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AFRICA REGIONAL REPORT

Skin Disease Landscape in Africa

A Summary of Contributions from the GlobalSkin Africa Regional Workshop

GlobalSkin, the International Alliance of Dermatology Patient Organizations, along with its 350+ Members, is dedicated to improving the lives of people living with skin conditions worldwide. Through contributions from representatives of skin patient organizations across the African region, GlobalSkin identified common areas of need shaping the diagnosis, care, treatment, and daily lives of people living with skin diseases in Africa. This work was conducted as part of GlobalSkin's Regional Engagement Workshop Series, a global initiative to understand patient priorities across all six World Health Organization (WHO) regions and to support the community's input into the development of the WHO Global Action Plan on Skin Diseases, along with member advocacy efforts for implementation of the Skin Diseases Resolution. This report presents the findings from the Africa regional workshop, held on February 10, 2026, and is intended to support GlobalSkin's African members in identifying advocacy, awareness, and research priorities.

The six areas of need identified in Africa are: low political prioritization, lack of coordinated action, systemic underfunding, and absent national skin health strategies; limited data collection capacity; widespread workforce shortage and weak health system structures; financial and geographic barriers to care; cultural stigma and absent mental health support; and much-needed education and community-based outreach. These areas are deeply interconnected and rooted in a persistent failure to recognize skin diseases as serious, chronic conditions that impose substantial burdens on individuals, families, and health systems. Policy implications across all six themes, along with the suggested actions identified by participants as the region's most pressing priorities, are discussed in the final section of this report.

The contributors to this report served as proxies for their broader skin patient communities, representing conditions including acne, albinism, alopecia, eczema, pemphigus, podoconiosis, psoriasis, vitiligo, and neglected tropical diseases affecting the skin, from countries including Côte d'Ivoire, the Democratic Republic of Congo (DRC), Ethiopia, The Gambia, Ghana, Kenya, Liberia, Nigeria, South Africa, Uganda, and Zambia. While the challenges described are common across the region, their severity varies by country, healthcare system capacity, and condition.

Across contributions globally, a consistent finding emerged: there is a need for greater recognition of the burden of skin diseases at both the individual and societal levels. Increased awareness would lead to more dedicated policy frameworks, proportionate research investment, a stronger, better-trained workforce, equitable access to care and innovation, and greater empowerment for patients and their families. Without this recognition, the cycle of underinvestment and under-prioritization continues. This report aims to make that burden visible and to translate the lived experiences of people across Africa into actionable priorities for policymakers, researchers, health systems, and the dermatology community.

Methodology

In 2026, GlobalSkin conducted an exploration of the needs of people living with skin conditions by engaging directly with its members across all regions. Participants reflected a wide range of experiences and perspectives, serving as proxies for their broader communities. The engagement aimed to understand patients' priorities, identify regional differences, and map the strengths and gaps in the health system for the prevention, diagnosis, treatment, and long-term management of skin conditions.

Information was gathered through the Regional Engagement Workshop Series, which included two-hour virtual regional meetings, interactive prioritization of needs, interviews, and offline/post-workshop written contributions. Workshops were organized for the following regions: Africa, Asia Pacific, Eastern Mediterranean, Europe, Latin America, and North America. Discussions were structured around topics including data collection and data sharing, research, affordability and accessibility of care, local healthcare, innovative service models, patient empowerment, and social awareness. Insights from these sessions were documented and reviewed to identify common themes, regional variations, and priority areas for action. The Africa region workshop was held on February 10, 2026. Thirty-two of GlobalSkin's African members contributed to this report through live interventions and written contributions, representing skin conditions including acne, albinism, alopecia, eczema, pemphigus, podoconiosis, psoriasis, vitiligo, and neglected tropical diseases affecting the skin, from countries including Côte d'Ivoire, the Democratic Republic of Congo (DRC), Ethiopia, The Gambia, Ghana, Kenya, Liberia, Nigeria, South Africa, Uganda, and Zambia.

The findings summarized herein provide a regional overview of the African skin community's priorities and are intended to support GlobalSkin's African members in identifying advocacy, awareness, and research priorities, as well as supporting national, regional, and global policy advocacy efforts, such as consultations into the development of the World Health Organization Global Action Plan on Skin Diseases.

Results

The following six themes were identified as the key areas of need across skin disease communities in the African region.

1. Low political prioritization and lack of coordinated action result in systemic underfunding and no national strategy
2. Limited data collection capacity yields absent or fragmented data on skin conditions
3. Widespread workforce shortage and weak health system structures produce poor care
4. Financial and geographic barriers to care lead to unsafe alternatives
5. Cultural stigma drives exclusion and delays care, with mental health support nearly absent
6. Education and community-based outreach essential for patient empowerment and care

1. Low political prioritization and lack of coordinated action result in systemic underfunding and no national strategy

Across the African region, skin diseases are consistently deprioritized by governments, health ministries, and international donors in favor of communicable diseases. Skin diseases are often perceived as non-priorities, being viewed as aesthetic rather than systemic conditions. This deprioritization manifests as negligible dedicated funding for dermatology research or services, the absence of national policies or strategies specifically addressing skin health, and the exclusion of dermatological conditions from most national health agendas. Contributors described a self-reinforcing cycle: without data, it is difficult to make a case for political action; without political action, there is no funding for data.

In Kenya, contributors noted that there is no dermatology department within the Ministry of Health. Without an institutional home, there is no internal government champion for skin health, no mechanism for sustained engagement with patient organizations, and no framework for developing the policies needed to improve care. In Ethiopia, a representative working on podoconiosis described a control program so weak that it is not included in annual service plans or drug procurement processes, with implementation severely undermined by the government's overwhelming focus on malaria, TB, and HIV. In Ghana, the Community Health Planning and Services model similarly prioritizes malaria and maternal health, resulting in minimal programmatic attention for chronic skin diseases. In the Democratic Republic of Congo (DRC), contributors described a health system in which funding priorities are largely set by external donors, systematically marginalizing conditions, including most skin diseases, that do not align with donor interests.

A recurrent theme across contributions was the absence of meaningful coordination among the actors whose joint action is needed to advance skin health in Africa: governments, health ministries, researchers, clinicians, non-governmental organizations (NGOs), and patient organizations. Without structured coordination, efforts remain fragmented, resources are duplicated or wasted, and the potential for collective influence on policy and funding goes unrealized.

Patient organizations remain largely uninvolved in any aspect of health agenda-setting. Patient organizations across the region described operating in isolation, without formal roles in health policy processes, without adequate resources, and often without recognition from government bodies and healthcare professionals. Contributors emphasized that the power of patient organizations lies in their proximity to communities and their ability to generate the kind of lived-experience evidence that clinical data alone cannot provide. Several contributors noted that patient organizations have made genuine progress through social media campaigns, World Awareness Day events, and media engagement, but that these efforts need the support of formal structures and international bodies to translate into sustained policy influence. Getting "inside the tent" rather than advocating from outside it was described as essential for dermatology voices to shape the decisions that matter most to them.

The inclusion of formal patient representation in district and national health governance bodies was identified as a key structural change. In Ghana, for example, this might look like getting formalized seats for patients within District Health Management Teams and facility committees. Contributors

called for the establishment of dedicated dermatology departments or units within Ministries of Health with focal points for engagement; the development of national skin health strategies that sit within broader NCD and universal health coverage frameworks; dedicated funding for skin disease research, surveillance, and social protection programs; and the adoption and active implementation of the World Health Organization Resolution on Skin Diseases[1] at the country level. Representatives from Uganda and Kenya specifically called for the WHO Resolution to be formally shared with national and local government bodies and for accountability mechanisms to be established to ensure adoption is followed by action. Contributors also called for international partners to play an active convening role, supporting African patient organizations in connecting, sharing strategies, and presenting a unified voice in international forums. Multi-stakeholder coalitions at the national level, bringing government, NGOs, healthcare professionals, and patients around a shared table, were described as the model most likely to generate the coordinated, evidence-based advocacy needed to shift political and funding priorities.

2. Limited data collection capacity yields absent or fragmented data on skin conditions

A challenge raised across all countries represented at the Africa workshop was the near-total absence of reliable prevalence data on skin conditions. Patient organization representatives described not just a gap but a structural void: skin diseases are largely invisible in national health information systems, leaving clinicians, policymakers, and patient advocates without the evidence base needed to make a substantive case for attention or resources.

In Kenya, skin conditions are not consistently captured in national health information systems, and available data fail to incorporate lived experience, treatment adherence, psychological impact, and financial burden. Most studies are small and facility-based, with almost no large-scale epidemiology, prevention trials, or innovation data tailored to Kenyan or African skin, except for a recent vitiligo study focused on darker skin types.[2] In the DRC, data collection policies and tools do not adequately address skin diseases, except for narrowly defined programs for neglected tropical diseases and leprosy. In South Africa, a representative of the psoriasis community described data collection as extraordinarily difficult under current conditions; for example, a 2024 survey distributed to 60 dermatologists, mostly from urban areas, yielded only 2 responses. Even where data exist, they reflect only those who have official touchpoints with the healthcare system, leaving the majority of patients completely unaccounted for. In Uganda, a representative of the vitiligo community described attempting to conduct a baseline prevalence survey in collaboration with district hospitals, but health officers had no data and therefore reported that no one in their communities had the condition, even as over 100 people with vitiligo were known to be living in a single district. Healthcare systems simply do not capture this information.

Across countries, challenges with data are compounded by systemic barriers to collaboration: government hospitals and medical professionals are unwilling to share data with non-profit organizations, either because they do not see a role for patient organizations or because they view them as competition for research funds if they were to gain access. In Uganda, dermatologists reportedly withhold even non-confidential aggregate data from patient organizations for fear of losing funding, while government institutions expect patient groups to collect data without providing the resources to do so. In Nigeria, dermatological societies have shown little interest in collaborating with patient support communities, and there is no mechanism for bringing

stakeholders together around a shared skin health research agenda. Most dermatological research is self-funded by clinicians or supported by small university grants, with no national registries for conditions like vitiligo and no sustainable funding mechanisms to understand long-term treatment outcomes or the psychological impact. Across the region, patient organizations are rarely involved in research priority-setting. The organizations collect anecdotal and small-scale data through local support groups and outreach activities, but this data is rarely standardized or integrated into formal data-gathering systems. Governments and funders deny support for data collection, leaving organizations without the technical and financial resources to conduct independent, large-scale data collection.

Skin disease research is perceived as low priority by governments and donors, who direct funding and data infrastructure elsewhere. In fact, a contributor pointed out that there is a willingness to pursue research projects in skin health, for example, a project on lived experience with Generalized Pustular Psoriasis (GPP), but researchers are not connected to funders. Research funding is mostly concentrated in biologics, but many are unavailable across Africa. In Kenya, the National Research Fund's calls and research priorities focus overwhelmingly on infectious diseases. Dermatology receives negligible dedicated funding or regulatory incentives for local innovation. Even the Global Psoriasis Atlas project,[3] which received substantial funding, was problematic in its execution in South Africa. Health data systems are fragmented, non-interoperable, and not designed to capture dermatological indicators. Stigma further limits case reporting, as people with visible skin conditions are often reluctant to seek formal care or be counted, and there is a high loss to follow-up.

Challenges in data collection and sharing are maintained by a combination of institutional weaknesses, limited infrastructure, low awareness of reporting standards, outdated policies, gaps in stakeholder interests, economic constraints, and cultural norms. Several contributors called for integrating skin diseases into existing systems and improving data quality as a first step. This should include strengthening digital data systems, coupled with training in data collection, management, and storage at the national and community levels. One contributor noted that community-based data collection models already exist for other conditions. In Uganda, village health teams are trained at the district level to collect data on HIV and malaria; integrating skin conditions into these existing processes was identified as a practical, near-term opportunity.

Contributors called for rural-inclusive national research agendas co-designed with patient organizations. National skin disease registries managed by the government, standardized data-collection templates, and digital patient-reported outcome tools were considered essential for improving data collection. In Kenya, the potential to add standardized dermatological indicators to the District Health Information Software 2 (DHIS2)[4] and Kenya Health Information System (KHIS) national health platforms was specifically raised. In the DRC, DHIS2 is already in place for routine health reporting, providing an existing infrastructure that could be adapted and piloted. Contributors agreed that data collection must be a joint effort across government, health providers, researchers, and patient organizations. A secure, interoperable African skin disease regional database with disaggregated data could be a long-term goal, supporting policy, funding, and service improvement, such as data-informed procurement decisions and regular national and regional burden-of-disease reports on skin conditions. One contributor proposed expanding successful research models such as the L'Oréal African Hair & Skin Research Grant[5] and the WHO/Kenya Medical Research Institute (KEMRI) SkincAIr Study.[6,7] Another participant suggested integrating

monitoring, evaluation, and learning (MEL) into research by applying robust MEL frameworks to study design, with clear indicators, learning loops, adaptive methodologies, and mixed-methods approaches that capture both measurable outcomes and lived experiences.

3. Widespread workforce shortage and weak health system structures produce poor care

Dermatological diseases are among the most common reasons for consultation at the primary healthcare level, but are often considered low priority within public health systems. As a result, a severe shortage of dermatologists, combined with minimal dermatology training for primary care providers, leaves most people across the African region without access to competent skin care. The few specialists who do exist are almost entirely concentrated in urban areas, creating profound inequities for the rural populations, who represent the majority of people across African countries.

In Kenya, the dermatology field is not seen as important by many medical professionals. A 2021–2022 Health Labour Market Analysis identified only 28 registered dermatologists for a population of over 50 million, approximately one dermatologist per 1.9 million people.[8] In the DRC, there is also a critical shortage of trained dermatology professionals per capita, mostly based in the capital. In a city of 2 million people, there are only about 2 dermatologists, leaving many without access. Across countries, there are long waitlists to see a dermatologist, and that is for the individuals fortunate enough to visit one.

Primary healthcare systems across the region are structurally ill-equipped to manage skin conditions, leading to high rates of under- and misdiagnosis.[9] In Ghana, primary care providers receive as little as two to four weeks of dermatology training across a three-year program, leaving them unconfident beyond basic cases. Currently, in Ethiopia, NGOs provide most services for podoconiosis patients with lymphedema, as health workers are reluctant to manage lymphedema due to a lack of training, skill, and awareness of the associated stigma, and there is a serious shortage of drugs and supplies in health centers. The integration and management of podoconiosis and other rare skin diseases within the primary health care system are at an early stage, but several policy and clinical documents are in place, offering clear opportunities for improvement. In Kenya, Community Health Promoters, who are often the first point of contact for rural populations, receive no dedicated dermatology training. A 2025 survey of Kenyan primary healthcare providers found that while 97.4 percent regularly see patients with skin conditions, only 5.3 percent felt confident diagnosing and treating the full range of cases independently.[10] Most providers rely on referrals or empirical approaches due to insufficient specialized training.

In Uganda, local healthcare faces major challenges beyond a shortage of specialists and health workers' misconceptions about skin health, including a lack of functional facilities and limited diagnostic equipment. Dermatopathology microscopes, dermoscopes, and similar equipment are in short supply across the region, which affects care. Contributors proposed conducting a basic lab needs assessment to support lab upgrades and allocating funding for primary lab kits. Contributors also suggested that government and academic centers should collaborate with patient organizations to pilot basic microscopy in rural counties and support scale-up. Organizational weaknesses, such as poor supply chains and inadequate service delivery structures, further complicate the situation. In Ghana and DRC, for example, supply chains are unreliable: essential

dermatological medicines are frequently out of stock at district hospitals and community health posts, directly undermining treatment adherence.

Technology-based solutions have been consistently underutilized. In Kenya, teledermatology adoption stands at only 10.5 percent despite 91.9 percent of providers believing it would improve care, with unreliable electricity and internet access cited by 80 percent of doctors as the primary barriers to adoption.[10] Mobile clinics and digital diagnostic tools represent other opportunities that remain largely unrealized. Care protocols exist, but not for skin conditions.

Contributors called for mandatory, culturally-adapted dermatology modules institutionalized in the training curricula of community health workers and primary care providers; collecting data on training needs for evidence-based scale up; development of mentorship relationships between dermatologists and frontline workers; functional referral systems; integration of teledermatology, AI-assisted diagnostic tools, and electronic information systems into primary care systems, such as the WHO skin-related neglected tropical diseases mobile application (WHO Skin NTD App)[11,12,13] and Kenya's Community Health Digitization Strategy;[14] support for mobile clinics to reach rural populations; definition of skin-related protocols; strengthened local health services, investment into rural clinics and diagnostic labs; and strengthened supply chains for essential dermatological medicines.

4. Financial and geographic barriers to care lead to unsafe alternatives

Even where dermatological care exists, the combination of cost, lack of insurance coverage, and distance makes it effectively inaccessible to the vast majority of patients across the African region. The result is that many people living with skin diseases go without care, seek out informal or traditional alternatives, or present to formal health services only at advanced stages when conditions have become significantly more difficult and costly to treat.

In most African countries represented at the workshop, skin diseases are not included in national health insurance schemes. In Ghana, skin conditions, including psoriasis, are excluded from the national insurance package, requiring patients to pay out of pocket. Medications are unaffordable, leaving patients with little choice. In Kenya, national insurance does not cover skin conditions, treatment costs are not subsidized, and dermatologists are concentrated almost entirely in the private sector, placing care out of reach for most patients. The Ministry of Health introduced free medical check-ups, but most dermatological conditions did not qualify, leaving people with skin diseases effectively excluded. In the DRC, the high cost of consultations and treatments, and the limited availability of essential dermatological medicines contribute to reduced access. There is no free care, so patients must pay directly out of pocket for every consultation and treatment. In Nigeria, most people cannot afford medication regularly. Barriers to care include limited access to skin care products. In South Africa, timely care is available through private care for those able to pay; in public hospitals, even the creams and treatments used are outdated. In Côte d'Ivoire, people with albinism have formal access to care but find it unaffordable, with most coming from families with very limited resources; some work is underway with the Pierre Fabre Foundation to improve access for these families. Across Africa, some dermatological conditions are increasingly included in benefit packages, but the premiums required are unaffordable for the majority of patients, creating economically based exclusions. National health insurance schemes lack social protection mechanisms for individuals living with skin conditions.

Geographic barriers compound financial ones. In Kenya, many rural patients must travel more than 3 hours to reach dermatological services, which requires significant resources. For patients in rural Uganda, the combination of long distances, transport costs, and time away from work creates an often-insurmountable barrier to care. In DRC, war and conflict lead to long-term social displacement, further impacting access to care. Contributors described a system that disenfranchises patients based on both where they live and their income level, with multiple compounding layers of exclusion.

The consequences of these barriers are severe. Eczema patients in Kenya routinely substitute non-conventional products such as bar soap and milking jelly for proper emollients; 11 percent use no moisturizer at all.[15] Across countries, many patients resort to self-medication, traditional remedies, or prayer-based interventions, which are frequently ineffective and sometimes actively harmful. In Ghana, basic skincare products such as emollients cost families two to five days' income, and transport to a district hospital can exceed a full day's wage, creating poverty cycles that extend far beyond direct medical costs. In Côte d'Ivoire, people living with albinism lack access to preventive measures such as sunscreen, regular dermatological follow-up is rare, and care is often sought only at advanced stages of disease, resulting in high rates of premature mortality from skin cancers. The high cost of survival — sunscreen, protective clothing, specialized medical care — similarly traps families in a persistent cycle of poverty.

Contributors called for national health insurance reform to recognize skin diseases, including autoimmune and chronic conditions, as serious medical priorities deserving coverage; the inclusion of essential dermatological medicines and digital services in benefit packages; social protection mechanism for all economic levels; micro-grant or economic support programs to prevent the poverty spiral caused by treatment costs; advocacy for subsidized or free access to critical preventive supplies such as sunscreen for high-risk populations; and expansion of community-level care to reduce the need for long-distance travel. Evidence that early intervention in skin conditions reduces long-term costs by preventing hospitalizations and amputations should be systematically gathered and used to make the economic case for investment.

5. Cultural stigma drives exclusion and delays care, with mental health support nearly absent

Skin conditions carry a profound social burden across the African region, extending far beyond the physical. Contributors described communities in which vitiligo is confused for leprosy, in which albinism is perceived as a curse or as having a supernatural origin, and in which conditions such as acne, alopecia, and eczema are treated as signs of contagion, moral failing, or spiritual punishment. These deeply rooted beliefs cause social exclusion, employment discrimination, family breakdown, and significant psychological harm, while simultaneously delaying or preventing people from seeking formal medical care.

In Kenya, vitiligo on fingers and toes is commonly mistaken for leprosy, and cultural beliefs include the notion that vitiligo is acquired by stepping on water used to bathe twin babies or that those affected should not eat white meat. In Ghana, conditions such as vitiligo and Buruli ulcers are frequently attributed to curses or witchcraft, causing families to prioritize traditional healers or prayer camps over biomedical care. Similarly, in Nigeria, religious and cultural beliefs lead many people to seek cures in prayer houses or through traditional healers before presenting to any

medical professional, meaning that by the time they do seek formal care, their condition has often become significantly more advanced. In the DRC, misconceptions link skin conditions to mystical and contagious causes, fueling fear, discrimination, and social exclusion.[16] Awareness initiatives exist but remain sporadic, poorly coordinated, and insufficiently integrated into public policy. In Côte d'Ivoire, campaigns including awareness films have begun to shift community attitudes toward people with albinism, but significant work remains.

Employment discrimination was described as a direct consequence of stigma in multiple countries: people with acne, vitiligo, and other visible skin conditions face barriers to customer-facing jobs and professional environments. Visible skin diseases routinely lead to exclusion from schools, churches, and workplaces. Gendered dimensions of care were also noted: women's health needs are frequently deprioritized, with family resources typically allocated to children or a husband's needs before addressing a woman's chronic skin condition.

Despite the severity of the psychological burden documented across all countries, holistic rehabilitation and mental health support specific to dermatological conditions are almost entirely absent from African health systems. No contributors described a routine integration of psychosocial care into dermatological services.[17] In the DRC, mental health services related to skin conditions are described as very limited. The isolation experienced by people with albinism was specifically highlighted, with an immense unmet need for psychological support and an active listening cell officially recognized by national health services. For people living with albinism, patient-centered and integrated care approaches with dermatological, ophthalmological, and psychosocial support were identified as an urgent priority.

Contributors called for community-level stigma-reduction programs that engage traditional leaders, religious guides, and school curricula. Ghana's Community-Based Health Planning and Services[18] program engages community members and traditional leaders in guiding health sensitization and could serve as a model for scaling. Successful global patient-led models on improving mental health in skin-of-color populations should also be studied for local adaptation. Contributors called for national awareness campaigns grounded in medical facts rather than moral frameworks; training for health workers on the clinical and psychosocial dimensions of skin conditions; the integration of mental health and psychosocial support into dermatological care pathways, universal health coverage benefits, and public budgets; and the inclusion of mental health and stigma-reduction metrics in national targets. In the long term, contributors envisioned communities where skin conditions are understood as medical, not moral, with full social participation and zero discrimination.

6. Education and community-based outreach essential for patient empowerment and care

Many people living with chronic skin conditions internalize the belief that they are "unworthy," which undermines self-advocacy, silences open discussion, and leads to delayed care and poor treatment adherence. Across communities, health literacy is low, and culturally appropriate materials on common issues like eczema, acne, and fungal infections are scarce, leaving major self-care needs unmet. Health materials across the region are predominantly in English, creating significant barriers for rural populations and caregivers who speak other local languages. Contributors identified education and community-based outreach as essential complements to

clinical and policy action. Given the scale of the workforce shortage, the geographic barriers to specialist care, the depth of stigma, and the limited health literacy, community health workers, skin health officers, and peer support networks are not simply desirable additions to care; they are the primary means through which most people living with skin diseases in Africa can receive meaningful support.

In Nigeria, about half the population in rural settings has poor knowledge of skin conditions, and deep-rooted cultural beliefs that override medical frameworks must be addressed through bottom-up community engagement involving traditional leaders and local government representatives.[19] In Kenya, patients describe getting better information from each other and online than from healthcare professionals, reflecting both the scarcity of provider time and the opportunity for community-led peer support. In Ghana, the Ark Development Organization[20] has achieved a 94.5 percent patient satisfaction rate through integrated biomedical and community support approaches, including the development of illustrated self-care guides in local languages and training community health workers in dermatology-specific counseling. These models demonstrate that high-quality, culturally adapted education and support are achievable at relatively low cost when they engage existing community infrastructure. In Uganda, peer support networks have proven effective in improving awareness, treatment adherence, and emotional resilience for people living with skin conditions. In Ethiopia, the podoconiosis control program has demonstrated that training health workers in lymphedema management and home care is feasible and impactful when adequately resourced.

Empowering patients and caregivers with clear, accessible, skin-specific education—through culturally adapted materials in local languages, free locally validated mobile applications or printed guides, and routine self-care training—can improve mental health, restore confidence, strengthen self-advocacy, and improve treatment adherence. Participants called for expanded community outreach and patient education; for patients and caregivers to be actively included in skin disease management and in the design of educational programs; and for skin self-care modules to be mandated and covered within national schemes, including universal health coverage benefits. They recommended adapting and evaluating successful digital tools, such as the WHO Skin NTDs App and eSkinHealth,[21] launched in Côte d'Ivoire. They also called for training individuals in patient rights, disease literacy, and storytelling for advocacy to drive recognition of skin diseases, inform policy development, and ultimately eliminate stigma. Furthermore, contributors called for the establishment and sustained operation of peer support groups; annual national awareness days that are scaled country-wide; community radio and media campaigns to normalize skin health conversations; and for patient organizations to be formally supported in registering as community-based organizations with defined roles in the health system.

Policy Landscape and Recommended Actions

The six thematic areas reflect a set of deeply interconnected policy gaps. Skin diseases across Africa are systematically invisible: in data systems, in national health strategies, in research funding frameworks, and in the training of health workers. This invisibility is both a cause and a consequence of low political prioritization, leading to underestimated patient needs and public health decisions based on incomplete data. It will not be resolved without deliberate structural intervention at national, regional, and international levels.

The near-total absence of prevalence data is the most foundational obstacle, undermining both policy prioritization and patient advocacy. Integrating skin disease indicators into existing digital health systems, such as DHIS2, would provide a practical, relatively low-cost entry point. In parallel, governments are called to create dedicated dermatology units within Ministries of Health, reform health insurance frameworks to include skin conditions, and invest in specialist and primary-care dermatology training. Teledermatology, AI tools, and community health worker upskilling can extend limited specialist capacity for rural and low-income populations if backed by enabling policies and infrastructure.

Stigma reduction and mental health support demand coordinated action at community and health system levels, including national awareness strategies, stigma indicators, and routine psychosocial support within dermatology care. Engaging traditional leaders, religious authorities, and schools can anchor a community-owned model of change. Across all these domains, patient organizations must be recognized as essential partners, not peripheral stakeholders, through structural funding, formal seats in policy and research bodies, and capacity-building support from international networks such as GlobalSkin.

Priorities for Policy Action

- Establishment of dedicated dermatology units or departments within Ministries of Health, providing an institutional focal point for policy development, workforce planning, and sustained engagement with patient organizations
- National skin disease registries and research strategies co-designed with patient organizations, with dedicated funding
- Integration of skin disease indicators into existing national digital health systems, such as DHIS2, as an immediate step toward building the evidence base needed for further advocacy
- Inclusion of essential dermatological conditions and medicines in national health insurance benefit packages, with explicit protections for low-income and rural populations, and subsidized access to critical preventive supplies for high-risk groups, including people with albinism
- Investment in teledermatology, mobile clinic infrastructure, and AI-assisted diagnostic tools as scalable means of extending specialist capacity to underserved communities, supported by enabling policy and infrastructure investment
- Mandatory inclusion of dermatology modules in the training curricula of community health workers and primary care providers, reflecting the reality that frontline workers are the primary point of contact for the majority of skin disease patients across Africa
- Integration of psychosocial support and mental health screening into dermatological care, with recognition of psychological care as an essential health service for people living with skin diseases
- National stigma-reduction and education strategies engaging traditional leaders, religious authorities, school curricula, and media, grounded in medical evidence and co-developed with affected communities
- Formal, compensated patient representation in research, national health governance, and district health management, alongside structural funding allowing patient organizations to employ dedicated staff

Conclusion

Contributions from patient organization representatives across the African region tell a consistent and urgent story: skin diseases are structurally invisible in the data systems, policy frameworks, funding mechanisms, and health workforce of every country represented. This invisibility is not accidental; it is the product of longstanding deprioritization, stigma, resource constraints, and a failure to engage patients and communities as equal partners in health.

Despite the diversity of countries, conditions, and health system contexts represented at the workshop, the same core challenges recur: lack of prevalence data, limited political will, a severe workforce shortage, restricted access to care, insufficient insurance coverage, and no formal seat at the table for the organizations closest to the people most affected.

Patient organizations across the continent are doing remarkable work with almost no resources, and without compensation, recognition, or the structural support needed to sustain their efforts over time. The pathway forward requires action at every level, from integrating simple dermatological indicators into existing health data systems to establishing Ministry of Health dermatology departments to reforming national health insurance frameworks to community-level stigma-reduction campaigns involving traditional leaders and schools. None of these steps are beyond reach. What they require is the political will to treat skin health as a genuine public health priority, and the recognition that patient organizations are not peripheral actors but essential partners in achieving that goal.

The overall vision is to achieve equitable, holistic care models that leverage virtual tools and integrate them with rehabilitation and mental health support to deliver accessible, high-quality, affordable skin care to every person living with a skin condition across Africa. While the World Health Assembly Resolution on Skin Diseases[1] represents meaningful international progress, it must now be translated into tangible national health strategies. Skin health is inextricably linked to overall health, dignity, and social participation. For the people represented by the organizations that contributed to this report, that connection has long been invisible to the systems meant to serve them. This report aims to make these needs visible and provide a foundation for coordinated evidence-based, patient-centered action.

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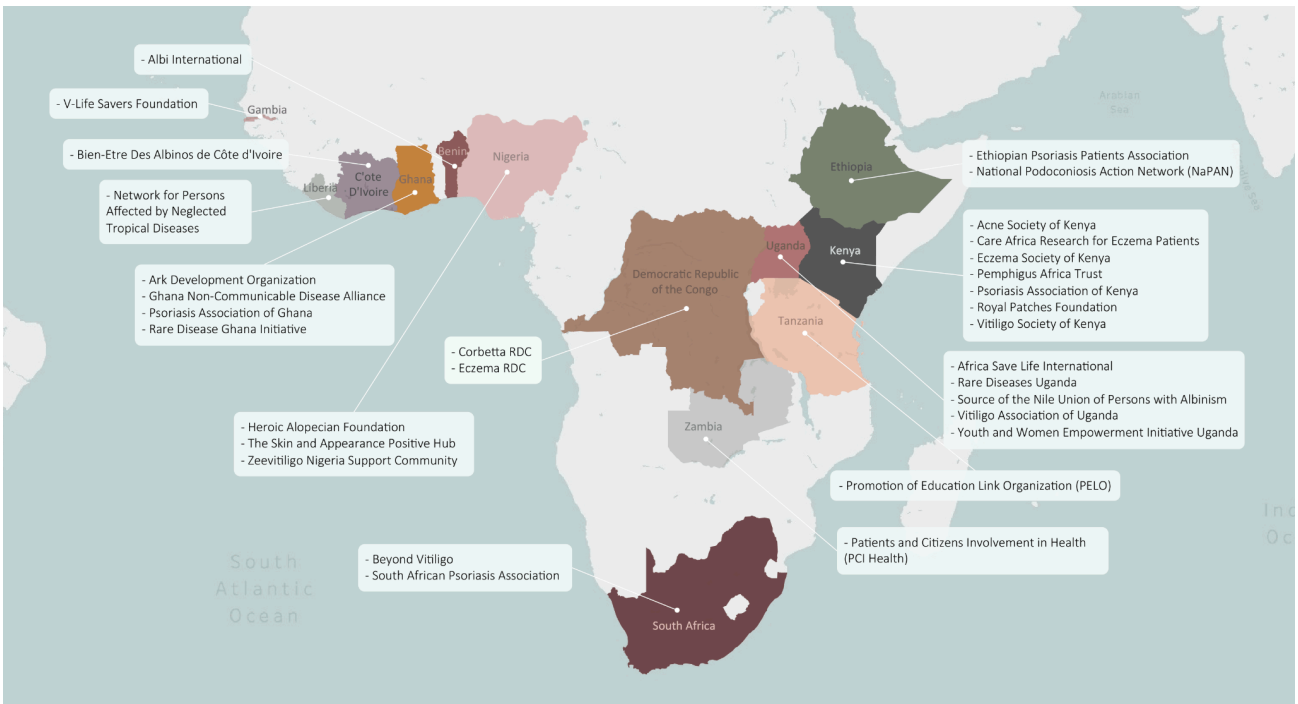
Africa Contributor Map



Geographic distribution of contributing organizations across online and offline engagement.