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Should active case-finding projects increase the number of tuberculosis cases notified at national level?

We thank Koura et al. for their critical review of active tuberculosis (TB) case finding (ACF) projects with TB REACH funding.[1] We agree with the authors' conclusion that ACF strategies as implemented under the TB REACH initiative did not have an immediate impact on national TB notification levels, but this is and was never expected.

First, as stated by the authors, the focus of ACF is on increasing case notifications in predetermined target groups.[2] Most projects funded by TB REACH had been tailored to specific target populations (e.g., prisons, migrants, urban poor) or contexts (e.g., existing community networks).[3] Consequently, the aim is not necessarily a scale-up to the entire population.

Second, most TB REACH projects were set up as pilots and for proof of concept on a limited scale. We calculated the intervention areas' notifications as percentage of national notifications for 2014, and found this to be low (median 16%, IQR 4–34), resulting in a dilution of the impact of the projects at national level.

Third, scale-up of successful and relevant pilot projects usually takes more than 1 year, as they require policy change at national level and dedicated funding. Evidence and lessons learned from TB REACH projects have been used in the revision of several national strategic plans and have contributed to policy change in countries such as Afghanistan, Uganda and Cambodia.

We agree with the authors that given limited resource availability, cost analyses are important. The cost assessment conducted in the mid-term TB REACH evaluation was not a cost-effectiveness analysis.[5] The $800 cost per additional case they refer to is likely to be non-representative, as it includes unsuccessful projects, and the costs during pilot phases may differ from cost after scale-up.

We should, however, be careful not to focus on costs per case only. The aim of ACF interventions is to reach risk groups that are currently not accessing care. Considering the universal right of access to diagnosis and care, higher costs may be justified.

We do not support the authors' suggestion that ACF cannot contribute to identify the 30% of TB cases that remain undiagnosed. Several pilots were successful in addressing the needs of diverse underserved populations. A mixed approach is essential to reach missed TB patients, including improving health services, reducing barriers to access to care and ACF strategies.

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In reply

We thank Richardson, Creswell et al. and Blok et al. for their comments on our recent article on active case finding, and for allowing us to better express our concerns.[1]

They were disappointed to read our analysis showing that active case finding (ACF) conducted in the TB REACH project had basically no impact at national level in the countries where they were implemented. We agree that this was 'of little surprise' in the year of implementation of the study because most of the projects were implemented only locally, and we cannot expect an 'immediate impact'. However, looking at one or two years after the ACF results we don't believe this is 'hardly of interest'.

In recent years, we have observed that funding agencies are putting increasing pressure on national tuberculosis programmes (NTPs) to develop various interventions, such as ACF activities, in order to find