However, as Stefan Grzybowski puts it: *poor chemotherapy prevents deaths but often keeps a large number of chronic excretors alive... . India could be considered a low incidence but high prevalence country, the high prevalence being due to large numbers of treatment cases, chronic and relapse cases produced by ineffective treatment programmes... . Were it not for Human Immunodeficiency Virus (HIV) infection, the future would look fairly bright provided that special programmes to find and cure chronic bacillary cases are established. HIV infection has indeed a very profound effect for TB. The epidemiological impact of HIV infection comprises i) increased risk of infection, ii) increased risk of disease among the infected, and iii) increased fatality among the diseased....By the year 2006, the incidence of TB in the 15-49 years of age group will rise threefold which means that it will be double in the population... . I hope by that time India will be prepared to meet this grave new challenge*[110].

4.5. Work on the training front

From the outset, the NTI gave priority not only to the training of DTC key personnel but the quality, duration and content of the training activities were constantly reviewed

Dr B Shankaran, DGHS with Dr A Banerji Director (Standing to his left) inaugurating the new training block on 16.9.1980

and upgraded. During the two decades, there had been a steady growth in the area covered and the number of trained personnel available for NTP in the country. By 1996, 72 regular training courses for DTP key personnel had been conducted. However, the NTI was not satisfied because the NTP was functioning below expectations. It had not shown the steady progress warranted by the ever increasing burden of disease to fight it effectively.

The reasons were apparent. Despite the fact that the NTI tried to enthuse the state governments, there has been a steady decline in the number of trainees being sent, for all the categories. Sufficient importance was not given to sending appropriately qualified personnel for training or, effectively utilising the benefits of training by keeping the trained ones in the TB field. While some states stopped sending trainees altogether, some others were lukewarm in their response. There was also the proverbial budgetary restriction. This affected the drug supply and consequently the programme.

In order to become more accessible to those who are quite at a distance from Bangalore, an unusual step was taken during 1990-91 to hold the Group Educational Activity (GEA) at different places of India, at convenient locations, so as to cover different states. For e.g., they were held at Chinsura and Hoogly (West Bengal); Aurangabad (Maharashtra), Chindwara (Madhya Pradesh), Agarthala (Tripura), Ahmedabad (Gujarat), Hyderabad (Andhra Pradesh), and Ajmer (Rajasthan). The GEA was a platform for information dissemination. The GEAs received support from the respective governments and there was an appropriate response in terms of the number of trained, untrained personnel. These included senior administrators also[111].

From early days, NTI began to organise two months to six months training programmes for young scholars in research methodology. The NTI developed different kinds of training/orientation/ familiarisation strategies for academicians, PGs, researchers, administrators and special groups

(Bacteriologists, Epidemiologists). To suit the different needs, it evolved course contents for seminars, workshops and Continuing Medical Education (CME). In 1995-96, 305 medical students from five medical colleges of south India visited the NTI for the briefing courses. Fifteen MOs and one para medical were briefed in TB control and other specified areas that year under the WHO fellowship. Occasionally, medical students came from USA, Canada and England for their tropical posting.

The NTI had also acknowledged the need to decentralise the training of DTC key personnel and transfer the responsibilities to the STCs so that each state became more independent. One of the main purposes was to make the state governments realise their own responsibilities to set up an effective STC to run the TB programme of the state. Thus, the NTI replaced the regular training course into the *Trainers Training Programme* of eight weeks duration; the first one was started on 8th January '96 from which participants of nine states benefited. It was also attended by two MOs from Myanmar and one para medical from Nepal. It was expected that the well equipped STCs will start the training courses for the DTC key personnel. In actuality none of the STCs could do so. Eventually NTI resumed the regular training courses after an interval of two years as the gap between trained and untrained staff started widening at DTCs.

81st Training Course, January - March 1999