COMMENTARY

COMMUNITY DERMATOLOGY IN INDIA

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Thirty-five years ago, there were just a score of dermatologists in India. Today, there are around 2000 dermatologists for a population of 843 million.[1] This amounts to 2.2 dermatologists per million population. Furthermore, they are concentrated in the cities and large towns. The rural population, which is around 80% of the total, has no easy access to a dermatologist.

Cutaneous morbidity is very high. We analyzed the records of outpatients attendances of primary health care centers and found that 25–35% were for dermatologic complaints. This means that the problem of cutaneous morbidity is large, and specialized manpower is meager.

As far as our medical manpower is concerned, the doctor-to-population ratio is one medical doctor holding an M.B.B.S. degree for 2200 people.[2] We have other systems of medicine that are recognized by our government at par with modern medicine. These include Greek medicine (Unani), ancient Indian medicine (Ayurveda), and homeopathy. Besides, these are graduates with integrated systems of medicine, mainly modern and ancient Indian systems. Traditional medical practitioners play a pivotal role in the health care in India. They are the first contact of sick people, are easily accessible to the community, are considered a part of it, and have an intimate knowledge of local health problems. It is one doctor for 700 population.

With such a large medical manpower, why is it that we are unable to deliver good dermatologic care? We studied the knowledge of dermatology of interns and recently practicing doctors and found it was negligible. In spite of having some share in the curriculum, dermatology remains a neglected subject because of its noninclusion in the qualifying examination. Furthermore, we conducted a study of 100 consecutive prescriptions of 10 senior practicing general practitioners for dermatologic problems which revealed that each prescription had a cocktail of an antihistaminic, an oral steroid, an antifungal, an antimicrobial, and a deworming agent, besides a topical steroid-antifungal-antimicrobial combination.

A study was conducted to train traditional healers in the national leprosy control program and an encouraging increase in the knowledge of leprosy was found. In another study[4] the feasibility and effectiveness of cutaneous health care in the community by these healers were assessed. It worked!

The training material consisted of: (1) manuals in local language; (2) clinical photographs for the diagnosis of disease; (3) charts to convey messages; (4) a blackboard, and (5) a demonstration of the medicine kit used.

The areas of training in the disease included: (1) salient diagnostic features; (2) the cause of disease; (3) prevention of disease spread; (4) simple curative management, and (5) a referral system.

Ten common skin diseases seen in primary health centers were identified. These included scabies, pediculosis, tinea, leprosy, vitiligo, pityriasis versicolor (and P. alba), dermatitis, urticaria, impetigo, and boils.

After this successful experiment, we involved a large group of paramedics working for the National Leprosy Eradication Program. In endemic areas for leprosy, one paramedic worker is in touch with a population of 25,000. The outcome of training them in cutaneous medicine was a very rewarding experience. We feared that their interest might not be the treatment of dermatologic problems rather than leprosy, for which they were employed. The advantages outweighed the disadvantages. They became more regular in clinic attendance; they were better able to differentiate leprosy from other dermatoses, and consequently there was better acceptance in the community. These workers, even without training, were using their own cocktail of medical prescriptions, but by giving them practical knowledge, we could improve the efficiency of their dermatologic care by 80% and leprosy care by 50%.

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