationship with new donors
3. Increasing our capacity to innovate and mobilize resources through strategic partnerships
4. Optimizing our internal coordination capacity for effective resource mobilization and innovative financing for TB control.

In our resource mobilization efforts, we will focus on seeking and developing long-term and core funding for KNCV's priority countries. In all other countries, KNCV will focus on project funding and/or short term TA assignments.

All resource mobilization initiatives will link to the lessons learned and KNCV's proven successes in ongoing projects and programs. By doing so, we will create a solid foundation to scale up successful models and further generate, apply and share knowledge with partners and donors around the globe.

By the end of the strategic period in 2020, KNCV will be fully geared towards innovative and effective resource mobilization.

Private fundraising

KNCV has a strong base in the Netherlands, where it was established as a collaborative effort by a group of civil society organizations. Our expertise and experience in organizing successful TB control in our own country was the starting point for KNCVs international role as a leading consultancy organization in the fight against TB. It is the cradle of our work and a testimony to our ability to effectively bring and keep TB under control.
The Netherlands is also our base for private fundraising, engaging private donors to help us with our mission. We are proud to be a beneficiary of both the Vriendenloterij and Lotto. KNCV acknowledges the importance of campaigning and private fundraising for funding, but also for keeping TB on the Dutch public agenda. We will therefore not only continue to build on existing relationships, but also seek to expand with new audiences, building an even stronger base of support and engagement for advocacy and private fundraising in our home country.

Strategic partnerships

To achieve its mission KNCV will seek, establish and maintain partnerships at various levels (global, country, within the Netherlands) when and where complementary to our niche and expertise.

Global level

At the global level, we will maintain and intensify current partnerships with organizations and structures relevant for policy development, such as the WHO, the Stop TB Partnership, advocacy groups and Product Development Partnerships such as FIND, the TB Alliance, AERAS and the TB Vaccine Initiative. We will also partner with organizations, including those in the TBCTA and Challenge TB Coalition, that bring complementary expertise in laboratory strengthening, HIV control, pediatrics, and m- and e-health, and several research fields (such as mathematical modeling), among others. These may include collaborations with commercial partners under conditions of strategic and scientific independence.

Country level

In our priority and Challenge TB lead countries KNCV will establish and maintain partnerships with implementing parties (e.g. local NGOs), civil society organizations, professional associations and organizations and corporations involved in health financing.
We will also strengthen scientific partnerships with academic and other local research institutes for research purposes. With the objective of building local capacity for TB research (linked to the national TB program) and local implementation of research projects, these collaborations will be established with the intention of long-term commitment. Whenever possible, these partnerships will collaborate with parties from other academic institutes (for example Amsterdam Institute for Global Health and Development (AIGHD)) in order to guarantee sufficiently broad scope and continued funding.

The Netherlands

In The Netherlands, our home base, we will maintain our partnerships with institutes and organizations relevant to TB control, such as local TB foundations and the National Institute of Health and the Environment.
In order to realize our 2015-2020 'evidence' agenda, KNCV will need to invest in expertise and scientific collaborations. Since it is not a research institute as such, KNCV takes a pragmatic view to balancing in-house expertise against involving expertise from outside through collaborations, aiming to maximize efficiencies by building on existing and evolving partnerships. It recognizes the importance of academic embedding of its researchers, and of collaboration with other research groups that bring complementary expertise and/or access to data. KNCV will aim for stronger embedding of its researchers in the Department of Global Health (Academic Medical Center, University of Amsterdam) through joint appointments, ideally partly salaried through grants that allow academic work, in the context of the AIGHD. KNCV already collaborates under the umbrella of AIGHD with organizations and institutes boasting expertise in clinical medicine and microbiology, epidemiology and statistics, diagnostics research, health financing, developmental economics, qualitative and health services research, and development of affordable technologies and technology assessment, thus providing an ideal multidisciplinary mix fitting KNCV's research priorities.
KNCV will furthermore continue and broaden its collaborations with other academic and non-academic research institutes based on specific expertise and added value. Collaborations in The Netherlands include Erasmus University Rotterdam and GGD Rotterdam (Academische Werkplaats), GGD Amsterdam, University Groningen/Beatrixoord and Radboud University Nijmegen/Dekkerswald.
Finally we will establish a broad platform of organizations and institutes that can represent the Dutch TB community towards government and parliament.

[3] *Mapping the donor landscape in Global Health: Tuberculosis, August 2013, p16. The Henry J. Kaiser Family Foundation (Prepared by Jen Kates, Josh Michaud, Adam Wexler, Allison Valentine).*

10. CONSEQUENCES FOR KNCV GOVERNANCE AND ORGANIZATION

The implications of KNCV's 2015-2020 strategy are that the organization should be optimally geared towards delivering high-quality technical assistance, evidence and policy input in a dynamic and competitive environment with strong focus on implementation and adaptation at the country level as well as innovation. This requires an organization that is flexible in its ability to respond to emerging demands and technological development, but at the same time solid and robust in its approach to meeting project and donor requirements.

Following the principle of "form follows function", during the period 2015-2020 this orientation will result in in two major changes from the directions taken in the previous strategic plan: a revised organizational chart and a different approach to decentralization. In addition, the need for flexibility in our response to emerging demands in specific technical areas (e.g. assistance to GF Concept Note development) prompts us to explore more flexible technical workforce arrangements. Finally, KNCV's aging workforce calls for a strategy for recruiting and retaining young technical staff.

Organizational chart

Starting in 2015 KNCV will operate using a revised internal structure based on the guiding principles that management lines should optimally support technical quality and project efficiency and output, and that technical staff should focus on technical aspects of their work. This encompasses clear division of tasks and responsibilities and assigning overall and final project and program responsibility. In this organizational chart, the project management units for specific projects (such as the USAID-funded Challenge TB program) will be integrated into KNCV's organizational structure while maintaining clear separation of responsibilities towards KNCV versus partner organizations as implementing agencies, as well as clear lines of accountability towards the donor.

The organizational chart (figure) will be characterized by separate departments (management lines) with technical, project management and financial responsibilities, respectively. A central element of the the new organizational chart is the project or country team, in which staff of each of these three departments plus the country director (if the country has a KNCV office) will work together to coordinate and reconcile technical, project management and financial aspects of each project or of several projects within the country concerned. Portfolio managers within the project management department will oversee all aspects of the projects and be responsible for the outputs of the project teams. The technical department will be structured in small teams composed along thematic lines to optimize assurance of the technical output, innovation in the thematic area, sharing of newly acquired knowledge and evidence, and initiation of new projects and associated resource mobilization.

Decentralization

One of the central themes in KNCV's previous strategic plan was the decentralization of the organization by building capacity at regional level through regional KNCV offices, from which countries would be served at the expense of the size and capacity of KNCV's central office in the Netherlands. This lead to the establishment of regional offices in Central Asia (Kazakhstan) and Africa (Kenya), and the intention to establish a regional office in Southeast Asia. Evaluation of this process and its outcomes brought the conclusion that it was inefficient (requiring investments that could not be funded through project income), did not result in mobilization of regional resources and, most importantly, was not appreciated by clients (countries as well as donors), among others because of difficulties in maintaining quality standards of the technical output where interactions with central office staff were necessarily sparse.
As a consequence, the regional office in Africa was closed and the plans for a regional office in Southeast Asia were aborted, while the regional office in Central Asia will be maintained for strategic reasons.
KNCV's 2015-2020 strategy will take a different approach to decentralization. Recognizing that the country is the level at which our technical assistance needs to be directed, we will regard the country as the core target of our efforts. Whenever possible, we will work through country offices were we build local capacity to provide technical assistance at all levels needed. In this model, this capacity is supported and strengthened through specialist consultations from and other interactions with our central office. Regional presence through regional offices will be pursued only when and where this is strategically advantageous (e.g. with regard to regional resource mobilization) and when technical quality can be sustained.

Flexible consultant network

In order to respond to emerging demands in specific technical areas, and recognizing the existence of a substantial international pool of specialized and highly qualified free-lance consultants, KNCV will create a flexible consultant network. Consultants participating in this network will be KNCV's preferred partners for subcontracting technical assistance work in specialized areas. The quality of network consultants will be guaranteed and maintained by arrangements for participating in internal quality assessments, training and technical updates.

Rejuvenating KNCV's technical staff

TB Control needs new and young talent. KNCV will increase efforts to attract young talent to foster the next generation of TB Control experts.
A number of opportunities to rejuvenate its technical staff base will be explored:

- Establishment of temporary attachments of young professionals with targeted training in TB control, using external funding sources where possible;
- Strengthen relationship with (international) governments, universities and NGO's specialized in public health to exchange and work together;
- Create junior TB consultant positions and career development plans through mentorships;
- Set up exchange programs with other (country) offices;
- Increase opportunities to specialize in certain expertise outside classic TB Control, such as health systems and financing.

In order to address the "evidence" strategic objective, young staff will be recruited making use of the opportunities of academic embedding and collaboration with the AIGHD and other research groups. The current research staff base provides a strong core of senior scientists with extensive expertise in operational research and population and field epidemiology. There is a need for additional in-house expertise in health economics, health services research and statistics. These can initially be junior, with in-house training supervised by senior scientists in collaborating institutes. Alternatively, joint appointments can be set up with collaborating institutes. There is an additional need for training junior scientists in KNCV's areas of research through PhD programs and MSc research attachments. KNCV further aims for one senior (mid-career) research position in each of the identified core countries to provide on-the-ground technical assistance to research work and help building local research capacity.

11. M&E PERFORMANCE FRAMEWORK

KNCV has defined 43 indicators on different levels:

I 8 KPIs (key performance indicators) will provide the monitoring framework for measuring progress in relation to our mission objectives.

II 12 strategic indicators reflect the KNCV focus areas: access, evidence, and supportive systems.

III 23 institutional indicators will measure progress in relation to operational efficiency and staying fit-for-future.

Development of the above indicators has been finalized, and final baseline measurements have been collected as of October 2015, with minimal ongoing baseline data validation.

Integrated Reporting

Indicator information is complemented by systematically collecting and reporting on additional information like facts and figures of interest that are not captured by indicator monitoring, lessons learned, success stories, critical reflection etc.

Key Performance Indicators[4]

1. Increase bacteriologically confirmed notifications to 60% among all forms TB notifications by 2020.

Description: Substantial increase (number and %) in case notification of bacteriologically confirmed cases[5] in target countries:

a. for total population
b. for population served by KNCV, if this can be disaggregated
c. key populations (where data is collected by countries)

The indicator for total population is in line with the Global Fund M&E framework. The indicator for key populations will differ per country. Only countries with electronic surveillance systems can measure indicator for key populations.

Purpose: This indicator is intended to reflect whether increased case finding strategies and activities, and more sensitive diagnostics such as Xpert and LED microscopy have led to more bacteriologically confirmed cases. We focus on bacteriologically confirmed cases to avoid counting cases that have only been clinically confirmed (i.e. without bacteriological confirmation) and therefore might be over-diagnosed.

Baseline: 50% of all forms notifications are SS+/Bac+ (n = 9)

Target: Increase SS+/Bac+ (bacteriologically confirmed) notifications to 60% among all forms TB notifications. (n = 11)

2. Reduce TB mortality among notified cases by 35% by 2020.

Description: The proportion of TB patients who died among those notified to the NTP. In some countries with reliable vital statistics, the total TB mortality may be used. We will calculate this both for all forms cases and for bacteriologically confirmed cases. We may use the recently proposed mortality/notification indicator where applicable.

Purpose: The WHO's End TB strategy aims to reduce TB mortality by 35% by 2020. Although it is recognized that the mortality rate in notification cohorts is an underestimate of actual TB mortality, the actual mortality is often not measurable in countries with weak vital statistics. We will increase efforts to measure TB mortality more accurately. This is also a Global Fund indicator.

Baseline: 10% mortality among TB cohort notified in 2013 (n = 10)

Target: Reach 6.5% mortality among TB cohort notified in 2018. This would be a 35% reduction of the 10% mortality rate baseline. (n = 11)

In most countries the TB mortality rate in a notification cohort is between 5 and 10%; however, initial defaulters who may be more likely to die are often not notified. The initial focus will be to measure mortality more accurately before achieving a reduction. A reduction of 35% in 5 years may be realistic.

3. Complete treatment for 90% of all detected drug-sensitive TB cases by 2020.

Description: This is the proportion of successfully treated DS-TB patients (cured and treatment completed) among those notified. We will calculate this both for all DS-TB cases and for bacteriologically confirmed DS-TB cases only. Until recently patients who did not start treatment were not included in this indicator. They should be included in future.

Purpose: This indicator is traditionally used by all countries and donors, and it represents the total care chain for the patients. (Reporting these as lives saved is very inaccurate.)

Baseline: 86% (2013 cohort) (n = 9)

Target: 90% (n = 11)

[4] All baselines are weighted averages based on estimated country population (2013 or 2014 depending on the indicator).

[5] In the strategic indicators we have also included an indicator (1.3) on the proportion of cases that is bacteriologically confirmed.

4. Initiate treatment for all identified drug-resistant patients by 2020.

Description: Increase in proportion of diagnosed persons with rifampicin resistant TB initiated on second line treatment. The majority of patients with rifampicin resistant TB have MDR-TB, and therefore this indicator measures roughly what proportion of MDR cases starts appropriate treatment.

Purpose: This indicator still needs improvement in many countries, although it does not measure what proportion of estimated MDR cases are actually diagnosed. The latter is difficult to measure since the number of MDR-TB cases in the country is dependent on WHO estimates. This is also a Global Fund indicator.

Baseline: 73% (n = 9)[6]

Target: 100% (n = 11)

5. Test all TB patients for HIV by 2020.

Description: 100% of TB patients should be screened for HIV. This is a composite indicator as in African countries the proportion tested is often very high, while in many Asian countries the testing proportion is still low. This is also a Global Fund indicator.

Purpose: Measure improvement in access to services through collaboration between TB and HIV programs.

Baseline: 86% (n = 8)

Target: 100% (n = 11)

6. Start all TB/HIV co-infected patients on anti-retroviral therapy by 2020.

Description: All TB/HIV co-infected patients should be started on anti-retroviral therapy. This is a Global Fund indicator.

Purpose: Measure improvement in access to services through collaboration between TB and HIV programs.

Baseline: 56% (n = 8)[7]

Target: 100% of TB HIV co-infected patients should be on ART by 2020. (n = 11)

7. Introduce measurement by NTPs of catastrophic health care expenditures for people with TB and their families in all target countries by 2020.

Description: Number of countries measuring proportion of people or families experiencing WHO defined level of catastrophic costs (direct health care expenditures corresponding to >40% of annual discretionary income (income after basic needs, such as food and housing). Indirect costs of care (e.g., transport) and income loss are not included.

Purpose: On average, TB patients in low-and middle-income countries face medical expenses, costs of seeking/staying in care, and income loss equivalent to more than 50% of his or her annual income. Approximately 60% of costs are related to income loss, and about 50% of costs are incurred before diagnosis. Strategies to reduce catastrophic costs include ensuring universal health coverage, access to essential services, and essential social transfers. This indicator will be designed to measure the proportion of people with TB facing catastrophic health care expenditures as defined by WHO.

Baseline: 0%

Target: Within three years (2015 – 2017), the target is that countries participating in the WHO's catastrophic costs study will be routinely measuring the proportion of families experiencing catastrophic costs due to TB care as defined by the WHO, while the target for 2020 is that all (n = 11) NTPs in KNCV target countries will be measuring this.

8. Prevent more people from developing active TB disease by 2020.

Description: Originally this was proposed to be calculated by doing a one-time modeling, as it is difficult to measure. The number of individuals developing active TB disease is shown in incidence estimates as part of the WHO Global TB Report.

Purpose: Internationally, the quantity and quality of models on TB transmission is increasing rapidly. KNCV considered using these to estimate prevented new active TB disease in our target countries. Since a large Challenge TB project is planned on this issue, we also considered taking an actual measurement in selected countries.

Baseline: TBD

[6] The unweighted baseline is 81%, and five out of nine responding countries reported second line treatment initiation rates approximately 90% or higher. Several countries with large populations and treatment initiation rates below 75% contributed to the lower weighted baseline of 73% shown above.

[7] The unweighted baseline is 80%, and indeed six out of eight responding countries reported ART initiation higher than 70%. One country with a large population and low ART initiation rate (27%) contributed heavily to the 56% baseline shown above.

TABLE 1: STRATEGIC INDICATORS

Focus Area: ACCESS		
Strategic objective: Improve access to early TB prevention and care for patients with all forms of tuberculosis and achieve better individual outcomes and public health impact		
Key Result Area	Strategic Indicators	Indicator specifications
1.1: Prevention of transmission	1.1: Proportion of target countries that have developed, implemented and monitored country specific TB-IC and laboratory biosafety strategies effectively by 2020	Baseline (2014): 36% (4/11 countries) Target (2020): All target countries have developed, implemented and monitored country specific TB-IC and lab biosafety strategies effectively.
1.2: Prevention of progression from infection to disease	1.2: Proportion of target countries that have developed, implemented and monitored contact investigation and screening policies and strategies by 2020	Baseline (2014): 27% (3/11 countries) Target (2020): All target countries have developed, implemented and monitored CI and screening policies and strategies.
1.3: Early diagnosis and effective treatment	1.3: Annual percent increase in proportion of notified cases that are bacteriologically confirmed in target countries	Baseline (2014): 0.3% increase (50.6% in 2013 to 50.9% in 2014) Target (2020): Among all target countries, 60% of all forms notifications are bacteriologically confirmed.
1.4: Overcoming barriers and ensuring equitable access for special patient groups	1.4: Proportion of target countries that have developed, implemented and monitored country specific strategies to address barriers and ensure equitable access for special patient groups by 2020	Baseline (2014): 18% (2/11 countries) Target (2020): All target countries have developed, implemented and monitored country specific strategies to address barriers and ensure equitable access for special patient groups.
Focus Area: EVIDENCE		
Strategic objective: Generate solid evidence base for existing and new tools and interventions		
Key Result Area	Strategic Indicators	Indicator specifications
2.1: Implementation research: evidence for scale up	2.1: Proportion of KNCV supported intervention studies/ demonstration projects resulting in a publication with contribution of KNCV staff as co-author	**Baseline value (2014)**: 17/17 [1] (from 2011 – 2014) **Target (2020)**: 80% within 3 years of project completion
2.2: Operational research	2.2: Number of research publications/reports that have contributed to international or local country guidelines/policies	**Baseline value (2014)**: 7 **Target (2020)**: At least 10 in total
2.3: Population epidemiology	2.3: Number of successfully completed population epidemiology relevant studies (e.g. prevalence and/or drug resistance survey) w/ substantial support of KNCV	**Baseline value (2014)**: 1 **Target (2020)**: At least 1 per year (i.e. at least 5 in total)
2.4: Research capacity building	2.4: Number of publications resulting from KNCV led research capacity building activities	**Baseline value (2014)**: 14 **Target (2020)**: 4 per year

[1] *Vietnam accounts for 13/13 of these publications.*

Focus Area: Supportive Systems SUPPORTIVE SYSTEMS		
Strategic objective: Bolster sustainable governance and management capacity of National TB Programs		
Key Result Area	Strategic Indicators	Indicator specifications
3.1: Strategic and operational planning	3.1: Proportion of target countries that have a valid, evidence-based, prioritized, costed, and endorsed national strategic plan, used for annual planning [2]	**Baseline value (2014)**: 8/11 (73%) **Target (2020)**: All KNCV-supported countries have an up-to-date NSP throughout up to and including 2020.
3.2: Engagement and coordination of other sectors and partners	3.2: Proportion of private providers and facilities notifying TB cases to NTP	**Baseline value (2014):** TBD [3] **Target (2020):** 50% of private providers/facilities in 8/11 countries
3.3: Monitoring and evaluation	3.3: Proportion of target countries that have a countrywide implementation of a patient based electronic recording and reporting system	**Baseline value (2014)**: 3/11 (27%) **Target (2020)**: 6 of 11 target countries w/ countrywide implementation
3.4: Measurement of catastrophic costs incurred by TB patients and their families	3.4: Proportion of target countries that have collected routine data on individuals experiencing catastrophic costs at least once	**Baseline value (2014):** 0% **Target (2020):** 11 of 11 target countries

[2] *Although many countries have recently developed such plans, they need new ones within the next 5 years.*

[3] *Approximately 12% of notified cases come from private providers/facilities (n = 4 target countries); however, we will measure the % of PPs notifying TB cases to the NTP.*

TABLE 2: INSTITUTIONAL INDICATORS

Key Area	Institutional Indicators	Baseline Available
1. KNCV Quality Services	1.1 (Definition still under development)	No
2. TB Policy & Advocacy Influence / Public Affairs	2.1 Strengthened TB and TB/HIV on the Dutch policy agenda	Yes
3. Project Management	3.1 Performance of projects supported by KNCV	No
4. Financial Resource Base / Acquisition	4.1 Number of multiannual institutional donors	Yes
	4.2 Rejuvenation of private donor base	Partial
5. Financial Management	5.1 Ratio of expenses on KNCV missions versus total expenses	Yes
	5.2 Ratio of expenses on KNCV missions versus total income	Yes
	5.3 Ratio of expenses for own fundraising versus income from own fundraising	Yes
	5.4 Ratio of expenses for management and control versus total expenses	Yes
	5.5 Average cost price including indirect cost per project day	Yes
	5.6 Indirect cost rate (ICR)	Yes
6. Human Resources Development	6.1 Personal development plans (PDP) available for all HQ staff	Yes
	6.2 Proportion of total available working days taken as sick leave	Yes
	6.3 Flexible consultant network established, maintained and utilized	Yes
7. Supportive Environment	7.1 Ability of KNCV staff to work in a functional ICT environment without restrictions due to location or time.	Partial
8. Communication	8.1 Number of printed and online publications that mention KNCV	No
	8.2 Number of public website visitors	Yes
	8.3 Number of corporate website visitors	Yes
	8.4 Number of Twitter followers, Facebook likes, newsletter subscriptions	Yes
9. Knowledge Management and Organizational Learning Strategy (KMOL)	9.1 Number and type of KNCV representation in (inter)national policy fora	Yes
	9.2 Number and type of policy papers that KNCV actively contributed to	Yes
	9.3 KNCV teams/countries use M&E info to reflect, learn lessons, and develop and implement improvements	Yes
	9.4 Number of KM/OL activities and attendees, including mentored field visits, trainings attended	Yes

12. FINANCIAL PLAN 2015-2020

Long-Term Budget KNCV Tuberculosis Foundation 2015 - 2018, per November 2014

Profit & Loss account	Actual 2013 *In € 1 mln*	Budget 2014 *In € 1 mln*	Prognosis 2014 *In € 1 mln*	Budget 2015 *In € 1 mln*	Long term forecast 2016 *In € 1 mln*	Long term forecast 2017 *In € 1 mln*	Long term forecast 2018 *In € 1 mln*
Organizational costs							
Personnel related costs	7.50	7.13	7.48	8.71	8.88	8.86	8.84
Regional office costs	-	0.33	-	-	-	-	-
Other indirect costs	1.29	1.46	1.68	1.68	1.60	1.64	1.67
Subtotal organizational costs	8.80	8.92	9.17	10.39	10.49	10.50	10.51
Charged to projects	-8.26	-8.32	-9.08	-9.86	-10.00	-10.00	-10.00
Total organizational costs not charged to projects	0.54	0.60	0.08	0.54	0.49	0.50	0.51
Investment and general income	0.35	0.13	0.16	0.12	0.12	0.12	0.12
Net result organizational costs	-0.19	-0.47	0.08	-0.41	-0.37	-0.38	-0.39
Activity costs							
Costs for fundraising	0.43	0.51	0.45	0.48	0.49	0.50	0.51
Other activity costs	0.08	0.10	0.18	0.27	0.27	0.27	0.27
Total Activity costs	0.51	0.62	0.63	0.75	0.76	0.77	0.78
Activity income							
Own fundraising	1.08	0.96	0.90	0.97	1.00	1.00	1.00
Lotteries	1.18	1.09	1.09	1.09	1.10	1.10	1.10
Total Activity income	2.27	2.05	1.99	2.06	2.10	2.10	2.10
Net result Activities	1.76	1.44	1.37	1.31	1.34	1.33	1.32
Project costs							
Charges organizational costs	8.26	8.32	9.08	9.86	10.00	10.00	10.00
Travel and accomodation	0.82	0.56	0.54	0.55	0.55	0.55	0.55
Material costs	15.16	11.15	14.55	15.03	20.00	20.00	20.00
Expenses coalition partners TBCARE I	28.49	32.50	24.50	30.00	35.00	35.00	35.00
Total Project costs	52.73	52.53	48.67	55.44	65.55	65.55	65.55
Project income							
Funding donors - fee	7.22	6.94	6.84	8.22	8.39	8.55	8.73
Funding donors - travel and accomodation	0.71	0.53	0.52	0.53	0.53	0.53	0.53
Funding donors - other direct project costs	14.81	10.81	14.10	14.46	19.90	19.90	19.90
Endowment funds contribution	0.31	0.31	0.36	0.31	0.31	0.31	0.31
Other income for projects	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Income coalition partners TBCARE I	28.49	32.50	24.50	30.00	35.00	35.00	35.00
Total Project income	51.55	51.09	46.34	53.54	64.14	64.31	64.48
Net result Projects	-1.18	-1.43	-2.34	-1.89	-1.41	-1.24	-1.07
General Result (minus is a deficit)	**0.38**	**-0.47**	**-0.89**	**-1.00**	**-0.44**	**-0.29**	**-0.14**
Covered by earmarked reserves / donated to earmarked reserves	**0.19**	**-0.47**	**-0.52**	**-0.80**	**-0.40**	**-0.30**	**-**
Influence on/movements other reserves	**0.19**	**0.01**	**-0.37**	**-0.20**	**-0.04**	**0.01**	**-0.14**

Staffing plan including direct reports regional and country level	Actual 2013 *FTE*	Budget 2014 *FTE*	Prognosis 2014 *FTE*	Budget 2015 *FTE*	Long term forecast 2016 *FTE*	Long term forecast 2017 *FTE*	Long term forecast 2018 *FTE*
Positions at central level, including region Netherlands/Europe	61.6	62.0	55.4	67.6	67.6	65.6	63.6
Positions at regional and country level, direct reporting to central level	18.2	19.6	20.8	20.0	22.0	22.0	22.0
Total	**79.8**	**81.6**	**76.2**	**87.6**	**89.6**	**87.6**	**85.6**

Giving information at A Coffee ceremony in Ethiopia, photo by Netty Kamp

Colofon

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