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Community dermatology

Collaboration with traditional health practitioners in the provision of skin care for all in Africa

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Based on a workshop in Oxford, October 30–31, 2010, under the aegis of the the International Society of Dermatology's Task Force for Skin Care for All: Community Dermatology, Global Initiative for Traditional Systems (GIFTS) of Health, and Action for Natural Medicine (ANAMED)

Abstract

The Task force for *Skin Care for All*: Community Dermatology seeks to meet WHO objectives, to draw attention to the role of Traditional Health Practitioners and to develop integrated skin care. In many African countries patients will first use traditional medicine to treat skin diseases. Many traditional practices are beneficial but some are harmful. The Task Force recommends education of traditional and modern health practitioners to improve collaboration, safety and efficacy. Thereby, it aims to improve skin care and to reinforce the best practices.

Introduction

Many systems of medicine are based on written or oral traditions. A recent article in this journal described in great detail how to integrate a written Indian tradition with biomedicine.[1] The African continent with its oral tradition requires a very different approach if all people are to have access to healthcare. It is necessary for three reasons.

1 To meet the World Health Organization's objective to support and integrate traditional medicine into national health systems in combination with national policy and regulation of products, practices, and providers to ensure safety and quality. For objectives see Ref. 2.

2 To draw the attention of professions caring for the skin that traditional health practitioners (THPs) have a substantial influence on the health of communities and collaboration is needed to increase safety and efficacy. Data needs to be collected and research is needed to clarify the best way forward. In the meantime, we aim to develop best practice guidelines, based on existing knowledge.

3 To develop integrated guidelines for the management of skin conditions, including both modern and traditional approaches, improving on existing guidelines such as the texts on natural medicine being distributed in Africa by Action for Natural Medicine (ANAMED, see http://www.anamed.net).

Background: The Task Force for Skin Care for All: Community Dermatology

The Taskforce for Skin Care for All: Community Dermatology is directed at demonstrating capacity to benefit and is responsible for a series of articles in this journal.[3]

In 1994, the concept of "Healthy Skin for All" was seen as multifaceted.[4] Unfortunately, "Health for All by the year 2000" was not achieved. "Skin Care for All" may be more nearly achievable but it too is multifaceted. The Task Force for Skin Care for All is under the aegis of the International Society of Dermatology (ISD). The ISD is a member of the International League of Dermatologic Societies (ILDS) to which most international and national

bodies belong and through which they have official relations with WHO. The ILDS sees its role in the developing world equal in importance to its role as a supporter of dermatologists in the developed world, but has created the International Foundation for Dermatology (IFD) to manage this function. The Task Force of the ISD collaborates with the IFD, which made a strong contribution to this workshop.

Good skin care provided by all systems of medicine, including THPs is essential not only per se, but also in the management of major global epidemics causing death and disability, such as diabetes and HIV/AIDS. Some of the most severe complications of diabetes begin as skin problems: neuropathic ulceration and skin infections. Therefore, early diagnosis and management of these complications depend on examination of the skin and simple, low-cost, ''self-help'' techniques. If complications are not recognized early, they might result in unnecessary common consequences of blindness and leg amputation. Carers of the skin should have a ''red flag'' policy to alert to dangers. Dermatology is also expert in the ''look-good, feel-good factor'' and the social marketing of self-esteem through attention to appearance. It is perhaps not employed enough to encourage those in need of skin care to manage themselves in such a way that they have enhanced self-esteem and are optimally welcome in society.

For the sake of simplicity, the Task Force is suggesting that four essentials of skin care should be taught. Attention by carers of the skin must be given to:

1 Skin barrier function. This ranges from the control of transepidermal water loss to wounds and ulceration.
2 Thermoregulation, being too hot or too cold.
3 Sensory function, itch, pain, and numbness.
4 Communication, the ''look-good, feel-good factor'' namely the stigma of being unwelcome because of one's appearance.

However, there are some conditions so common that they should be diagnosed (i.e. recognized), named, and managed by the most effective system of medicine. Clearly, the Neglected Tropical Disease Group includes several of these. Dermatology has identified as most common and in need of diagnosis, eczema (dermatitis), impetigo, superficial cutaneous fungal disease, and scabies. In some countries pigment disorders must be identified and named such as albinism for more complex reasons such as managing witchcraft and gaining recognition of the damage caused by the sun. Utilization of skin lightening creams is a major cause of poor skin health and needs regulation.

From a patient's perspective, there are many routes into skin care and many organizations managing conditions requiring skin care. There are three groups of leading organizations that, through policy and education, are seeking to guide primary healthcare and THPs in skin care best practice, many of which have strong collaborations with WHO:

1 Dermatologists and allied health professionals (nurses) providing skin care for skin diseases and sexually transmitted infections.
2 The World Alliance for Wounds (inclusive of burns) and Lymphoedema Care (WAWLC).[5]
3 The Neglected Tropical Diseases programs tackling 13 major disabling conditions, many of which require skin care, such as leprosy, leishmaniasis, lymphatic filariasis, onchocerciasis, buruli ulcer, yaws, and trachoma. These are currently grouped together for fundraising purposes.[6]

The Task Force sees itself as having the capacity to benefit and it intends to do this at low cost using mostly low technology and ultimately self-help. The education underlying this approach is led by experts that must teach to the lowest possible level in primary care, including THPs and must educate all who at the highest level manage health systems, such as governments and ministries of health.

Why the need to collaborate with traditional health systems?

To achieve the objective of ''Skin Care for All'' the Task Force must seek collaboration with all health systems and it should be understood that traditional health (TH) systems might be the only ones available in some countries or regions within countries. Where the Task Force is supporting major initiatives such as the elimination of scabies, treatment of impetigo and fungal infections, or early recognition of rarer problems such as leprosy, early referral from THPs is essential.

The Task Force is particularly concerned that some of the good work of both the IFD and WAWLC will not achieve optimum benefit because some who may benefit stay within TH systems and any ultimate referral to health centers is delayed. This is often for good reasons such as easy access, and local knowledge about the people and medicinal plants. Up to 80% of the world's population use these traditional systems as the entry point for skin care. In some regions, as in central Sierra Leone, there is almost 100% utilization of THPs.[7] In others such as Iran where the health center provision is generous, traditional medicine is frequently used as a back-up after biomedicine has failed. This creates a substantial problem for those planning to provide ''Skin Care for All'' through a mostly biomedical point of entry. Proposals such as the eradication of scabies are in dermatology's sights but are inconceivable without collaboration with all systems of medicine.

It should be recognized that the most common minor ailments are treated within the family. Some conditions not tolerated in the developed world are rarely presented even to the THPs; for example scabies, tinea capitis, and minor degrees of pyoderma. The facial washing regimens for trachoma to prevent flies spreading the disease is superimposed on people for whom water is a luxury and is needed first and foremost for domestic animals.

In Mali, Dr. Ousmane Faye managed an IFD program that provided training of all health center personnel for diagnosing impetigo, fungal infections, scabies, and leprosy.[8,9] The good effect was diluted by the fact that most patients either do not seek help or go first and/or only to the locally available traditional healer. It is suggested that where there is a program based at a health center expecting and needing referral, local THPs must be informed and educated about such a program. It is necessary that the THPs have an understanding about those biomedical programs most important to the health of their community.

In a review for WAWLC/WHO of the dermatology (especially wound care) needs in Sierra Leone, it was observed the best plant-based therapies provided by THPs were being destroyed by deforestation.[7] Cooperation with the Forestry Commissions alerting them to this fact is necessary.

Dermatology is also concerned by adverse reactions affecting the skin. Throughout Asia, the Middle East, and Africa, skin lightening agents are the most common cause of this and there are numerous publications focusing on hydroquinones, mercury, and steroid creams.[10–12] Mostly this is the result of self-medication initiatives and purchasing from the ''roadside seller.'' If a campaign to reduce this is to be effective, counseling and prescribing by THPs will have to be integrated into any plan. The Australian Social Marketing program managed to reduce the demand for deep tanning and a future article in this series on community dermatology will promote social marketing.[13] Those practicing aesthetic medicine sometimes advocate ''natural is beautiful'' and it is a theme that could be marketed more extensively by dermatologists wishing to promote safe and low-cost practices.

Benefits of working with traditional healers

There are many arguments for working with traditional healers.[14–21] First, there are large numbers of THPs (up to 1/200 per population) who are an accessible, available, and affordable resource particularly in rural areas for common diseases such as diabetes.[22] Indeed, without THPs health centers would be overwhelmed by the less seriously ill. Second, many possess effective treatments and collaboration will enhance the development of new useful phytomedicines. Third, THPs are more client-centered, culturally appropriate, holistic, and offer a form of family counseling, although more research is needed on this.[20] Fourth, they will abstain from dangerous practices if dialogue and cooperation is initiated; they are enthusiastic wherever cooperation boosts their income and capacity to treat illness more effectively. Traditional healers' associations are effective as they produce ethical guidelines, can develop increased knowledge and skills, increased confidence in their practice, increased transparency, and earlier referral to biomedical practitioners. Fifth, knowledge of what patients are taking is needed by all systems of medicine. It is enhanced by collaboration and avoidance of critical statements to the patient of the other systems of medicine. Sixth, THPs are often respected opinion leaders with credibility (indeed they are often ''priests'' and political leaders) and are often more knowledgeable than village health workers. They exist, they have not gone away, and they will be there for the foreseeable future.

On the other hand, there are several challenges to such cooperation.[21] First, training and licensing are difficult to oversee and quality control is difficult as is monitoring of claims. Second, some THPs engage in harmful practices and cause delays in referral, so there is the danger that promotion of THPs may undermine efforts to increase referrals to health centers. Some herbal medicines may antagonize biomedical treatments such as contraception. Third, legitimizing THPs may undermine testing of their effectiveness. In some cases, traditional medicine is based more on superstition than science, and usually record keeping is poor, which impedes evaluation. None of these challenges should be insurmountable if an appropriate strategy is adopted. For example, in South Africa three categories of traditional healers are recognized: herbalists, divine healers (who determine the cause of illness by using ancestral spirits), and faith healers (who are Christian and heal by prayer).[23] It may be most appropriate for education about skin care to be focused on the herbalist. Snake-bite management illustrates some of the problems arising in care by THPs.

Snake bites

Snake bites are wounds affecting the skin, most of which occur far from any center equipped with antivenoms. The WHO *Guidelines for the Prevention and Clinical Management of Snake Bite in Africa*,[24] which is an excellent biomedical treatise, states: ''It is essential that first aid is carried out by bite victims themselves or bystanders, using materials that are immediately available …. Ideally all patients bitten by snakes should be assessed by medically-trained staff …. Reassure the victim who may be terrified. Reassurance is justified as most bites result in negligible or no envenoming.'' The treatment to be taught is reassurance, immobilization, and identification of the

snake. Everything else is discouraged except quick transport to medical aid, which in the African setting is usually a frightening shake up in the dark, the snake never having been seen, and the health center having no antivenom. As discussed below, intervention by THPs is both common because of easy access and of questionable safety.

Regarding the management of snake bites, WHO guidelines suggest that traditional healers should be "educated in evidence-based snake bite management" and discouraged from using traditional practices.[24] However, in practice, traditional healers are frequently consulted and provide a range of treatments, including cuts at the site and elsewhere on the body (causing exsanguinations in those with hemorrhagic consequences of the bite) and medicaments of herbals and snake heads; also these very sick patients are often given emetics.[24–26] Tourniquets and procedures encouraging infection such as the application of cow dung must be discouraged and patients should be referred early to specialized centers for antivenom if this is needed and available. On the other hand, the deleterious affects of extreme fear can be well managed by the TH system. ANAMED promotes application of a form of charcoal called Black Stone made from long bones of cows, which is a powerful adsorbent, but whose effectiveness other than for reassurance is disputed.

How to work with traditional health practitioners?

The experience of the Task Force in Africa is limited to experiences particularly of the IFD through its Regional Dermatology Training Centre in Tanzania (RDTC). Several of the 200 graduate dermatologists wrote dissertations on THPs as the first point of entry into skin care. Management of specific conditions such as albinism has required understanding of routes of entry into care. Witch doctors in some parts of Africa have murdered persons affected by albinism to use body parts in their practice. One of the permanent African staff of the RDTC has made collaboration with THPs a special interest and 600 persons affected by albinism are cared for in special clinics open to THPs in the region of Mt. Kilimanjaro. At the RDTC, the 200 graduates have been taught that every healthcare worker should bridge the gap and open dialogue with THPs, followed by on the spot transfer of knowledge. Leprosy reactions are given as an example of the need for early referral.

Training of traditional birth attendants was promoted between the 1970s and 1990s and was shown to be effective in reducing neonatal and perinatal mortality.[27] Frequently they are on call to other sectors of healthcare. The International Foundation for Dermatology when active in Guatemala in the 1990s found them supportive for skin care projects.

In 1995 WHO with the International Development Research Centre (ICRI) produced a review describing projects in which THPs were used as community workers in Afghanistan, Bangladesh, Brazil, China, Ghana, India, Nepal, Nigeria, Philippines, Sierra Leone, Sri Lanka, Swaziland, Thailand, and Zambia.[28] It concluded that evaluation of projects was not good but that THPs are available and willing to work in community health. They can be trained to perform a wide range of primary healthcare tasks and are cost-effective.[29] Like any other community programs, they should be based on an assessment of local needs. Developing a formal referral system and follow-up discussion groups was helpful. Thanking systems did not have to be financial but included awards and inducements such as certificates, badges, and gifts such as umbrellas.

There are also organizations that train healers to improve their traditional practices. For example, ANAMED combines the best effects of herbal medicines with scientifically based modern medical practice. Recognizing that biomedicine is unavailable or unaffordable to many, it provides oral and written training to healers and health professionals, aiming to enable people in the tropics to become as self-reliant as possible.[30,31] This advice includes herbals used in skin care, and this workshop has provided suggestions for improving and incorporating additional knowledge into integrated guidelines.

Education of THPs and their patients cannot simply take biomedicine's guidelines and expect those with different beliefs to understand them. Many who have not been influenced by the church or biomedical science and have not been brought up in a developed world environment perceive themselves as under the influence of a spirit world in which plants and rocks are living, human relationships are extended, and the daily or yearly calendar of events is more flexible. This has been well illustrated in many publications and films focusing on the Australian Aboriginal. The "true" cause of an ailment based on such beliefs is interpreted by many THPs in many areas. It is divined and the therapy interwoven into daily living practices and perceived influences. Hariramamurthi *et al.*[32] write "different foundations, world views, philosophical framework, logic concepts and categories merit conservation as a means to preserve cultural diversity. While traditional knowledge can no doubt contribute to and be enriched by modern science, it is important to note that it existed independently and has been enormously productive for centuries without the aid of the latter."

The Organization of African Unity at meetings supported by the WHO in Nigeria and Zambia designated 2001–2010 as a decade of African Traditional Medicine. All Ministers of Health prepared documentation on

policy but there is a question about how far this was enacted. At the end of the decade, it is appropriate to review integration of TH with biomedicine.

Avoiding exploitation while increasing utilization: intellectual property rights

In the research and development of herbal medicines, there is a drive to find constituents that explain efficacy. Traditional knowledge must be protected from exploitation and much has been written in the context of intellectual property rights. It could be of benefit to reproduce the centuries old advantages of understanding and producing effective drugs from herbal sources, but there is a question of who owns the knowledge and should benefit from sharing it. If there is no benefit for the possessor of knowledge, there is no stimulus to the sharing of it. The orthodox, Western, biomedical emphasis on the risks of side effects, and the lack of randomized controlled trials to provide evidence of effectiveness, require that integration gives due weight to the systems used to reduce the side effects of some herbals and understand some of the cost and cultural reasons for preferring other levels of evidence: "Instead of science mining natural resources for new ingredients, traditional knowledge could reshape the scientific world by offering paradigms and solutions that will broaden outlooks and offer holistic solutions".[31]

Collaboration with THPs that encourages greater utilization will also be a threat to its sustainability unless effort is put into systems that enhance production. Deforestation and harvesting that exceeds supply for purposes of export to overseas markets must be monitored. THPs sometimes need assistance to grow herbs and understand the factors that lead to an increase in their active principles. In addition, providers of healthcare need to understand how rising costs of biomedicine shift patients to TH. Medicinal plants can be produced in small plots in remote areas where other options are minimal, as promoted in India by the Foundation for Revitalization of Local Health Traditions[31] and in Africa by ANAMED.[28]

Development of guidelines for collaboration between skin carers and traditional healers

The enormous impact of the HIV/AIDS epidemic in Africa has brought to the attention of governments the need for collaboration with TH systems, and has resulted in guidelines.[21,22] It is the intention of the TASK Force for Skin Care for All ultimately to provide guidance of a similar kind in the field of skin care. The UNAIDS guidelines include: the role of traditional medicine; health policy and traditional medicine in Sub-Saharan Africa; documented examples of collaboration; questionnaires given to project leaders to determine best practices; criteria for selecting "genuine" or "authentic" healers; the approach used to establish trust with traditional healers; training methods, collaboration and project design and implementation; the effectiveness, ethical soundness and efficiency, sustainability, and relevance.[21]

There are many versions of algorithms currently in existence. Some are more detailed and advanced than others. Simplicity in wording and clarity in illustration is needed. It is suggested that one should be produced for THPs, which should dovetail with that used by health centers. The guidelines for traditional healers should indicate when referral is needed, and can include more information on medicinal plants, but should not include guidelines for prescribing modern medicines except possibly very safe over-the-counter medicines. Health center guidelines should include prescription of biomedicines, as biomedically trained health workers are authorized to prescribe them, but traditional healers are not.

Apart from its guidelines on medicinal plants based on utilization and not determined by proof of efficacy, ANAMED has developed a detailed code of conduct for traditional healers.[31]

What the task force wishes to achieve

1 To improve skin care in general:
   a. To take a patient, community, and ecosystem-centered approach to wellness and access to a better affordable service everywhere.
   b. To improve access to best practice and encourage cross-referral between biomedical practitioners and THPs, taking the current WHO definition of traditional medicine.
   c. To promote good general public hygiene and nutrition.
   d. To facilitate two main objectives of the International Foundation for Dermatology:
      i. To control the most common bacterial, superficial cutaneous mycoses, and scabies with the eventual elimination of the latter in a WHO-led program.
      ii. The introduction of water fit for drinking and for use in skin care. A collaboration with the focal philanthropy program of Procter and Gamble to long-term supply at not-for-profit of the water purifier PUR.
2 To reinforce good traditional practices:
   a. Promoting codes of good practice for THPs, including those of ANAMED,[33] the African Union, and of traditional healers' associations.
   b. To support education to share and document knowledge of traditional practices, reviving household

knowledge and skills in using plants for the prevention and treatment of disease, focusing on local knowledge and indigenous (rather than exotic) plants.

c. To promote good clinical governance of all health practitioners, for example through supporting the development of responsible, educative, officially recognized professional organizations for self-regulation, as required by the WHO Charter for Traditional Medicine.

d. To record traditional herbal knowledge that is in the public domain, identify herbals effective in skin care but also hazards, photograph the source plants, record preparation of medicines and storage, labeling and dosage systems.

e. Where requested by traditional custodians, provide a safe facility for recording and storing proprietary knowledge (such as restricted access databases).

f. To make an international online tropical pharmacopoeia for the production of medicines for skin diseases.

g. To recommend the use of traditional soaps that are acid and antiseptic, and for which irritancy and allergy are rare.

h. To develop practical guidelines for health practitioners in the use of traditional medicines and other low-cost health technologies, which can be disseminated for example through the seminars and publications of ANAMED.[33]

i. To ensure policies are based on principles of sustainability and equitable benefit-sharing arrangements.

3 To prevent harm:

a. To encourage open discussion of risks of traditional practices relating to the skin, with a view to establishing safe practices and harm reduction. Examples of harmful practices in the field of skin care include scarification with unclean materials and skin-lightening creams.

b. To support ongoing efforts to prevent unprofessional and commercially exploitative practices.

4 General policy goals:

a. A strong policy statement that the involvement of competent THPs in the prevention, control, and management of most common skin diseases of public health concern and importance will be beneficial for the implementation of primary dermatological care at ''grass-roots level''. Competence at that level means proper training and constant coaching and quality assurance through licensing and registration of THPs. There are many examples of clinics in which THPs and biomedical practitioners consult together.

b. To support efforts at improvement of quality, safety, and efficacy of herbal products.

c. To identify the best systems for teaching THPs

d. Guidelines must be developed through an understanding of the local culture, which is fully consulted.

e. Encourage women's groups as custodians of the growth of herbals and best practice.

f. To support interdisciplinary research efforts into the evaluation and conservation of medicinal plant genetic resources.

g. To make alliances for the further development of public health policy.

5 To provide a background for and to stimulate future research by the disciplines of skin care.

In conclusion, the Task Force recommends that the professions responsible for skin care collaborate with THPs and help to educate them, to improve safety, and preserve their beneficial practices until such time as their efficacy can be thoroughly researched. Exactly how this should be done will vary from place to place.

Presenters at the Oxford Workshop

Dr. Mazin Al-Khafaji, Founder & Clinical Director, Avicenna Centre for Chinese Medicine, Hove, UK; Dr. Anthony Bewley FRCP, Consultant Dermatologist, Whipps Cross Hospital, London; Professor Gerry Bodeker, Chairman, Global Initiative for Traditional Systems of Health; Gemma Burford, Aang Serian and GIFTS of Health; Professor Jeff Burley, Department of Plant Sciences, Oxford University; Dr. Simon Challand, Doctor in Palliative Medicine and member of ANAMED UK; Dr. Ousmane Faye, MD PhD, CNAM ex Institut Marchoux, Bamako, Mali (Centre National de la Lutte contre la Maladie); Dr. Carsten Flohr, NIHR/DH Clinician Scientist, Senior Lecturer and Honorary Consultant Dermatologist, St John's Institute of Dermatology, London; Professor Henning Grossmann, Regional Dermatology Training Centre, KCMC, Tanzania; Dr. Roderick J. Hay, Chairman, International Foundation for Dermatology; King's College Hospital NHS Trust; Dr. Hans-Martin Hirt, Chairman and Founder, ANAMED; Dr. Margaret Hughes, Oxford International Wound Healing Foundation; Prof Quinton Johnson, Director, South African Herbal Science and Medicine Institute, University of the Western Cape, Capetown, South Africa; Dr. Alexander Kumar, Department of Anaesthetics, Royal Sussex County Hospital, Brighton, UK; Alex Laird, Medical Herbalist, Whipps Cross Hospital, London; Professor Terence Ryan, Emeritus Professor of Dermatology, University of Oxford; Dr. Babara Turay, Ethnobotanist, Chief Pharmacist and Advisor, Traditional Healers' Associations of Sierra Leone; Professor David Warrell Emeritus Professor of Tropical Medicine, Nuffield Department of Medicine,

Oxford; Dr. Merlin Willcox, Department of Primary Health Care, University of Oxford and trustee, GIFTS of Health.

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