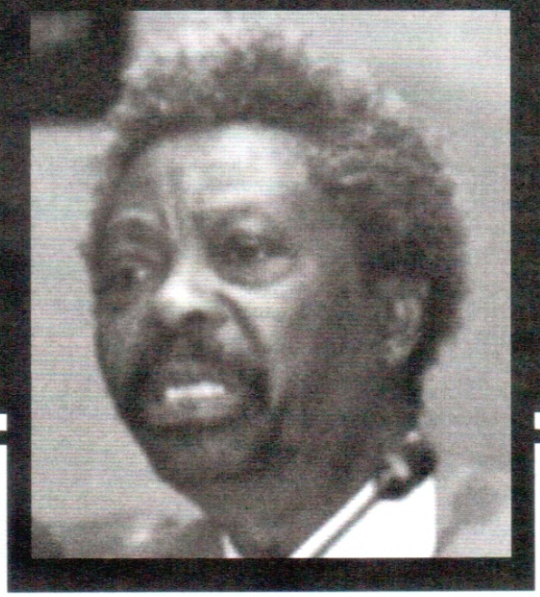
THE CHALLENGES OF PRACTICE OF DERMATOLOGY IN WEST AFRICA

By Femi Soyinka



INTRODUCTION

I sincerely appreciate the honour done to me through your invitation to deliver the keynote address for the 6th Annual meeting of the Nigerian Association of Dermatologist (NAD) of which I have been a member since its inception. I feel highly honoured and I thank you all.

The Theme for NAD's 2012 meeting titled "The Challenges of Practice of Dermatology in West Africa" was in itself a great challenge to me, until the coordinator of this meeting Dr. (Mrs.) Olasode came to Ibadan, to throw more light into the objectives that you had in mind in choosing the topic. I thank her for her assistance and I hope I will be able to meet your expectations.

I interpreted your choice of the theme for this meeting as a way of performing an audit of our performances in West Africa as dermatologists, (individually and collectively), till date; how we have fared in our mandate, where we are today, what the gaps and challenges have been, and in which direction we should move to get to where we ought to be.

The focus of our workshop during this meeting, "Aesthetic Dermatology", is a bold step in the right direction as it seeks to expand the scope of our dermatological practices for better delivery of qualitative dermatological services and towards the goal of "healthy and vibrant skin" for all in the West African sub-region and perhaps also in the African continent.

Initially, when I was asked to deliver this keynote address, I was not willing to accept, basically because I feel too passionate about the deplorable state of the practice of Dermatology in Africa. I would have felt compelled to talk about and against myself, laden with guilt - for the failures and lapses of the past.

In 2012, we should have reached the point of consolidation and expansion into other areas of sub-specialties in dermatology, taking the lead in the advancement of medicine, and being in a stronger position of authority to dictate as a professional group, how dermatology should be practiced, manpower developed, and how the state of the art in dermatological research should be conducted.

Our primary objective as dermatologists should be to "deliver quality services to a large proportion of the populace (urban and rural areas of West Africa) at a reasonable and affordable cost". This can be achieved primarily through manpower and system development, research and strong engagement.

The question that begs for an answer presently is "What had impeded progress to achieve our primary objectives and goal" over the years? What were the challenges that we have faced?

The challenges that I have faced since I started practicing as a dermatologist in Nigeria and to some extent in some parts of Africa, would not be very much different from those that others before me had faced. Hence, what I have to narrate as part of my experiences are already known to many of you.

Talking about dermatology is about talking about my life, as I had spent a good part of it learning, providing clinical services, teaching and researching. It is an experience of over 40 years and I cannot tell it all in one of my early publications, I wrote as follows:

"The challenges that skin diseases pose to dermatologist in Africa are many. Not only do the available dermatologists have to cope with the types of skin problems that are prevalent in the developed countries but also with myriads of other skin diseases that are specific to the tropical environment".

"In Africa, we have to cope with bias, ignorance, and poverty, non-recognition of dermatology as a specialty, the rising cost and scarcity of dermatological drugs".

Our young colleagues prefer to specialize in other more lucrative medical specialties. "There are few opportunities for training development and research in the specialty. Opportunities for peer review and interaction with colleagues of like minds are limited or not available".

These words were said over 30 years ago!

Personal Experience

Allow me to narrate a bit out of my life experiences, but limiting the narration only to relevant aspects as they have some bearings on the topic on the table today.

In Europe, after scaling through the medical school and it was time to embark on a residency programme, I was plunged into making the decision on the specialty which I felt I would have to live with for life. It was like getting married.

Pressure came from all quarters especially from home that I should specialize in any of O & G, Surgery or Medicine as these were the known specialties at home and where money could be made in Nigeria.

However, none of these much sought-after specialties interested me. I was rather interested in Laboratory and Clinical research work. Hence, I took a job at the Asthma and Allergy Research Institute in Germany as a Research Fellow, working on Allergies and Immunological diseases for 2 years. I made enquiries from the Lagos University Teaching Hospital and the UCH about the availability of position as a residency in dermatology and venereology where my training in allergy and Immunology would become useful.

The responses I got from both institutions were short and very much uninformed. From Lagos, the governor wrote: "We do not have such a specialty here and we do not even need it in Nigeria". From Ibadan, the response I got was "Was that what your parents sent you to read overseas?" He further added that he never heard of Dermatology. Is that "Leprosy?"

I wrote back saying, "No, it is skin diseases". He wrote back again, advising me to go and specialize in Medicine and he would give me a job.

During the same period, still in Germany, I attended a conference in Berlin where I delivered a paper on Chloramphenicol Allergy which was based on a non-inverse technique which we developed to establish cutaneous and systemic allergic reactions to Chloramphenicol, which was then commonly use.

After my presentation, I was approached by a Professor, who introduced himself as the Chief Medical Director of the Dermatology and Venereology University Hospital in Giessen. He invited me to visit his Teaching Hospital in Giessen to discuss an appointment he was prepared to offer me and I followed up the invitation. In Giessen, I was requested to establish an Allergy Department in the Dermato-Venereology Teaching Hospital of the University, while at the same time I would be trained as a specialist in the Dermatology and Venereology Hospital as part of the bargain. I signed in immediately. It was a very fulfilling period, in terms of remuneration, research and training all combined in one.

The question that begs for an answer presently is "What had impeded progress to achieve our primary objectives and goal" over the years? What were the challenges that we have faced?

As a Residency in training in Dermatology & Venereology, I spent 3 years rotating through various departments including; Clinical Dermatology, Skin tumors and radiotherapy of the skin. Paediatrics Dermatology, Mycology and Microbiology, Andrology, Venereology, Laser, Hydro and Cyro-therapy, as well as Dermato-histopathology, in addition to my responsibilities as the Head of the Allergy department. The University skin clinic was a 120 bedded hospital with 30 bedded ward for private clinic, and 20 bedded ward for pediatric cases and with a total of 15 Consultants out of which 5 were Professors.

When it was time for me to finally return to Nigeria in 1971, I was offered a consultant appointment to stay on in Giessen, concentrating on Allergy Research & Clinical immunology as my research focus. Against all odds, however, I decided to come back to Nigeria, where I finally joined the Department of Medicine at UCH as a Senior Registrar with the promise to be made a Consultant soonest or when a vacancy is open. I came back to Nigeria, with high hopes; I recall the last discussion I had with my boss in Giessen shortly before I

finally put in my resignation. He asked me what I was hoping to achieve on getting back to Nigeria. I mentioned 2 things: one was to make Dermatology the most sought after specialist profession in Medicine in Nigeria and the other one was to make a stunning discovery in Mycobacteria Leprea. He reflected inwardly for a while, and then said to me "Femi, remember that you are always welcome back here at anytime. I will leave your position vacant for you for a period of 12 months in case you decide to come back to us". We parted on that note.

I sooner arrived at UCH, but what I hadn't said earlier on, was that I found my way back to Giessen before the one year ended, to pick up my job in Giessen and it was the late Professor Ige-Grillo that came to Giessen to bring me back to Nigeria, precisely to O.A.U. in Ife.

The challenges I faced in my attempt to practice Dermatology at UCH were overwhelming, so much so that I felt that it was a wasted one year in Nigeria;. I felt I was not made use of. Not only was dermatology not recognized as a specialty, it appears to me that it was not even seen as very necessary and needed in Nigeria". Some of the senior Colleagues that I discussed with (with the exception of the Head of the Department Prof. Ogunlesi) did not think much of Dermatology as a specialty. And they behaved that way too. It was either you are an Internist, a Surgeon, a Gynaecologist or Psychiatrist. The environment was hostile to new ideas at that time. I must quickly add that the UCH of today is much different from the UCH in those days. Thanks to the young generation.

However, recently, a consultant dermatologist in one of our Teaching Hospitals narrated her personal experience to me, which I feel compelled to narrate here, given the fact that her experience happened just about 5 years ago.

The lady doctor on completing her Housemanship in one of the Premium Medical Schools in Nigeria applied for a Dermatology Residency position, in the Department of Medicine. She was asked point-blank during the interview, by the then Provost of the College "What are you going there to do? Another one told her "You are too brilliant for that subject." I am talking about very influential Medical Educators in Nigeria, renowned Professors, highly intelligent and much-respected personalities in University Education!! Both of them were referring to Dermatology.

Interestingly and on reflection, I feel that the attitude of our learned colleagues might have been due to their training, or where they were coming from. Some African countries that were once colonized by France had a better training in dermatology, even as medical students, than those countries that were colonized by the British. This I believe had to do with the different patterns of medical trainings in Europe, the UK and the US.

Are Dermatologists Becoming Dying Species in West Africa?

"At an informal meeting in Lagos sponsored by Swissco Nigeria Limited in 1992, to discuss and promote a new antifungal drug called LAMISIL, the few dermatologists that were present at that meeting expressed dismay about the deplorable state of dermatology practice/services, training and research in Nigeria. It was then and there that a decision was taken to form Dermatology Club, which, with the assistance of Swissco, would promote the interest of dermatological practice in Nigeria.

I came back to Nigeria, with high hopes; I recall the last discussion I had with my boss in Giessen shortly before I finally put in my resignation. He asked me what I was hoping to achieve on getting back to Nigeria.

Hope was expressed then, that with the launching of a Dermatology Club, the practice of dermatology would be improved, services made available to many in Nigeria and consequently enhance training and research of Dermatology". It is encouraging to note that faith has been kept with one of the resolutions at that meeting. We now have a Dermatology Association in Nigeria the first in West Africa. We also have an increased number of practicing dermatologists. I need to appreciate the dedication of our colleagues for bringing our profession to focus in Nigeria.

In the first edition of the Sandoz Journal of Dermatology in Nigeria in 1993 and as the Chairman of the Editorial Advisory Board, I wrote in the Editorial of the 1st edition (and the last) with the title "Are Dermatologist becoming dying species in Nigeria?" as follows:

"It is obvious that with our present strength - numerical or otherwise - we are not coping. There are no

opportunities for training, development and research. A good number of the few dermatologists that were on ground five years ago have left the country in search of professional satisfaction and or better financial placement. The rest that are left behind, about a dozen in number are concentrated in the urban areas of the country, leaving the rural areas without basic dermatology".

"Dermatologists who are present during the inaugural meeting of Dermatology Club were anxious about the deplorable state of dermatological services, training and research in Nigeria".

For those who did not have the luxury of exposure to medical history, (which is a specialty in Europe), let me remind us that Dermatology was established as an independent specialty in the 1870s (exactly two hundred and twenty-two years ago). Those regarded as giants and pioneers of Dermatology in the USA such as the famous Sulzberger and Groekerman, who helped establish dermatology in the US in the early 1900 were trained in Europe - including Vienna, Paris and Germany.

As Dr. George rightly said in his article titled: Dermatology in Nigeria: Evolution, establishment and current status". I trained in Europe precisely in Heidelberg and Giessen in West Germany and I can attest to the fact that I had the best of training that could be offered in Dermato-Venereology as of that time.

The theme of this year's NAD Annual meeting becomes very necessary and apt given the fact that it seeks to answer the question, "Why do we still have in Africa (or West Africa) so many challenges in practicing dermatology, over 200 years after the discipline of dermatology had been firmly established in Europe?"

Why do we still have problems recruiting best students into the profession? Why do we have difficulties with teaching materials and why is dermatology not yet recognized as an independent specialty? Why is it that the quality of research in Dermatology is still at such a rudimentary stage in West Africa? Why can we not provide state of the art "dermatology care" to millions of our people that need such care considering the fact that brilliant doctors have been produced in Africa and many have made their marks all over the world?

Today, we still rely heavily on our clinical impression based on our recall system, which is quite a fit, and on past encounters to similar lesions seen years back, irrespective of the fact that the presenting skin problems might have drastically been changed due to the application of various concussions including potent steroid based creams, which are freely available at Jankara, Dugbe, or Onitsha markets.

Having said this, I must add very quickly that I am not implying that clinical knowledge of skin disease is not important or essential - quite the opposite. A well trained dermatologist must have a good clinical orientation. A dermatologist without a good clinical knowledge of skin disease will make mistakes at his/her primary point of contact with the patients and in presenting a guiding diagnosis of the skin problem to the pathologist. The dermatologist must guide the pathologist to enable him give an informed histo-pathological report of a skin biopsy.

In many cases, systemic diseases are usually preceded or accompanied by and through morphological changes in the skin. I recollect some years back, on noticing some changes on the facial appearance of an African President/Head of State on the television, I shared my suspicion with a fellow dermatologist that the Head of State was most likely suffering from a systemic problem, most likely to be associated with the renal system. This was confirmed after his death.

Clinical recognition of skin disease forms the basis of thorough training of any future dermatologist.

Skin Health for all: Dreams or Realities?

From what we know and still observe, dermatology services and care is not high on the list of priorities of our various governments and universities in West Africa especially where financial resources for health care are limited. The health authorities, health and medical educationists, planners and implementers do not seem to be aware of these problems especially in West Africa, where only a few dermatology clinics exist, and teaching, training and research in dermatology is more than limited or partly non-existent.

Earlier in the 70s and early 80s, in some countries in Africa, skin clinics were synonymous to Leprosy clinic or VD clinic as these were just the health problems that were thought to be of relevance to ill health that needed to be eradicated. However, through the assistance of the developed countries, attempts were made to make dermatological services available to the rural population in Africa through the integration of dermatological services into the Primary Health Care system of some countries in Africa - notably in the Eastern African countries. To facilitate this initiative, the WHO, UNDP and some dermatologists from the developed countries initiated the process of making basic dermatology services available to the rural areas through the training of Para-medicals, or so-called rural health care workers in basic dermatology care.

finally put in my resignation. He asked me what I was hoping to achieve on getting back to Nigeria. I mentioned 2 things: one was to make Dermatology the most sought after specialist profession in Medicine in Nigeria and the other one was to make a stunning discovery in Mycobacteria Leprea. He reflected inwardly for a while, and then said to me "Femi, remember that you are always welcome back here at anytime. I will leave your position vacant for you for a period of 12 months in case you decide to come back to us". We parted on that note.

I sooner arrived at UCH, but what I hadn't said earlier on, was that I found my way back to Giessen before the one year ended, to pick up my job in Giessen and it was the late Professor Ige-Grillo that came to Giessen to bring me back to Nigeria, precisely to O.A.U. in Ife.

The challenges I faced in my attempt to practice Dermatology at UCH were overwhelming, so much so that I felt that it was a wasted one year in Nigeria;. I felt I was not made use of. Not only was dermatology not recognized as a specialty, it appears to me that it was not even seen as very necessary and needed in Nigeria". Some of the senior Colleagues that I discussed with (with the exception of the Head of the Department Prof. Ogunlesi) did not think much of Dermatology as a specialty. And they behaved that way too. It was either you are an Internist, a Surgeon, a Gynaecologist or Psychiatrist. The environment was hostile to new ideas at that time. I must quickly add that the UCH of today is much different from the UCH in those days. Thanks to the young generation.

However, recently, a consultant dermatologist in one of our Teaching Hospitals narrated her personal experience to me, which I feel compelled to narrate here, given the fact that her experience happened just about 5 years ago.

The lady doctor on completing her Housemanship in one of the Premium Medical Schools in Nigeria applied for a Dermatology Residency position, in the Department of Medicine. She was asked point-blank during the interview, by the then Provost of the College "What are you going there to do? Another one told her "You are too brilliant for that subject." I am talking about very influential Medical Educators in Nigeria, renowned Professors, highly intelligent and much-respected personalities in University Education!! Both of them were referring to Dermatology.

Interestingly and on reflection, I feel that the attitude of our learned colleagues might have been due to their training, or where they were coming from. Some African countries that were once colonized by France had a better training in dermatology, even as medical students, than those countries that were colonized by the British. This I believe had to do with the different patterns of medical trainings in Europe, the UK and the US.

Are Dermatologists Becoming Dying Species in West Africa?

"At an informal meeting in Lagos sponsored by Swissco Nigeria Limited in 1992, to discuss and promote a new antifungal drug called LAMISIL, the few dermatologists that were present at that meeting expressed dismay about the deplorable state of dermatology practice/services, training and research in Nigeria. It was then and there that a decision was taken to form Dermatology Club, which, with the assistance of Swissco, would promote the interest of dermatological practice in Nigeria.

I came back to Nigeria, with high hopes; I recall the last discussion I had with my boss in Giessen shortly before I finally put in my resignation. He asked me what I was hoping to achieve on getting back to Nigeria.

Hope was expressed then, that with the launching of a Dermatology Club, the practice of dermatology would be improved, services made available to many in Nigeria and consequently enhance training and research of Dermatology". It is encouraging to note that faith has been kept with one of the resolutions at that meeting. We now have a Dermatology Association in Nigeria the first in West Africa. We also have an increased number of practicing dermatologists. I need to appreciate the dedication of our colleagues for bringing our profession to focus in Nigeria.

In the first edition of the Sandoz Journal of Dermatology in Nigeria in 1993 and as the Chairman of the Editorial Advisory Board, I wrote in the Editorial of the 1st edition (and the last) with the title "Are Dermatologist becoming dying species in Nigeria?" as follows:

"It is obvious that with our present strength - numerical or otherwise - we are not coping. There are no

opportunities for training, development and research. A good number of the few dermatologists that were on ground five years ago have left the country in search of professional satisfaction and or better financial placement. The rest that are left behind, about a dozen in number are concentrated in the urban areas of the country, leaving the rural areas without basic dermatology".

"Dermatologists who are present during the inaugural meeting of Dermatology Club were anxious about the deplorable state of dermatological services, training and research in Nigeria".

For those who did not have the luxury of exposure to medical history, (which is a specialty in Europe), let me remind us that Dermatology was established as an independent specialty in the 1870s (exactly two hundred and twenty-two years ago). Those regarded as giants and pioneers of Dermatology in the USA such as the famous Sulzberger and Groekerman, who helped establish dermatology in the US in the early 1900 were trained in Europe - including Vienna, Paris and Germany.

As Dr. George rightly said in his article titled: Dermatology in Nigeria: Evolution, establishment and current status". I trained in Europe precisely in Heidelberg and Giessen in West Germany and I can attest to the fact that I had the best of training that could be offered in Dermato-Venereology as of that time.

The theme of this year's NAD Annual meeting becomes very necessary and apt given the fact that it seeks to answer the question, "Why do we still have in Africa (or West Africa) so many challenges in practicing dermatology, over 200 years after the discipline of dermatology had been firmly established in Europe?"

Why do we still have problems recruiting best students into the profession? Why do we have difficulties with teaching materials and why is dermatology not yet recognized as an independent specialty? Why is it that the quality of research in Dermatology is still at such a rudimentary stage in West Africa? Why can we not provide state of the art "dermatology care" to millions of our people that need such care considering the fact that brilliant doctors have been produced in Africa and many have made their marks all over the world?

Today, we still rely heavily on our clinical impression based on our recall system, which is quite a fit, and on past encounters to similar lesions seen years back, irrespective of the fact that the presenting skin problems might have drastically been changed due to the application of various concussions including potent steroid based creams, which are freely available at Jankara, Dugbe, or Onitsha markets.

Having said this, I must add very quickly that I am not implying that clinical knowledge of skin disease is not important or essential - quite the opposite. A well trained dermatologist must have a good clinical orientation. A dermatologist without a good clinical knowledge of skin disease will make mistakes at his/her primary point of contact with the patients and in presenting a guiding diagnosis of the skin problem to the pathologist. The dermatologist must guide the pathologist to enable him give an informed histo-pathological report of a skin biopsy.

In many cases, systemic diseases are usually preceded or accompanied by and through morphological changes in the skin. I recollect some years back, on noticing some changes on the facial appearance of an African President/Head of State on the television, I shared my suspicion with a fellow dermatologist that the Head of State was most likely suffering from a systemic problem, most likely to be associated with the renal system. This was confirmed after his death.

Clinical recognition of skin disease forms the basis of thorough training of any future dermatologist.

Skin Health for all: Dreams or Realities?

From what we know and still observe, dermatology services and care is not high on the list of priorities of our various governments and universities in West Africa especially where financial resources for health care are limited. The health authorities, health and medical educationists, planners and implementers do not seem to be aware of these problems especially in West Africa, where only a few dermatology clinics exist, and teaching, training and research in dermatology is more than limited or partly non-existent.

Earlier in the 70s and early 80s, in some countries in Africa, skin clinics were synonymous to Leprosy clinic or VD clinic as these were just the health problems that were thought to be of relevance to ill health that needed to be eradicated. However, through the assistance of the developed countries, attempts were made to make dermatological services available to the rural population in Africa through the integration of dermatological services into the Primary Health Care system of some countries in Africa - notably in the Eastern African countries. To facilitate this initiative, the WHO, UNDP and some dermatologists from the developed countries initiated the process of making basic dermatology services available to the rural areas through the training of Para-medicals, or so-called rural health care workers in basic dermatology care.

In 1987, an International Workshop on Dermatology in Basic health services was organized in West Berlin by the German Foundation for International Development in cooperation with the CMD. I think that was the first time I met Professor A.N. Okoro - the grandfather of Dermatology in Nigeria.

In the abstract presented by Prof. Anezi Okoro during this workshop, he stated as follows:

"With dermatologists so few and skin diseases so rampant, doctors should be in the vanguard of programmes to mobilize and train auxiliary staff among a wide range of health personnel to help out with routine evaluation and treatment and with preventive, promotive and educative assignments. This will enable dermatologists to enrich their clinical endeavours with teaching and research and extend the frontiers of dermatological knowledge"

A well-trained dermatologist without a good clinical knowledge of skin disease will make mistakes at his/her primary point of contact with the patients and in presenting a guiding diagnosis of the skin problem to the pathologist.

During the same workshop, I advocated for the promotion of Preventive dermatology through health education and through the integration of dermatology care into the Primary Health Care programmes in Africa.

I also listed the challenges that impede progress in the provision of dermatology services to our population in Africa among others as:

- Inadequate training of personnel at the Primary Health Care (PHC) level on basic dermatology care.
- Scarcity of dermatology specialist to make an in-road into the training and provision of quality dermatology care.
- Lack of basic economical dermatology preparations and making use of traditional or locally made preparations that are known to be effective.
- Lack of promotion of skin health education and teaching aids to the rural communities
- Lack of knowledge and failure to research into effective local skin preparations that are known to have worked and which should have helped in commonly encountered skin problems in the rural areas.
- Lack of appropriate formulary, focusing on local products and production, aimed at meeting basic dermatological needs of the majority of the population at affordable and accessible ways

25 years after this workshop in Berlin, I wonder if much had changed in our overall performance in dermatology practice and teaching.

Even though skin diseases are reported to be one of the main reasons for seeking medical attention in the tropics or in Africa, nevertheless, little attention has been paid up till today to the provision of appropriate dermatological agents that could be helpful, useful and affordable to the population that need them most. Almost 85% of dermatological preparations come from the western countries; most of these drugs are brought to the tropics at an exorbitant cost to the people without consideration of the local environments where they would be used. We are however good in manufacturing bleaching creams particularly in West Africa.

I recollect that a dermatologist colleague collaborated with a department in the Faculty of Pharmacy a couple of years back in examining the efficacy of a locally prepared traditional antifungal ointment. The preparation was reported to be efficacious. But what happened after? Nobody was interested.

Reflections on the Challenges in Dermatoses Encountered in the Tropics

It is my contention that dermatoses encountered in the tropics is any different from dermatoses elsewhere and more so that dermatology in any region of Africa (South, West, North and East) are virtually similar, albeit with differences in presentation, incidence and distribution, which may differ from place to place and which are primarily influenced by the environment, cultural practices, nutritional status, hygiene and social status. There is no myth about tropical dermatology, except for those, that for various reasons need to mystify what happens in the 'dark continent' as Africa is often referred to.

There is no doubt that some dermatological problems

are peculiar to specific regions of the world and that there are some dermatoses which can only be acquired in the tropics. But these would be mainly due to the environment that favours the indigenization of such dermatoses or those that persisted in Africa due to the level of development, attention to health and level of medical care advancement. For example, chicken-pox is still widely encountered in Africa, while it is rare in developed countries.

On the other side, certain dermatological problems in developed countries, where the inhabitants reach the age when degenerative diseases which are features of the advanced countries start to appear are not commonly seen in Africa, where many do not reach the advanced age due to poverty and "deprived life". Even up till today, the life of the majority of inhabitants of Africa or the tropics is a poor one, brutish, deprived and short. We may be reaching the stage when degenerative skin conditions start getting to be common in West Africa, but for other reasons other than development. The presentation of a skin problem is likely to be different in an African child that had lived in developed countries than an African child that had lived all his life in a deprived environment in Africa.

Hence, we have the challenges of appropriate teaching materials that assist in the recognition of these variants in presentation of skin problems in our environment, for better recognition for our students, rather than teaching materials and text books that present the same skin conditions in another environment. I must commend the contributions of our colleague, Professor Olumide in this respect.

The British Association of Dermatologists will be holding its 92nd Annual Meeting in Birmingham in July 2012. This translates in the wisdom that the Association started holding annually its Annual Scientific meetings since 1920. During the meeting in Birmingham next month, over eight British Dermatological Societies will be present and participating viz:

- British Society of Photo-Dermatology society
- Involvement of British photo-Dermatology society
- British Society for Dermatological Survey
- British Society for Dermatopathology
- British Society for Pediatric Dermatology
- British Society for Cutaneous Allergy
- British Society for Skin Care in Immune Suppressed individuals
- British Society to Historical Dermatology

Today in Britain, there are many other interest groups that have developed out of the mother dermatology group, pursuing vigorously sub-specialties in dermatology and with the focus on improving the services they provide to their patients. In West Africa, the fact is that we have failed to continue to develop our dermatology skills, to the advantage of the dermatology trainees and to the benefits of our patients as end users of our skills.

The majority of us practicing dermatology in West Africa today are British and French trained. Trained very many years back, but still practicing at the same level that we were trained. The British system on which we built our health system had since left us behind as we have failed to follow the advancement that they have further achieved over the years.

The majority of us practicing dermatology in West Africa today are British and French trained but still practicing at the same level that we were trained. The British system had since left us behind as we have failed to follow the advancement that they have further achieved over the years.

Once again, I wish to commend NAD for the innovation and pro-activeness of establishing sub-committees such as the product endorsement committee education and research committee and others which in future will expand the scope of sub-specialties development in the profession.

Dermatology Training in Africa

For some mundane reasons (some of which had been earlier on mentioned) ranging from share ignorance, willful incompetence, system-failure, lack of planning etc, Africa (with the exception of South Africa, Egypt and perhaps Tanzania) still suffers from an acute shortage of dermatologist.

The few dermatologists that are available in most of the African countries tend to be centered in the cities thus living a large percentage of the African population deprived of competent dermatological services.

In Nigeria, I guess (not so sure) that we have roughly

about 50 formally trained dermatologists servicing a population of over 120 million in a country of 36 states. I feel that the majority of available dermatologists in Nigeria are concentrated in the Southern region of the country - leaving a large chunk of the North without specialist care, and leaving patients with skin problems in these regions, to the care of health care personnel who are with no training in dermatological care.

In West Africa, there are very few dermatology training programmes. In most of the teaching hospitals or medical schools, dermatology training of medical students is just a tokenism or "A passing through". Of course, you do not blame the system, since many of them do not have trained dermatology teachers/consultants and they cannot give what they do not have.

In 1992, the International Foundation of Dermatology - a non-profit organization that aims to improve dermatologic care in undeserved areas of developing countries, established a Regional Dermatology Training Centre (RDTC) in Tanzania. The RDTC among others provided a 2-year dermatologic training programme for medical assistants and nurses from Kenya, Malawi, Botswana, Cameroon, Swaziland, Uganda, Ghana and Sierra-Leone. Nigeria never benefited from this programme.

Furthermore, a 4-year dermatology residency training programme was established at the RDTC in 1998. I learnt that this centre has developed into a tertiary hospital with a specialized dermatology clinic.

The Mbarara University of Science and Technology in Uganda also provides a 3-year dermatology residency programme, which matriculated one new dermatologist each year since 2004. I would have wanted to learn more about their dermatology residency programme and why they produce only one new dermatologist yearly.

What is however more worrisome is the fact that there is no interaction or collaboration between these institutions and the dermatologists in the West African Regions to form a joint or collaborative training programme for man-power development.

The point I am trying to put forward is the fact that various international bodies and countries in my view had tried their best to assist in the establishment of dermatological care and training programmes in various parts of Africa (except in Nigeria). But I failed to see an appreciable effort being made within African academics, professionals or government bodies to improve the dermatology practice, training or research in the continent.

While trying to square up to the challenges we are facing today in delivering appropriate dermatology care to the population, we must start with the training of "appropriate groups" that will deliver dermatological services to them. Training of dermatology care providers should be at 3 levels of the health care system as we have in most of the African countries today - The Primary, Secondary and the Tertiary.

At the primary health care level, efforts should be made to ensure that all medical students have a minimum level of training in the clinical recognition and treatment of commonly encountered skin diseases that are prevalent in our environment.

Nursing trainees and CHEWS who make up the bulk of health personnel at the PHC level e.g. in Nigeria should also receive basic training in the recognition and management of simple skin problems at the PHC level and how to timely refer patients to the doctors, who would be given more responsibilities to handle cases that are referred to them.

At the 2nd tier level of training, it is essential that medical students have adequate exposure to clinical dermatology, so that they have fairer knowledge of the spectrum of common skin diseases in our environment. Based on my experience as a teacher, I would recommend a minimum of 6 weeks full time attachment or rotation in a dermatology unit or department during the medical students' training period. The students should be mandatorily assessed and examined in dermato-Venereology which must be passed before graduating. In addition to this, 6 weeks medical students should be exposed to community dermatology training when undergoing their community medicine posting usually in the final year at the medical school.

During the community medicine posting of the medical students, they should be taught more, in problem based learning in chronic skin presentations, as usually encountered in the rural areas, as well as in psychological and social issues that emerge as a result of skin problems in the communities.

I feel that this type of exposure would also help the cadre of doctors that go into private practice at the end of the day.

The doctors that choose public health/community medicine as their future career should be exposed to a minimum of 3 months posting/training in dermatology during their residency training.

It stands to reason that a doctor wishing to specialize in General Medicine, should go through a prescribed training in dermatology and examined in this sub-

specialty before he/she is certified a consultant in General practice medicine. We should consider part-time training or part-time rotation programme for GPs which will equip them to take special interest in dermatology and which could also enable them to become full dermatologists without going through the rigor of the traditional residency programme.

Currently in Nigeria, general practitioners are made to collect (points) as part of their continuous education programme. The traditional CME lecturers for doctors in which the lecturers show as many slides as he can in the allocated time, does not in my view meet the needs of the GPs, who attend such lectures, just to collect the mandatory points per year. We need to be more proactive and initiate new ideas as to how dermatology education can be better delivered, in a more rewarding way, beneficial to the GPs, increase their knowledge base and even become dermatologist through short clinical attachments to dermatology clinics with attendance at dermatology teaching clinics.

The RDTC among others provided a 2-year dermatologic training programme for medical assistants and nurses from Kenya, Malawi, Botswana, Cameroon, Swaziland, Uganda, Ghana and Sierra-Leone. Nigeria never benefited from this programme.

We can award GOPs that attend such in-house training a Diploma in Dermatology. Make it a 2-year programme and later allow those who have the diploma a train for another 2-3 years to award them a Fellowship in Dermatology.

For the post-graduate dermatology training i.e. after earning a medical degree, the length of training as a general dermatologist, to be eligible for Board Certification by the corresponding board should be a minimum of 3 years depending on the country.

This training usually consists of an initial medical and surgical year followed by a 3-year dermatology residency. Following this training, one or two years post residency fellowships are available in various specialties e.g. immune-dermatology, phototherapy, and laser medicine, Micrographic surgery, cosmetic surgery and dermatopathology which would be accessed later.

In West Africa, a dermatologist certifying Board should be established to give directions on the training and certification of dermatologist in West Africa as it is the practice in the USA and some parts of Europe. The Board should be empowered to direct the content of training in the specialty, the duration, and the minimum sub-specialty that the dermatology trainee must go through within a specific time frame, which I suggest, should span a minimum of 3 years. Call this West African Dermato-Venereology Fellowship.

The Board should accredit the schools top trained dermatologist and the accreditation criteria must be standard.

Majority of our colleagues in the medical practice, arrogate to themselves the inalienable right to determine which specialty should be accorded the honour to be recognized as a specialty or subspecialty of medicine and surgery, forgetting or unaware of the fact that internal medicine which they consider as the mother of all medical profession is in itself a specialty or sub-specialty of medical practice just as dermatology, which mirrors to the outside world what happens internally is a specialty of medical practice on its own.

RECOMMENDATIONS AND CONCLUSION

1. Product endorsement by NAD

NAD should start the process of improving on its process/criteria for the endorsement of dermatological related products. I know that this process is already being initiated.

This scheme is yielding good results. However, I wish to suggest that the process of endorsement should be improved on, given the fact that substandard products are sometimes imported into the country. Our endorsement of these products needs to be backed up by some basic laboratory or bio-chemical tests carried out locally. (I have just read in the NAD's minutes that

this is also being considered).

A contact allergy screening tray could be established based on identified core allergens in these products which should be used by our Association (NAD) as a screening process before endorsing any of these products. Toxicity tests could also be carried in collaboration with relevant organs or laboratories. We could collaborate with the Faculties of Pharmacy.

2. Dermatology Board for Certification of Dermatologists

We should start planning for the establishment of Certification Board for Dermatology in West Arica and influence policy for the establishment of such.

The Board or a group of dermatology teachers should develop a training curriculum for dermatologists. This should be uniform across the country and the West African sub-region. The curriculum should be divided into segments of essential dermatology posting/rotations taking cognizance of available resources (manpower and expertise).

3. Regulatory Authorities

- Self-regulatory process on dermatological practice must be put in place, pursued and regularly revised/updated. This guideline will include:
  - Treatment
  - Training of dermatology specialists
  - Intra-disciplinary research among dermatologists
  - Protocols for treatment of dermatological diseases

In addition, we should be looking forward as we increase in numbers to form working groups to look into issues such as:

- Continuous education in dermatological practice especially for private practitioners
- Continuous update in Dermatological practice and Research for consultants.
- Involvement of GP in conference or workshops such as we are having now
- Lobbing to influence decision making process on dermatological issues
- Working closely with other specialties with common interest e.g. Plastic Surgeons to promote Aesthetic Dermatology as a sub-specialty in Dermatology
- Formation of Dermato-Venereology examination/accreditation Board and get it accredited.
- Multi-disciplinary Research collaboration between Dermatologist and other relevant discipline e.g. microbiology and parasitology, anatomy (Histo-Chemistry), Immunology.
- Community based dermatology care at the Primary Health Centre facilities
- A uniform residency curriculum for Dermato-Venereology across the West African Country (or in Nigeria for a start).
- Collaboration within and across the continent
- Centers of excellence in specific areas of specialization and encourage exchange programmes during residency training program within the region.
- Quality Standard for Dermatological Practice.
- Training of Dermatology Teachers.

CONCLUSION

The challenges facing dermatological practices in West Africa are numerous and appear insurmountable given what lies ahead of us to catch up with - the past, the present, and the future. Hence, we must start earnestly to work on the present, setting our goals to square up with these challenges. The past is gone with the older generations, even though we must learn from the past as well. We must define clearly, with timeline and action plans what we must achieve in the coming years to meet up with standard International Dermatological Practices.

Presently, I do not feel that Dermatology as a career is very attractive to our younger colleagues in West Africa. Many do not see it as a viable specialty, worth pursuing. A career path in Dermatology practices must be created to make the specialty attractive to the younger ones coming after us, as many do not see a future in it, either economically, academically or even scientifically.

For a start, we should negotiate to have a reasonable training slot e.g. a block of 6 weeks training in dermato-venereology for the medical undergraduates in our various medical schools, whereby the students would develop a firsthand insight into the fascinating field of dermatology and grasp the basics of clinical dermatology, and very basic laboratory investigations that would enable them to provide basic dermatological services even if they happen to be posted to the rural areas or to the primary health care centers. Every dermatology ward, even dermatology out-patient clinic should have side-room laboratory however small.

Experiences had shown that the majority of medical doctors, who are posted to rural areas for their Youth

service postings in Nigeria are excellent in the practice of surgery, and obstetrics, particularly D&C, but are naught when confronted with simple impetigo or napkin rashes or chicken pox.

It is my view that medical students who are exposed to some basic dermatological training during their medical school period are likely to take interest in pursuing the discipline as their future career. The dermatology consultant/teachers should detect such students and guide them properly to make a choice as to their future career in Medicine.

Despite the challenges facing us as dermatology consultants and teachers, we should not give the impression to the young medical students that dermatology treatment is only about prescribing steroid and antibiotic creams, but to teach these students that there are other arrays of treatment, which the system and environment in which we practice are not providing.

In West Africa, a dermatologist certifying Board should be established to give directions on the training and certification of dermatologist in West Africa as it is the practice in the USA and some parts of Europe.

I was very pleased and happy but at the same time amazed when a young resident dermatologist in training came to me to ask if I had cyro-therapy machine which their consultant dermatologist talked to them about, but which she could not show or demonstrate to them because there was none available at the teaching hospital. The good part of this is that the Consultant found it important to teach the trainees about the existence of this type of management in dermatology practices even though it was not available to her to demonstrate its usage.

I might have spoken as a frustrated dermatologist - frustrated in the sense that what I had set out to do had not been achieved at the end of the day.

This frustration became more evident recently, when I had to re-arrange my library, and was going through past works, files, unfinished manuscripts, dermatological research protocols of years back, sketches of equipment prototypes and treatment which I brought down from Europe, years back, but which I never had time to use the way I had intended to. I then stormed out of the library meeting my wife in the corridor I busted out saying "Oh! I have done enough. Let her continue with my work!"

I am not sure if I was understood, who I referred to as HER.

Let me thank the department of Dermatology and Venereology OAU for giving me the hope to have been able to say those words with confidence.

Almost in the same vein, I would repeat: Let us all ensure that we have trained those that will take over from us to fulfill our dreams.

It is like building blocks. When you start to build, you put one block put in place and then another one on top and another one on top. Our objective is to build up dermatology. Let us start to build through efficient manpower development.

I have chosen a profession, which I stand by. It is a noble one that stands out clearly. The skin reflects the body to the world. It can attract and it can also repel. Let us make the choice to make the skin attractive in all ramifications.

In dermatology, you cannot deceive your patients. They see what we have done to their skin. A healthy and beautiful skin is the testimony of our profession.

Let me conclude the way I concluded my inaugural lecture at OAU 30 years ago by quoting:

The black skin is the most beautiful skin in the world and there is no controversy about it.