CORRESPONDENCE

Active tuberculosis case finding in India: need for introspection

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In India, active case finding (ACF) for tuberculosis (TB) has been implemented in 300 districts of the country among high-risk populations. The Revised National TB Control Programme (RNTCP) has decided to scale up this activity to a further 252 districts from 2017 onwards as part of its latest national strategic plan.^{1,2} The strategy is to conduct ACF in identified high-risk populations in selected districts at least three times per year.² ACF is gaining momentum across the country, and it is high time for introspection on several aspects of this activity.

First, health education: implementation of any health programme on a larger scale is intended to create awareness in the community. It is important to know whether this activity has led to increased awareness about TB or changed health-seeking behaviour among high-risk populations.

Second, integration with health systems: the general health systems staff are directly involved in implementing the strategy, which has further strengthened integration. It would be of great value, however, to know the extent of involvement of the public health system, the private health sector and non-governmental organisations in implementing this activity.

Third, hidden TB cases: ACF has led to the detection of more TB cases and to early detection of cases in areas where no cases were detected prior to this activity. Understanding the patient response to the health system dynamics will help the programme cater to the needs of the patients.

Fourth, collateral learning: there remains a great deal to learn about the attitude of general health

staff toward delivering ACF services in the community. If there are any gaps in the programme's reach or in access among high-risk populations, district-specific strategies for improvement can be devised.

Fifth, trends in detection: the strategy is to conduct ACF activities at regular intervals in defined high-risk populations over a period of a few years. It will be worthwhile to watch the trend of cases detected in subsequent years; ideally, a downward trend is expected.

Sixth, cost effectiveness: the budget involved in the ACF approach compared to other forms of TB case detection needs to be known; this is of paramount importance if the programme intends to shift the focus of ACF from the high-risk population to the general population. This information will guide the RNTCP in effective management of human resources during ACF.

It is well understood that ACF can have multiple effects, and this is an opportune time for introspection and to measure the relevant impact. The systematic implementation of ACF activities in India is a step in the right direction toward eliminating TB.

References

- 1 Prasad B M, Satyanarayana S, Chadha S S, et al. Experience of active tuberculosis case finding in nearly 5 million households in India. *Public Health Action* 2016; 6: 15–18.
- 2 Central TB Division, Ministry of Health and Family Welfare. National strategic plan for tuberculosis elimination, 2017–2025. New Delhi, India: Ministry of Health and Family Welfare, 2017. <https://tbcindia.gov.in/WriteReadData/NSP%20Draft%2020.02.2017%201.pdf> Accessed November 2017.

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