An Invitation to

skincareforall.org

Community Dermatology
A task force of The International Society of Dermatology
The International Society of Dermatology’s Honorary President Dr Terence Ryan invites you to join Skin Care For All

For some 50 years I have played roles concerning a failing skin in many parts of the world, tending to skin disease, wounds, lymphoedema and tropical diseases such as leprosy.

Most of the time I have emphasised that a failing skin is a heavy burden and only recently have I understood that funding agencies want us to prove that we have the capacity to benefit and not to keep telling them how terrible skin conditions can be.

Dermatologists are great diagnosticians. They are skilled at making people look good and therefore feel good. Their research into mechanisms have been outstanding. Few, however have contributed to public health and they are not perceived as among the leaders on the needs in the developing world where low technology, sustainability and low cost solutions are desperately needed.

The International Society of Dermatology has served this purpose for more than half a century and as its Honorary President I am pleased to be Chairman of its task force Skin Care for All: Community Dermatology. I seek to use the language of public health and to show that we are notably good at it.

I invite you to read this booklet and visit the accompanying website so that in future, with the language of community dermatology at your finger tips and on the tip of your tongue, you can be ambassadors to ‘Nations in Need’ and ‘Resource givers with Funds’, be proud of our achievements and make clear our capacity to benefit. Please listen to these members of the public, from many different walks of life, who so vividly give their support to this ABC of public health themes.

Yours,

Terence Ryan
The title goal of Skin Care For All is to aid the adaptation and self management of community dermatology, to actively engage in our surroundings as health practitioners to better the lives of those living with the effects of poor skin health. This must be achieved in part through alliances. Health for all is Utopian, skincare for all and its funding is not. The endpoint is the education of a work force with evidence based intervention from the public health syllabus presented on this web site.

Appeals for resources should be a combination of an assessment of burden, proof of the ‘Capacity to Benefit’, ‘How it is Done’ using a public health frame work, and a list of partners who will help to achieve qualitative skin care. This should help to upgrade the potential of our profession to provide Skin Care for All: Community Dermatology. The end point is the education of a work force with an evidence based intervention programme.

The International Society of Dermatology, Tropical Ecologic and Geographic was launched in 1965 with a name that clearly indicated its focus. Later it was renamed The International Society of Dermatology (ISD). The International Committee of the International League of Dermatological Societies, of which the ISD is a member, in 1987 launched the International Foundation for Dermatology. Focusing mainly on education it perceived that the burden of skin disease was poorly managed in the developing world. It chose Africa to launch a Regional Dermatology Training Centre in Tanzania and went to both the World Health Organisation and UNESCO to launch its programme of Healthy Skin For All. This was prepared with the education and science divisions of UNESCO. It was named UNIDERM and helped to achieve Official Relations with WHO. It was a five year plan for the International League of Dermatological Societies prepared in the first five years (1991-96) of the International Foundation for Dermatology. The programme was later given the name of Healthy Skin for All.

Community Dermatology embraces common skin diseases, wounds, burns, lymphoedema and neglected tropical diseases such as leprosy. Its interventions are low cost. It concerns populations of individuals rather than individuals in a one to one relationship. It requires data on prevalence and human resources. It trains community based workers to manage common problems of the skin. Its interventions are low cost and address the needs of those with few resources; though not exclusively. These may be isolated, periurban or mobile communities, often against a threatening background such as strife or climate change.

Give every child the best start in life. Enable all children, young people and adults to maximise their capabilities and have control over their lives. Create fair employment and food and work for all. Ensure a healthy standard of living for all. Create and develop healthy and sustainable places and communities. Strengthen the role and impact of ill-health prevention. Focus on poverty and health inequalities induced by social exclusion, unhealthy living habits and societal stressors.

Most urgently needed is the finance to develop the skin carers themselves. Many of these carers work, and will continue to find a place, in well resourced environments, but especially hoped for is to employ those who would like to work in the developing world without damaging their career opportunities in the developed world. They should receive guidance on what to do, should be observed and assessed of their progress, given as much support as possible and be rewarded by due recognition for achievement.
Ageing and end of life

The population is getting older. More and more attention from governments are being focused on how best to cope with the largest ever generation of the elderly. The illnesses and afflictions common with this group are becoming the most frequently treated and diagnosed, consuming an ever increasing amount of resources administered by an ever thinner, less custom force of care.

Last October, a nurse was quoted in The Guardian newspaper: “Many older patients in hospital have dementia, combined with very high levels of need, such as incontinence, and requiring assistance with eating or walking. Meeting care needs is complicated by communication difficulties. Severe short-term memory loss means that reassurance and comfort given has no lasting effect. Patients may call out repeatedly and persistently, and responding can appear futile to staff.”

**Warning** Families are only getting smaller with younger members migrating and added pressures in work and life meaning unadulterated care of the elderly is becoming more and more difficult to ensure. The elderly are being left behind and in an ever ageing population, it is now that we must ensure care, of a higher quality, comes first.

**Action** With time and resources more of an issue than ever, we must look to any and all changes that can be made to enhance and prolong a comfortable life for the elderly. Most importantly, we must instil within them, ourselves and our communities that a substantial proportion of the elderly are capable, conscious members of society, and if looked after thoroughly, could become, in part, carers and beneficiaries of their own needs. For us, we must ensure the earliest identification of problems associated with life threatening illnesses, make impeccable assessments of skin failure to relieve and prevent suffering and to, above all, strive to manage physical, psychosocial and spiritual problems wherever and however possible. At the end of life people are unwell, dependent and soon to die. They require palliative skills and cultural competence that improve the quality of life of patients and their families. A healthy skin can determine this.

“I’ve been in and out of hospital five times this year. Every time it changes you and makes you feel low and in the end, more than any visitor, it’s the people seeing to you, caring for you, that makes the difference” — Joyce
In a generation dominated by the ceaseless reach of the internet and the unlimited resulting changes to how we communicate, the images and ideas we are subjected to have changed alongside them. Most notably, the way we view others, ourselves and our bodies has become a barometer of the health and wellbeing of our society. Looking good contributes to our wellbeing and consequently, our health. Of late, Beauty’s ideals have begun to lean in a positive direction, towards the natural, away from costly, ineffective remedies and more and more brands turn to ingredients less processed. Careers play a role too in body image, helping to transform the lives of people disillusioned by modern standards of beauty.

**Warning** Community Dermatology must protect families from the often high cost of interventions and from ineffective and harmful remedies. Too much focus and resources are placed upon appearance and too vast a portion of skin remedies include harmful assaults on the skin leading many to believe involvement in cosmetic dermatology trivialises our speciality. Yet quality of life is about more than quality of care, it includes results of studies which have clearly indicated how looking good and the absence of disfigurement contribute to health. We have all witnessed the marketing of a youthful and sexually robust society which has presented unrealistic ideals of beauty. Furthermore those with pigmented skin look to whitening and those with white skin like to be ‘tanned’ as indications of ‘good health’ and social mobility. The end point of the long term repercussions of such thinking is yet to be realised.

**Action** Beauty has been a motive and a force since time immemorial, but a positive body image can only be achieved through the right frame of mind and continued support from the skin care community. Marketing of self esteem has its advantages when it clearly makes people confident, happy and living with dignity within their means. In seeking to prove their capacity to benefit society and each other, skin carers must show excellence in aesthetic medicine. Yet there is a fine line between educating about managing defective skin function and coercion to do something about it to enhance the educators income.

‘I share a bedroom with my older sister in a house full of women and we've been raised to talk about our problems, with our bodies and ourselves. I couldn’t imagine not having that and what effect it would have on my confidence’ — Keisha
Climate Change

Our skin is our largest organ. It covers our body from head to foot through varying thickness, size and strength, it is our greatest defence, designed to protect us from the environment. There are simple ways to assist and care for our skin, that all people should be aware of to better defend ourselves and this vital organ against a threatening environment.

Warning Climate change is often mooted as the issue of our times, its hazards are well publicised and the effects commonly seen. Blistering heat, worsening cold and rising floods have huge potential to effect the quality of lives of so many, but none more so than those with least defences; the infant, the elderly and the homeless.

Action Doing nothing is not an option! Rapid climate change is a possibility and none should say ‘that’s all we can do as Dermatologists!’ Our influence must extend to all animal and plant life. Exploration societies’ and Armed Forces’ literature, on coping with extremes of climate, should be read. Climate change literature on management of hazards from sun burn and skin cancer to water immersion includes a long history of interventions and acclimatisation skills to build upon. We must be bringing superior coping mechanisms and simple solutions to those who so require it in extremes that are progressively worsening. Uncomplicated measures can be adopted from wearing several thin layers rather than one thick layer which traps warm air close to the body. Likewise, in excessive heat plan outdoor activities in the early morning, plan ahead to map shaded areas and meeting places with air conditioning. Natural fibres, an umbrella and equipping yourself with sufficient water fit for drinking all ensure maximum relief from harsh sun conditions.

Insulation and ventilation play key roles in the survival of extreme conditions and to the benefit of skin care in basic terms. Obvious though these solutions may seem to us, they are fundamental tactics in ensuring a greater method of preventing long term conditions and should be made obvious to the community as a whole.

‘I’m originally from the Miyagi Prefecture in Japan, the capital of which, Sendai, was destroyed in the tsunami last year. The disruption to basic care of the community, access to medicine etcetera, was devastating.’ — Jun
Diagnosis

Dermatology’s finest art is the recognition and naming of physical warning signs and illness. As experts we are called upon to engage with patients and assess them to the fullest of our abilities, yet as communication is an imperative of any medical professional, we must do more to be explicit and effective relators of comprehensible advice and diagnosis.

Warning The nomenclature of dermatological disease is huge. Terms such as macule, papule, or nodule and the distribution of rashes are useful, yet more so for communicating from one expert to another. Diagnosis in the developed world increasingly relies on the laboratory. Where there is no access to such, it is too costly or where there is no refrigeration of reagents, simple and cost effective training procedures such as the algorithm are used to determine therapy. For example, rapid identification of snake or spider bite and access to anti-venoms are essential and must be sought quickly.

Action The skin carer can recognise function and especially signs of skin failure; failure of barrier, thermoregulation, sensory system, and communication through the skin. We must strive to maximise understanding wherever possible, in as simple a way possible, coupled with looking and touching appreciated as involvement and as an indicator of care. Recognising predisposition and weaknesses in the constitution are more characteristic of Asian systems of medicine. Culturally, they give more time to questioning, detecting changes in the constitution using terms that indicate excitability or lethargy, overheating or cooling. They use Tongue and Pulse diagnosis. They are concerned with balance.

In the rapid assessment of illness, we must tap into technological advancements such as developing aids and technological portals including mobile phone apps and smartphone technology for people to access with a clear and simple interface in a changing world of communication and access to information.

‘For months my girlfriend told me to go get a small, indistinct mole on my back examined. Eventually I did and was told it was benign. It was only then that I realised how much better I slept knowing it was all OK.’ — Charlie
Empowerment of Women

In this world there are traditional practices that make life for some women more difficult. In some areas of the world, girls as young as four are betrothed, leave their homes and some take part in intercourse before they are yet teenagers.

Warning Over 137 million women have undergone female circumcision, they have experienced extreme pain and undue suffering, complicating pregnancy and childbirth. There may be immediate haemorrhage, retention of urine, infections such as tetanus or HIV. Then follows dysparunia, difficult menstruation, difficult childbirth and consequent vaginal fistula, as well as in some cases, maternal death. In many parts of the Muslim world this practice continues rampantly. Men will not marry a woman who has not been circumcised and women fear being unmarried, creating a cycle of life threatening practices. Where there is poverty, contraception and pregnancy are poorly monitored, many girls are missing school because sanitary pads are lacking and a severe lack of privacy in schools for managing menstruation breeds potentially harmful misinformation. Whilst care of the breast has improved, a focus on breast cancer has led to a debate about the cost effectiveness of Breast Clinics and anxiety about body image has greatly increased breast reduction and the technology and safety of implants. In Saudi Arabia where 69% of women are overweight, girls are banned from participating in sports in state schools by the Supreme Council of Religious Scholars, contributing to the obesity epidemic.

Action Setting up vulva clinics by dermatologists, rather than as a branch of venereology or gynaecology, has made a big impact in the last 20 years and continues to improve the lives of many women globally.

It is essential the momentum for empowerment of women is not lost as we strive for greater promotion of women professionals in senior and academic posts. This will allow a greater spread of rights for women in areas of the world most in need of it, which will in turn implement a more effective use of micro-finance by women in the Developing World.

“I grew up in Eastern Europe in small communities that had very rigid expectations for women. When I came to the UK I didn’t look back and grasped every opportunity with both hands.” — Tamsin
Skin care is all about restoration of four functions that are easy to remember compared to its several thousand named diseases. There is skin failure due to:

1) Failure of barrier function ranging from changes in Transepidermal Water Loss (TWL) to full thickness wounds allowing penetration of infections, irritants and allergens, and activating the repair and remove mode when the epidermis makes and distributes chemicals to stimulate blood supply and to activate recognition and elimination of harmful invaders. This is inflammation and immuno-surveillance.

2) Thermoregulation is being too hot and too cold, controlling sweating and by increasing or decreasing the blood flowing through the skin to maintain optimal body temperature for all functions including wound healing. Inflammation also brings the skin, which is usually cooler than the core, up to body temperature.

3) Sensory loss from injury to nerves in the skin, the spine, and brain, unconsciousness or impairment of awareness. Disturbances of this function underlie both itch and pain. The brain centres that control emotion have a strong influence on the neural pathways involved in inflammation. Amputation is a too common consequence for pain and numbness of the foot.

4) 'The Look Good Feel Good Factor' - Skin failure includes the unwelcomeness of the disfigured of which leprosy and elephantiasis or the severely burned are well recognized prototypes.

**Warning** Fear and lack of understanding lead people to taunt, assault, run away or hide from the disfigured. Beliefs surrounding the illness are powerful factors and must be changed.

**Action** Water loss is relieved by emollients. Thermoregulation is helped by the use and weave of clothing and avoidance of the sun. Sweat spread by body grease and trapped by hair evaporates and cools. Healthy skin is rarely immobile and offloading protects against the effect of pressure. Management should be patient centred, image aware and culturally competent. Chronic illness dominates by far, as does living beyond four score years.

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*I work metal in often uncomfortable conditions and often found my hands chapped and blistered. My pharmacist taught me to care for my skin properly and invest in the right regimen.* — George
Global Burden of Disease

Medical and scientific professionals count upon the most up-to-the-moment data to best support and create solutions and treatments. Therefore, a solid and vast factual knowledge of the size of the burden of diseases is essential for planning Community Dermatology.

Warning Without proper investment and focus applied to attaining the best possible information and without dedicated teams supplying this data, we may miss important opportunities in the global community affecting disease spread and growth.

Action It is imperative to organise and collect data on the common versus the rare, on buildings, equipment, human resources and the costs associated with those we’re trying to help.

Collecting data on prevalence of disease, doing house to house surveys and identifying common objectives helps us all to gain experience and practice. However, we are strongest when this information is shared and is equally reachable by us all as a global community of dermatologists.

The mechanisms for collecting data are well illustrated in dissertations on Health Systems Research, 213 of which have been written by students at the Regional Training Centre in Tanzania, who in a typical dissertation, have a description of the location, climate and community where the study is done ranging from outreach in small villages to large urban based communities. Each dissertation has an introduction setting the scene that includes, the population and its urban, peri-urban and rural distribution, economy, social, sexual and cultural practices, the birth rate, infant and maternal mortality, literacy and life expectancy. Health Care Delivery Systems and Health seeking behaviours are recorded to better serve the dermatological community as a whole.

Publications in the International Journal of Dermatology by Marigdalia Ramirez-Fort et al (2012) and Estrada et al (2012) are seminal works amongst others that can help us to draw on these ideas.

“I volunteer for a charity that gives advice to young mothers. Knowing their circumstances and the details of their lives helps us to tailor their care and improve what we can offer them.’ — Fatima
Housing: The Home and Health Centre

The facilities we use as well as the places in which patients are treated are often overlooked as ways of improving the uptake of skin care and the betterment of our work. Yet it’s poor conditions of a general nature than can prolong suffering and open us to disease and infection beyond the simple fact that a bright, clean and airy environment is a positive atmosphere to be in.

**Warning** Bad Housing at home or in the health service encourages skin disease and discourages attendance at such facilities. Gregory Karelas writes from Nepal:

“We [the staff] care so much about this hospital, because it is ours. If we see dust on the equipment, we wipe it. We do not do it because it is our duty, or in our job description. We do it because this is our home.”

When addressing the question of access it is clear that diagnosis and treatment depend on attendance which is enhanced by a homely and inviting room rather than by the decor of a police cell.

**Action** Reducing the hazards of climate change can be addressed by improvements to our immediate locations, reducing freezing, overheating and risks from storm and flooding. Investment against biting insects goes well beyond just mosquito nets and managing waste is a key intervention. Likewise, contact dermatitis from Parthenium or Oak Procession Moth is in some places very common and its skin irritancy can be easily remedied. In basic terms alone, the open air and the presence of natural sun light under which to examine the skin as well as having sufficient space within which to treat people, is a major advantage of any facility.

Basic therapeutic advantages are access to outdoor areas, ensuring qualitative palliative care, especially when dealing with odorous cancers. Issues such as privacy are also highly important, concerns of overcrowding and single sex wards with many environments having insufficient safe storage facilities against theft, animals, flies and other insects. Fundamental quality care extends further than the medicine and advice we impart, it also concerns the conditions in which we allow our patients to survive and thrive.

‘When me and my family lived in our old house we would get sick all the time. Now we’ve been moved to a new place and we don’t cough or get sick anymore.’

— Harry
The progress the international medical community is making is happening at a staggering rate and much of that is due to the broad advantages that IT developments offer. Over a billion people are connected worldwide by social networks that just a decade ago did not exist. The internet is now not just a way of communicating, it’s a vital component of our economy and of a modern way of life. The lives of countless people have been drastically improved and the breadth of their connections with one another have never been greater due to untold developments in Information Technology.

Warning Western modes of health care are just one standard globally, but from the mountainous regions of Nepal to the vast rural landscapes of South America, entire communities are cut off from greater, vital means of care. Skin conditions should be seen by the right person, in the right place, at the right time and should move readily between levels of care as necessary. In the developing world there are many reasons why this cannot happen besides distance and local ignorance, it is our role to combat them.

Action IT developments offer unprecedented opportunities to reach communities cut off from more advanced forms of care. Telemedicine, mobile phone apps, web forums and more are vital means of conversing with patients and keeping records and collecting data. It is clear that ownership by Traditional Health Practitioners of a mobile phone in even the most resource poor regions will have a particular advantage for conditions of the skin which can be so easily photographed. This allows a snake bite for example, to be identified and anti-venom to be sourced. The proliferation of smart phone and internet technologies now enable us to make even more of these avenues of communication.

‘I work for a small internet start-up where we’re creating an app to help people donate to charities more effectively. Knowing new skills and technologies are helping people is very fulfilling.’— Simon
Job Selection and Supervision

When combating any illness or disease, it is those around us that can play the most important roles, with positive or negative reactions a particular point of concern for patients. Unemployment is a common consequence of skin conditions. Help includes adjustment of the work place to safeguard the skin and awareness of moderate mental ill-health or musculoskeletal disorders. Each of the most prevalent Skin Diseases has Patient Associations with National and International sources of advice.

Warning Vulnerability to climate revealed the impossibility of reducing contact dermatitis. A threatening environment includes Contact (industrial) Dermatitis, and other occupational hazards, such as podoconiosis which are managed by avoidance, or by using protective devices. Having a job or being able to return to looking after house and family is part of adaptation, self help and income generation.

This though, can be extremely difficult for those in other cultures. Abolishing untouchability is a distant dream in most villages of India. It has a major impact on employment. Colour prejudice exists in South Africa even when Apartheid has been outlawed.

Action Guidelines must be prepared for persons affected by skin disease. They are needed for job centres and employers as well as for the patient. Apart from the obvious Industrial Dermatitis of hairdressers, cement factories, copper or coal mines, lowered resistance to wear and tear explain the near impossibility of controlling all harmful environmental factors.

Vulnerability of the skin to the environment makes it more difficult to manage its impairments including loss of manual dexterity as well as sleeplessness, fatigue and the extra time taken to treat, reduce work efficiency. A component of public health, is to get meaningful occupations for people with disabilities who are marginalised by stigma, poverty, chronic illness and even violence. Thus in Africa, Albinism has recently been the focus of murder for body parts for the practice of witch craft. There has to be support from a legal framework, Human Rights and from local and national Government.

‘I work in a government funded job office and the effects of people struggling in life can be heart-breaking; getting ill, loss of hope.’ — Rajesh
Kindness

Kindness is making people feel welcome, talking with empathy, touching, and perhaps most importantly, being on the same wavelength as sufferers. It is cultural competence that is too often reported as lacking in modern care facilities. Dermatologists in particular have many stories and parables of kindness from which to draw, including the Good Samaritan, Father Damian and leprosy on Molakai and Dr Treves and the Elephant Man. Kindness is mediated by word and by touch. Kindness is ‘the oil that allows the machinery of interpersonal relationships to function smoothly.’ (Jemec G (2011) “The Role of Kindness” Compassion, sympathy, empathy, altruism are key components of good medicine.

Warning

Most of us are incredibly fortunate to not live in a society dominated by a caste system. What does it feel like to be untouchable? Equal opportunities and respect for all communities has remained unfulfilled since both Union and State have failed to eliminate the caste system.

Action

One response to Kindness is Happiness. There is a relationship between improved self esteem and to self satisfaction. It includes positive family or guardian participation. The public health component is being culturally competent, and being on the same wave length as your patient. Do not have an apartheid which is both unkind and creates barriers. Honour the aged and bring to the fore their much greater experience. Health clinics can be threatening and alienating. Home visits may be the only way to get an insight into a disabled person’s relationships. In the same way we must immerse ourselves in another culture to truly grasp its intricate minutiae underlying a well functioning health service. Likewise, our practices should be inviting and welcoming, clean and attractive, in the best possible interests of our patients.

‘I volunteer as a weekly food drive where we meet people from all walks of life. A shoulder and an ear can be so effective in lifting someone’s spirits.’—Eileen
Whether it is a diabetic foot, leprosy, lymphatic filariasis, Buruli ulcer, venous ulcer or an overgrown toe nail, the need for skin care is central to its management. Our legs are for standing and for access without assistance, we hardly comprehend their importance until they are compromised or damaged.

**Warning!** Simply put, not being able to walk threatens our very survival and not being able to stand makes our daily lives much harder to fulfil. From cutting toenails properly, with specific instruction on how best to manage them, to making clear that washing and emollients are key precautions to preventing infections in wounds and broken skin, basic care is an essential life enhancing skill.

Pressure over bony prominences such as the heel, hip, sacrum and elbow of those confined to bed by unconsciousness or paraplegia, or so ill that they are unaware of discomfort, is a major cause of ulceration. Feeling for foot pulses is an essential skill. Every fully equipped health centre claiming to be able to manage impaired blood supply should have the laser doppler equipment to measure foot blood pressure. Ulcer healing needs all the oxygen it can get from an effective blood supply. When it is noted that the surrounding skin is scaly and red extending up the leg, the skin will be in repair mode stealing oxygen from where it is most needed.

**Action!** Simply by washing and generously applying emollients, this repair mode and demand for oxygen can be switched off. ‘Legs to Stand On’ is an impressive International initiative focused on developing community based approaches to improving lower limb care to preserve mobility and prevent disability in less resourced environments. Their promotion of clean water, safe driving, safe cooking fires, polio immunisation, folic acid in pregnancy, and plain decent footwear are actions we should all be extolling.

—I never appreciated my independence until I broke my leg last summer. They are our means of being independent and living fully.—Christine
According to the World Health Organisation in the year 2000 there were 750 million migrants. Often they did not have skin disease on leaving their country but acquired conditions such as scabies or fungus infections from poor housing conditions and overcrowding during migration.

**Warning** Strife affects many nations and many countries are host to internally displaced persons. Such mobile populations have common skin infections and lack of acceptance in the community and malnourishment. The health facilities available may not have the drugs to treat the condition and consequently visits to local traditional health practitioners are common. Nomadic people such as the Massai tend to have close contact with animals and so cattle ringworm is prevalent. There are frequent changes of sexual partners in remote areas and no access to condoms. The migrant often is also often poorly adapted to food that is foreign and malnourishment is common.

**Action** No one person or group can be lawfully prevented from receiving primary health care services and in most countries the laws support the right to emergency care. Guidelines to management, assessment of cultural differences, cultural competence, identification of torture, dealing with immigration control have been published in The International Journal of Dermatology and are on the website. The most helpful skill for managing migrants is to be able to communicate, to speak their language and get a full history. If, as is sadly common, you find yourself assessing skin conditions due to torture, be sure to record a full history and using photography ensure thorough documentation.

Migration from rural to urban areas and sedentary lifestyles, transition from a Mediterranean to a Western diet, control of infectious diseases and consequent longer life expectancy especially in urban areas, have all contributed to the rising prevalence of hypertension and diabetes. To get help from workers that are culturally competent and able to deal with these issues, there must be adaptation to the complexities of living which the immigrant has to deal with.

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**Mobile and Migrating People**

'I help at an organisation that helps people new to the UK find decent housing and helping them set up their lives here. Migration is not new and won’t soon end, it’s about making transitions easy.'
— Mohammed
Nurses account for by far the largest proportion of all health practitioners. Much of their time is spent on care of the skin yet the significance of this fact is hardly recognised by their leaders. The International Skin Care Nursing Group (ISNG) allied to the International Council of Nurses is making some important headway in bringing about a positive change in this respect.

Dermatologists worldwide are gradually acknowledging the crucial role that nursing has to play in strategic planning of skin care services. To draw attention to the significance of skin related health needs and build up a capacity to respond as a health care team, it is necessary to achieve a united voice from all key health professionals on the level of suffering, disability and poverty created by skin disease. Nurses have a key role to play in developing appropriate community-based skin care services around the world. They possess key observations and knowledge to contribute to the International Society of Dermatology’s Task Force for Community Dermatology. They have the capacity needed to meet global skin care and dermatological needs, promoting wellbeing and quality of life, whether supporting those living with chronic dermatoses or the infestations and infections that have a major impact in resource-poor countries.

Supervision, knowledge and basic care define the Nurse as the seminal character in offering qualitative skin care for all, they must be supported and encouraged to achieve the best healthcare we can deliver.

Warning There is still a trend for Nursing administration in the developing world to undervalue skin care training and experience. Several studies show that the Nursing Cadre, in spite of being the most in touch with the skin, has a low level of knowledge.

Action In Primary Health the nurse can and must be trained to a high level to become responsible for the carrying out of Triage, ensuring that patients are seen in a timely manner by appropriately trained healthcare professionals, including nurses, in an appropriate setting.

‘I’m currently training as a nurse and have wanted to since I was treated so well by a nurse when I was little. Helping establish health centres in developing worlds is something I’m passionate about.’— Jillian
Case Study

It’s important when discussing new objectives in any project, to see where the aims and objectives are currently being successfully utilised, an example of dermatology integrated with the ethos of this initiative and incorporating the objectives promoted by the task force for Skin Care for All. Two of these include The Regional Dermatology Training Centre in Tanzania and the the Institute of Applied Dermatology in Kasarargod in the Indian state of Kerala. 250 Africans from 14 countries have been taught to be practitioners and teachers of Community Dermatology. They learn both advanced and up to date technology but do not ignore low and affordable technology like cutting toe nails to fit shoes. In India the focus, especially on lymphoedema due to a neglected tropical disease, draws attention to an extreme example of skin failure amenable to restoration of function. It is devastating the lives of agricultural workers in remote villages and fisher folk by the sea who take to their beds with the enormous disfigurement of elephantiasis and suffer from intermittent high fevers and painful inflammatory episodes due to bacterial infection. Medicines that break the transmission of the disease by mosquitoes are available but they do not improve the size of the legs. A few are managed by debulking surgery or occasional costly microsurgery to the lymphatics. The majority of seven million affected persons are untreated. Community Dermatology at the Institute providing skin care has measured the burden of disease, studied quality of life, focused on empowerment of women, sought clean water and applied the low technology of washing the skin. Using integrative medicine, Yoga and local herals, as well as advice on healthy eating, have all been applied in a frame work of biomedicine’s physiology. Advice to inaccessible areas has been given through telemedicine. Neglected buildings have been rented and upgraded to become attractive treatment centres. Using locally available sustainable and low cost measures, coupled with self help and community participation, their legs return to an acceptable size and earning a living becomes once again possible. Careful measurement, statistical analysis and partnerships with the leaders of evidence based medicine and participation with International frameworks of disease have led to international accreditation and increasingly strong support from the government of India.
Obesity, Associated Diabetes and other forms of Malnutrition

This is the greatest epidemic of all. Obesity predisposes diabetes and diabetes underlies several skin conditions and especially skin infections. In the obese diabetic acanthosis nigricans is common.

Warning Diabetes often makes the treatment of other systemic conditions such as tuberculosis much more difficult. Whether a skin infection or a wound, damage to the skin of the obese is both more likely and repair is less effective. Diabetes has become a top priority for urgent intervention by all carers of the skin. 100% of diabetics have skin failure and in 70% it is manifest by skin lesions. Attention must be given to problems arising in the care of the overweight affecting the carer such as back injuries from lifting.

Action Carers of the skin can alert populations to the link between obesity and diabetes as well as making an early diagnosis. Care should prevent and certainly delay amputation. The 2012 Olympics have reminded the world that achievement of the perfect body should begin at school with a full, dedicated sports programme. Malnutrition due to starvation affects all functions of the skin. 2 billion people are iron deficient, 255 million children are vitamin A deficient and 1.6 billion people are iodine deficient.

Gardens grown for the personal procurement of fruit and vegetables are recommended. In Rwanda the focus is on linking an agricultural worker and a demonstration garden with a health centre and then providing from that resource help with home gardening. In India the focus is more on tribal knowledge and support for valuing and restoring the earth.

‘My doctor warned me that as I get older, weight could prove to be a potential risk to my health. I was thankful for the advice.’ — Richard
The largest proportion of humankind are those aged 10 years and under. They present a unique challenge to health care and dermatological professionals. In response to this, many organisations, from local, national and international entities - such as DEBRA for epidermolysis bullosa, Psoriasis, Eczema, Scleroderma, or Ichthyosis - produce on the internet, clear, informative literature as guidelines for the care of children.

Likewise, over the past 30 years charities such as Child-to-Child have spread to over 70 countries worldwide, impacting over a million children’s lives and quality of care annually. They are actively engaging children on health and development issues who then disseminate and share their learning to other children, their families and their wider communities through participatory research activities.

**Warning** It is a sad fact but a reality that the importance of play and education is often, in the developing world, over ruled by putting a child to heavy and tedious work. Likewise, prevailing attitudes to gender often are to the disadvantage of the female child, who is an unwelcome cost. Much of the skin carers’ time may be taken up seeking support for neglected children from the community.

Also, the difference between caring for an infant rather than an adult includes seeking short but frequent absence of distraction, clear and simple instruction, reinforcement by approval, opportunity for imitation and waiting long enough for a response. Children are in many communities, underestimated in their capacity to understand and be carers in their own right.

**Action** We cannot underestimate the importance of encouraging a spread of vital information from adult to child as the young population develop, allowing them to, in time, become their own carers and carers of others. The sharing of information can only improve the right of all to provide themselves better quality of life for them, their families and their community. The school should become a guardian of the child’s health.

‘Our school nurse teaches us to wash our hands and what to do if someone hurts themselves.’
— Sara
It is a truth constantly acknowledged within the medical profession that the measurement of quality of life correlates with the measurement of consequences of chronic illness.

The development and interpretation of ‘Quality of Life’ research led by Andrew Finlay and a global base of contributors, has been one of the greatest contributions from dermatology to contemporary medical practice. This attention to an individual’s health status, to the consequences of intervention and measurement has grown and developed the understanding we now have of the term ‘Quality of Life’.

The concept began simplistically with a discussion on the use of the term ‘aversive’ which was creeping into the handicap literature after the polio and the thalidomide disasters, describing being unwelcome because of difficult wheel chair access, appearance or odour.

**Warning** Quality of life influences happiness. Happiness in the UK is at its highest level in the teenager and in the 7th and 8th decade and reduced in the 4th and 5th decade. Being out of work makes people unhappier and more anxious, this is even linked with carelessness which underlies being accident prone.

**Action** As has been shown in a study of vitiligo, two people with the same degree of disfigurement may have different quality of life scores because they have different degrees of anxiety and depression or they have different self esteem scores. Persons who are more anxious in their daily life and who have poor self esteem will perceive their disfigurement as more severe. This comes to a point when we consider how stigmatisation can affect ones life, and how the public can inadvertently affect another’s life through comment. We, as health professionals, must do more to understand our patients individual experiences and conditions in order to tailor their treatment and respond to their worries and difficulties. We must also engage with the public to share our knowledge and increase understanding and reduce stigma.
Journals on repair and regeneration of the skin are abundant and far reaching and have greatly helped in the development of skin care. Many wound healing organisations were initiated by Dermatologists in dermatology departments from the work of Ryan and Lapiere, Westerhoff, and Romanelli in Europe to Eaglestein and Lazarus in America, and management has had a strong nursing input through tissue viability organisations. These organisations have brought us some of the most far reaching aids and industry devices such as dressings and many offloading devices. Also, the advances in stem cell research have provided insight into regeneration. There are numerous partners, many growing out of dermatology departments recognising the need for better management of non-healing wounds and the burden of lymphoedema. They include plastic surgery, podiatry and the nursing profession.

**Warning** Much work is still to be done in this area, continuing from a broad and dense base of work across multiple disciplines. We must strive to focus and aim our work, consolidating research across plains of illness.

**Action** It was the need for additional advice on wound healing in the management of Buruli Ulcers that lead to lists of five essential interventions for wounds and three for lymphoedema.

**Wounds:**
1. Treat Systemic Illness eg Anaemia Diabetes, Malnancy.
2. Protect the wound from Trauma. Cover and offload.
3. Promote a clean wound bed and reduce infection of the wound base.
4. Maintain a moist environment.
5. Control oedema.

**Lymphoedema:**
1. Increase Lymph flow: eg by body movements including breathing.
2. Reduce overload from a failing venous system; eg by elevation and ankle movement.
3. Reduce overload by managing Inflammation due to infection or irritants.

**Arterial Disease of lower limb:**
1. Stop smoking.
2. Keep walking.
3. Wash and apply emollients to the whole leg.

‘I smoked for many years in my youth and it was only when I found myself taking longer and longer to recover from minor illnesses that I realised I needed to help my body help me.’ — Ingrid
Besides the skills of the practitioner and the environment in which the patient is cared for, an essential element for the care of any person in need is the presence of essential, reliable supplies that can be reached as soon as needed. There is a huge range of variables to be considered when describing the equipping of an ideal health centre which determine its capacity to manage the many problems relating to the skin. The commonest medicines in the tropics include essential drugs for infections such as impetigo, superficial mycoses, scabies, insect bites, eczema, burns, wounds and with geographical variation, other neglected tropical diseases that affect the skin.

**Warning** Most Governments provide an essential drug and devises list which will satisfy only if in its preparation it had the input of experienced advisers with knowledge about the skin.

Much of the more expensive high technology purchased or donated for therapy in the Developing World is so poorly maintained that it is quickly out of service. At the road side and even in some dispensaries there are many fake drugs to be purchased and many in the drug industry offload medicines that have long passed their shelf life. Adverse drug reactions are a major cause of skin failure.

**Action** Dermatologists must give priority to the giving of good advice to the preparation of essential drugs and devices lists of hospitals, national governments and the World Health Organisation. Organisations concerned with skin care that give advice include The International Foundation for Dermatology, The International Skin Care Nursing Group, The World Alliance for Wounds and Lymphoedema Care (WAWLC), International Federation of Leprosy (ILEP), the International Lymphoedema Framework (ILF) and the Global Alliance for the Elimination of Lymphatic Filariasis (GAELF). Many more can be elicited but these are the ones regularly making reference to dermatology in the developing world. We urge you to visit the SCFA website [www.skincareforall.org](http://www.skincareforall.org) to view these and many more recommended alliances. Fortunately, most skin diseases can be treated with cheap and simple preparations. It is important to identify the commonest skin problems and provide for them.

‘I have eczema that used to hurt but everyday me and my mum put some cream on it and it doesn’t hurt anymore.’ — Neha
Understanding Traditional Medicine is necessary because it is what people mostly use in the developing world, but it causes delay in attending Biomedicine, which can be important for conditions like snake bites or leprosy. Complimentary and Alternative Medicine is used by 80% of the developed world’s population.

**Warning** Concerns about Traditional Health Practice (THP) include:
1. How to collaborate with this predominant health service?
2. How to approach the finding of evidence?
3. How to use Traditional Medicine and when not to do so?
4. Herbal Medicine and its identification, preparation, dosage, and its use as a topical: including written regimens such as Chinese or Indian Systems of Medicine.

**Action** The topic of Traditional Health Practitioners is addressed in Ryan et al’s (2011) Collaboration with Traditional Health Practitioners in the Provision of Skin Care in Sub-Saharan Africa (International Journal of Dermatology 50:564-570). The long term aim must be to train all THPS in the best possible practices.

Yoga and Ayurvedic herbals have proved essential in a successful Community Dermatology project for the control of Lymphoedema in South India lead by Dr. Narahari (see case study). It stresses the importance of physical exercises, posture and breathing-control in promoting physical and mental well being and the importance of demonstrating its control of the autonomic system. The accurate identification and home growing of herbal systems of medicine differs from biomedicine in the encouragement of synergism; in frequent changes in dosage and in mixtures, together with a planned intervention based not so much on physical signs but on the make up of the constitution when healthy.

‘For ten years I struggled with a really painful chest condition that just wasn’t being helped by anything my GP prescribed. It was a small chinese herbalist who eventually spotted what was wrong.’— James
Urban versus Rural Health

About half of rural populations have in one lifetime moved into a town environment. ‘Access’ was one of the most used words in Public Health some 40 years ago. Long distances separated most people from the best of care. Now to our vocabularies we must add ‘transitional’. Dermatologists have never populated the Developing World but now the Transitional World can provide many of them with an income almost to its borders with the countryside. The car and the motor bike increase access but raise the injury level of the pedestrian. While the railway and bus station, school and supermarket may be more accessible to some, they are less accessible to others and where there is rising human density there is a rise in criminal activities including assault.

Warning Skin Health following general health and well being has changed proportionately with this rural to urban shift. Access to water, firewood, shops and schools, different quality of housing and availability of a different kind of employment brings with it a change in body weight, different foods, more smoking and more sex workers. There is no where to disperse sewage or plastic bags. These block drainage and house mosquito larvae in small amounts of retained water. For children, overcrowding brings more head lice, scabies, impetigo and superficial fungus infections. Road side sellers provide counterfeit drugs and there is less instant advice from herbalists. These too move into cities with less reliable purchase of their favourite remedies as their homelands become deforested.

Action Availability of electricity in urban and transitional centres adds health messages from local radio TV and the mobile phone, as well as more pamphlets and posters. There is street lighting and frequent public transport. As people survive childhood and live longer, there is a double burden of only partly controlled infectious disease, such as tuberculosis or HIV/AIDS, plus degenerative age associated illness. In factories and mines with little accident prevention, children are employed as cheap labour and health centres see more wounds and burns. As described in the Capacity to Benefit section of this website a disease such as leprosy can be well managed in a large city such as Mumbai.

‘I found a job, a girlfriend and a great place to live in the city. I was stuck in the country and I found my life by moving and I feel all the better for it.’— Will
Many countries still use this term for sexually transmitted infections (STI). It is an antiquated term used in an era before penicillin when syphilis was the major global burden. These common infections still have the capacity to cause major life threatening epidemics such as HIV/AIDS.

**Warning** The WHO estimated that 340 million new cases of the four main curable STIs, namely gonorrhoea, chlamydial infection, syphilis and trichomonas, occur every year, 75-85% of them in developing countries.

Added to this, management requires skills in diagnosis, education of the young, essential drug delivery, control of prostitution and tracing of contacts.

Teaching the use of protective devises such as the condom does not have the support of a major global religion and early management of infection is not everywhere affordable. The antibiotics available for some infections, such as gonorrhoea, are limited by increasing resistance. Furthermore, the side effects of some regimens such as Toxic Epidermal Necrolysis are life threatening and difficult to manage.

**Action** '...because of the increased burden of skin disease due to the HIV/AIDS epidemic we must redouble our efforts to provide dermatology education to care providers. A review of the burden of skin disease in Africa, how it relates to HIV/AIDS and global infectious disease, current educational strategies in Africa to address this need, suggests potential solutions to move these efforts forward.' HU et al (2011) Dermatology and HIV/AIDS in Africa, Journal of Global Infectious Diseases 3 275-280.

We must act on this advice now lest we see a loss in the momentum already built with the major contribution of diagnostic skill from the dermatology profession.

'I work with a charity teaching young people about the importance of looking after yourself and STIs are a common issue but engagement and education are the key.' — Aaron
Water for Washing

Water is at the very core of care in Dermatology. We depend on it to hydrate and wash our patients as well as the environments in which we treat. However, water is not an infinite resource and in some climates and areas of the world it is becoming increasingly difficult to obtain. Washing of the failing skin should be with water fit for drinking. Water is an essential component of the skin, it ensures that it is pliable and the outer layers control water loss only when there is sufficient water in the Stratum Corneum. At a fundamental level, moisture is essential for rapid repair of the skin’s barrier function.

Warning By 2025 the United Nations estimates water scarcity will threaten day to day survival of 1.8 Billion people. Some have even gone as far as to suggest the next World War will be about water. Added to this, at present much of the world has water that is undrinkable. Even when pouring water from a container on to the hands, it spills to the ground and remains inefficiently utilised. In the developing world washing is consistently the last priority after drinking water for humans and livestock.

Action Water can be conserved by applying it from a water absorbent material similar to hand towels issued on aircraft. In this way, it is possible to wash the whole body with just 100ml of water. The International Foundation of Dermatology and The International Skin Care Nursing Group have a memorandum of understanding with Procter and Gamble to distribute a water purifier. Most nations have a PUR® distributor from whom this product can be obtained. Those who have access to the internet should inform themselves of the Children’s Safe Drinking Water program or PUR®.

Water is often fetched from long distances making it in turn a precious commodity and it is cherished by local populations. With PUR® available, the burden on procuring supplies in this way is lessened.

The provision of water and of making it fit for drinking as well as for washing is inextricably linked to sanitation. If the billionaires of India were to invest in toilets and sewage disposal, the health of that nation would improve many fold.

‘My dad works for a water company, he works with houses and shops and hospitals. Everyone needs it for lots of different things. I need it too!’ — Imran
Xerosis: Treating a Dry Skin.

Xerosis is dry desiccated skin. Such skin is unable to fully control its barrier function and loses its pliability. It is vulnerable yet responsive to the use of emollients in aiding relief and helping recovery. Control of transepidermal water loss, using emollients and consequent switching off of the skin’s repair mode such as the release of cytokines and its call for neutrophils, is a basic mission for every carer of the skin. In support of their water initiative, Procter and Gamble are giving away Glycerol, a known ideal emollient. This ‘miracle’, an emollient applied as a first principle for the maintenance of the health of the skin and often to cure it of its sickness, has a rational scientific basis for such claims, justifying its promotion as the subject of the ‘First Commandment’ in Dermatology.

Warning The slightest breach of the epidermal barrier places the epidermal factory in repair mode. It is only during the last decade that the full picture of the activated epidermis has been seen to be more than just the release of histamine and the production of prostaglandins. It now includes interleukins, interferons, tissue necrosis factors as well as growth factors such as Vascular Endothelial Growth Factor (VEGF). These are rapidly produced in the epidermis to flood the dermis and activate the blood vascular endothelium – to bring into play the white cells and macrophages for elimination of the undesirable and for repair.

Contemporary technology can breed mice without essential components for the epidermal factory. This has confirmed that when the barrier is broken, the cytokine production is switched on and when repair is complete they are no longer manufactured. Probably the epidermis first knows that its barrier is breached when transepidermal water flows faster and is lost from the surface.

Action Such flow and loss can be instantly slowed down by placing an artificial barrier on the skin surface such as an emollient, petrolatum, honey or a covering of polythene or hydrocolloid dressing.

‘As I’ve gotten older I’ve needed to take better care when I shave and treat my skin. Creams, oils, more water, everything needs more diligence.’ — Jonathan
Yin and Yang: Keeping a Balance

Because so many in the world believe their diseases are occasioned by imbalance, it is necessary to understand the process of restoring harmony. The body is symmetrical and asymmetry may need to be repaired to restore self esteem. Whether it is Starling’s Law, the concept of homeostasis by Claude Bernard or the Greek concept of symmetry, the desirability of balance pervades many systems of medicine. These ancient systems seek harmony of man, earth and cosmos.

In Ayurveda the three constitutional types (Doshas, Vata, Pitta, Kapha) should be in equilibrium and may be aggravated or diminished. There are channels along which energy should flow and there are wastes that must be eliminated.

It is surprising how many similarities there are in for example the Chinese system and Indian systems of Medicine or the beliefs of primitive people about inter-relationships and the environment.

Warning Failure to understand the importance of balance in the delivery of Public health will result in mistakes in the management of culture, customs, religions, beliefs and ideals. When examining other systems of medicine it is also looking at other ways of life with attention to physical, mental, social and spiritual well being.

Action When applied to medicine good health is perfect harmony with a rejection of excesses inclusive of diet and sexual activities. It perceives an ebbing and flowing between Yin and Yang. In the form of energy it must flow freely along invisible channels. Yanchi (1988) writes ‘disease occurs when the dynamic equilibrium within the body and environment fails, damaging the normal physiological functions to the point that there is an imbalance between Yin and Yang’.

‘I’ve started doing yoga with my Mum and sister, it’s lovely, it’s calming and makes you feel better when you’re ill.’ — Hayley
Zealousness Versus Equanimity

Tackling problems fervently, actively, and enthusiastically, as a zealot or with an even mind and temper (Aequanimitas, Osler) is linked to how to encourage participation and keenness to get involved and reward altruism and charity, while promoting anti-corruption, equity and human rights.

Warning How does one take Skin Care to the patient with zeal and at the same time equanimity? Often there is not enough zeal or it is misplaced. It is clear that ‘what’s in it for me’ determines whether people buy into public health, and this is based in the emotional centre of our brain. Magnetic resonance imaging has shown that decision making mostly is initiated in the most primitive parts of the brain and are initially emotional rather than rational. They may even be subconscious.

Action ‘To you - the silent workers of the ranks, in villages and country districts, in the slums of our large cities, in the mining camps and factory towns, in the homes of the rich and in the hovels of the poor - to you is given the harder task of illustrating, with your lives, the Hippocratic standards of learning, of sagacity, of humanity and of probity.’

Osler

What is more important than compensation? Is it challenge, self development, making a difference or being appreciated?

‘When I was a student I was a bit of a campaigner, now I work in fundraising and it’s great to see resources go where it’s needed’
— Samuel
Editors Letter

As a new graduate from the London College of Fashion, working on this project offers a different perspective on the theme of beauty than those often portrayed by the media. Getting to work with the health care community has enlightened me to how much there is left to do in informing the global community to public health issues, in all fields, and how we can all play a part in attracting new investment, new talent and new ideas to combat these issues. Presenting this information in an engaging and sincere way is indicative of a new age of sharing plans globally through the Internet and between one another. Based in London this project is imbued with the city’s status as the Multicultural centre of the world, where any and all gather for the opportunities to live and share together, throughout this booklet you will see an array of these people; a cross-section of our world. So I invite you, once you finished this, to pass it to someone else, a colleague or a student, and share and begin SCFA’s action plan as a community.

— Nicholas Smith

Contributors

Maeve Redmond is a Graphic designer who specialises in typography and book design. After graduating from The Glasgow School of Art, she has worked on projects for a range of clients including Rizzoli, Violette Editions and the Victoria and Albert museum, London.

Stuart Howat is an award winning photographer known for his striking and characterful portraits. He graduated from London College of Communication with distinction and has gone on to work on many prestigious commissions. Stuart enjoyed capturing the diverse cross section of ages and cultures for this project which allowed him to celebrate beauty in the differences of his subjects.
What you have read has been a preview of the potential for change encapsulated within Skin Care For All. We invite you to visit www.skincareforall.org, and to share it amongst your colleagues, to bring you up to date with relevant ideas and research pertaining to community dermatology and to the International Society of Dermatology www.intsocderm.org.

There you will find a video, welcoming you to the project and explaining the reasons behind the initiative. You’ll also be able to download the full Capacity to Benefit and Skin Care For All package to help you implement the essence of this initiative in your own communities. www.ifd.org provides you the twice yearly Community Dermatology Journal.

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