I was pleasantly surprised to see that highly selective vagotomy was included. I had begun to think that the indications for this operation (gastric outlet obstruction not being one of them) had largely disappeared. In the chapter on benign bile duct stricture, magnetic resonance cholangiography as a diagnostic procedure is missing. Wherever available, it has replaced percutaneous transhepatic cholangiography. The non-inclusion of radical gastrectomy for benign diseases may also be an oversight that has slipped through the editorial net. In the chapter on anterior resection of the rectum, greater stress could have been placed on washing out the rectal stump distal to the line of transection in order to eliminate luminal cancer cells.

Professor Kaushik has done the surgical community proud in bringing out this book. Priced at Rs 300, the reader is assured of good value for money.

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Pandits (priests) as links in improving the reproductive health of women:
An alternative strategy

The health care infrastructure existing in the Himalayan region of India is far from satisfactory. Despite the provision of primary health care with the principle of equitable distribution, as pronounced in the National Health Policy of India, there are only skeleton services in the Uttaranchal state of north India. The problems that plague the health services in this region include inadequately trained health manpower (doctors, health workers, laboratory technicians), inaccessibility of the existing health care centres due to the difficult terrain, underdevelopment of communication facilities including lack of vehicles for transporting patients in an emergency, as well as inadequate life-saving and essential drugs in the primary health care centres and sub-centres. Other factors such as illiteracy, poor socio-economic conditions and cultural taboos hamper the process of achieving a satisfactory health status of the people, especially women in the reproductive age group.

A study conducted among 300 ever-married mothers aged 20-34 years in 5 villages each from 6 districts of the region (Pauri, Almora, Pithoragarh, Chamoli, Tehri and Dehradun) revealed a high morbidity; anaemia (77.3%), leucorrhoea (55%), pain in the lower abdomen (42.7%) and dysmenorrhoea (42%). The study also found that 49% of women were illiterate, the mean age at marriage was 17.3 years, and only 13.3% received complete antenatal care. The majority of deliveries were conducted by untrained daias (traditional birth attendants) or family members who cut the cord with unsterilized blades, sickles, bamboo slivers, knives, etc. Deliveries in a cowshed were widely prevalent and 57% of women did not have access to health care services.

In December 1999, a workshop was organized jointly by the Sri Bhuvaneshwari Mahila Ashram and Research, Advocacy and Communication in the Himalayan Areas (SBMA-RACHNA) to address the reproductive health problems of women in Uttaranchal and discuss strategies to improve their health status, and find out the possibility of involving pandits for the same. Thirty pandits representing all areas of the Uttaranchal region participated in the workshop.

Pandits are a group of educated, respected, religious leaders who propagate the Hindu religious doctrines by reciting verses from ancient scriptures, performing religious rites and ceremonies, and advocating the prevailing socio-cultural customs and practices. They also work in various other capacities, especially as priests in temples and school teachers. They represent a group of progressive people facilitating social transformation by way of education and creating awareness among people on various aspects of life. They have good communication and public relation skills. In view of the lack of trained health manpower in Uttaranchal, pandits could act as ‘link persons’ between health care providers and the community. The workshop exposed various social and cultural traditions, practices and customs prevalent in the region which adversely affect the health of women during the antenatal, natal and postnatal period. It also discussed the possible role of pandits in determining the composition and size of the family including the preference for a boy child and the acceptance of contraceptive measures among the people.

The workshop showed that pandits were willing to learn scientific facts about dietary habits, and the phenomena of menstruation, pregnancy and childbirth. They were also eager to review and interpret religious texts linked to these events. It was brought to the notice of the participants that there is a list of taboos and social restrictions on the eating of certain foods by pregnant and lactating women. When the scientific viewpoint on these food items was brought to the notice of the participants, a discussion ensued on the origin of these food taboos in the context of religious scriptures and ayurvedic principles. Finally, it was agreed that religion and ayurveda did not oppose the consumption of these food items and they could be safely advised for pregnant and lactating women. This showed the flexibility in the interpretation of food taboos that could be removed by integrating science and religion.

The key roles identified for pandits in improving the health status of the women in this region were:

1. As health educators in removing prevalent food taboos by motivating people to consume a balanced diet during pregnancy and lactation;
2. To impart information on the availability of basic health provision in the public sector and promote better utilization of health services such as immunization, screening for high-risk pregnancy and the need for referral, avoidance of unwanted and unsafe abortions, promotion of gender equity, contraceptives for spacing of pregnancies and limitation of family size. Such information can be provided by the pandits during their home visits while performing rituals, ceremonies and during sessions for reading horoscopes.
The future strategies identified for achieving these goals included:

1. Provision of short term orientation programmes for pandits to acquaint them with the facilities provided in public sector health centres and hospitals, principles of a balanced diet, basic information on the process of menstruation, pregnancy, childbirth, lactation, and the identification of danger signs during pregnancy and the postnatal period.

2. Incorporation of these issues in the teaching and training programmes of pandits while studying in Sanskrit colleges.

The involvement of pandits may thus help to improve the reproductive health of the underprivileged in the difficult terrains of the Himalayan region.

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Comparison of reported drug use and urinalysis in the assessment of drug use

A valid assessment of drug consumption is critical for evaluating substance abuse treatment programmes and interpreting treatment outcome data. Self-reported drug use is a principle measure in the evaluation of treatment outcome. As there have been concerns about the accuracy of self-reporting, it is necessary to establish its validity by an objective method. Also, drug-dependent subjects tend to falsify their pattern of drug use. Currently, urine testing has gained popularity for validating self-reported drug use.

We examined the concordance between reported drug use and urinalysis among drug-dependent subjects undergoing treatment at the Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi. Opiates (heroin, morphine) were the focus of our study as they are the most commonly used drugs in north India.

Urinalysis was used for the detection of opioids. Hydrolysis method was used for the detection of opioids. After hydrolysis, the samples were screened for drugs by thin layer chromatography (TLC). This method detects recent drug use, i.e. within 48 hours of the last drug use.

All the subjects were men and diagnosed as having opioid dependence syndrome. Their mean (SD) age was 30 (8.2) years. Over a period of 6 years (1990–1995), 7728 urine samples were tested. Of the total samples screened, 43% of the urine samples were from outpatients and the rest from inpatients. Table I shows the comparison between the results and self-reported drug use. Among the patients who did not report recent drug use, 18.2% of outpatients and 10.6% of patients had positive urine tests. Interestingly, the number of patients reporting recent drug use was more than those detected on TLC. While 60% of the urine test results matched with self-reported drug use, 44% of outpatient and 37% of inpatient samples were discordant. These could be due to over-reporting or under-reporting of drug use by the subject. However, it may also be due to the limitations of the method used for analysis of the urine samples. Of the subjects who admitted to drug use in the past 48 hours, 26% had negative results on urine analysis. This may be due to actual over-reporting or due to a limited sensitivity of the TLC procedure. However, we have found the TLC procedure to have a moderate degree of sensitivity as confirmed by gas liquid chromatography. Thus, it is reasonable to assume that the majority of these subjects did over-report their drug use. Some of the TLC negative results may be due to a low consumption of the drug or because the time between use of the drug and urine collection was short.

At our centre all patients receive free medications for treatment and hence they may have over-reported drug use in the hope of obtaining more prescription drugs.

This study also indicates that discordance was lower in inpatients compared to outpatients. This may be because of supervised care in the inpatient setting. Thus, self-reporting may not accurately reflect actual drug use for a number of reasons. The literature also suggests that there is a high degree of variation in the validity of self-reported drug use, depending on the methodological and research context variable including the type of drug used, type of measure (e.g. frequency or amount), and characteristics of the sample population. It is difficult to compare the results of previous self-reporting validity studies because of the differences in such variables. However, our study suggests that urine analysis may help in substance abuse treatment programmes and better methods need to be evolved to assess recent drug use in drug-dependent subjects.

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Table I. Comparison of urinalysis and self-reported drug use (n=7728)

<table>
<thead>
<tr>
<th>Reported opiate use</th>
<th>Urinalysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>Outpatients (n=3309)</td>
<td>391 (11.8)</td>
</tr>
<tr>
<td>No</td>
<td>599 (18.2)</td>
</tr>
<tr>
<td>Inpatients (n=4419)</td>
<td>285 (6.5)</td>
</tr>
<tr>
<td>Yes</td>
<td>470 (10.6)</td>
</tr>
</tbody>
</table>

Figures in parentheses are percentages.
at our Centre for referring patients for urinalysis and the laboratory staff of the Centre for their technical assistance.

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