



TB Control Seminar

normal terrain and rainfall. iii) Shimoga district: a model health district developed by the state authorities with adequate infrastructure and awaiting sanction of DTP and posting of NTI trained team.

As a matter of principle, it was decided that NTI and its staff shall not take any initiative in the development of DTPs in these test run districts but would provide any technical assistance and guidance if asked for. The results obtained from these districts should be of great interest in future⁴⁴.

2.9. TB control seminars

From the Anantapur experiment came the realisation that training of DTC personnel or implementing district centres alone were inadequate. To be effective, senior officers responsible for TB work in various states should also be trained. They should be made conversant with the new strategies being implemented and their active support should be obtained. No programme however scientific would succeed without their support because health is a responsibility of the state

governments. Accordingly, between 22nd May 1962 to 2nd June 1962, the NTI organised the first TB control seminar. It was attended by Assistant Directors of Health Services (TB) and Directors of TB Demonstration and Training Centres. Twenty two delegates from different states deliberated on the proposals of the NTI regarding the national TB control for India and made recommendations for a district TB control programme⁴⁰.

2.10. Papers published

During 1960-62, twenty three papers were published by the NTI in national and international journals. They are listed chronologically in Annexure IV. The first two were authored by Dr Bordia, the then Director.

As it is of historical interest, the first paper was on *Drug prophylaxis in the control of TB in India*. A brief summary is extracted: *Prophylaxis means prevention of disease and its manifestations. But this definition is not satisfactory in TB. There are two situations in which prophylaxis is applicable: (i) to prevent development*

of infection (chemoprevention) and (ii) to prevent development of disease and its complications among the infected, as revealed by a positive tuberculin test. In general, 4-7 mg per kg body weight of INH should be given for a period of six months. For practical reasons, chemoprophylaxis could be limited to high risk groups. It may not be possible to carry it out on a country-wide basis without acceptance of the people and an organisation to do it. A pilot study for applicability and acceptability of the drugs on a community basis can bring out knowledge on this subject.

Many interesting observations were made by Bordia and others in the paper, *tuberculin sensitivity in young children (0-4 year old) as an index of TB in the community: Tuberculin testing with 1TU RT23 was done on a random sample of 0-4 year old children in Bangalore city (2883) and in rural areas (2589) within 100 miles. Variation of the tuberculin sensitivity status in different areas were compared against one another and further to socio-economic conditions. The relevance of the tuberculin sensitivity (> 14 mm taken as positive) as an index of tuberculous infection*