RUSEN AND ENARSON RESPOND

We appreciate Lauer and Birn’s interest in our article. However, many of the concerns they raise are speculative and are not consistent with the operational reality of FIDELIS. First, the authors question the local nature of the FIDELIS projects and suggest that FIDELIS is most accessible to organizations affiliated with developed countries. In fact, the projects approved to date are truly local in nature; internationally associated nongovernmental organizations and academic institutions have been awarded only 7 of 32 projects approved in rounds 1 through 4.
Second, Lauer and Birn wonder whether the members of the “existing TB control structure” who are charged with evaluating proposals will endorse innovative ideas. Our experience indicates that this concern is unfounded; innovative approaches are routinely approved by the proposal review committee. Recently approved activities such as mobilizing students to identify persons suspected of having tuberculosis or enlisting religious leaders to speak about tuberculosis at the mosque after Friday prayer can hardly be considered “existing standardized strategies.”

Third, the authors question the focus on cost-effectiveness within the FIDELIS initiative. We agree that cost should be only one of several factors considered in evaluating potential tuberculosis control interventions. In an ideal world, costs would not be a consideration at all. However, to be competitive with other health priorities in need of funding and to ensure that successful interventions can be scaled up, FIDELIS projects must be able to show that they can produce results at a reasonable cost. Several FIDELIS projects have demonstrated that interventions can successfully target those with limited access to health services and still be cost-effective. Furthermore, the figure of US $80 per outcome is for additional costs related to the proposed innovative intervention, not including the routine costs of the existing program.

Fourth, Lauer and Birn question the advisability of the 1-year funding cycle. We agree that the time frame for implementation is short and challenging. However, the innovative ideas funded by FIDELIS are being implemented in the context of ongoing public health programs and should not require extensive preparation or infrastructure. Furthermore, many projects have been able to meet this timeline and either obtain a second year of funding or incorporate successful activities into other country funding mechanisms. Of 32 projects in rounds 1 through 4, 11 have been awarded phase 2 funding and at least 4 other phase 1 projects have been able to continue their activities with funds obtained through other sources.

FIDELIS is a relatively new initiative. We are continually examining our practices and procedures to reach our goals, and we welcome constructive input.

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