GLOBALSKIN.ORG

International Alliance of Dermatology Patient Organizations

GLOBALSKIN

LATIN AMERICA REGIONAL REPORT

Skin Disease Landscape in Latin America

A Summary of Contributions from the GlobalSkin Latin America 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 skin patient organizations across Latin America, GlobalSkin identified common areas of need shaping the diagnosis, care, treatment, and daily lives of people living with skin diseases in the region. 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 Latin America (defined as the Spanish-speaking countries in the WHO Americas region) workshop, held on February 12, 2026, and is intended to support GlobalSkin's members in the region in identifying advocacy, awareness, and research priorities.

The six areas of need identified in Latin America are: political instability and lack of prioritization in national plans; absence of registries, epidemiological surveillance, and reliable data; shortage and poor distribution of specialists; high costs, medicine shortages, complex administrative procedures, and lack of research; fragmented care and lack of multidisciplinary services; and stigma, misinformation, and low health literacy. These areas are deeply interrelated and largely stem from a tendency to regard skin diseases as cosmetic or non-serious conditions, rather than as complex, chronic, and often systemic disorders that significantly affect patients, families, and health systems. The policy implications of these six themes are discussed, along with the suggested actions identified by participants as the region's most pressing priorities.

The contributors to this report served as proxies for their broader patient communities, representing conditions including albinism, atopic dermatitis, psoriasis, vitiligo, and other skin conditions, from Argentina, Chile, Colombia, the Dominican Republic, Mexico, Puerto Rico (USA), Peru, and El Salvador. While the challenges described are common across the region, there is considerable variability in political support, healthcare system structure, and patient organization capacity, meaning these needs manifest differently across countries and conditions.

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 the Latin American region 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 from countries 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. Discussions were structured around topics including data collection, 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. Workshops were organized for the following regions: Africa, Asia Pacific, Eastern Mediterranean, Europe, Latin America, and North America. The Latin America regional workshop was held on February 12, 2026. Eleven of GlobalSkin's Latin America members contributed to this report through live interventions and written contributions representing conditions including albinism, atopic dermatitis, psoriasis, vitiligo, and other skin conditions, from Argentina, Chile, Colombia, the Dominican Republic, Mexico, Puerto Rico (USA), Peru, and El Salvador.

The findings summarized herein provide a regional overview of the Latin American skin community's priorities and are intended to support GlobalSkin's Latin American 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 Latin American region.

1. Health care for skin conditionsmlimited by political instability and lack of prioritization in national plans
2. Absence of registries, epidemiological surveillance, and reliable data weakens advocacy efforts
3. Shortage and poor distribution of specialists create geographic inequalities in access to dermatological care
4. High costs, medicine shortages, complex administrative procedures, and lack of research leave people without timely access to care
5. Fragmented care and lack of multidisciplinary services prevent a comprehensive response for patients
6. Stigma, misinformation, and low health literacy discourage patients from seeking care

1. Health care for skin conditions limited by political instability and lack of prioritization in national plans

In almost all contributions, dermatological conditions are described as having low political priority,[1] especially rare ones such as albinism. Health systems remain focused on transmissible diseases or conditions with high immediate mortality, leaving many skin diseases outside the scope of national agendas. Governments are reported to show limited interest, which peaks temporarily around election periods, and major shifts in government and health system models in Argentina, Colombia, and El Salvador have created instability, service closures, and the loss of previously available coverage.

A recurring structural obstacle is the lack of reliable data and registry systems. In Argentina, contributors described the impossibility of producing reliable prevalence data to support calls for public policies for albinism, weakening arguments presented to decision-makers. The absence of censuses, registries, and up-to-date statistics means many conditions are perceived as marginal, and sometimes available data "work against" advocacy by showing very low prevalence, further reducing political interest. Participants propose simple tools for ministries to collect prevalence data—for example, asking about skin conditions during electoral processes—as a pragmatic way to begin making the true burden visible.

Contributors also highlighted major access gaps and governance failures. In Colombia, recent political reforms have drastically weakened the health system: a significant number of patients have lost access to medicines and treatments, with deaths reported due to not receiving their medications on time, which has led to criminal charges before the Inter-American Court of Human Rights against the Minister of Health. In addition, there is a reported breakdown in dialogue between authorities and patient organizations, which are sometimes even perceived as "enemies." By contrast, other communities have managed to establish formal cooperation mechanisms with their governments and to promote specific legislation. However, even in these cases, policies tend to be fragile, poorly implemented, or dependent on favorable political circumstances. In El Salvador, Psoriasis Nueva Vida and the Ministry of Health signed a cooperation agreement that, although incipient and with much room for improvement, has provided a formal channel for joint work. In Puerto Rico, the approval of a law for students with atopic dermatitis is cited as progress, although it is currently shelved, illustrating how legislative initiatives can open doors but require sustained political follow-up.

Drawing on these experiences, organizations in the region converge on several priority actions: ensuring continuity and gradual adjustments toward universal coverage instead of disruptive reforms that dismantle existing benefits; explicitly recognizing dermatological diseases—including rare ones—in national health plans, non-communicable disease programs, and rare disease frameworks; and establishing institutionalized spaces for dialogue among ministries of health, scientific societies, universities, and patient organizations to co-design public health policies that are better aligned with Latin American realities.

2. Absence of registries, epidemiological surveillance, and reliable data weakens advocacy efforts

Across the participating countries, there are no official data or robust registries for dermatological diseases, whether common or rare. Available information is usually estimated, extrapolated from other countries, or limited to a few referral centers (as in Bogotá, Colombia), making it impossible to determine the true prevalence and incidence of albinism, atopic dermatitis, psoriasis, vitiligo, and other conditions. In several cases, epidemiological surveillance systems report only infectious diseases and exclude non-communicable diseases, leaving skin conditions invisible.

This is compounded by strong institutional fragmentation. Data collection is scattered across ministries of health, hospitals, medical societies, research centers, and referral centers, with no integrated system to centralize or share information. In some countries, national epidemiology departments do not share data even with other health institutions, making planning and research more difficult.

The contributions also point to cultural, knowledge-related, and data-protection barriers. Many people with albinism or vitiligo do not have a precise diagnosis or do not self-identify with their condition, resulting in “statistical invisibility.” At the same time, concerns about privacy—reinforced by data protection laws, such as those in Chile, which require re-contacting every database contact to ensure consent—generate resistance to participating in surveys or registries and limit organizations' capacity to act. The contributions highlight patient mistrust, as many feel that their questionnaires will not be treated with sufficient confidentiality.

Some countries have managed progress and report positive experiences. Chile provides a concrete precedent: an alliance with the government enabled funding and execution of a study that, for the first time, generated official statistics on cow’s milk protein allergy in infants, demonstrating that robust data can be produced when the State leads and physicians and organizations collaborate. From Argentina, the Unión Latinoamericana de Albinismo conducts health surveys focused on albinism[2] as a first step to generate preliminary evidence. In Mexico, Fundación Piel de Luna promotes state-level censuses, national surveys, and lists of people with albinism, and has built agreements with academic institutions, civil society, and state governments, achieving, for example, the declaration of an albinism awareness day in the state of Hidalgo. In the Dominican Republic, regional surveys are used, and concrete mechanisms are being proposed to register psoriasis, such as weekly reports from public hospitals and notifications through pathologists and dermatologists. At the international level, the Global Psoriasis Atlas seeks to collect data on the number of psoriasis cases worldwide.[3]

Based on these experiences, organizations propose priority actions. At the policy level, they call for dermatological diseases—including rare ones—to be included in national and regional censuses and registries of non-communicable or rare diseases and, with active patient participation, for stable budgets to be allocated to research and information systems. At the technical level, they propose collaboration among patient organizations, universities, research centers, medical societies, and health authorities to define minimum data sets and standardized diagnostic criteria. They also propose leveraging existing channels (pathology laboratories, dermatology consultations, weekly epidemiology forms) to report cases routinely and dynamically. At the community level, they stress the need to strengthen trust in the responsible use of data, to clearly explain who manages the information and for what purpose, and to support patient organizations as generators of

preliminary data that can later be integrated into official systems. This would enable the design of evidence-based public policies, improve health service planning, and strengthen prevention programs.

3. Shortage and poor distribution of specialists create geographic inequalities in access to dermatological care

Across countries, the same reality is repeated: there are few dermatologists in the public system, and they are heavily concentrated in large cities. In Argentina, Colombia, Peru, and El Salvador, patients outside the capitals must travel long distances at high economic and personal cost to see a specialist. In many cases, waiting lists for dermatology appointments reach 6 months or more, leading to abandonment of treatment and late diagnoses.

In Colombia, the shortage of specialists is attributed to an academic bottleneck, with very few training posts. In El Salvador and the Dominican Republic, many dermatologists are described as focusing on cosmetic surgery, Botox, and hair implants, as care for skin diseases is seen as “not very attractive,” further reducing the availability of clinical care for chronic conditions.

This scarcity is combined with significant gaps in knowledge and clinical prioritization. For psoriasis, several countries identify diagnostic failures as a central barrier: in Argentina, it is named as the main barrier, and in El Salvador and the Dominican Republic, there is a lack of training on psoriatic disease among primary-care physicians. Even among health personnel, the belief persists that psoriasis is not serious because it is “just a skin condition.” Similarly, in Chile, underdiagnosis of atopic dermatitis is reported in both primary and specialist care.

In the case of albinism in Argentina, territorial inequalities and gaps in comprehensive care are particularly evident. Although dermatologists and ophthalmologists with experience can be found in some large cities, in many regions the supply of specialists is limited, and local services do not always provide integrated management of albinism. This affects the prevention of skin cancer and low vision. There are training gaps on albinism among primary-care professionals and an absence of specific public health programs that include this condition.

The lack of technology integration into established care pathways also poses a barrier. In El Salvador, limited access to technology, low education levels, and scarce financial resources constrain the potential of virtual care. In the Dominican Republic, telemedicine “does not exist,” despite a clear need.

In this context, contributors converge on several priority actions. In the short term, they call for strengthening primary-care training on psoriasis, albinism, and other skin conditions, and rolling out educational and awareness-raising campaigns for both frontline doctors and dermatologists. In the medium term, they propose developing specific programs that guarantee regular check-ups (dermatological, ophthalmological, and genetic in the case of albinism), creating referral networks between local centers and specialists, and integrating the management of these conditions into public health programs and clinical guidelines. In the long term, participants recommend promoting telemedicine strategies that connect specialists with local providers and ensuring that appropriate healthcare is available close to where people live, without the need for prolonged travel.

4. High costs, medicine shortages, complex administrative procedures, and lack of research leave people without timely access to care

Across the region, advanced treatments, especially biologic medicines, are scarce or nonexistent in public health systems. In El Salvador, there is no access to biologics for psoriasis or atopic dermatitis, and stock-outs are almost constant; there is no dedicated budget for these drugs and no equity in medicine procurement, as skin diseases remain invisible. In Peru, there are major difficulties in accessing biologic treatments in the national system, contributing to treatment abandonment and patients presenting with very advanced disease. In Mexico, although medicines for vitiligo are available, they are not readily accessible in the country.

These limitations are compounded by financial barriers and restricted access to essential supplies, even when biologics are not involved. In Argentina, people with albinism face high costs for basic items such as sunscreen, visual aids, and some dermatological treatments, creating a significant economic barrier. Unequal access to sunscreen and low-vision devices reinforces health inequities, although some provincial programs and patient-organization initiatives that support access to sun protection and medical awareness are mentioned as positive developments.

Another recurring issue is structural failures in access frameworks and in updating standards of care. In El Salvador, there are no updated essential medicines lists, and biologic drugs are not included in the national health system; psoriasis clinical guidelines are outdated, and there are no guidelines for other skin diseases. In Colombia, access barriers are linked to medicine delivery and to broader treatment access. These regulatory and management gaps are reinforced by the exclusion of dermatology from procurement priorities and essential medicine lists.

There are important differences between countries in how access is organized. Chile has the Ricarte Soto Law, which provides coverage for high-cost treatments, though the budget is limited and families resort to litigation and media pressure to secure access—showing both progress and its limits. In the Dominican Republic, there is a high-cost medicines program that includes treatments for psoriasis; however, administrative processes are lengthy and burdensome, funding levels vary, and there are frequent changes in procurement (e.g., switching to similar or generic products). Patients and organizations propose fully digitizing the application process, speeding up approvals, and better coordinating treatment delivery, including on an outpatient basis.

Building on these experiences, organizations in the region highlight several priority actions: explicitly including biologic medicines and other advanced treatments for skin diseases in essential medicines lists and high-cost programs; securing stable budgets and more transparent, equitable procurement mechanisms, with patient participation in purchasing decisions; updating and expanding clinical guidelines for psoriasis and other dermatological diseases; and reducing bureaucratic barriers through digital processes and more predictable response times. They also stress the need to fund essential supplies such as sunscreen and visual aids, particularly for conditions like albinism, as part of a comprehensive access approach rather than one focused solely on high-cost drugs.

In addition, there is a notable lack of systematic research on dermatological diseases across the region. In the Dominican Republic and El Salvador, there are no research programs or clinical trials within the health system, and low patient participation in surveys or studies further limits evidence

generation. In Argentina, research on albinism is limited and fragmented, and the lack of epidemiological data reduces authorities' interest in funding new studies, perpetuating a cycle in which the absence of evidence prevents the development of solid policies and projects. In response, contributors propose advancing a progressive research agenda—pilot studies, community surveys, and collaborative projects—that includes epidemiological, clinical, and social dimensions; strengthens collaboration among patient organizations, academia, and health authorities; and generates evidence capable of guiding public policies and improving the quality of life of people living with skin conditions.

5. Fragmented care and lack of multidisciplinary services prevent a comprehensive response for patients

Contributors from the region agree that care is episodic, skin-focused, and poorly coordinated across specialties, despite the fact that dermatological conditions involve systemic comorbidities, psychosocial impact, and significant educational needs. Psychological and emotional support is limited, even though it is essential for coping with a visible condition and its effects on daily life.

In El Salvador, stakeholders argue that treatment for psoriasis and atopic dermatitis should be comprehensive and multidisciplinary, involving psychologists, psychiatrists, nutritionists, cardiologists, rheumatologists, and other specialists, with a preventive medicine approach and timely referrals. However, this is presented as an ideal rather than the current reality. In the Dominican Republic, mental health services in the public system remain deficient. The perception that psoriatic disease is "just a skin problem" persists, limiting understanding of its systemic nature and justification for integrated teams. The need for multidisciplinary support is recognized, and the development of a specific guideline for the comprehensive management of people with psoriatic disease is proposed.

The case of albinism in Argentina exemplifies the fragmentation of systems and the absence of comprehensive care models for rare conditions. Care is described as being based on isolated consultations, with no sustained coordination between dermatology, ophthalmology, genetics, educational support for low vision, and social support. Knowledge gaps about albinism and its multiple dimensions also persist, reinforcing a skin-only focus. Outside major cities, these gaps are compounded by resource shortages and the lack of interdisciplinary teams. In response, contributors envision clinics where a person can receive dermatological, ophthalmological, genetic, and psychological care all in the same day, inspired by international experiences already underway, such as in France.

Contributors converge on several priority lines of action: raising awareness among authorities and professionals about the systemic and psychosocial nature of these conditions and demonstrating the value of an integrated approach; creating interdisciplinary teams and reference centers that link health, education, and social inclusion; developing clinical guidelines that integrate dermatological, ophthalmological, genetic, and psychosocial dimensions; and promoting pilot programs for comprehensive care, supported by telemedicine, as an intermediate step toward sustainably incorporating these models into the public system. For patients and caregivers, this would mean more complete, continuous, and person-centered care.

6. Stigma, misinformation, and low health literacy discourage patients from seeking care

Across the region, the same pattern is repeated: a lack of clear, tailored information; stigma; and myths about skin diseases, both in the general population and among health professionals. In Argentina, the Dominican Republic, and El Salvador, there are widespread beliefs that psoriasis is contagious or "just a skin problem," which fuels shame, fear of rejection, and many patients' refusal to be visible or to take part in public activities or research. In Mexico, in the context of vitiligo, the sense that "nothing can be done" leads people to deny the diagnosis and not seek care.

In Argentina and Mexico, representatives from the albinism community highlight a combination of stigmatization, discrimination, and misinformation in schools, workplaces, and social settings. Myths and misconceptions about this condition persist, increasing the risk of violence against those who live with it, including bullying, harassment, and rejection. This results in low self-acceptance, fear of being identified, and limited participation in support networks or data-collection processes. There is also a poor understanding of skin cancer risk, visual impairment, and emotional impact. Contributors stress the need for practical information on sun protection, visual health, and daily care, as well as psychosocial support for individuals and families.

Representatives from several countries agree that health education and self-care are not integrated into public policies, limiting the health system's ability to provide information and ongoing support. Knowledge gaps exist among both patients and health professionals, including direct discrimination by health staff in El Salvador. Organizations note that, without data and evidence, it is difficult to convince decision-makers to support sustained awareness campaigns.

Despite these gaps, patient organizations are already driving good practices and forward-looking visions. In Argentina and Mexico, albinism associations run educational campaigns, support groups, and dialogue spaces that strengthen self-care and inclusion; they promote surveys and the generation of accurate information, and put forward a vision of empowered individuals who can fully participate in social, school, and professional settings. In the Dominican Republic, the psoriasis community proposes creative social campaigns, alliances among associations for different skin diseases, and a leading role for empowered patients who share their testimonies to change narratives, foster a more empathetic public, and underline how timely treatment leads to people who are functional members of society rather than a burden on the State. In El Salvador, stakeholders propose using social media, schools, and companies as permanent platforms for education on psoriasis and atopic dermatitis and engaging with bodies such as the Pan American Health Organization to leverage existing resolutions on skin diseases and psoriasis.

The contributions converge on several mutually reinforcing priority actions. First, to develop sustained, culturally adapted public education and awareness campaigns in clear language on psoriasis, albinism, vitiligo, and other skin conditions, using schools, workplaces, social networks, and mass media as platforms for broad outreach. At the same time, they call for integrating self-care education—sun protection, daily care, emotional health, and condition management—into public health programs and professional training. It is also crucial to strengthen psychosocial support and support groups, promoting self-acceptance and reducing the fear of public visibility that currently prevents many people from participating actively. In parallel, contributors propose empowering people in their rights and responsibilities as patients, so they can become multipliers of information, sources of peer support, and socially productive individuals. All

of this requires recognizing and funding the central role of patient organizations, which currently lead much of the educational work with very limited resources; professionalizing their management and ensuring structural support would allow them to expand and sustain their impact in the region.

Policy Landscape and Recommended Actions

The six thematic areas reflect a broader systemic issue. Skin diseases are not recognized as a public policy priority at either the national or regional level. Decision-makers focus on conditions associated with mortality or severe disability, and the burden of skin diseases in terms of quality of life, mental health, and economic productivity is poorly captured by existing research.

While the World Health Assembly Resolution on Skin Diseases[4] represents a significant international step forward, it still needs to be translated into concrete national health strategies. Skin diseases must be explicitly integrated into health policies and rare disease programs. Education plays a central role for both patients and professionals through accessible and culturally appropriate materials. It is also essential to incorporate psychosocial support that addresses self-acceptance and stigma. Experience shows that patient organizations are key actors in education and support. Health authorities, healthcare teams, the education system, and civil society organizations must all work together. Otherwise, the region will remain trapped in a cycle in which the lack of data justifies the lack of policies, and vice versa.

Priorities for action

- Explicitly integrate dermatological diseases, including rare conditions, into national health plans, non-communicable disease (NCD) frameworks, and rare disease policies, with specific budget lines and formal participation of patient organizations.
- Establish permanent working groups between ministries of health, scientific societies, and patient organizations to avoid disruption with each change of government and to co-design policies, models of care, and medicine procurement.
- Create registries and specific modules in information systems and epidemiology forms for psoriasis, atopic dermatitis, vitiligo, albinism, and other conditions, integrating both clinical data and patient experience data.
- Clarify the uses, responsibilities, and benefits of health information and work with patient organizations to reduce fear around data sharing.
- Provide structural support (core funding, training in management and public policy) so that patient organizations can produce preliminary data, lead community education, and participate professionally in decision-making processes.
- Increase dermatology training positions, expand the distribution of specialists beyond major cities, and include dermatological training in primary care, with an emphasis on early diagnosis and comprehensive management.
- Create referral networks between primary care and dermatology reference centers, supported by telemedicine strategies to reduce travel and improve access in rural areas.
- Include biologic medicines and other advanced treatments for dermatological diseases in essential medicines lists and high-cost programs, as well as sunscreen and visual aids for populations such as people with albinism, with stable budgets and reduced bureaucracy.
- Review, update, and develop clinical guidelines, incorporating referral criteria, use of biologics, comprehensive and multidisciplinary management, and self-care components.

- Design and pilot comprehensive clinics or care pathways, including teledermatology, that link dermatology with other specialties such as rheumatology, cardiology, mental health, ophthalmology, genetics, nutrition, and educational supports.
- Integrate psychological assessment and support into dermatology care pathways, reduce stigma within the health system itself, and ensure that mental health care is accessible and free of taboo.
- Implement national and local campaigns that counter myths, promote self-acceptance, explain self-care, and make patients' rights visible, using schools, workplaces, social media, and mass media.
- Strengthen and support patient organizations and foster collaborations with medical societies and health authorities to respond to the needs of the dermatology patient community in Latin America.

Conclusion

Contributions from patient organization representatives across the Latin America region tell a consistent and urgent story: skin diseases remain significantly under-recognized, underfunded, and poorly addressed by national health systems. The consequences are borne directly by patients—through delayed diagnoses, unaffordable treatments, geographic barriers to care, social stigma, and unaddressed mental health needs—as well as on their families and caregivers, whose burden remains largely invisible to health systems and policymakers.

Despite variation between countries, the same core problems recur across the region: low political prioritization, insufficient data, geographic inequity, limited specialist workforce, unaffordable therapies, an unrecognized mental health burden, and inadequate patient participation in the decisions that affect them. Patient organizations across the region are doing essential work with limited resources, often without compensation and without a genuine seat at the policy table.

The way forward requires coordinated action at the clinical, national, and regional policy levels: formal inclusion of skin diseases in health strategies and surveillance systems; funding for research and data collection; investment in the health workforce and digital care infrastructure; strengthened insurance coverage; and meaningful partnerships with patients at every stage. Skin health must be recognized as an essential component of overall health throughout Latin America, with patient organizations as equal partners in achieving that goal.

References

1) Scorecard política pública en enfermedades dermatológicas. COLAPPIEL – Coalición Latinoamericana de Pacientes de la Piel. Consultado el 30 de abril de 2026. https://www.colappiel.org/scorecard/

2) Formulario de Datos de Salud de Personas con Albinismo en América Latina Comisión de Salud – Unión Latinoamericana del Albinismo (ULA). Consultado el 30 de abril de 2026. https://docs.google.com/forms/d/e/1FAIpQLSeDZcNKmyhdnjsOz0wocSWz7E1YocWHYCx_gXhowcnypfoEzg/viewform

3) Global Psoriasis Atlas. Consultado el 30 de abril de 2026. https://www.globalpsoriasisatlas.org

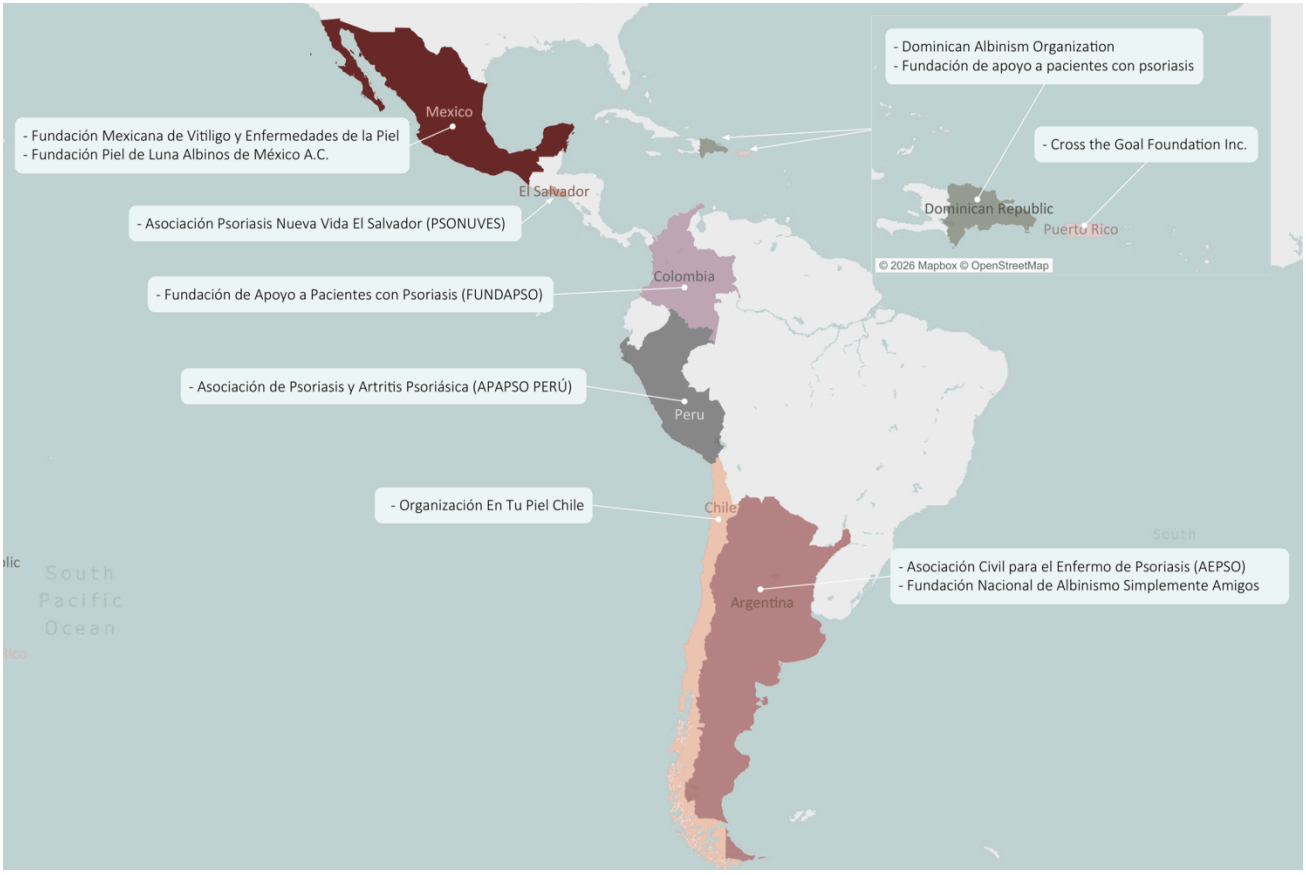
4) WHO. Agenda item 13.4 - Skin diseases as a global public health priority. Published online May 27, 2025. Consultado el 30 de abril de 2026. https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R15-en.pdf

Acknowledgements

We would like to extend our sincere gratitude to the following organizations for their participation and contributions:

- Asociación Civil para el Enfermo de Psoriasis (AEPSO)
- Asociación de Psoriasis y Artritis Psoriásica - Perú - APAPSO PERÚ
- Asociación Psoriasis Nueva Vida El Salvador (PSONUVES)
- Cross the Goal Foundation Inc.
- Dominican Albinism Organization
- Fundación de Apoyo a Pacientes con Psoriasis
- Fundación Mexicana de Vitiligo y Enfermedades de la Piel
- Fundación Nacional de Albinismo Simplemente Amigos
- Fundación Piel de Luna Albinos de México A.C.
- FUNDAPSO-Colombia
- Organización En Tu Piel Chile

Latin America Contributor Map



Geographic distribution of contributing organizations across online and offline engagement.