NTI remained ad-hoc and the newly created ones were on annual renewal. A majority of the staff continued to languish without any promotion in their respective cadres. Perhaps, these along with posting of the gazetted officers of different backgrounds and aptitudes were the key reasons for NTI's reduced capability to undertake important studies for programme evolution later.

Beginning from 1988, the spectre of Acquired Immuno Deficiency Syndrome (AIDS) appeared. Experts predicted an ever increasing grimness in TB situation. This should have been considered and the required fillip to the NTI should have been given from time to time to promote efficiency. It did not happen. The Five Regional Centres had been recommended by Dr Nagpaul. These would have perhaps increased the pace of training, introduced an effective supervision and boosted TB control activities in their regions. These were not set up. The programme bore the brunt of these lapses. These apart, there were the inevitable budget cuts. Indeed, it is to the credit of the faculty and staff of NTI that it continued to function with a zeal and dedication rarely seen elsewhere.

4.9. The evaluation of NTP

The NTI had believed in assessment and evaluation as an ongoing process. It welcomed the idea of periodic assessment, especially from experts, on scientific lines as they are vital to the growth and improvement in the programme. As Dr Nagpaul said in 1975: *It is now widely accepted that most of the corrective actions needed for improvement of NTP are administrative and operational. Assessment becomes a mere exercise in research if not desired by the management. While reduction of TB may be the overall goal, the achievements of NTP must be measured in their operational terms*[121].

The NTP was evaluated by three agencies, ICMR, Institute of Communication, Operations Research and Community Involvement (ICORCI) and WHO. Salient recommendations were:

ICMR Review : An ICMR Expert Assessment Committee evaluated the NTP in 1975. The report was carefully considered by the TAI and the GOI. Since TB continued to be the most important public health problem, health should be brought to the concurrent list of subjects in the constitution like education to facilitate the programme as a centrally sponsored one. The Committee felt the need to extend the implementation of the programme to the remaining districts and to strengthen the DTP organisation. Like Dr Nagpaul it felt the need to create five regional centres with adequate provision of funds and staff[122].

The above are well considered recommendations aimed at strengthening the NTP. It was for the government to accept these and implement them because the NTI is not a centre of power but an operations research facility. It is a small cog in the huge machinery of the government.

ICORCI Review : In 1988, twelve years after the ICMR Report, the ICORCI undertook in-depth study of the NTP. A systems approach was adopted to study the NTP since the programme had been integrated with the GHS system. The report contains sixty recommendations which were to be introduced into the programme after proper testing by field trials. Some are: emphasis on integration of health programmes as recommended by the Kartar Singh Committee (1973): strategies to avoid distortion in the priorities to be given by the GHS in the on going programmes; orientation courses to bring about the necessary changes in the Knowledge Attitude and Practices (KAP) of the personnel running the services; sample checks to ensure the validity of records for reliable monitoring; monitoring and evaluation cell to be headed by a statistician; annual evaluation of the integrated health service system; once in three year evaluation of the operational efficiency of NTP; and a national reference and information bureau to prepare and distribute classified handouts for the continuing education of doctors. Incidentally, the report also recommended the withdrawal of targets for NTP,

particularly those regarding case detection to avoid over diagnosis. They were introduced in 1981 under 20 point programme scheme. Till then NTP did not have any targets and the programme was being monitored on the basis of 'potentials' based on studies and 'expectations' on actual performance in some states[123].

WHO Review : In 1992, the NTP was reviewed by a team representing the GOI, the WHO and the Swedish International Development Agency (SIDA). The review team made a situation analysis by analysing relevant documents, making field visits and by holding discussions with concerned authorities. It highlighted some of the following shortcomings: (i) inadequate allocation of funds, shortage of drugs, lack of political will; (ii) inability of the GHS with which the NTP is integrated to keep up with the population growth; (iii) undue dependence on X-ray rather than sputum examination (this implies over diagnosis and unnecessary treatment of patients not requiring anti TB drugs) instead of achieving treatment completion by preventing defaulting; (iv) deficiency in reporting; (v) lack of consensus among practitioners regarding treatment regimens; (vi) inadequate health infrastructure especially in urban areas.

However, the team found that the basic strength of the NTP was considerable. The objectives with which the programme was established in 1962 - integration, decentralisation, free service, priority treatment of infectious cases - are still valid today, 30 years later, in 1992. The programme therefore should be revitalised with strong leadership, political commitment by forming a task force at the apex level[124].

In the light of these recommendations and concerns expressed by the Central Health Council, steps were taken since 1993 to implement the Revised National TB Control Programme (RNTCP) in selected areas with World Bank assistance. Fifteen project areas were identified covering a population of 14 million. This was to be expanded in a phased

manner throughout the country[125].

As part of the strategy, the NTI took up the responsibility of training *nodal personnel* involved in its implementation in ten cities and five districts under the GEA. It conducted two training programmes in 1993-94 and trained 57 MOs. The NTI officers were also sent to supervise and conduct training on RNTCP in Andhra Pradesh, Maharashtra, Kerala and West Bengal[126]. The faculty was also involved in the finalisation of modules required for training on RNTCP.

4.10. Evaluation of NTI

An evaluation or a comprehensive review of the NTI has not been made after 1968. Primarily because it just cannot be done by any outside agency. It is true the founders in the mid-fifties who drew up a plan of operations did have tremendous vision. They succeeded in articulating the objectives with a staff pattern suitable for an emerging institution at that time. The new institution did not fail them because it produced the biggest results i.e. formulation of the programme within three years of its creation and continued to carry out path breaking operations research in many areas for quite sometime. With the passage of time the need was felt for diversification and change in its role. Perhaps that was based on immediate vacuum created in the field of TB. The enthusiasm created in 1967-68 by the news of evaluation of NTI is best described in NTI Newsletter under item "News and Views". As the year 1967 drew to a close, we were informed of the GOI's intention to appoint a high powered Reviewing Committee to examine afresh the purpose for which NTI was established, the achievements so far, and in what directions the Institute must grow. Naturally, joy knew no bounds and we celebrated the occasion by holding several TCC meetings to discuss in detail the future vision of NTI, section-by-section, research protocol-by-protocol, and each staff individually. The new year saw us working on a report which has gone to the Reviewing Committee as background material. Now crystal