International Journal of Dermatology

Community dermatology

The International Society of Dermatology's Task Force for *Skin Care for All*: Community Dermatology

Introduction

Conceived in Ethiopia (Verma 2007) and launched by the International Society of Dermatology (ISD) in Berlin (2008) The Task Force for *Skin Care for All*: Community Dermatology is ambitious but, unlike *Healthy Skin for All*, it is not utopian and should be possible to achieve. The targets are the commonest skin conditions that affect millions, many of which are disabling or have the potential to disable. For instance, with impetigo or streptococcal pyoderma secondary to scabies, which are very common infective skin conditions, it is a concern that glomerular nephritis and rheumatic heart disease are sometime consequences. However, even common conditions are misdiagnosed and ineffective remedies are frequently prescribed for them. Pilot Community Dermatology schemes have proven their capacity to manage this problem.

The Task Force is up against, and can record that our profession often overcomes, the ill effects of strife and man's inhumanity to man, the hazards of climate change, bureaucracy, the mobility of populations, corruption, and several other potential impediments to its achievement. However, the main background factor it must assuage is poverty.

Community Dermatology was a term used by Gurmohan Singh 40 years ago when taking skin care to tribal people in Bihar. When Rod Hay used it in an article in *The Lancet* in 1991,[1] he was articulating a simple principle, in that health workers should consider illness in the wider community as well as in the individual patient. Furthermore, such a concept is not confined to disadvantaged communities but as with the challenges of tanning, skin lightening, and solar damage it applies to resource-rich communities as well. Rod Hay has pointed out that the control of tinea capitis in the early to mid 20th century was organized from dermatology departments. Ma Haide in China created the dermatology department in Nanjing, China, in part to reduce the stigma of diseases such as syphilis, tinea capitis, and leprosy in the massive elimination programs ordered by the communist regime.[2] It has been more recently used by Paul Buxton when launching *The Community Dermatology Journal*, which has now become an organ of the International Foundation for Dermatology (IFD) that is distributed free to all who request it but focuses on those such as the graduates of the Regional Dermatology Training Centre of Tanzania, who benefit from twice yearly updating.

Thus, Community Dermatology is not new. However, in Ethiopia its terminology was adopted[3] to emphasize a developing branch of dermatology in which people such as Aldo Morrone in Rome focus on mobile populations and in Australia projects such as the scabies control programs among the Aborigines are given greater advocacy. The discussions in Ethiopia were reported in the *International Journal of Dermatology* by Shyam Verma,[3] by whom like many in India, the concept was adopted with enthusiasm. It was previously clearly described in *Tropical Doctor* by Estrada and Andersson.[4]

Community dermatology embraces common skin diseases. It is inclusive of wounds and lymphedema and has long had neglected tropical diseases such as leprosy as a major interest. It concerns populations of individuals rather than individuals in a one-to-one relationship. It requires data on prevalence and manpower. 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, peri-urban or mobile communities, often against a threatening background such as strife or climate change.

In the context of Community Dermatology, one must not forget that sexually transmitted infections are important in dermatology and in countries with huge populations such as India, China, Indonesia, and Brazil these infections are professionally supervised by dermatologists.

The constituency of carers for the skin

Skin Care for All expects *all* dermatologists to contribute their skills but a new profession of community dermatologists must lead this particular intervention. It is a relatively new subspecialty for those interested in epidemiology and public health. The Task Force collaborates very closely with the IFD and the International Skin Care Nursing Group (ISNG) to bring about necessary changes to be carried out by professions mainly concerned with skin disease. It is a Task Force of the ISD and will also interact with two other major initiatives of that society: "Climate Change" and "On a Human Scale," the latest initiative of the *International Journal of Dermatology*.

Skin care, however, is required for wounds, burns, and lymphedema and a partner will be the World Alliance for Wound and Lymphedema Care (WAWLC) another

new body recently launched by an initiative within WHO conceived because of the needs for better management of Buruli ulcers. Skin care is also needed by the neglected tropical diseases such as leprosy, lymphatic filariasis, onchocerciasis, leishmaniasis, yaws, Buruli ulcer and, less obviously, by the facial washing of trachoma.

Health needs assessment and proof of capacity to benefit

During the past few decades, there has been much emphasis on need. Moreover, it has not been difficult to show the effect of common diseases to potential funding agencies through various publications (e.g. World Health Organization[5,6] or national publications such as *Skin Conditions in the UK*[7]) and many other publications on the dire consequences of disfigurement and the huge impairment of quality of life. In addition to the contributions being made by dermatologists to the *WHO Global Burden of Disease*, the Task Force must now add to the case of need, proof of its capacity to benefit without which funding agencies will not be supportive. An important rider is that, in accordance with longstanding United Nations policy, what is being offered is that which communities everywhere are needing. It is termed local participatory planning. This is key to the WHO 21st century *Health for All* planning:

Stronger local governance of sustainable health systems, supported by national and global systems of governance, will ensure access to life span care and provision and maintenance of healthy living and working conditions. Local participatory planning, full use of local capacity and resources, and more effective collaboration in bringing environmental, social and economic services closer to people will increase their use and strengthen community ownership of those services. WHO April 28, 1997 EB 100/2.

Task Force publications

Leading up to the World Congress in Seoul the *International Journal of Dermatology* will publish articles relevant to the aims of the Task Force. Some will suggest ways in which public health should play its role in skin care and others will describe the effectiveness of existing programs of community dermatology, the contribution of the nursing profession and those who manage sexually transmitted infections, the major impact we have on our alliances with other branches of medicine needing skin care, and many new approaches to skin care. Importantly, it will collect, for marketing purposes, all these identifying achievements for everyone to use to prove capacity and benefit of the profession to which we belong as carers of the skin.

Our aim is to inform those who do not know how great is the benefit already achieved and enlighten, among others, potential resource providers. The Task Force is not asking for anything comparable with the billions of dollars provided for malaria, tuberculosis, or HIV/AIDS, but is emphasizing no-cost self-help initiatives and altruism and, by collating achievements, hopes to convince donors that we have the capacity to benefit hugely when we are funded. It will show that the challenge Oumeish Yousef Oumeish so thoughtfully prepared in 1999 when advising the ISD[8] has been taken up to good effect.

Governmental controllers of financially managed care will learn from us that skin care is not costly when there is the availability of self-help, the low technologies of knowledge we have from the past, and humanitarian gifts. Washing and emollient use may be the lowest technology but also the most needed technology advocated by the new Task Force. It is an example of the low-cost objectives identified as skin care. It is also an example of how the Task Force may work with partners. Recently, the IFD and ISNG have signed a Memorandum of Understanding with Procter and Gamble to take advantage of P&Gs humanitarian initiative of the gift of "Water Fit for Drinking" provided by its purification system PUR. It is needed for washing. Moreover, the gift of glycerine provides one of the best ingredients to restore the skin's barrier function.

The huge list of named conditions affecting the skin is too complex for everyone to learn, other than those specializing in dermatology; "I am not sure there are any skin diseases that are not disjunctions between the patient and his/her environment and which cannot be cured but which dermatologists are best equipped to manage (Hugh Molloy, 2007, Sydney, personal communication)." These disjunctions are systemic disorders with skin involvement, which can be described most simply by stating there are only four main consequences. These are upsets in skin function with four sets of interventions: (i) restoration of the epidermal barrier; (ii) managing being too hot or too cold; (iii) restoring normal sensation by controlling itch and pain and protecting when there is sensory loss; (iv) assisting communication by the skin, the look-good/feel-good factor, first sight impressions, stigma, and being unwelcome because of disfigurement.

Interventions based on such a simple list are led by a profession that uses the complex skills of recognition and naming of physical signs. It is a key asset and achieved by extensive training. It is also a profession with ever-increasing skills and effectiveness in the field of cosmetic surgery and other interventions to improve self-esteem.

The high moral ground

Given participation between communities and those representing the objectives of the Task Force, they will work from a high moral ground. It is important to identify those who will help. Because altruism thrives on the identification of heroes and heroines and organizations who volunteer their help, thanks and public acknowledgment by the ISD must continue to be generously provided. Thanks at international meetings costs very little. ''Community Dermatologists should consider charity as their job and support community as their discipline'' (personal communication SR Nararhari Institute of Applied Dermatology Kasaragod, Kerala India). The Task Force can respond to such philosophy by making it support its curriculum and seeing that it gets positive recognition.

Although the aim is community dermatology and, therefore, examining populations, it can still be patient focused and seek participation of individuals. These will be the sufferer of skin impairment, as well as members of the family and community in which he or she resides. The contribution of improved well-being to *Health for All* must take into account the look-good/feel-good factor and the link between happiness and self-esteem that often enhances participation. The Chairman of the Wellcome Trust, Sir William Castell, speaking recently at the Said Business School, Oxford, said ''Against a background of the inequitable distribution of wealth, the feel-good factor must come from something other than materialism. Financial stability is overrated as a contribution to happiness. Dignity and self belief is more important than having a job.''

We cannot solve the problem of poverty by providing finance but we can enhance well-being and add dignity and self-belief as a substitute for begging and other signs of destitution. The feel-good factor is linked to looking good but this does not have to be an expensive or heavily marketed pursuit of the higher-cost cosmetic interventions. We can promote natural as beautiful and admire the hunter-gatherer's athletic physique in preference to the overweight corpulent figures of a Ruben's festival.

The ISD's move to influence climate change and the IFD/ISNG campaign for water for washing can reduce the need for extravagant utilization of energy, such as wood for burning or washing machines for each household. This collaboration with industry can be assessed against a prediction by Sir William Castell that water shortage is the one element most likely to lead to war. Our advocacy of self-help and community care of the skin can lead to the avoidance of climate change hazards.

Having worked closely with Maria Duran and her first publications on the role of women in our field, I believe also that the Society's committee in her name is making a significant contribution and can do more in the future. Indirectly and especially through the empowerment of women, the Task Force can influence the rising population and mankind's disastrous effect on the globe.

We promote changes in human behavior using patient participation and community support. We make access to the ''market place'' rewardable by the availability of low-cost sustainable provision of knowledge that we have already.

To publicize these concerns, the *International Journal of Dermatology* will publish under the heading ''Community Dermatology'' 10 articles as a special edition this month. A CD covering all relevant topics will be distributed at the World Congress in Seoul in 2011 edited by Terence Ryan and Roderick Hay. We will aim for a briefing document similar to that given each year to those who attend the meeting of Commonwealth Health Ministers.

Having traveled extensively during the past year on a number of projects, I am impressed how many organizations carrying out skin care are well aware of and support the mission of this ISD Task Force. Some, like the Indian Association of Dermatology Venereology and Leprosy, are giving space at their annual meeting to support the mission. It is a mission that, as pointed out in the EADV News, has ''WHO initiatives supporting dermatology.''[9]

The Task Force Committee includes: Henning Grossmann, Roderick Hay, Aldo Morrone, Deedee Murell, Thomas Ruzika, Sinesio Talhari, Luitgard Wiest, Shyam Verma, and *ex-officio* Vangee Handog as General Secretary of the ISD. Useful advice is provided by many others who in due course will be listed. It is chaired by Terence Ryan.

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