epidemiologists, bacteriologists, PHNs, statisticians and senior technicians. Ten day seminars were arranged for senior health administrators, professors of medical colleges and the other key persons to focus on the NTP. Guest lectures by eminent doctors, like Frimodt Moller, KL Hitze, K Toman, NL Bordia and others, were arranged to increase the involvement. Soon these courses became very popular and were well attended. The benefit of such courses was not measured. Yet, they did produce a positive influence on the programme as is evident from a letter from Dr TB Master, Prof. and HOD of TB and Chest Diseases, Grant Medical College, Mumbai: *"I have been very impressed by the work being carried out, particularly from the point of research, in the very vast field of epidemiology. The group of doctors working there are very sincere, conscientious and dedicated; some of them are also of international repute. It is sad to learn that advantage is not taken of the work at this Institute and also of the knowledge imparted by the workers there. The Seminar is a great success. Knowledge is propagated to the delegates without any reservation. In conclusion, I do not hesitate to say that my thoughts and ideas have become clearer and wider. I wish more people working in the field at different levels attend such seminars and apply the knowledge gained in practice during their daily work"*[50].

3.3. Development of State TB Centre

The second aspect of energising the state governments proved to be much more daunting. The states had a number of things to provide on a regular basis such as infrastructure, DTP personnel, other supportive staff, equipment and drugs. The state itself should provide the vital leadership in implementing the NTP and keep it functioning efficiently. It should interact with the GOI and the NTI for the necessary support and technical guidance. Not only is India a big country, different states have different socio-economic settings. Local compulsions forced each state to develop its own administrative procedures. Differences in language and customs pose problems, which are

not easily overcome. There may be budgetary constraints in sending trainees to Bangalore for 13 weeks. In addition, every DTC required, sustained administrative and financial assistance. Their activities must be effectively supervised. It would therefore be better for the states to train its own staff to run its DTCs. These should evolve an effective supervision and evaluation system. There should be a superstructure at the state level to coordinate the working of different DTCs and monitor efficiency.

Hence, the NTI concentrated on developing strategies for preparing key officers, infrastructure and assessment staff to run a state centre. They would directly control their respective DTCs. Fortunately, the experience gained at the LWSTC, Bangalore proved valuable. The document *Functions and responsibilities of State TB Control Centres,* was prepared, revised on 28.1.67 at the NTI, in the presence of the Advisor in TB. It was submitted for final test on 2.2.67 at Hyderabad, one day before Annual TB Conference. The DHS and STO of the state and representatives from DGHS were present. The document was slightly amended and it was presented to the government for circulation among the states[51]. From 1962, State TB Centres (STCs) were set up right across the country in Uttar Pradesh, Gujarat, Maharashtra, Madhya Pradesh, etc.

As the NTI was located in the adjoining state, Dr Nagpaul took keen interest in the development of STC for Andhra Pradesh at Hyderabad. He was assisted by other NTI faculty, Dr BC Arora who had recently joined NTI, Dr GD Gothi, Mr C Satyanarayana, SA and others. All the guidelines were given so that this new Hyderabad STC would function like NTI. The next on the line was Madras STC in Tamil Nadu. Meanwhile, a methodology of training was evolved. The first training course of three months for the STC personnel was started at NTI on 13th November 1972[52]. Drs GC Banerjee, AK Chakraborty and Mrs M Prakash joined the NTI. This strengthened the ongoing work.

Experience gained from these varied activities proved invaluable. Most manuals were revised from the actual work experience. By 1969, 345 MOs, 338 TOs, 331 LTs, 330 XTs and 275 SAs had been trained. By 1970, NTP had been expanded to 191 districts, to cover 57% of the country.

It was a satisfying decade for the NTI because much had been accomplished, both in improving the content and methodology of training and implementing the NTP. Yet the NTI did not bask in contentment. It had developed a robust philosophy. It could be summed thus: We often hear of the big difficulties faced by the NTPs. But, has anyone anywhere visualised a programme in which the implementers did not face any difficulty? Are other similar health, social or economic programmes devoid of difficulties? At least, we are lighting knowledge lamps of NTP at an increased pace.

3.4. Sustainability of the model

After the passage of time, the Hyderabad STC which was so painstakingly initiated, did not continue to function as expected. The Madras STC also was not keen to train DTP key personnel. The situation nearer home in Karnataka, at the LWSTC, was not different. The laboratory facilities were not appropriate and there was no effective drug surveillance. Most of the STCs were not effective in training or supervision of DTCs under their jurisdiction due to lack of staff and other facilities. The qualified staff when retired or transferred were not replaced by suitable personnel. The NTI could enthuse them even less because of logistics and perseverance required for this task.

The TB Demonstration and Training Centre (later known as STC) at Agra, sets an example of how advocacy, commitment and highly motivated people can make a difference between success and failure of institutions. This centre was established in 1962 by the Uttar Pradesh government with the assistance of GOI, WHO, UNICEF with Dr ML Mehrotra as its Director. He overcame every obstacle to make the centre one of