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## Assessing capabilities in India today and the role of “outside” opinions

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We have followed the exchange of comments between Dr Sankaranarayanan and Dr Suba (1–3) closely and with interest, but also with rising concern that this angry dialogue will eventually harm rather than benefit the goal to which both aspire (and have devoted considerable effort and time). We hope that the editors of this journal and both parties will agree to a period of cooling down, after which the discussions could be continued in an appropriate technical forum.

However, we wish to make two points. First, medical technologies and diagnostic capabilities are moving targets. While it is entirely reasonable to assess the applicability of techniques on the basis of pilot assessments and historical studies, it is becoming increasingly difficult to do so today. The speed of change in all aspects of the world, including technological advancements, communications and medical developments, is so fast now that technology which was current 10, or even five, years ago is obsolete today. A really long time ago, medical men diagnosed diabetes by tasting a sample of urine. Benedict's test, conducted mostly in specialised laboratories, was the technology in use when most of the authors were training as physicians. Now, a clinical test strip, which is used even in the remotest corners of Indian districts, can diagnose diabetes in a matter of minutes.

Judging the feasibility of cytology-based screening on the basis of assessments carried out 29 years ago (2) may not be entirely valid in the India of today. It is to be noted that the rejection of cytology as a screening measure is not based on the inherent characteristics of the test (demonstrated to unequivocally decrease the incidence of cervical cancer in western countries), but rather on perceived problems in implementation and possible challenges for “follow-up”. The failure of patients to follow up, while more pronounced in LMIC countries, is a challenge that plagues all screening protocols, including those in the western world. It may be necessary to engage social scientists, engineers and communications experts to assess the reasons for the failure of patients to return for follow-up, and innovative solutions will have to be sought to address this issue.

The India of today is a technologically advanced society, which is moving progressively towards joining the leading powers of the world in a multitude of ways. India has shown the world that despite all adversities and a very large population, it has the brain-power and will power to provide cutting-edge technology and medical expertise. A case in point is Dr Sangeeta Desai, a renowned pathologist and leader in the field of molecular pathology, who has introduced high-quality molecular diagnostics in India (especially the HER-2/Neu FISH studies, which have changed the paradigm for the management of breast cancer in the country). India has produced leading cytopathologists, including the current President of the American Society of Cytopathology (4) (Ritu Nayar – proudly trained by one of us – GJ). In the light of the strides taken by the country, we hope that assessments of the utility of cytology screening programmes for cervical cancer will be based on the India of today, rather than the India of yesteryear. Our own pilot programmes, conducted for the local NGOs in Thirunelveli, Thanjavur and Tiruchirapalli, Tamil Nadu, indicate that high-quality cervical cytology laboratories can be established in India, at a manageable cost (less than a dollar/patient). We are also piloting an SMS-based messaging system to facilitate follow-up of patients who have tested positive.

Second, the ‘foreign-ness’ of a person (Dr Suba, in this case) making an argument does not, a priori, indicate that the argument is poor (2). Dr Suba has given shape to the Vietnamese cervical cancer screening project (5) and the experience on the basis of which he speaks is legitimate. In addition, looking in from the outside often helps to make opinions bias-free. External examiners in graduate and post-graduate examinations and doctoral defences serve a similar purpose. They are independent, form an unbiased opinion and are blinded to the candidate's inherent nature. Global health workers such as Paul Farmer(6), are external from a cultural standpoint, but their repeated visits and programmes have helped to generate workable, creative solutions to global health problems<sup>1</sup>, as demonstrated in Haiti and Rwanda. At the same time, local physicians, investigators and workers on the ground are essential for finding solutions as they have an

understanding of the realities on the ground and the socio-cultural norms. Both bring valuable insights and experience to the table, and collaboration between the two groups yields the best solutions.

Going forward, we hope these exchanges will take a constructive turn and there will be a genuine discussion on the applicability of cytology-based screening programmes to India. Indian institutions of world renown (including Tata Memorial Hospital, Mumbai, Maharashtra, Post Graduate Institute of Medical Education and Research, Chandigarh and the Institute for Cytology and Preventive Oncology, New Delhi) have earlier proposed training programmes for cytology-based screening in the country. We hope that these recommendations will be revisited in the light of these discussions. At the very least, the discussion should focus on the potential use of cervical cytology in high-risk populations as a primary screening strategy, and in confirming VIA-positive cases in other circumstances.

**Note<sup>1</sup>** *The subject of ethnic and cultural background of individuals involved in global health work in a completely different region is contentious. In a personal conversation with Ravi Ramamurthi, Professor at NorthEastern University, Ravi Ramamurthi describes such global health workers from different ethnic/cultural backgrounds as "Bulls in a China Store". However, in the same breath, he describes the distinct advantage of someone who is 'foreign', to look at issues with a very fresh and unbiased perspective. Perhaps the major advantage is their not being blind-*

*sighted to problems inherent to the system that local workers are so used to that they think they are normal.*

### Statement of authorship

*All the authors have contributed equally to this paper.*

*This article was published online on August 8, 2014, at [ijme.in](http://ijme.in).*

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