International Journal of Dermatology

Community dermatology

Bringing treatment and control programmes for sexually transmitted infections (STIs) through international development and cooperation: a commentary on the Task Force for Skin Care for All

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Introduction

In most parts of the World sexually transmitted infections (STIs), which include not only the traditional sexually transmitted diseases but also HIV/AIDS, are increasing (Table 1).

They infect mostly young people, that section of any society that is the most productive to the industry and prosperity of any country; but the effects on societies, where the family unit is still the main force and in which there is no public aid to fall back on, are infinite. The health of women and children is especially affected; whole communities are blighted; their health is made worse; diseases that are controllable are allowed to spread. Those of us from the Developed World should feel some sense of shame that so little deep thought is given to the control and prevention of STIs in many countries by established and comfortable members of the medical profession.

Aims

The Task Force aims to reinforce effective cooperation in tackling the ravages of STIs through a Community Dermatology voluntary group of those dermatovenereologists who have the vision to see that public health and community aspects of dermatology and the control of STIs need to be active in the often neglected impoverished regions of the World. This means that education has to be utilised efficiently by the limited availability of existing treatment and preventive groups.

One of the best known examples is that of the Regional Dermatology Training Centre at Moshi, Tanzania, designated as WHO Collaborating Centre for Dermatology, Sexually Transmitted Diseases and Leprosy, which has trained 200 Dermatology Officers to manage STIs in Eastern and Central Africa. Their experience and scholarship with limited resources in the field are a humbling example to those of us who come

Table 1 Global summary of the AIDS epidemic, 2008

Number of people living with HIV in 2008	Total	33.4 million [31.1–35.8 million]
	Adults	31.3 million [29.2–33.7 million]
	Women (aged 15 and above)	15.7 million [14.2–17.2 million]
	Children under 15 years	2.1 million [1.2–2.9 million]
People newly infected with HIV in 2008	Total	2.7 million [2.4–3.0 million]
	Adults	2.3 million [2.0–2.5 million]
	Children under 15 years	430 000 [240 000–610 000]
AIDS-related deaths in 2008	Total	2.0 million [1.7–2.4 million]
	Adults	1.7 million [1.4–2.1 million]
	Children under 15 years	280 000 [150 000–410 000]

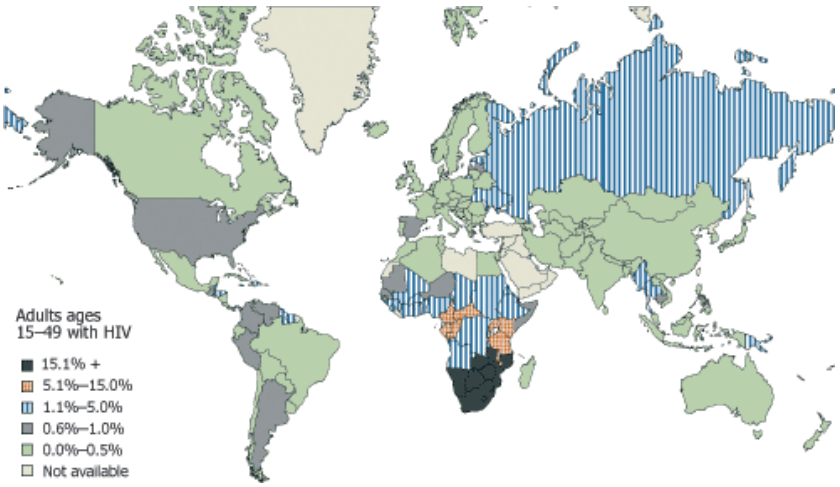

Figure 1 UNAIDS map of the global distribution of HIV (2008). (*Sources*: Prevalence 2008, UNAIDS 2009)

to visit for short periods but then return to our well-paid practices (Fig. 1).

But of course there are excellent schemes elsewhere linked to dermatology all over the World that already exist to tackle STIs in limited-resource regions. Examples are syndromic management of STIs in South Africa, programs for providing support and prevention of STIs in Peru, Brazil, Benin, Mozambique, and the enormous sustained and prolonged help given to a variety of communities in the Western Pacific through a variety of Australian initiatives. These practical schemes are regularly reported to the International Union against Sexually Transmitted Infections (IUSTI) at its World Congresses, the most recent being in Capetown, South Africa in November 2009 and the next to be in New Delhi, India in November 2011. In addition, WHO and the European Branch of IUSTI have skilled members and intelligence from Eastern Europe, where there has long been concern about the increase in HIV infections. Most recently in September 2010 the Conference at Tbilisi in Georgia informed the audience about problems and progress in independent states of former Soviet Russia.

International Development agencies that concentrate in the field of STIs must always be listened to and cooperated with. Their finances and intelligence have enormous clout. They not only stem from WHO or UNAIDS, but are supported by governmental departments and agencies from many of the richer countries of the World and international charitable organizations.

Thus, there are the well-known professional skills for global treatment, control and epidemiology of STIs, often funded and researched by some of the most excellent centers in the World. These have been mostly in the West until now. They do not need to be duplicated.

What does need to be done is to inform many dermatovenereologists, especially in those regions where both disciplines, dermatology and STI, are traditionally taught together such as in the Middle East, Iran, India and parts of Africa and South and Central America, that there is the other perspective of care for populations affected by STIs – often among the poorest members of any society that do not have the ability to pay a doctor for the consultation to begin the curative process.

This is essentially public health or community dermatovenereology, a concept only understood by a few dermatologists but readily understood by any public health medical specialist or sexual health physician.

Conclusion

The Task Force has a key role in pinpointing deficiencies in the broad education of dermatologists and helping those who offer themselves as Community Dermatologists to serve towards fellow humanity in the field of STIs.

Acknowledgment

Michael Waugh is an Emeritus Consultant Genitourinary Physician from the General Infirmary, Leeds, UK. He was President of the International Union against Sexually Transmitted Infections (IUSTI) from 1995 to 1999, is Chairman of the Ethics Committee, and is a founder of the Signatory European Academy of Dermatology and Venereology (EADV).

