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The Public Health Intervention of Skin Care for All: Community Dermatology

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1. Introduction

So often said, "The skin is the largest organ of the body and the most visible." Less often emphasised is *Skin Failure,* a public health problem of great magnitude that is global and a major precursor of long term disability and non-participation.

Skin failure manifests as; 1) the loss of barrier function between the body and a threatening environment; 2) the inability to manage overheating or excessive cooling; 3) sensory impairment so that there is itch, pain or numbness, and 4) the disfigurement and consequent faulty communication of the 'look good feel good factor'.

Skin failure is managed by physician belonging to the profession of Dermatology that has had several years of additional training in the diagnosis and management of skin diseases. There are also wound healers, lymphoedema managers,employees of burns units, and custodians of neglected tropical skin diseases such as, for example, leprosy, leishmaniasis,onchocerciasis, lymphatic filariasis, yaws and Buruli ulcer, which must be members of an alliance to provide skin care and promote skin health for all.

The perception of Public Health is that the dermatologist is one who treats individuals with skin disease and who markets good looks served by cosmetic interventions. It fails to recognise that there is significant branch of Dermatology named Community Dermatology which promotes '*Skin care for all'* (1). The mission 'Healthy Skin for all', an offspring of the WHO *Health for All* (2), adopted first of all by The International League of Dermatological Societies and later by some of its members such as the British Association of Dermatology, is Utopian. *Skincare for all* is more achievable. It focuses on low cost interventions, relying on self help and low technologies such as washing, as well as knowledge of how to examine the skin and the acquiring of the skills of the diagnosis of physical signs in the skin.

Recent discussions at the WHO have initiated the view that *Health for All*, which is inclusive of wellbeing, would be more appropriately renamed if it were to focus on capacity to adapt and self-manage (3). The end point of treating skin failure would be a disfigured person who is coping well with self-management and feels healthy.



Fig. 1. A Photograph that has become a much used *logo* of the *International League of Dermatological Societies* to illustrate *Healthy Skin for all(2).* Those who treat must have access, (the bike) essential drugs and devices, (in the accompanying portable case) and knowledge(appropriate education).

The nature of community dermatology, and its clear capacity to benefit, has been highlighted by the International Society of Dermatology in 10 articles published in the May 2011 edition of the International Journal of Dermatology and in a CD of 44 articles prepared for the World Congress of Dermatology held in South Korea in the same month www.intsocderm.org. The capacity to benefit within the skin care field is dependent not only on the medical profession but on an effective response from the nursing service, the largest group of health professionals worldwide. This situation is directly relevant also to both the prevention and management of chronic wounds and Neglected Tropical Diseases worldwide, given the major involvement of nurses in routine skin care and maintenance of skin integrity.

2. The background to community dermatology

It is a significant advance that there has been recent effort by the WHO to record the burden of diseases and there is a sub-committee tasked with recording skin disease (discussed by Hay et al 2011 at the World Congress of Dermatology in Korea).Hay and Fuller (2011)(4)state that the questions that must be asked are

1. What and how common are the main local diseases?
2. What is their impact on those affected by them in terms of disability, reduction in quality of life, and cost?
3. What obstacles prevent people from seeking remedies?

These range from lack of understanding of the potential for treatment, tolerance of disease, distance to health center, to cost of treatment.

Some countries such as the UK(2009) (4) and USA(2006) (5), have much improved the accuracy and approach to collection of data on skin disease and its assessment and expression as a burden with needs to be met. Assessment and management in resource poor environments are now improving but still inadequately funded. In the developing and emerging countries, the education needed to ensure skilled examination and recognition of skin conditions is almost everywhere lacking. But with imported expertise some thorough analyses of the prevalence of skin disease in rural areas have been done, viz: Ethiopia,(6,7)Nepal,(8) Mali)(9) Tanzania,(10) Indonesia(11) and Brazil(12.) These show a high prevalence of skin disease, usually exceeding 50% and sometimes when there are endemic conditions such as scabies, onchoceriasis, tinea capitis or lice, as much as 80% of the population, For instance, Walker's study in Nepal(8) used data from a survey conducted in five villages and found an overall point prevalence of skin diseaseof 62.4%. Superficial fungal infections accounted for 20%, but acne, melasma and eczema were among the top five diagnoses.



Fig. 2. A rural clinic in Ethiopia for women with podoconiosis, a condition of lymphoedema due to not wearing shoes where the soil is irritant(13). In this clinic for foot inspection,better care of the feet with significant improvement in the skin is awarded with microfinance for job development.

Another medical problem endemic in Ethiopia (Figure2) is podoconiosis (13), a chronic form of lymphedema associated with exposure,through not wearing shoes, to certain soil types, where in one village 5.8% of those over 50 years old had this problem.

In Gibbs' study of two villages in Tanzania,(10) there was a lower prevalence rate for skin disease (28.6%), but again over 70% of these patients had skin infections.

In a survey in Assuit (14) Egypt a higher level of skin disease, with 87% of those examined having at least one skin problem being recorded. This study included individuals with pediculosis capitis, which had a prevalence of 19.37%. In addition, 10% had bacterial skin infections and 16% fungal infections. Eczema prevalence was also high at 19%.(14) By contrast, the survey carried out in Sumatra, Indonesia(11) showed a lower prevalence of skin problems. In children and adolescents, 28.2% of the population studied had skin disease although, as is usually found, fungal and bacterial infections were the most common diseases seen. It is children under the age of 15 years that account for most of the diseases affecting the skin in developing countries. For instance, Mahé's survey in Mali (9) showed that 34% of children had one or more skin problems, with infections predominating. Any such study will be aware that the world's population is dominated by children. A study of skin disease in 12,586 Indian school children ranging in age from 6 to14 years showed an overall point prevalence of skin conditions of 38.8%. Of these, 30% had only one skin disease, 6% had two and 2.7% had three skin problems.(15) The most common of these were infections (11.4%), but pityriasis alba (8.4%), eczemas (5.2%) and infestations (5.0%) were also common. Bechelli in Brazil (12) found a prevalence of skin disease in the villages surveyed that ranged from 20 to 87% in children, aged 5–16 years,living in different municipalities in Acre state, Brazil. Again, infestations and infections were the dominant conditions; for instance, the prevalence of pediculosis capitis exceeded 50% in most areas.

A common theme of all these studies is that the prevalence of disease is often affected by the prevalence of parasitic infections, such as scabies. A key point is that parasites carry other infections and scratching exposes the skin to additional infections and attracts flies. Some medicaments such as honey attract other insects such as ants..A special concern is the prevalence of streptococcal infection in those populations where scabies is prevalent. For instance, in Northern Australia amongst aboriginal children, scabies often affects over 50% of the population, and pyoderma and infected sores with staphylococcus and streptococcus affect 70%.(16). Quality of life can be seriously affected, clinics can be overwhelmed, rarer but very important diseases given less attention, and family money spent on ineffective remedies.

It is not only dermatology medical professionals that lead advocacy for a public health approach to these skin diseases,but, as well, there are other health professionals taking an interest. The International Skin Care Nursing Group (ISNG), initiated in the UK, affiliated both to the International Council of Nursing and to the International League of Dermatological Societies (ILDS), is giving additional nursing leadership (17). From its earliest days members of its board have acted as a catalyst by visiting departments in India, Mexico,Nepal and Africa. In Guatemala the International Foundation of Dermatology with some help from the ISNG focused on teaching 255 American Indian nurses working in rural areas. This was 10 days of instruction into skin care over a 5-year period (18). In the last few years in countries such as India and Nepal, where the nurse is predominantly female and dermatology nursing is not well developed, the ISNG has begun to exert an influence by

demonstrating how important it is to have a profession providing skin care that uses hands-on low technology in skin care delivery. The nurse becomes an educator and counsellor, with more time than the rare dermatologist, available to teach the patient self-help. In the Community Dermatology projects led by Dr Roberto Estrada Castanon in rural Mexico, the nurse acts as a ''sentinel'', diagnosing and managing patients in their rural homes. In Manaus, Brazil, in the Dermatology Clinics and the Institute of Tropical Medicine, all attendees are first seen by a dermatology- trained Triage nurse, who selects whether they should be returned to primary care, tested for malaria, admitted to a ward or referred for a skin consultation.

The significant lack of dermatologists worldwide, most of whom are based in the secondary hospital sector, means that expertise in skin care cannot always be delivered to those who need it. A paper written by the International Skincare Nursing Group (18) outlines initiatives by nurses to do this and examines the development of nursing within the dermatology field- and the need to cascade dermatological expertise from specialist to generalist community based health workers. It logically follows that there is a need to adopt a strategic approach that identifies the educational needs of nurses, harnesses the appropriate expertise, shares good practice and operates in close inter-professional collaboration with dermatologists. Work led by the *International Skin Care Nursing Group* (ISNG) has sought to stimulate and develop the capacity of nursing to respond to these widespread needs through promoting service delivery models that operate interdependently with dermatologist-led care. Such health professionals are well placed to work with community workers in resource poor countries and manage core clinical issues, including skin barrier protection and maintenance and the management of chronic wounds, applying preventative and educative strategies where possible. Evidence of such work is seen in South Africa with the development of a new Postgraduate Diploma in Dermatological Nursing to adequately prepare a cadre of nurses who can work in peripheral community based clinics addressing issues of skin and wound integrity. To realise this potential there is a need for the development of inter-professional team working, support for nursing development and education and identification of service delivery models that effectively integrate and complement their expertise. In this context diagnosis is based on focusing on the common diseases. The most frequent of these are usually infections such as impetigo, cutaneous fungal infections or parasites such as scabies. Attention to better diagnosis and the availability of essential drugs must include awareness and reminders of diseases such as the Neglected Tropical Skin Diseases. Reducing the prevalence of ineffective remedies often bought at the road side, is also a part of the programme.

2.1 Gender and the provision of Skin care

Those involved in skin care, including dermatologists, allied health professionals, (principally nurses) or most often a family member, are more likely to be female than male.

Women are the largest users of health services, including alternative and complimentary medicine.

The empowerment of women to improve their effectiveness has the backing of an organisation founded in the memory of Maria Duran, a Columbian Dermatologist who helped to organise in Turkey the first meeting on the Advancement of Women in

Dermatology (19). Dermatology is a profession in which women are successful and numerous, and much past criticism of the undervaluing of women in professions and in universities has been influenced for the better by the experience of dermatology. Thus, especially in the integration of an immigrant population, dermatology has an important role to play. It continues to be a model of how women in social class 1 cope with a professional career. The late Dr Turkan Saylan, Professor of Dermatology and Leprology at Istanbul University, stated that the solution to ''Advancement of Women'' is humaneness rather than laws, lore or religion(20). It was the International League of Dermatology Societies (ILDS) and International Society of Dermatology that initiated the concept that dermatology could provide guidelines for equal partnerships between men and women to counteract the male dominance of many codes of practice taught by religions. The laws that govern health and hygiene are mostly written by men.

Dr Rokea A el-Azhary, of the Mayo Clinic, in a presentation at the Cairo International Congress of Dermatology in 1996, stated that the change in the ratio of women to men in dermatology would bring with it the necessary gender choice for the patient, a perception of greater kindness, better communication as well as greater empathy.

The setting up of vulva clinics in Dermatology departments (21)has led to a model of care that is neither based on sexually transmitted infections nor on the surgical approach of gynaecology to genital skin disease, such as in the management of lichen sclerosus et atrophicus. Many publications from women dermatologists now show that previously incurable conditions can now be better diagnosed and treated. In many countries, social norms dictate that female genital skin conditions be managed by female dermatologists and, indeed, many female patients prefer this. Measurement of quality of life has shown how miserable the lives of women suffering from genital skin disease have been (Finlay in CD intsocderm). Dermatology, through its knowledge of the handicap of disfigurement, can do a lot to seek ways to remedy this, and to raise self-esteem and reduce perceptions of having an appearance which is unwelcome.

Cultural concepts of beauty that are almost entirely to be found in the skin, affect marriage. Young girls must be given more confidence to delay marriage and a greater choice in their life partners. There has been improvement in maternal and child mortality through better diagnosis of some skin conditions in pregnancy. In future an aim is to ensure girls are as well nourished and well dressed as boys and, in a threatening climate, that they are as protected as boys. The Albino project of the Regional Dermatology Training Centre (RDTC) in Tanzania is a model for gender equality both for the treatment of skin cancers and for ensuring the educational needs of girls as much as boys.(22) Currently of major concern in Tanzania there is a market for the selling of body parts of those affected by albinism for witch craft and girls are most vulnerable.

Circumcision of males is currently advocated for protection against HIV/AIDs but better education on genital hygiene has a place in management of the foreskin. Female genital mutilation is a major concern and is discouraged by a global drive to reduce this practice often led from Dermatology.Thus Morrone a dermatologist on behalf of the International Society of Dermatology, wrote ''Stop female genital mutilation: an appeal to the international dermatologic community''.(23) At the RDTC in Tanzania, much support has been given to the drive against this procedure and to the education of health care professionals on how to discourage this practice.

2.2 The regional dermatology training centre: A flagship for community dermatology

In resource poor countries, in recent years, greater effort by leading organisations governing dermatology (The International Society of Dermatology, the ILDS and The International Foundation for Dermatology, IFD) resulted in the creation of the Regional Dermatology Training Centre in Tanzania, RDTC (www.ifd.org); this has produced 200 dermatology graduates serving 12 English speaking countries of Sub-Saharan Africa which were without any hospital or university advice on the skin except for the occasional visitor from the developed world. It initially focused on the development of Allied Health Professionals but the number of Specialist Doctors, MDs, in training is increasing. The two year curriculum includes skin diseases, STI and Leprosy. The students also receive instruction on wound management and lymphoedema. Another programme based in Mali, West African and French speaking, was a one day training of all health centre personnel to recognise and manage the three commonest conditions, resulting from bacterial, fungal and parasitic invasion of the skin: namely impetigo, superficial fungus and scabies. This training prevents the health services being overwhelmed by common diseases and allows the health worker to give more attention to more serious skin conditions such as leprosy, or wounds and burns. Other programmes now exist in Mexico, Mali, Patagonia and Cambodia (see the CD www.intsocderm.org) all administered or supported by The IFD from Willan House,4 Fitzroy Square London, the HQ of the British Association of Dermatology.

In the field of wound healing the curriculum includes improving techniques of making wounds; incision and suturing for example after biopsy or excision of early skin cancers and avoiding disfiguring scars. In resource poor regions effective low technology interventions are promoted including the use of herbal remedies such as honey and biosurgery employing maggots to aid wound healing.

Information Technology, including telehealth, is advancing in expertise and becoming more available as mobile phone technology and distribution expands. (See Schmidt Grendlemier in CD, www.intsocderm.org) It is used by all levels of health care, inclusive of traditional health practitioners of rural Africa. The skin is easily photographed and easily biopsied. Samples can be posted and histopathological analysis sent back to guide the management of skin lesions (see Bertramelli in CD, www.intsocderm.org). It is increasingly common practice to teach Allied Health Professionals to biopsy the skin using disposable punches. One author emphasised that honey was an excellent transport material even for histopathology needing immunoflourescence (24)

The morbidity and health issues facing mobility of populations forced to move due to strife, climate change or economic migration has been extensively studied and supported by the dermatologist Aldo Morrone (CD www.Intsocderm.org) through the establishment of the National Institute for Health, Migration and Poverty, in Rome.There are 214 million international migrants and 740 million internally displaced people. The immigrant, even if without skin ailments before migrating, is very likely to develop such during a difficult migration. In a paper in press, the human right to have access to skin care and the legal duty of the carer to provide it is emphasised(25)

Dermatology also overlaps and embraces venereology-sexually transmitted infections including HIV/AIDS. These conditions both present frequently in the skin and resulting therapy can commonly produce adverse skin reactions. Tissue viability may also be

generally impaired and for example skin grafting more often fails in immunocompromised patients.

Skin Care for ALL is difficult to achieve when considering the challenges of climate change. (26). Those who care for the skin have developed expertise in the management of hazards from sun, flood and cold exposure. Programmes to protect the skin from the hazards of climate are well developed in Australia with their *Slip slap slop* sunscreen campaign, in Tanzania there is the Albino programme and along the western mountain ranges of the Americas there is protection of the American Indian genetically prone to Polymorphic Light Eruptions. Many conditions such as these which are influenced by climate may get worse unless the experience of skin carers is fully appreciated and funded.

Skin lightening with often harmful depigmenting agents containing strong steroids or mercury, has become a significant public health problem in Asia and Africa adding to the disorders of pigmentation such as albinism and vitiligo an increasing burden in primary health. It is a consequence of the perception that to be lighter implies a higher social class less burdened with outside work and better off financially.

2.3 Social marketing of self-esteem and 'look good feel good factor'

Much of the advice to patients and the support given to self-help groups, divorces beauty from market forces, advising on lifestyle and removing from their vocabulary being contagious or unclean.

Dermatology textbooks addressing social and sexual communication help to explain how display is used not only for sexual purposes, but in conflict behaviour to establish territorial rights or social dominance.(27) Social marketing (28) of concepts such as "Black is Beautiful" or "Natural is Beautiful" is important in reducing the use of skin lightening creams containing harmful agents such as strong steroids or mercury. Those who provide or receive these rely entirely on dermatology to make them safe, particularly from adverse skin reactions. Many cultures use cosmetics or tattoos to enhance communication. Often too there is a request for their removal with the passing of time.

The importance of hair as an adornment, especially in women, too much or too little, also requires advice from dermatologists.

There is a great increase in the demand of teenagers for tattoos,and body piercing followed by a more adult demand for their removal at a high cost. These are initiated by a desire to raise self esteem. The take up of smoking in adolescence is also part of the same need and even graffiti can be shown to be a 'marking' of the environment as part of impressing ones identity. The Community Dermatology Task Force believes that understanding these issues, and anything that encourages the carer of the skin to understand the need and to develop interventions to raise self esteem, are key to managing wellbeing. People with disfigurements due to skin ailments, or having selected a pattern of adornment no longer fashionable or having scarring and consequences of burns, in particular, need help and support by councillors well trained in managing communication skills. They can be helped by organisations who specialise in bringing out skills as an alternative to good looks.. When severely disfigured one may have to learn to walk into a room of people having relearned how to introduce oneself by both the loudness of one's voice and the strength of one's hand shake.

All such aforementioned programmes are a development of public health interventions, but they will succeed only if distributed alongside other public health programmes. Indeed Western biomedical practice cannot intervene successfully without awareness and a degree of partnership and effective integration with other systems of medicine. These include Indian and Chinese systems of medicine as well as Traditional Health Practice in Africa (29). There are many more Traditional Health Practitioners(THP) than biomedically trained practitioners. They are a huge work force with potential for delivering skin care sustainably and locally available. In managing a problem such as for example snake bite there are interventions they should not do, such as scarification and the use of the tourniquet. They can identify the snake. They can manage shock due to fear. Increasingly some urban based THPs even use a mobile phone and in future communication with experts from THPs in rural areas may be the custom, even showing over great distances a photo of the snake to antivenom centres and seeking advice whether venom is needed and available. The THP can be helpful in disease control, as for example managing HIV/AIDS or adding to the work force for elimination of disease campaigns as well as morbidity control. Well established written traditions, such as Indian or Chinese medicine are important collaborations if *Skin care for all* is to achieved. For example the thousands of years old traditions of Ayurvedic Medicine and Yoga have,inspite of initial biomedical opposition, been shown to be effective low cost management of lymphoedema due to filariasis in the villages of India.(30)

All programmes need to be patient-centred, to ensure effective patient engagement to uphold treatment adherence and empower people to self-manage. Even in community management, awareness of individual needs has to be preserved, but recognised as a part of the community profile. Where possible the self-management dimension for care should be supported through planned education and encouragement to enhance treatment adherence and prevention of skin barrier deterioration; nurses have a key role here. The extent to which the absence of skin care leads to morbidity and indeed at times mortality (31), should be emphasised through educational initiatives. Morbidity needs the back-up of formal *quality of life* scoring so that the burden is fully realised and the basis of community participation and income generation can be worked upon (32).

3. The future of community dermatology

The International Society of Dermatology Task force for '*Skin Care for ALL: Community Dermatology*', has set out the scope and range of the public health programme needed. Following on from this background work descriptions of interventions, both by addressing the service need in terms of workforce and materials required, must be acted upon.. The Task force is preparing an ABC of *how to do it* procedures to promote community dermatology. The agenda and curriculum has to be shared with many partners in an alliance to achieve *Skin Care for All*. Such an alliance will work with those organisations managing wounds, burns and lymphoedema and will work with the World Health Organisation to contribute to its interventions on skin care for the Neglected Tropical Diseases Programme. Many of these have a work force to deliver drugs to whole populations to break transmission from vectors and between humans. They all need backing with programmes of morbidity control. Leprosy is long a prototype for the Stigma of skin disease. Hopes for its elimination as a public health problem have not been fulfilled. There are still far too many new cases.Often these are multibacillary, have advanced disability and

are seen in children. Such worrying aspects of this disease,particularly in India and Brazil, are made more serious by the widespread disbanding of Leprosy's vertical programme and therefore of its experienced workforce in the belief that the battle had been won. Programmes from Dermatology such as that at the Regional Dermatology Training Centre in Tanzania, which is a WHO collaborating centre for leprosy as well as Dermatology and STI, are insufficiently utilized within a framework of leprosy led control programmes.

Podoconiosis has recently been added to the list of Neglected tropical Diseases. This is a condition illustrated above (Fig2) for which active skin care and the introduction of footwear has the potential to benefit more than one million Ethiopians. Current simple NGO projects are already helping thousands of patients (see Davey 2011 CD www.Intsocderm.org). When contributing to a lymphatic filariasis programme in Kerala S India, the authors of this chapter, acting as mentors, have witnessed a significant advance in morbidity control through the integration of conventional medicine and traditional effective practices such as massage and yoga. With many millions of persons in India having grossly enlarged limbs, the pilot study of some 2000 limbs has revealed an effective response to integrated medicine, making use of the availability in villages of self help interventions using yoga and herbals (30).

Onchocerciasis elimination has focused on the use of the drug Ivermectin to eradicate the filarial infection but the needs of a heavily scratched skin covered in bites from black flies require a concomitant planned programme of skin care. Leishmaniasis is another common disease resulting in disfigurement which is greatly in need of techniques to prevent or treat scarring.

Buruli ulcer has recently benefited from improved instruction on the technology of wound healing. It was the WHO's need for wound healing expertise for Buruli ulcer that lead to the formation of the World Alliance for Wounds and Lymphoedema Care (WAWLC) and the publication of a White Paper (a document prepared by experts for advice to Governance)in the form of a Handbook is now on the shelves at WHO. (34) It simplifies management of chronic wounds down to five interventions and lymphoedema to three. Table 1

Wound healing
1. Manage systemic conditions such as diabetes, anaemia, HIV AIDS
2. Protect the wound from trauma such as sustained pressure
3. Promote a clean wound base and control infection
4. Maintain a moist environment
5. Control periwound oedema
Lymphoedema
1. Enhance movement of lymph
2. Reduce overload from the venous system
3. Reduce overload due to inflammation from entry points for irritants and bacteria.

Table 1. The minimal requirements for Wound healing and Lymphoedema



Fig. 3. Pyramid distribution of advice provided by carers of the skin must be both to Governance above as well as to practitioners below.

Experts working within the framework of a pyramid of care Fig 3 with the most needy at its base and governance at the top must give equal attention to both. At the bottom there is a need to provide locally available, sustainable, low cost care, mainly through primary care initiatives. The support of the nursing profession is crucial to this service delivery model. In the pyramid of care the Task force for skin care sits in the middle levels often collaborating with university and tertiary hospital care. For the management of prevention or first aid tertiary care extends downwards to the health centre, Traditional Health Practitioner, and to self help. For this to happen it is perhaps even more important that time is put aside for advocacy to extend upwards to those who govern health provision. So far this has resulted in little understanding of the significant role the carer of the skin plays in health care in general.

3.1 Wounds burns and Lymphoedema

Throughout the development of the Taskforce for *Skin Care for All: Community Dermatology* there has been emphasis that this is a programme extending beyond dermatology to include Wounds, Burns and Lymphoedema. This leads us into the public health territory of *Global Injury Epidemiology*. Injury is a leading cause of death, highest in middle income and lowest in lower income groups. While acute injury such as the head injury of a motor bike accident resulting in death cannot be included as part of the remit of the Task Force for skin care for all, trauma resulting in chronic non healing skin wounds should be. As mentioned above in reference to a paper by Escadon et al(31)these, such as pressure ulcers in the paraplegic, can lead to death and add to the little emphasised statistic of mortality due to skin conditions. Its prevalence is underestimated in data describing the scale of the injury problem.

The discussions that can be read in the literature of classification and coding of injury tend to focus on anatomical site such as head, trunk or limb but an *Injury Severity Score* does separately identify *external*, meaning the skin. The literature relating to injury includes much that is written about the economic and social burden. The care of the person living with an amputation stump, the pressure ulcer in the paraplegic and of course burns are just a few examples. Preventing and managing the consequences of injury becoming a top cause of loss of disability adjusted years falls commonly to the carer of the skin.

The burned patient is an appropriate subject for a Task force providing care for people with skin conditions that arrive in the primary care health centre or requiring self help. This hardly needs further emphasis, yet a glance at the headings so far illustrating how education provided by carers of the skin has the capacity to benefit, will reveal the following: - the greater susceptibility to burns of the skin without sensation, the importance of clean water availability, the need to avoid inflammable clothing and furnishings, child to child programmes to prevent the youngest approaching the fire place, and the whole question of disfigurement restoration and the look good feel good factor that permeates the management of all skin disease. These require environmental, engineering, legislative, and educational approaches requiring rules on inflammable clothing and bedding, as well as whole country teaching of first aid

If the definition of *Health* is to change, current debate may revise it to meaning the *capacity to adapt as an agency to effectively self-manage*, in which case those who care for the skin are well in the lead to contribute to *Health for all through* by their promotion of skin health.

4. Conclusion

Community Dermatology must pervade all health systems- making the correct diagnosis and intervening with available and affordable interventions, including health promotion and the prevention of the deterioration of the skin barrier and the development of chronic wounds. Data must be collected on prevalence of disease and access to interventions and the size of the work force, and Essential Drug Lists must be prepared. As an example of the globalisation of key interventions there is the Memorandum of Understanding between Procter and Gamble, the International Foundation for Dermatology and The International Skin Care Nursing Group to provide *Water Fit for Drinking* for washing by issueing very low cost water cleaning systems and adding glycerine as an emollient. This can be seen as a collaborative initiative promoting the lowest level of technologies used in skin care (35).

Public Health strategies have not been sufficiently inclusive of skin care. Public health inclusivity of common problems requiring skin care is largely unfunded while there is the receipt of billions of dollars for management of HIV/AIDS, malaria and TB. Donors have yet to be persuaded of the benefits of skin care possibly because of the lack of focus by public health professionals and perhaps a lack of appreciation of the public health relevance of skin health.

The task force for *Skin Care for All:* Community Dermatology can demonstrate in its recent publications its 'capacity to benefit'. It will in the near future with greater clarity than ever before, explain how to approach the problem. But this will be a waste of potential achievement for solving very common public health needs unless a strategic approach is taken and the resources are provided to enlarge a work force that is skilled and equipped to aid effective self-management. An alliance of all who interested in skin care will be needed.

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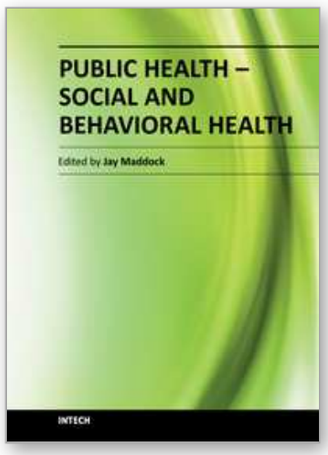
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Human behavior accounts for the majority of morbidity and premature mortality throughout the world. This book explores several areas of human behavior including physical activity, nutrition and food, addictive substances, gun violence, sexual transmitted diseases and more. Several cutting edge methods are also examined including empowering nurses, community based participatory research and nature therapy. Less well known public health topics including human trafficking, tuberculosis control in prisons and public health issues in the deaf community are also covered. The authors come from around the world to describe issues that are both of local and worldwide importance to protect and preserve the health of populations. This book demonstrates the scope and some of the solutions to addressing today's most pressing public health issues.

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