

# Community Dermatology Journal



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## Community Dermatology – A Latin American Perspective

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**In August 2011 I was asked to write an editorial about Community Dermatology for the *Dermatologia Argentina* journal, describing the essence and pitfalls of this kind of work in Latin America. I entitled it “Community Dermatology: an attractive way to practise, teach and learn about Dermatology”.<sup>1</sup>**

The expression ‘Community Dermatology’ is used to describe a series of activities in which the dermatologist’s role extends beyond an individual patient to the community as a whole. Organizations such as the International Foundation for Dermatology (IFD) promote and support initiatives like this, such as the Regional Dermatology Training Centre (RDTC) in Tanzania and the Dermatología Comunitaria (DCM) in Mexico. The Dermatologic Primary Care Programme in the province of Neuquén is one of the programmes developed in Argentina to provide accessibility to dermatological expertise for rural communities that, either for geographic or socio-economic reasons, do not have access to a specialist. The programme follows the Mexican model with working days (‘jornadas’) held in different rural areas including health care (dealing with patients), educational (dermatology courses for health care givers) and preventive (workshops on photo-protection for children and primary school teachers) activities. Different organizations and individuals make this possible: the International Foundation for Dermatology (IFD), the Ministry of Public Health of the Province of Neuquén, the pharmaceutical industry and a group of dermatologists from different parts of Argentina and the world who, on a voluntary basis, take part in the ‘jornadas’, provide materials and give medical advice on difficult cases from their workplaces. Knowledge acquires a different dimension: materials in general (lectures, photographs, epidemiological data, experience) are not meant to impress colleagues or to stand out at a congress but to serve the needs of the community and the non-specialist medical practitioner. The material thus provided must

### KEY WORDS

*community dermatology, health education, primary care, photoprotection*



be managed in a way unfamiliar to most specialists. All participants make their contributions and suggestions. These contributions are then integrated to the project: they evolve and improve at every ‘jornada’; they cease to be the participants’ property and become

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the property of the community. The use of these materials is not restricted in any way provided it is meant for educational, altruistic and community purposes.

People taking part in these activities rely on their free time to do so. If these activities are not imbued with a joyful spirit, if no positive attitude is experienced on resuming their daily job routine, a heavy drain on human resources will, sooner or later, become apparent and wither away (the usual fate many similar programmes face). Every single activity, even the simplest one, should generate enthusiasm: from the moment it is designed, organized and started. Human relations should also be imbued with affection and empathy. Results, either good or bad, should be analysed with this positive philosophic attitude.

I believe that the enthusiasm and the passion displayed by the group is the fuel that feeds back and keeps the dermatology community project alive. Every contribution is unique, depending on the ability of each participant, to a greater or lesser extent, from far away or nearby, to take over a job from another person. The key to the continuity of a project does not lie in one person but in teamwork.

However, we must be honest and admit that, though essential, enthusiasm alone does not guarantee the continuity of a project. The project should not only depend on private finance but on a reliable and sustainable government subsidy as well.

The benefits derived from the activities described above are numerous and evident: primary health care to large communities at a low cost but keeping quality standards, training of health care givers (the idea behind it is to teach people how to fish rather than give them the fish), epidemiological data collection, a professional forum for the exchange of experiences, objective information, etc. Identifying any potential risks or negative effects both on the population and on the group of volunteer workers is the biggest challenge to face. Key concepts such as *primum non nocere* (first do no harm), health multiculturalism, planning, continuity, safety, and quality control processes require a conscientious interdisciplinary approach as well as the recording and dissemination of previous experiences in various socio-cultural contexts.

Latin American Community Dermatology is still a long way from becoming a branch in its field, it is therefore intent on finding its place in the spheres of scientific organizations, public health institutions and universities. Any human being with a deep-rooted liking for communication, human relationships, knowledge-based

self-fulfilment, research and the exchanging of experiences will surely find a magnificent work universe in community dermatology.

Seven years had passed from that editorial, and very little has changed in gaining our space in Scientific Societies, Educational Institutions or Public Health Systems.

According to this scenario, we developed our 'Community Dermatology Workshops': some simple and humorous strategies (Figs 1-3) in order to improve our reach to large community groups requiring less human resources and economic funding, with the flexibility to be used in different communities and by different health providers, not only full trained dermatologists. Each short educational activity can be used by one person in a single school or community group, or be expanded in a long-term work including other institutions like the Primary Educational System, Medical Universities and Dermatology Residences. The simplicity of the pedagogic model allows it to be used with different contents, depending on the needs of each community (photoeducation, atopic dermatitis, scabies, pediculosis, etc).

Education is now the leading purpose of every 'on field' action we hold. It is easy to sustain, does not require large funding nor Inter Institutional agreement. On the other hand, the impact of our work is difficult to show, as it may only be seen in long term, specific analysis. Our actual immediate society links success with big numbers, easily seen and short term impact results, which are difficult to achieve with very few people and institutions involved in this kind of projects.

As I have said in 2011, very little has changed: Community Dermatology is, and will always be, a field for enthusiasts!

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1. "Community Dermatology: an attractive way to practise, teach and learn about dermatology" *Rev Dermatol Arg* 2011, 17 (5): Editorial



# INTERNATIONAL MIGRATION AND HEALTH: A DERMATOLOGICAL PERSPECTIVE

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## Abstract

This article reviews the issues faced by international migrants and outlines the major skin conditions they experience.

## Background

In the last years Europe has experienced one of the most significant influxes of migrants and refugees in its history. Pushed by civil war and terror and pulled by the promise of a better life, hundreds of thousands of people have fled the Middle East and Africa, risking their lives along the way. To date there is no universally accepted definition of a migrant. Depending on the phase in the migration cycle, the mode of travel and the legal status, different types of migrants can be defined: asylum seekers, refugees, documented and undocumented migrants.

Some people move to new countries to improve their economic situation or to pursue their education (economic migrants). Others, such as refugees and asylum seekers, leave their countries to escape human rights abuses, such as torture, persecution, armed conflict, extreme poverty and even death.

A refugee is defined as a person who, "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country". Refugees are protected in international law and must not be expelled or returned to situations where their life and freedom are at risk.

The conflict in Syria has forced many Syrians to seek safety in other parts of the country or neighbouring nations<sup>2</sup>. Employment opportunities in these poor towns and cities remain low, and large proportions of both refugees and host communities continue to live in acute poverty. Many of the Syrians taking refuge in neighbouring countries like Lebanon, Egypt, Jordan and Turkey are therefore leaving those nations for Europe.

The International Organization for Migration (IOM), the United Nations Migration Agency, reports that 171,635 migrants and refugees entered Europe by sea during 2017, with just under 70 per cent arriving in Italy and the remainder split between Greece, Cyprus and Spain. This compares with 363,504 arrivals across the region in the previous year.<sup>3</sup> The vast majority of people currently attempting the crossing pass through Libya, a country in chaos, and are exposed to alarming levels of violence and exploitation including torture and rape. A global total of 5,376 migrant deaths was recorded for 2017; although it continues to be high it is a third lower than the 7,932 deaths recorded in 2016.

## KEY WORDS

*migration, refugees, torture, burns, female genital mutilation, tuberculosis, skin diseases.*

## The new face of migration

The face of migration is changing. In 2016, the number of unaccompanied children crossing from North Africa to Italy was more than double the figure for 2015, exposing them to the risks of detention, rape, forced labour, beatings or death while fleeing from war, poverty and despair in their countries of origin.

Approximately half of all international migrants today are women<sup>4</sup>. Therefore, in recent years the term "feminisation of migration" has become commonly used. Men and women show differences in their migratory behaviours, face different opportunities and have to cope with different risks and challenges, such as vulnerability to human rights abuses, exploitation, discrimination and specific health risks. It is becoming increasingly obvious that migration is not a gender neutral phenomenon. From the very moment they decide to migrate, women's experience as migrants differs from that of men.

## Skin conditions in migrants

Migrants are not a homogeneous group, and their health is affected more by the conditions under which they travel and the social conditions in which they live in the receiving country. The wider determinants of their health are often different from those of the settled community and require a different approach from healthcare professionals.

Many studies report that migrants who decide to leave their country of origin have inherently good health, which upon arrival in the host country might change<sup>5</sup>. Dermatological conditions observed at arrival are related with the perilous journey and sea crossing. A descriptive study of demographic and clinical data of sea migrants seen at the port clinic in Augusta (Italy) in 2014 showed that the most common morbidities were respiratory, dermatological, trauma-related and gastrointestinal conditions. The authors compared migrants from Near Eastern war-torn regions and the others, mostly African, and found that acute and chronic cardiovascular disease, as well as diabetes, were more frequent in the first group, whereas skin diseases predominate in the latter<sup>6</sup>.

In a project carried on by the National Institute of Health, Migration and Poverty (INMP) in Lampedusa island, the southernmost part of Italy and popular entry point of thousands of migrants and asylum seekers from Africa, skin infections including scabies, abscess, and pyoderma were commonly seen at migrants' arrival due to the poor hygiene conditions in the Libyan detention centres (Fig 1). Boils were common, starting as tender,

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**Fig 1. Erythema and multiple pustules on right foot, due to *staphylococcus aureus*.**

pinkish-red, and swollen lesions on a firm area of the skin, followed by spontaneous rupture (Fig 2). Dermatitis due to the sea water and chemical burns, mainly on the buttocks, were other common findings in “boat migrants” (Fig 3). Second degree burns due to contact with the boat engine were also observed in Lampedusa as self-inflicted injuries, in the attempt of asylum seekers to obliterate their fingerprints and be relocated in a different country (Fig 4).



**Fig 2. Eroded areas after rupture of pustules.**

In an unpublished study conducted in 2014 at the periphery of Rome during medical outreach activities targeting 849 migrants in transit through Italy, skin diseases, mostly infective, were recorded in 52%. (Fig 5). Respiratory disorders in particular upper

tract respiratory infections, were reported in 20%. Water-borne gastrointestinal disturbances were recorded in 7% of migrants. For many migrants, the transition period had no health consequences because of the short duration of transportation. For other migrants, such as those in transition through refugee camps or those experiencing trafficking or smuggling as a means of arrival, the transition period can greatly affect health.



**Fig 3. Chemical burns on buttocks, due to prolonged contact with seawater, urine and fuel. migrants often sit for several hours in cramped conditions on overcrowded boats.**

Migrant women are the most at risk of being trafficked, coerced into survival sex, and subjected to sexual violence. The contribution of migrant populations to the HIV epidemic is notably higher among females, highlighting the feminization of the HIV/AIDS migrant epidemic in Europe. Sexually transmitted infections (STIs) and HIV/AIDS have become urgent concerns for populations affected by armed conflict and migration. The available data suggest that STIs and HIV transmission is indeed greater among people in forced migration settings as compared to stable populations<sup>7</sup>. The effects are not limited to refugees themselves but extend to all those in the conflict or post-conflict setting. Poverty, powerlessness, and social instability affect the spread of STIs and HIV. These conditions are characteristic of the lives of most refugees. Although many governmental bodies and agencies recognize the importance of reproductive health services, and HIV/AIDS prevention and care services, in particular for refugees, health policies have been translated into practice in only a few cases.



**Fig 4. Second degree burns, from contact with the boat engine, on the fingers of an Eritrean refugee who admitted trying to avoid identification so that he could be reunited with his family in northern Europe.**

Immigrants and refugees originating from areas where infections persist can pose a significant challenge for national disease control and elimination strategies<sup>7</sup>. Infectious diseases with cutaneous manifestations are emerging in

Europe and reported cases of endemic mycosis and vector-borne diseases, such as leishmaniasis, onchocerciasis and filariasis, are increasing in the medical literature<sup>8,9</sup>. Imported skin diseases and infections, including a case of undiagnosed lepromatous leprosy in a Mali immigrant (Fig 6, with close up of inflammatory nodule on upper arm in Fig 7), were reported among migrants hosted in the reception centres in Malta by a team of doctors during the project *Mare nostrum*.<sup>10</sup>

The INMP project reported numerous cases of cutaneous tuberculosis in migrants from endemic countries (Fig 8). The *Mare nostrum* project in Malta identified 22 new cases of active tuberculosis, (18 pulmonary, 3 lymphnodal and 1 bone tuberculosis) in migrants living in reception centee, who were screened negative at the time of arrival. Poor housing conditions in the host country, lack of work and income, and dietary changes contribute to disease. The “health



**Fig 5. Sycosis barbae in a North African migrant.**



**Fig 6, 7. Leprosy reaction (erythema nodosum leprosum) in a 32 year old man from Mali leaving a reception centre in Malta.**

heritage" which the immigrant is "endowed" with, assuming he or she arrives in good health, begins to collapse rapidly, thus representing a potential and substantial risk of illness.



Vulnerable migrants face numerous barriers to accessing an appropriate level of healthcare and this has implications for both individual and public health, as well as for healthcare providers. Many countries restrict access to health care for certain migrant groups, including irregular migrants and asylum seekers. Other barriers include language, unfamiliarity with rights, entitlements and the overall health system, underdeveloped health literacy, administrative obstacles, social exclusion, and direct and indirect discrimination. To improve access to health services some European countries have introduced the role of transcultural mediators, most of them coming from migrants' main countries of origin, having themselves experienced a migration process and integrating into the hosting country. The transcultural mediation implies the process of crossing from one culture into another and vice versa.

## Victims of Torture

Many asylum seekers, including children, were tortured in their country of origin because of their gender or race, religious or political affiliation<sup>12</sup>. Worldwide, only about one third of asylum applicants are granted protected status and assured personal safety from repeated torture or death. Dermatologists may be faced with patients with unique features such as chemical weapon burns, electrical shock injuries from primitive electrodes or rubber bullet contusions and real bullet scars (Fig 9 overleaf). Identification and documentation of physical injuries are critical elements for verifying the credibility of allegations in political asylum and in torture survivors. Health professionals are requested to identify, and document injuries related to torture, despite very little specialized dermatological training address this issue.

## Female Genital Mutilations

Female genital mutilation (FGM) is the term currently used by the World Health Organization to indicate all procedures involving partial or total removal of the external female genitalia for cultural or other non-therapeutic reasons. FGM has become an issue of increasing concern in host countries due to its harmful consequences on physical, sexual and psychological health<sup>13</sup>. Many European countries that are hosting migrants from countries where FGM is perpetrated have addressed the issue of FGM in relation to their health care systems and have established guidelines on FGM for medical providers, whereas others are not dealing with the specific needs of women victims of FGM in a consistent manner.

Even though international organizations condemn FGM as a violation of human rights, and most nations have banned it, it remains prevalent in many African countries, and is slow to decline. This persistence raises questions about the effectiveness of international and national laws prohibiting the practice as well as the potential role of returning migrants in changing embedded cultural norms<sup>14</sup>.



**Fig 8. Cutaneous tuberculosis in a 33-year-old migrant from Peru. Scrofuloderma, also known as *tuberculosis colliquativa cutis*, was the most commonly observed form of cutaneous tuberculosis before the advent of tuberculostatic drugs and still is the most common form in developing countries.**

## Conclusion

Recent events in North Africa and the Middle East have triggered a dramatic increase in migration, which highlights the need to identify best practices and engage in a cross-national political dialogue on migration in Europe. Public health and health systems must adjust to the needs of migrants and refugees in vulnerable situations. A particularly important issue is that of unaccompanied minors and women. Ensuring social inclusion and cohesion is beneficial for the mental and physical well-being of migrants themselves and leads to better outcomes for society as a whole.

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**Fig 9. Bullet injuries in an Eritrean refugee; physical scars can often reflect severe psychological trauma.**

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## JOURNAL CLUB

### Moghassa E *et al.* Iranian native plants on treatment of cutaneous leishmaniasis: A narrative review. *Iran J Parasitol* 2017; 12:312-322.

Cutaneous leishmaniasis is a major health problem in Iran, particularly in the northeast. Around 20,000 new cases are reported annually. Pentavalent antimonials are the treatment of choice but patients are understandably keen to explore herbal alternatives which would be cheaper and potentially less toxic. Over 50 plant species have been studied worldwide for their potential efficacy in leishmaniasis. The authors of this thorough review summarize the available data, with particular reference to plants native to or cultivated in Iran. They stress that many reports relate to unconfirmed *in vitro* studies, often performed by PhD students, and most plant extracts have not been tested for cytotoxicity or *in vivo* activity. Plant derivatives of interest include sesquiterpene lactones from members of the daisy family (Asteraceae) and tyrosyl esters from papaya. Among the few clinical studies, honey containing black cumin (*Nigella sativa*) accelerated wound healing of lesions treated with intralesional glucantime, compared with honey alone.

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## JOURNAL CLUB

### Wiese S *et al.* Tungiasis-related life quality impairment in children living in rural Kenya. *PLoS Negl Trop Dis* 2018; 12(1);e0005939.

Tungiasis (skin infestation with sand fleas) is common in resource poor areas of Africa, and can be dismissed as trivial. The authors conducted a survey of 50 affected children in Kilifi County, coastal Kenya. They measured their quality of life using a modified Dermatology Life Quality Index, before and after treatment following recommended national guidelines. They found that tungiasis was severely detrimental to quality of life; affected children had disturbed sleep and impaired concentration due to pain and itching. The degree of impairment was related to the number of sand fleas in the skin. Multiple foot lesions reduced mobility and sometimes led to deformity. The symptoms were often exacerbated by secondary bacterial infection. Embedded sand fleas were often unsuccessfully attacked with non-sterile instruments such as pins and razor blades. Effective treatment led to a dramatic improvement in quality of life.

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# Traditional Medicine Strategies for Skin Conditions in Conflict Zones

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## Abstract

As the global crisis of displaced persons and refugees from conflict zones and collapsed states continues to grow, dermatology is presented with the challenge of developing strategies for managing skin conditions in resource poor settings with a high prevalence of disease. Our experience shows that local solutions can be drawn on to provide sustainable solutions that are safe and effective. Examples from different refugee settings illustrate how community resource people, local knowledge and traditional treatments can provide a means of managing skin conditions in challenging environments.

## Introduction

The UN High Commission on Refugees reported in June 2017 that: "An unprecedented 65.6 million people around the world have been forced from home. Among them are nearly 22.5 million refugees, over half of whom are under the age of 18. There are also 10 million stateless people who have been denied a nationality and access to basic rights such as education, healthcare, employment and freedom of movement." <http://www.unhcr.org/en-my/figures-at-a-glance.html>

Few studies have documented the extent of skin disease among immigrant and refugee populations, but atopic dermatitis was found to be most common among Latin American immigrant children in Spain, with scabies six times more likely to occur in immigrant children than in Spanish children (Perez-Crespo et al 2014). In Greece, immigrant children had a higher rate of bacterial infections and scabies than local children, with dermatitis being the most common (34.7%), followed by skin infection (19.3%)



Refugee camp outside Mae Sot, Thailand.

## KEY WORDS

*Refugee health, traditional medicine, medicinal plants, herbal medicine, traditional knowledge, wound healing, skin disease, local health solutions*

(Katsarou, et al., 2012). In the US, data from HealthPartners in Minnesota show a wide range of dermatological conditions among refugee and immigrant populations (Insert Table 1).

## TABLE 1

### Skin Conditions common among Refugees/Immigrants

**Itching** – Numerous causes

**Inflammatory:** atopic dermatitis (eczema), psoriasis, lichen planus, lupus, Infectious: Herpes simplex, genitourinary dermatoses, tinea, scabies, parasitic infestation

**Systemic illness:** HIV, liver or kidney disease, anaemia

Dry skin

Pain

Keloid scars

Ulcers

Disfigurement

Abnormal appearance of skin

Scars – from disease or scratching

Pigmentary changes

Scars or exacerbation of skin disease in survivors of torture and the associated mental trauma

From: *Skin Disease in Refugees and Immigrants*. Alexia Knapp, MD Dermatology, HealthPartners, Minnesota Dept. of Health, March 1, 2016. <http://www.health.state.mn.us/divs/idepc/refugee/metrotrf/pres16marderm.pdf>

## The Global Initiative For Traditional Systems (Gifts) Of Health

The Global Initiative for Traditional Systems (GIFTS) of Health was created in mid-1993 at meetings at the Pan-American Health Organization in Washington DC. Supported by Canada's International Development Research Centre (IDRC) and the then NIH Office of Alternative Medicine (now the National Center for Complementary and Integrative Health), with participation

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from indigenous peoples groups and academic researchers in related fields, the Initiative was created to bring into policy focus the importance of traditional (indigenous) medicine in the daily lives and health care of the majority of the population of most developing countries ([www.giftsofhealth.org](http://www.giftsofhealth.org)).

Between 1993 and 1995, GIFTS was based at the National Museum of Health and Medicine, Washington D.C. Subsequently, GIFTS moved to the University of Oxford's Department of Dermatology and subsequently to Green College, University of Oxford (now Green Templeton College). The interest from Oxford's Department of Dermatology came from recognition by the second author (TR) that community dermatology needed to focus more on the role of local health care providers in order to understand what could be offered in resource-poor settings, often to significant clinical advantage (Ryan 1994). The Oxford Wound Healing Institute, headed by Dr. George Cherry, was researching wound-healing properties of medicinal plants from China and Vietnam and involving young dermatologists and surgeons from these countries in the programme. This began a focus over more than two decades by the GIFTS network on local solutions to skin disease and health in the developing world (Bodeker et al 2016)



**Recording health knowledge from monks who are also master practitioners of traditional medicine.**

## Conflict and Traditional Medicine.

Conflict has long driven populations to turn to their local traditional medicines in the absence of access to modern medicines (Bodeker 2010). Our own work through GIFTS in the 1990's with the Vietnamese National Institute of Burns found that a number of treatments for burns and wounds developed during the Vietnam War used local medicinal plants out of necessity in jungle warfare. Plants were used for haemostasis and wound healing, dried frog skin for grafting, and flexible bamboo splinting for fractures (Trung & Bodeker 1997). A local ointment made from an extract of the plant *Chromolaena odorata* was found to be highly effective in healing wounds and reducing infections (Phan TT et al, 1996).

In Myanmar (Burma), on the eastern border with Thailand, we were asked by a medical doctor, Dr. Cynthia Maung, herself a Karen refugee, to assist in identifying local herbal medicines for common conditions as people in remote jungle settings were cut off from medical supplies and services due to intense hostilities from the Burmese army. This began a programme from 2001 to 2013 that



**Karen Women's Group recording women's traditional health knowledge.**

included working with local herbalists to document plants used for common ailments. The project entailed identifying the locations of important species in the areas concerned, facilitating the creation of medicinal plant gardens in refugee camps for local use and health worker training and advising on establishing herbal clinics in remote jungle areas. Outcomes included the production of a database and then a book in the Karen and Burmese languages documenting appropriate plants for safe use with common ailments, including skin conditions, burns and wounds (Bodeker et al 2005, Bodeker & Neumann 2013) over a 200km long network of herbal clinics and training programs for local health workers. Accompanying this was a sense of resilience and autonomy that is not common in refugee populations, especially with respect to their healthcare.

Colleagues in Australia drew on this work through The Victorian Foundation for Survivors of Torture, known as 'Foundation House', a mental health service provider for refugees and asylum seekers in Melbourne. Focusing on traditional herbal medicine from the diverse cultures represented among refugee women from the Middle East, Asia and Africa, they reached the same outcomes. A sense of identity and confidence re-emerged as women shared traditions learned from their mothers and grandmothers, grew familiar plants in the refugee centre garden, created small scale enterprises selling herbal products, and managed common



**GIFTS researchers cross-checking the data collected from herbalists with a master traditional practitioner and Buddhist monk.**





Compounding the herbal medicines at the herbal clinic in the jungle.

illnesses using methods that linked them in memory and feeling with their culture and family. This had longer-term benefits in not only physical health but in mental wellbeing and social adjustment (Singer & Adams 2011).

The Vaseline Healing Project was created by the international aid organization Direct Relief, initially from work with Syrian refugees in Jordan (<http://healingproject.vaseline.us/>). In a news report, one of the doctors, Dr Grace Bandow, noted: "Vaseline is used as a skin protectant to help soothe eczema, psoriasis, burns, and dry, cracked skin and lips. Refugees fleeing the Syrian civil war are walking miles through hot deserts, often in open rubber sandals that leave their feet exposed. We saw many patients with deep, painful cracks in their skin, which made walking or working painful, and sometimes impossible... Thousands of Syrians are living in crowded tents and cooking over open flames and sadly, burns are commonplace. Vaseline, while inflammable, provides protection and an emollient effect to the burns as they are healing." ([http://orient-news.net/en/news\\_show/98957/How-Vaseline-is-helping-Syrian-refugees](http://orient-news.net/en/news_show/98957/How-Vaseline-is-helping-Syrian-refugees))

Simple plant extracts in local emollients such as coconut or sesame oil – or, indeed, Vaseline, have wound healing and skin repair properties. At the vast Rohingya settlements on the Bangladesh-Myanmar border, turmeric, for example, which is antimicrobial and a wound-healing agent, can be crushed and applied topically in a locally available emollient.

A precedent for this type of work may be found in programmes at the Institute of Applied Dermatology (IAD) in Kerala, India (<https://iad.org.in/>). The IAD provides evidence-based Ayurveda herbal therapies and medicated oil massage treatments, along with yoga for lymphoedema, and many other methods, combined with modern medicine, to treat a range of skin problems effectively (Narahari et al, 2015, 2016).

## Ethics

The International Society of Ethnobiology (2006) has set out a framework for ensuring that prior informed consent is obtained

before commencing any studies of traditional knowledge, as well as outlining a framework for access to these plant species and benefit sharing from any commercialization that may result. This ethical position is also enshrined in international law through the Nagoya Protocol of the UN Convention on Biological Diversity, 2014 (<https://www.cbd.int/abs/>). Researchers in this field should become familiar with these protocols as well as with the UN Declaration of the Rights of Indigenous Peoples ([http://www.un.org/esa/socdev/unpfii/documents/DRIPS\\_en.pdf](http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf)), which recognizes the right of indigenous people to have access to and to use their own traditional medicines.

Field workers should establish partnerships with experienced herbalists and local knowledge holders as they are certain to be aware of safety issues with the various plant species in their area. Family home

herbal knowledge, by contrast, may not have the same degree of alertness to safety issues and uninformed self-medication can result in adverse reactions (Willcox et al, 2015).

## Community Dermatology Practice

So that damaged skin has the best possible chance of healing, refugees from conflict need help not just for the skin problem but to sustain health and well being. The body's defences and healing powers have been developed over millions of years to manage very well on their own.

The following obvious points are offered as the basis of planning.

1. The skin will have difficulty healing if there is anaemia, diabetes and or malnutrition, local cooling, added bacterial infection, exposure to insects, swelling of the tissues, or either an excess of moisture or dryness. This means that identification of the cause of a skin problem and treatment to eliminate such a cause must be followed by an assessment of these background factors.
2. The availability of clean water for washing depends on local knowledge of where it may be found. There are several

*Continued overleaf...*



A herbal clinic built in a jungle location by the Karen refugee community as an outcome of the herbal medicine programme.



**GIFTS researcher sharing collated data from several herbalists with the herbalist advisory group.**

techniques for cleansing water (filtering, added cleansers, heating, use of flocculant plants, charcoal, etc.) some of which have been discussed in previous issues of this journal.

3. If available, mosquito nets protect from flies at night, which are always attracted to damaged skin. Open wounds should be covered and shielded from the environment.
4. Footwear, washing, and emollients can prevent the severe inflammation which makes it impossible to walk long distances. The regular inspection and prevention of entry points for bacteria and soil irritants must be ensured.
5. Infants transported in the arms or on the backs of relatives need protection from excessive sun exposure but also from excessive heating or cooling. Older children can be helpful in this respect.
6. In conflict zones trauma may be the commonest cause of breakdown of the skin. There will be a need to halt bleeding and many plants have haemostatic properties. Most species of Aloe provide a juice or gel helpful for burns. Antimicrobial properties of plants are well known. Plants protected themselves in this way long before humans evolved (see review by Bodeker et al 2016).
7. Suitable plants vary according to location and every ethnic community may have a different name for the commonest of herbal remedies. A local Traditional Health Practitioner or wise woman should be looked for to locate such knowledge. Humanitarian responses to traditional medicine for refugee care and those most experienced in managing their problems understand best how beneficial local traditional knowledge can be (Neumann and Bodeker 2007).
8. Two organisations that provide many useful teaching aids are:
  - The Hesperian Foundation in Palo Alto, California (<http://hesperian.org/>)
  - Health Books International - formerly TALC: Teaching Aids at Low Cost (<https://healthbooksinternational.org/>)

In a most helpful book, *Where There is No Doctor; A Village Health Care Handbook* (1), David Werner and colleagues state that "ordinary people provided with clear, simple information can prevent and treat most common health problems in their own homes - earlier, cheaper, and often better than doctors".

The book is published in English, Spanish and Portuguese; For healthcare workers away from home, the book's low-cost simple advice can be supplemented by local health personnel and traditional practitioners.

9. Conflict is a cause of extreme anxiety and in seeking locally available resolution there has been much emphasis, since the earliest of health interventions, on not just the technologies of care but the benefits of an attitude of care, which is a kindly and friendly response to those who are in distress. In addition, techniques such as meditation, mindfulness, and yoga have all been shown to help in reducing anxiety associated with trauma.
10. Past issues of this journal have provided advice in several relevant areas ( Table 2).

**TABLE 2**

## Relevant material in *Community Dermatology Journal*

Emollients and Skin Care vol 1, 2004 pp3-5,
TALC: images for Development , vol 2, 2005 pp13-14.
Essential Drugs in Dermatology vol 2 , 2005 pp9-10,
Honey and Wounds vol 4 2006 pp20-22,
Traditional Wound Dressings , vol 5 2008 pp1-3,
Water for the World, vol 7 , 2011, p1 and purification systems vol 11 pp7-9, 2015.
Washing wounds , vol 7, 2011 pp 2-3,
Sterilization of Banana leaves , vol 7 , 2011 p 11,
Recommended treatment for Sexually Transmitted Infections, vol 9, 2013 pp 2-6
Gentian violet, vol 12, 2016 pp 22-23,
Effective water use in skin care, vol 13, 2017 pp 7-10.



**GIFTS researcher sharing collated data from several herbalists with the herbalist advisory group.**

## Conclusion

Conflict not only displaces people but it frequently destroys the resource base and health infrastructure. A key to harnessing this potential for local solutions to common ailments, even in the most seemingly desolate of settings, is to identify traditional knowledge holders who are willing to share their knowledge and are given respect for this status and protection for the knowledge that they share. A sound ethical framework before proceeding is important.

Mobilizing such resources has been shown to empower a community, reduce the sense of loss that inevitably accompanies displacement, create resilience, and stimulate microenterprise development. A key healthcare outcome is the mobilization of community-based dermatology solutions to common skin conditions that would otherwise go untreated and risk more serious complications developing.

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# Community Dermatology Journal



**Comm Dermatol J 2018;14:1-12**

If you have any interest in medical care, whether in well established medical centres or in a rural health centre then the Community Dermatology Journal is for you. It brings up to date, relevant information on the diagnosis and treatment of skin disease and is particularly for health workers in developing countries.

So please share your interest and experience by sending articles, reports and letters that are welcomed by the Editorial Board - see Guidelines for Authors below.

You will find it is also a useful resource for educating health workers and the populations they serve and for keeping in touch with dermatology services in developing countries.

It is published twice a year and over 7,000 copies of each issue are sent, free of charge, to nearly 200 countries. All issues can be viewed online, free of charge, on the IFD website [www.ifd.org](http://www.ifd.org).

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Grants of up to US\$5,000 are available to undertake initiatives that help patients with skin disease in resource-poor parts of the world.

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