The National Sample Survey conducted by ICMR in 1955-58 documented the alarming burden of TB. GOI launched the NTP in 1962 to tackle this problem. The programme was based on a 50:50 sharing basis between the Central and State government. The NTP performed the commendable job of establishing 446 DTCs, 330 TUs in urban areas and in setting up 47,000 beds for TB patients. The programme was implemented integrating it with the general health care system of the country. However, in spite of all good intentions, it failed to make any significant epidemiological impact.

A programme review of the NTP by a team of national and international experts was undertaken in 1992. The problems identified by the team amongst several others were:

- Undue importance given to X-ray as a primary means of diagnosis
- Undue importance on case detection rather than cure/treatment completion
- Irregular supply of drugs
- The wide use of non-standardized treatment regimens
- Poor follow up of patients with results of only completion of treatment being available
In the light of these observations, GOI formulated RNTCP comprising of the five internationally accepted principles of DOTS. This was pilot tested in 1993 on a population of 2.35 million in 5 districts. These pilot studies demonstrated the operational feasibility of the RNTCP in a country like India known for its wide and varied terrain, large population, different languages and culture.

Despite the initial long preparatory period, the programme has now demonstrated to the world at least four things:

- The principles of DOTS, based largely on the research conducted in India is an effective strategy for TB control
- India has achieved the fastest expansion of DOTS in the world
- Quality of implementation has remained good despite the rapid expansion
- How a programme can be run effectively.

Today, the programme is implemented covering a population of more than 425 million. By the end of this year, this coverage is expected to be around 450 million increasing upto at least 500 million by next year. Future expansion plans are to cover 800 million by 2004 and the whole country as soon as it is operationally feasible. With the continued enthusiasm and zeal, I am confident that we will be one of the few countries in the world to have an effective TB control programme equipped to fight even the onslaught of the HIV TB epidemic and the threat of MDR-TB.

Many of the achievements made by the programme today are because of the due priority given to the programme as well as the commitment of all those involved in the programme at all levels - Central/ State and District. The success of the programme has enhanced the morale of the STOs, DTOs and other field workers who are now working in a dedicated manner with renewed zeal and enthusiasm. I will be failing in my moral duty if I do not attribute the internationally recognised success of the Indian programme primarily to Dr S.P. Agarwal, DGHS for his deep involvement and commitment to the programme. In my five decades of working in government and non-governmental sectors, I have never experienced a unit as remarkable as the CTD, under the energetic leadership of Dr G.R. Khatri. Dr. Khatri and his unit are in the office, working for the success of the programme, until late in the night virtually every night, and on most weekends as well. They are working with missionary zeal 365 days a year. I think they may also dream about TB. I see good prospects if the enthusiasm and zeal is sustained and if all of you here can imbibe that spirit. With increasing support from medical colleges and other stakeholders in the health sector, the achievements can be even further improved.

I wish fruitful discussions in the ensuing two days. I wish all of you success in your missions.