5. IN THESE TIMES

Dr. (Mrs) P Jagota,
Director (1997- .....)

5.1. There is more to TB than scientific discoveries

The year, Koch discovered the bacillus, G.Bacelli reportedly remarked: "The *bacillus is not yet all there is to TB".* The relevance of this remark continues to hold even today. Technology has been developed to harness the fruits of research at different places and make these ubiquitously available. Yet in 1993, WHO declared that TB was a global emergency. In 1994, Dr Arata Kochi**,** Director of the Global TB Programme, WHO, lamented: "TB *is one of the most neglected health crises. In spite of its alarming dangers surprisingly little action has been taken to address the TB epidemic. Is it possible that no one really cares*

whether 30 million people will die in the next decade from TB?... How can TB be such a neglected priority, when TB is one of the most cost-effective adult diseases to treat?... How can one ignore a germ that infects a third of the world's population[130]*?* WHO listed India along with Zambia, Bolivia, South Africa, Nigeria and other countries where situation continues to be grave.

According to the editorial of Tubercle & Lung Disease : "*If the number of victims that a disease claims is the measure of its significance, then all diseases, particularly the most dreaded infections such as bubonic plague, Asiatic cholera etc.,... must rank far behind TB"*[131]. TB was described as an epidemic of injustice, in 1998, by the editors of the International Journal of TB and Lung Diseases. They believe that "*the prevalent political trends that place economic exigencies before human health and quality of life"* are the main structural barriers inhibiting the conquest of TB[132]. The International union against TB and lung diseases (IUATLD), comprising 138 constituents, intends to establish a united front to *spearhead public health advocacy on behalf of the millions of sufferers of TB*[132].

In a scathing attack, nailing complacency and inappropriate treatment for the resurgence of the disease and emergence of drug resistant strains, Reichman of the National Tuberculosis Centre, New Jersy, USA exhorted: "The *failure to eliminate this easily eliminatable scourge, ranks as one of the human race's most serious ongoing blunders. TB is different from almost any other disease, in that, cases of TB must be actively sought to keep them from spreading the disease to others. In most diseases, the untreated or improperly treated cases die and harm nobody. In TB, these cases become resistant and spread drug resistant TB. We physicians blame our patients for non-compliance in taking drugs. However, our failure to deal with TB rests with a lack of compliance at several levels. TB will never be eliminated until this is corrected...The problem with TB control is a global co-operative effort, the operative word being "cooperative" and as such a* team effort." Reichman emphasised these concerns while

addressing the conference on global lung health and 1996 annual meeting of the IUATLD, at Paris[133].

It seems he was restating the trials and tribulations of the NTI, while elaborating on global worries. The NTI had also discovered that the solution lies not in accumulating further knowledge, but in working with it and in dealing with the providers, end users and managers of the system. Its experience of four decades chronicles how problematic it was to adopt scientific rigour and to follow the technical guidelines.

As already stated in the earlier chapter the review of Indian TB Programme carried out in 1992 by, WHO, GOI and SIDA revealed that India's NTP had many basic strengths. The team observed in its report that a sound revitalisation of National TB strategy was in order. An updated and strengthened RNTCP could reduce the magnitude of the problem by half every 10-15 years. This would require political commitment, initial investment and strong leadership[124].

In the light of the above recommendations and concern expressed by Central Health Council, **RNTCP was introduced in 1993 in some selected areas of the country** with World Bank assistance. The main thrust of RNTCP was to give priority to the sputum smear positive pulmonary TB cases by quality diagnosis (three smear examination, use of binocular microcope), by giving Directly Observed Therapy Shortcourse (DOTS) with at least four drugs in the intensive phase, and two drugs in the continuation phase, intermittently. Operations research was also envisaged as an integral part of RNTCP to evaluate its performance and obtain base line epidemiological information to measure reduction in the risk of infection[125].

Operational studies and on the job experience guided the NTI not to design the methodology of NTP with a separate vertical framework but to merge it with the country's vast GHS network. NTI knew NTP will "sink or sail" with the efficiency of the GHS which was and continued to be low. It also knew that the performance of NTP would be totally

dependent on the efficiency and priority given to it by the GHS, yet it did it not develop alternate plans? It seemed convinced that there was no better alternative plan for the country. Perhaps health being a state subject came in the way of proper implementation and performance of the NTP. Judith Margaret Brown in her book on "Profiles in Power: Nehru", says that the Constitution which gave the states power over subjects like agriculture, education and health - also inhibited social change. Nehru was a visionary but had no power to implement his ideas. I quote "It would almost be a mistake to call him a figure of power because he never really had power"[134]. Had these been central subjects, there was a chance of controlling TB effectively and NTI would have an opportunity. For controlling TB, the execution of control programme through health services was crucial and social development was equally vital.

If these are the core issues then what is the fate of RNTCP, as it is also integrated with GHS? At the initial stage, there is a central thrust but plans have to be developed to keep the states committed before leaving the programme entirely in their hands. DGHS and NTI realised this and gave top priority to monitoring and supervision on regular basis.

No doubt the new strategy requires skill and hard work to succeed. Dr Nagpaul wrote in 1997: *"The NTP, introduced in the country in 1962, started showing signs of bureaucratic and professional inertia with passage of time. Doctors of GHS remained unconvinced that they could diagnose and treat TB patients, DTOs and other TB specialists continued to believe that they alone could handle TB patients properly and not necessarily through standardised procedures and regimens; and bureaucrats running the NTP loved their office chairs more than the nitty-gritty of a public health oriented programme*[135].

Writing on the 24th March 1998, World TB Day from Kathmandu (Nepal) in the Rising Nepal, Dr P Kumar, Deputy Director, South Asian association for regional co-operation (SAARC) TB Centre ,

says: *"TB is a major public health problem in the SAARC region with the burden of occurrence of more than three million TB cases each year and one million deaths... This serious situation will worsen further with TB-HIV co-infection and multi-drug resistance (MDR) TB. Recognising the already serious situation, which is reportedly worsening, in both developing and developed countries due to insufficient priority being given to TB control programmes and noting the lack of adequate political will and resources for operating effective programmes, the World Health Assembly endorsed a global TB control strategy, which is to provide adequate and efficient treatment...* [136]*".*

It is hardly surprising in 1998 for Dr Jagota to stress: "*TB control is likely to take long in India... It will take a minimum of three to five years before the RNTCP is implemented in the entire country. Till such time, the districts operating under NTP, specially using SCC for treatment, should be strengthened by following the guidelines*[137]*."* She is not alone in her concern.

5.2. The work continues

There is one refrain that emerges: *NTI is a great operations research centre with an international reputation. It has now become a sleeping giant. It must awake. It must emerge stronger than before to enliven that image of olden times and to scale newer heights!*

At the time of writing these lines, Dr Prabha Jagota is the Director. Two major advantages occurred, one administrative and the other technical. Some of the recommendations of the Fifth Central Pay Commission were ordered to be implemented with effect from 1.1.1996. Dr BT Uke, the predecessor, had taken efforts to prevail upon the NTI staff and officers to draft a common proposal for the benefit of the entire non-gazetted staff and forwarded it to the pay commission. The pay commission revised scales only for a few cadres. The extension of these benefits to other similar cadres came through the efforts of Dr Jagota. For the first time, the technical cadres with requisite qualifications and technical