Psoriatic Disease Response Index

Africa

IFPA
GLOBAL LEADER IN FIGHTING
PSORIATIC DISEASE

Content

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Preface

The African region is home of one of the most active and expanding psoriatic disease patient communities. As long-established, newly-formed and perspective patient organizations start their journey into regional advocacy, the local conversation gradually shifts towards structural and societal challenges that people living with psoriatic disease experience every day.

While governments in the region have focused on combating communicable diseases for decades, the burden of noncommunicable diseases (NCDs) continued to grow, and now NCDs are on the way of becoming the main cause of mortality.

Because of gaps in data, high level of stigma, and structural issues within health systems, the burden of psoriatic disease in Africa is still unknown. Individuals who receive a diagnosis face difficulties in accessing specialists and treatments. Medications for psoriatic disease are, in certain settings, either unavailable or unaffordable.

This has to change. This can be changed.

As cardiovascular disease is now driving NCD mortality[1], policies for NCDs such as diabetes, cancer, cardiovascular disease, and chronic respiratory diseases have slowly been adopted. Governments and health care professionals are more aware of NCDs, people affected and their families are learning about them and teaching the public about these emerging diseases.

The Psoriatic Disease Response Index: Africa provides a glimpse into how psoriatic disease is managed by four countries in the region. It highlights the remarkable efforts that IFPA member associations in those countries are making to radically change perception of the disease and support those living with it. The Index pinpoints barriers to proper management of psoriatic disease that can be overcome by following the recommendations laid out in the World Health Organization's Global Report on Psoriasis. As its predecessors – the Psoriatic Disease Response Index Europe, Western-Pacific, and Americas – it is an advocacy tool mapping out challenges, so that they can be overcome.

In a rapidly changing world, where long-standing power structures are losing their stability, creating ripple effects for millions worldwide, it is only through solidarity and unity that progress can be made. The psoriatic disease community, in Africa and worldwide, stands united to make sure that no one is left behind.

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Executive summary

Background

Psoriatic disease, encompassing psoriasis (PsO) and psoriatic arthritis (PsA), is a chronic, noncommunicable, immune-mediated condition associated with substantial physical, psychological, and economic burden. The burden of psoriasis varies considerably across Africa. According to the Global Burden of Disease (GBD) 2019 study, an estimated 40.8 million cases were reported globally, with substantial heterogeneity across African countries. In 2019, South Africa recorded the highest prevalence among the sampled countries (119,491 cases), while Ghana (63,901) and Kenya (60,934) experienced comparable burdens, and Rwanda reported a lower prevalence (14,860), highlighting marked regional variation (1).

> “This report assesses health system responsiveness to psoriatic disease across four sample countries: Kenya, Ghana, Rwanda, and South Africa.

In 2016, the World Health Organization (WHO) released the Global Report on Psoriasis (2), designed to support policymakers by providing practical strategies to strengthen health care delivery and promote the social inclusion of people living with psoriasis. Building on the WHO's recommendations, the International Federation of Psoriasis Associations (IFPA) developed the first Psoriatic Disease Response Index for Europe in 2020, assessing health system responsiveness to psoriatic disease across five countries (3). Subsequently, IFPA expanded this initiative through the development of a Western Pacific Region (WPR) Index Report, evaluating progress in psoriatic disease care in Australia, China, Japan, the Philippines, and Singapore (4). A further Index Report for the Americas was also produced, examining health system performance in five representative countries: Argentina, Canada, Colombia, Panama, and the United States (5). As part of this ongoing global effort to monitor implementation of WHO-aligned priorities, IFPA has now undertaken the development of an Index Report for Africa. This report assesses health system responsiveness to psoriatic disease across four sample countries: Kenya, Ghana, Rwanda, and South Africa.

> “The burden of psoriasis varies considerably across Africa.

Methods

Evidence was gathered through a literature review of published and grey literature, supplemented by local materials from IFPA member organisations, and a structured programme of stakeholder interviews conducted in each country. Stakeholders included dermatologists, rheumatologists, general practitioners, nurses, academic researchers, and people living with psoriatic disease, with 35 interviews completed across the four countries. The interviewers followed a discussion guide to keep data collection consistent across interviews. Findings were synthesised and evaluated against ten WHO-aligned indicators using a predefined 1–3 scoring scale to reflect levels of progress. This pragmatic framework enabled cross-country comparison while accounting for contextual differences in health system capacity and resources.

Table 1: Summary of indicator scores

Indicators	Ghana	Kenya	Rwanda	South Africa
Awareness campaigns	3	3	3	3
Perceived discrimination	1	1	1	1
Training for GPs	2	2	2	2
Treatment guidelines	1	1	2	3
Support for adherence	1	1	1	1
Wellbeing assessments	2	2	2	2
Time to diagnosis	2	1	1	1
Access to medicines	1	1	1	1
Specialist care access	1	1	1	1
Economic costs	1	1	1	1

Key: GPs = General practitioners

Results

Across the four countries assessed, implementation of the WHO Global Report on Psoriasis recommendations remains limited and uneven. While some progress is evident, particularly in civil society–led awareness efforts, substantial structural and systemic gaps persist across nearly all domains of psoriatic disease care. Public awareness campaigns represented the strongest-performing indicator, scoring highest in all countries. National patient organisations actively organise World Psoriasis Day initiatives and other outreach activities, contributing to increased visibility of psoriatic disease. However, these efforts remain largely urban-centred and resource-constrained. Importantly, high awareness activity has not translated into meaningful reductions in stigma. Perceived discrimination scored lowest across all settings, with persistent misconceptions – including beliefs that psoriasis is contagious or associated with curses, continuing to drive social exclusion, workplace discrimination, delayed care-seeking, and psychological distress.

Provider capacity remains constrained. Although some training opportunities for general practitioners exist in all countries, these are generally informal, association-led, or delivered through continuing medical education rather than embedded within core curricula. As a result, misdiagnosis; particularly confusion with fungal infections and delayed referral are common. Treatment guideline availability varied considerably: Ghana and Kenya lacked nationally adapted guidelines; Rwanda's guidance was limited and embedded within broader dermatology materials; and South Africa had more comprehensive guidance for PsA, although psoriasis protocols were reported to be outdated.

> **While some progress is evident, particularly in civil society-led awareness efforts, substantial structural and systemic gaps persist across nearly all domains of psoriatic disease care.**

Patient engagement indicators revealed consistent weaknesses. Structured support for medication adherence was absent in all countries, with care largely limited to brief verbal counselling at the point of prescribing. While physical comorbidities are typically assessed once patients access specialist services, mental health evaluation remains inconsistent and rarely integrated into routine care. The use of patient-reported outcome measures, such as the DLQI, is largely confined to tertiary centres or biologic eligibility assessments, indicating that patient-centred wellbeing evaluation is not systematically embedded within care pathways.

Conclusions

The findings of this report lead to the following prioritized recommendations:

- Pursue public awareness campaigns to reduce stigmatization in the general public
- Reduce the patient/provider stigma associated with mental health care
- Promote accessibility and equality of care for those who live in remote areas
- Reduce out-of-pocket costs, in part by advancing universal health coverage
- Increase the availability of specialists, or train GPs to support with care
- Reduce waiting times for specialists
- Raise awareness regarding the early diagnosis of psoriasis and the prevention of disability

Rationale & objectives

Psoriatic Disease

Psoriatic disease is a chronic, noncommunicable disease that affects the skin (psoriasis [PsO]), joints (psoriatic arthritis [PsA]), and sometimes other organs of the body (6). Skin symptoms of psoriatic disease typically present as scaly, red, and itchy plaques, while joint symptoms include pain, swelling, and stiffness. Although the exact cause remains unclear, it is thought to result from a combination of genetic and environmental factors that trigger a dysregulated immune response, leading to chronic inflammation primarily affecting the skin and joints. Given its systemic nature, psoriatic disease is also associated with comorbidities such as cardiovascular disease (CVD), metabolic syndrome, obesity, inflammatory bowel disease, and mental health disorders (7-10).

According to the Global Burden of Disease (GBD) 2019 study, psoriasis remains an important chronic inflammatory skin disorder worldwide, with an estimated 40.8 million prevalent cases reported globally in 2019. Within Africa, country specific estimates indicate that Kenya and Ghana experienced a comparable burden, with 60,934 (95% UI: 58,821–63,192) and 63,901 (95% UI: 60,284–67,619) cases, respectively. A comparatively lower burden was observed in Rwanda, which recorded 14,860 (95% UI: 13,995–15,826) cases. In contrast, South Africa demonstrated a substantially higher prevalence, with 119,491 (95% UI: 115,279–123,466) cases in 2019, highlighting notable heterogeneity in psoriasis burden across African countries (1).

Individuals living with psoriatic disease often experience significant economic and quality-of-life (QoL) burden throughout their lifetimes. Evidence from rural community settings indicates a substantial QoL burden associated with chronic skin disease in Ghana. A population-based study using the Dermatology Life Quality Index (DLQI) reported 19% experienced a moderate effect, 16% a large effect, and 1.7% an extremely large effect on QoL, while 30% reported no impact (11).

Addressing the needless suffering of people living with psoriatic disease

In 2014, efforts from the international patient community led to the adoption of the Resolution on Psoriasis by the World Health Assembly (WHA 67.9) (12). The Resolution underscores that "too many people in the world suffer needlessly from psoriasis" and mandates the publication of a report on the public health impact of psoriasis." In 2016, the World Health Organization (WHO) published the Global Report on Psoriasis (13), intended to "empower policy-makers with practical solutions to improve the health care and social inclusion of people living with psoriasis in their populations." The report compiled a variety of recommendations for different types of stakeholders including governments and policymakers, health systems and health professionals, and patients' organizations and civil society.

> Given its systemic nature, psoriatic disease is also associated with comorbidities such as cardiovascular disease (CVD), metabolic syndrome, obesity, inflammatory bowel disease, and mental health disorders.

Index Report for Africa

The African region, defined by the WHO, consists of approximately 1.53 billion people across 47 countries (14, 15). This geography consists of a diverse mix of socioeconomic, cultural, geographic, and environmental conditions that are evolving over time and influence how health systems respond to different health challenges. Consequently, the wellbeing of many individuals with psoriatic disease depends on the Africa progress towards the goals listed in the WHO Global Report on Psoriasis.

The Psoriatic Disease Response Index – Africa (Africa Index Report) aims to measure health system responsiveness to the recommendations detailed in the WHO Global Report on Psoriasis. Thus, indicators were developed with the goal of measuring progress towards implementing the recommendations listed in the WHO Global Report on Psoriasis. Ten indicators across five categories - public awareness, provider awareness, patient engagement, health systems, and enabling environment – were selected for assessing the progress of psoriatic disease care in the Africa. They were chosen for this report based on relevance for people living with psoriatic disease, the likelihood of identifying data and the ease with which the associated recommendations can be implemented.

> **“ The Psoriatic Disease Response Index – Africa (Africa Index Report) aims to measure health system responsiveness to the recommendations detailed in the WHO Global Report on Psoriasis.**

This Africa Index Report included a sample of countries (Ghana, Kenya, Rwanda, and South Africa), based on the presence of a local IFPA member association and diversity in geography, culture, and economics. The evidence base of this report was collected from a mix of published literature and interviews with local stakeholders. In line with the Western-Pacific Region Index Report published in 2023 (4) and the Americas Index Report published in 2025, the Africa Index Report includes data and stories from people with psoriatic disease.

The purpose of the Africa Index Report was to provide a summary of the selected countries’ progress towards implementing the recommendations listed in the WHO Global Report on Psoriasis and encourage further measures to support the health and wellbeing of people with psoriatic disease in this region.

Africa countries included in study

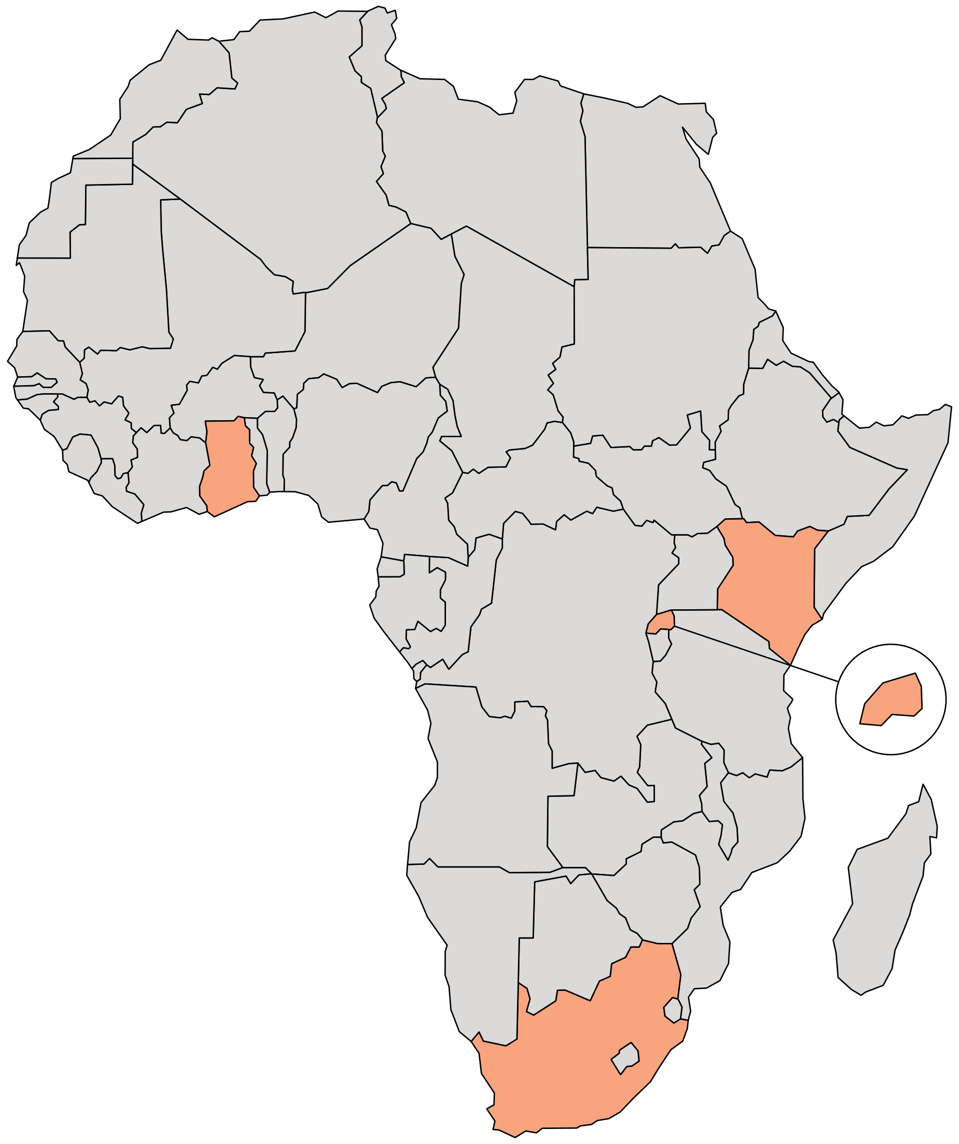


Figure 1: Map of the Africa region, with sample countries highlighted (Ghana, Kenya, Rwanda and South Africa).

10 indicators of interest

- Public awareness campaigns
- Discrimination and stigmatization
- Training for general practioners
- Treatment guidelines
- Support for medication adherence
- Patient-centric investigation of wellbeing
- Time to diagnosis
- Access to medicines
- Access to specialist
- Direct and indirect costs to the economy

Methods

To collect data for the index scores, a targeted literature review and a series of stakeholder interviews were conducted. The details, including scope and approach for each review method, were pre-specified in a study protocol that was followed throughout the course of the work.

The literature review collected records that met the eligibility criteria from bibliographic databases, ad-hoc google searches for grey literature and materials sent in by local IFPA member organizations. Those records were then screened in two steps for relevancy to one or more of the chosen indicators, and then included for extraction. Relevant data for each indicator was then extracted into a grid for the data synthesis process.

In tandem with the literature review, a series of stakeholder interviews were conducted to provide context and a variety of perspectives in the chosen countries. Twelve interviews were planned in each of the four countries, including two of each of the following stakeholders: dermatologists, rheumatologists, academic researchers, general practitioners GPs, nurses, and people living with psoriatic disease. The interviews followed a discussion guide, responses were recorded and collected in a grid for the data synthesis process.

Index scoring followed a simple scoring approach of 1, 2 or 3, based on a set of pre-defined criteria to represent progress towards the recommendations from the WHO Global Report on Psoriasis.

The methods and scoring criteria are described in more detail in Appendix B.

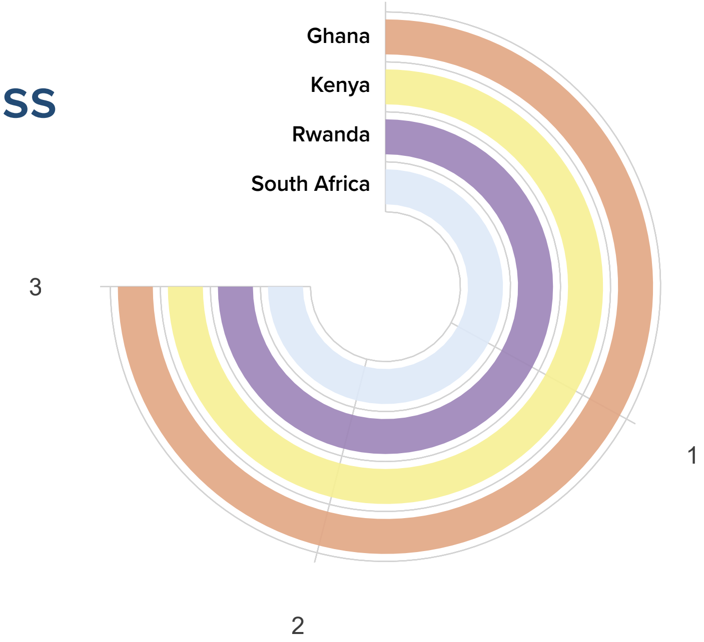
Public Awareness Campaigns

Public awareness and understanding of psoriatic disease including recognition of symptoms, impact on daily life, and available treatment options can shape how individuals living with the condition are perceived and supported within society. At the health-system level, increased awareness can support resource allocation, government-led initiatives, and the access to appropriate healthcare services. However, awareness of psoriatic disease remains limited in many settings, with the level of understanding differing considerably between countries (16, 17).

Across the African Region, as in other parts of the world, patient organizations and healthcare stakeholders actively deliver events and awareness initiatives to engage people living with psoriatic disease, healthcare professionals, and the wider public. Larger campaigns often aim to strengthen collaboration across countries and support coordinated advocacy at both national and international levels. A key example is IFPA's World Psoriasis Day (29 October), which is promoted globally to raise public awareness and encourage greater support for individuals living with psoriatic disease.

> “At the health-system level, increased awareness can support resource allocation, government-led initiatives, and access to appropriate healthcare services.

Country progress



Ghana — 3

In Ghana, evidence indicates that public awareness activities for psoriatic disease are primarily led by the Psoriasis Association of Ghana (PAG). These campaigns try to target members of the public with the goal of improving understanding of psoriasis and reducing stigma associated with visible skin disease (18). For World Psoriasis Day 2024, PAG held an awareness walk and educational forum themed “Psoriasis and the Family,” emphasizing the impact of psoriasis on people living with it, their caregivers, and family members. The campaign included education on prevention and promoted respectful and compassionate treatment of people living with psoriatic disease. Campaign messaging explicitly highlighted the need to address stigma and misconceptions surrounding psoriasis (19). Additional evidence also demonstrates community-level awareness outreach beyond annual observances. A public psoriasis awareness outreach conducted on 11 May 2025 in Cape Coast, in collaboration with a local radio partner (TW Radio Station), included public education activities, distribution of educational flyers and branded materials, direct one-on-one engagement with community members, and involvement of community leaders (20).

Kenya — 3

Public awareness activities related to psoriatic disease in Kenya have been implemented through both individual advocacy and initiatives linked to patient organizations. The Psoriasis Association of Kenya (PAK) has supported structured awareness efforts, including a World Psoriasis Day 2023 symposium with a documented agenda, participant discussions, and presentations (21). In addition, a recently published feature describes a former Kenyan High commissioner, Rose Jebiwott Boit, as a “psoriasis ambassador”, and indicates that she began creating awareness on skin conditions and started advocacy via a stress management consultancy (22). Reports also suggest that public information campaigns may be contributing to improved attitudes, with people living with psoriasis increasingly feeling able to go out, use public transport, and explain their condition when asked. Interview findings further indicate that both PAK and the Dermatological Association have conducted previous and ongoing awareness activities; however, these efforts reportedly engage mainly healthcare providers and patients, with limited outreach to the public.

Rwanda

3

In Rwanda, evidence suggests that public awareness activities related to psoriatic disease are emerging and are primarily led by the Rwanda Psoriasis Association (RPAO/RwandaPsO). RPAO obtained legal status in April 2024 and has since started raising public awareness, including a press briefing on 2 June 2024, with a stated focus on awareness, knowledge, and advocacy. Rwanda has also marked World Psoriasis Day (29 October) since 2024 (23, 24). Interview findings indicate that while no sustained national campaign is currently ongoing, RwandaPsO has conducted awareness activities through meetings with dermatologists and targeted media engagement, including a Kigali-based World Psoriasis Day event involving journalists, health centre managers, and nurses, supported by the dermatological association. Educational leaflets were distributed to healthcare staff and referral messaging was included, although outreach was described as largely Kigali-centred, with some efforts planned to expand to rural areas.

> **Psoriasis is not a popular disease in terms of awareness, so there is a lot of misinformation about it. Some people think it is a curse; we have members who also face the stigma of witchcraft, who seek help from traditional remedies.**
>
> *Person living with psoriatic disease in Kenya*

South Africa

3

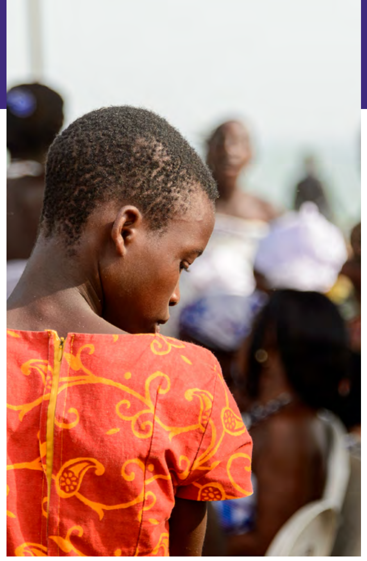
Public awareness activities related to psoriatic disease appear to be primarily driven by the South African Psoriasis Association (SAPSA), with limited evidence of broader government-led or other non-profit awareness initiatives. World Psoriasis Day (29 October) is recognised as an opportunity to increase awareness of psoriasis and strengthen support for individuals living with the condition. Interview findings suggest that SAPSA-related activities take place annually in major cities such as Johannesburg and Cape Town, supported by an active website and patient support channels including WhatsApp groups (26). Stakeholders also noted informal advocacy through individual ambassadors and occasional educational materials; however, awareness efforts were commonly described as concentrated around World Psoriasis Day and constrained by limited resources, which may affect consistency and sustainability beyond annual events.

Recommendations for best practice from the WHO Global Report on Psoriasis

1. Patients’ organizations must continue advocating for the rights of individuals suffering from psoriasis. They should be involved in raising awareness of psoriasis among the population in collaboration with governments and policymakers.
2. Society, not psoriasis, causes the exclusion and discrimination faced by people with this disease. This situation can change through campaigns to raise awareness of psoriasis among the population and by condemning discrimination of patients who suffer from it.
3. Patients’ organizations have a responsibility to encourage the formation of patients’ associations where currently none exists.

Source: WHO 2016 Global report on psoriasis (14)

Discrimination & Stigmatization

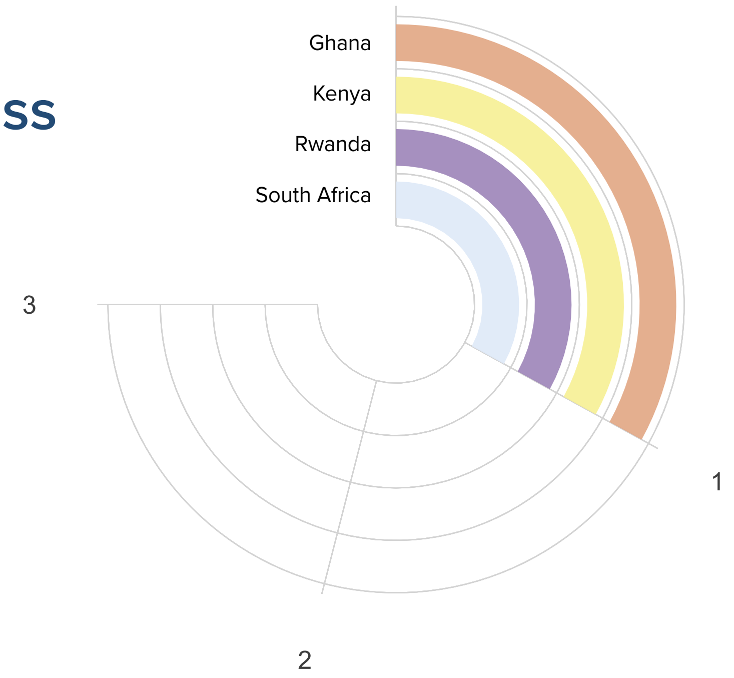


> Visible skin lesions and, in some cases, joint deformities can contribute to misunderstanding and negative reactions, particularly when misconceptions such as fears of contagion persist.

Stigmatization in psoriatic disease reflects negative social attitudes toward affected individuals, while discrimination refers to unfair treatment that may arise from these perceptions. Both have serious consequences, as many people living with psoriatic disease experience some form of stigma or exclusion. Visible skin lesions and, in some cases, joint deformities can contribute to misunderstanding and negative reactions, particularly when misconceptions such as fears of contagion persist. These perceptions may lead to social avoidance and create barriers in employment, especially in customer-facing roles, while also affecting family, social, and romantic relationships. Moderate to severe psoriasis has been associated with extended work absence, undermining job stability and financial security. Overall, evidence consistently indicates that psoriatic disease can significantly impact self-image, self-esteem, and quality of life across psychological, physical, social, sexual, and occupational domains (26-28).

Addressing the psychological and socioeconomic consequences of stigma in psoriatic disease is essential. Strengthening public understanding through education and the visibility of lived experiences may help challenge misconceptions and reduce discrimination toward individuals living with the condition.

Country progress



Ghana

1

In Ghana, stigma associated with psoriatic disease was closely linked to limited public awareness and misconceptions, including beliefs that individuals with visible symptoms are contagious. Interview and literature evidence described instances where individuals were perceived as being "cursed," particularly when symptoms did not respond to common or traditional treatments, leading to rejection by family members and relationship breakdown. Impact on employment was also reported in some instances, including job loss and reduced ability to work due to visible symptoms, pain, delayed diagnosis, and untreated disease progression, including psoriatic arthritis. Several accounts highlighted severe psychosocial consequences, including emotional distress and family exclusion during disease flares. Evidence further indicates that one-to-one education and engagement by advocacy organisations has been effective in reducing misconceptions and encouraging earlier care-seeking (19, 20).

Kenya

1

In Kenya, stigma related to psoriatic disease was described as widespread and highly visible in everyday life, particularly in public-facing environments. Misconceptions that psoriasis is contagious were frequently reported to drive social avoidance in public transport, salons, and schools, with discrimination common-

> “I know people who have lost their jobs and others that have lost their relationships. Some people might think that it is a curse or some sort of spirit.
>
> *Nurse, Ghana*

ly affecting employment in hospitality and food-handling roles. Paediatric and adolescent individuals were identified as especially vulnerable, experiencing isolation in schools and within families, sometimes resulting in withdrawal from education or social activities. Cultural beliefs, including associations with curses or witchcraft, were reported to further exacerbate stigma and delay engagement with medical care (22, 29). Across interviews, stigma was described as a major contributor to emotional distress, low self-esteem, and self-imposed social withdrawal.

Rwanda

1

People living with psoriatic disease in Rwanda experience discrimination and stigma across multiple areas of daily life, particularly when symptoms are visible. Misbeliefs that the condition is infectious were reported to result in social avoidance in public spaces and discrimination in customer-facing jobs, with some employers requiring medical confirmation that the disease is not contagious (23, 24). Interviewees also described challenges in personal relationships and family life, including shame, relationship strain, and beliefs linking the disease to curses. These experiences were reported to contribute to social isolation and delayed healthcare-seeking, as individuals often avoided care until symptoms became severe.

South Africa

1

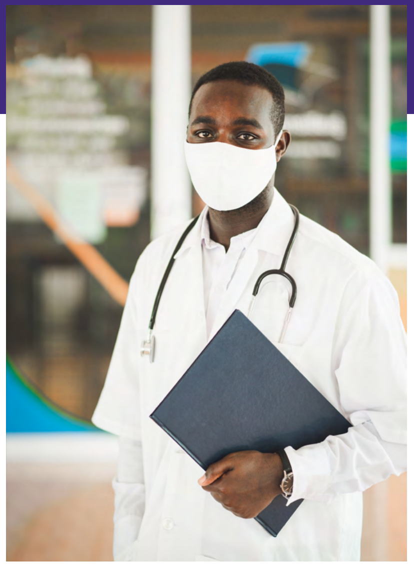
In South Africa, stigma associated with psoriatic disease was described as moderate to high and largely driven by low public awareness rather than specific cultural targeting of psoriasis (30). Interviewees reported that visible skin symptoms frequently led to anticipated or experienced discrimination, particularly in employment, with examples of individuals in customer-facing or food-related roles being sent home due to fears of contamination. School exclusion and bullying were also described, alongside social avoidance in public settings and strained personal relationships. Evidence suggests that stigma persists due to limited education and awareness, leaving many individuals self-conscious and emotionally burdened, even when discrimination is subtle rather than overt.

Recommendations for best practice from the WHO Global Report on Psoriasis

1. Governments have a key role in reducing stigma and discrimination.
2. Active steps by Member States include anti-discrimination legislation and enforcement of existing legislation.
3. Patients’ organizations have a key role in providing support to people suffering from psoriasis and in creating networks to foster mutual support and exchange of experiences.
4. Patients’ organizations and civil society have a key role in holding governments and policymakers to account on global commitments, and in fighting discrimination of people with psoriasis.

Source: WHO 2016 Global report on psoriasis (14)

Training for general practitioners

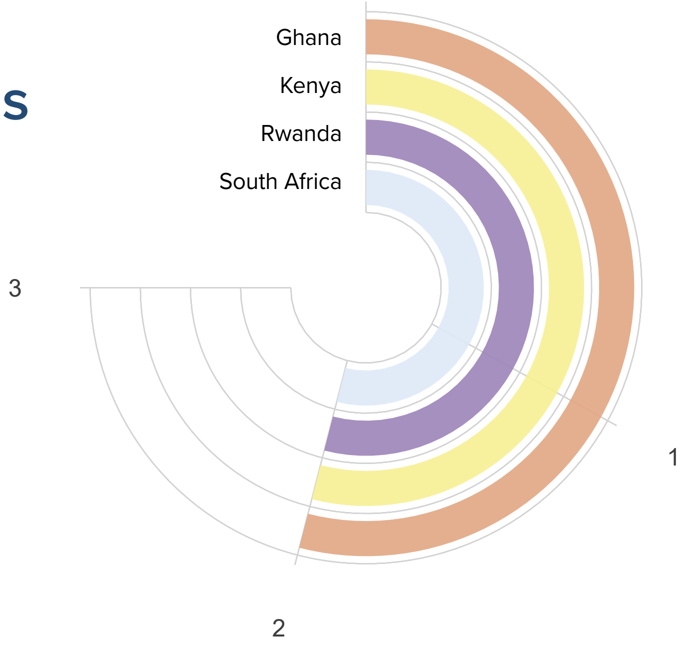


Individuals with early symptoms of psoriatic disease commonly first seek primary care, where GPs act as the initial point of contact. As the first point of contact in psoriatic disease care, GPs should play a crucial role in ensuring timely diagnosis, managing milder cases, and referring patients with moderate to severe symptoms to appropriate specialists when necessary.

Availability of psoriatic disease–related resources and the level of training among GPs vary considerably across healthcare systems (31-33), contributing to uneven capacity for disease recognition and management in primary care. In settings where clinical knowledge is limited, patients may be misdiagnosed, receive ineffective or inappropriate treatment, remain on suboptimal therapies for prolonged periods, or have associated comorbidities overlooked. Consequently, international bodies have increasingly emphasized the need to strengthen awareness and education on psoriatic disease at the primary care level (13, 34).

> “Patients may be misdiagnosed, receive ineffective or inappropriate treatment, or have associated comorbidities overlooked.

Country progress



Ghana — 2

Training opportunities for GPs and other primary care providers (PCPs) in Ghana appear to be available but remain limited in scope and consistency. Evidence indicates that the Psoriasis Association of Ghana (PAG) has organized awareness and training sessions for GPs focused on recognising psoriatic disease, basic management, and appropriate referral to dermatology specialists; however, these activities are not reported to occur nationwide. Stakeholders also described continuing professional development initiatives led by the dermatological association, including online Zoom-based meetings that provide guidance on identifying the disease and referring patients when uncertain. In addition, since 2010, the Utah Department of Dermatology has provided dermatology-focused continuing medical education (CME) for physician assistants through the annual International Seminar, representing the first specific CME courses in Ghana (35). Despite these efforts, interviewees repeatedly noted persistent knowledge gaps in primary care, with many frontline providers reportedly unable to recognise psoriasis and often treating patients unsuccessfully for fungal infections, highlighting the need for more systematic and broader training to support timely diagnosis and early intervention.

Kenya — 2

Evidence from Kenya indicates limited dermatology capacity among PCPs, who are the first point of contact for most patients outside major cities. One study found that only 5% (2/38) of surveyed PCPs felt comfortable diagnosing and

> Training more primary care practitioners (PCPs) would be useful because the truth is, most PCPs can’t recognize the disease; they keep treating it as a fungal infection.
>
> *Dermatologist in Ghana*

treating most skin conditions, highlighting potentially substantial knowledge gaps (36). Interviewee input suggests that while continuing education opportunities exist through CME programmes, tertiary-hospital webinars, and international or local seminars, access is inconsistent, and many frontline providers remain unaware of available training. Strengthening PCP education was emphasised as critical to reducing frequent misdiagnosis, particularly the common treatment of psoriasis as a fungal infection, and to support timely referral to specialist care where available.

Rwanda 2

A Ministry of Health–supported national initiative to strengthen rheumatology capacity is present in Rwanda, including intensive training of internists and the establishment of rheumatology-oriented units across district and referral hospitals (37, 38). Interviewees, however, reported that formal training on psoriatic disease for primary and secondary care providers remains limited and is often considered a low priority. Educational efforts are largely driven by RwandaPso and the national dermatological association, but their reach and psoriasis-specific content were described as brief and concentrated in tertiary settings. Training and access to information on PsA were described as particularly scarce, with interviewees noting that the severe shortage of rheumatology specialists leaves PCPs with almost no structured support in identifying or managing PsA. Overall, the evidence highlights an ongoing need for broader, more systematic training for frontline healthcare professionals across Rwanda.

South Africa 2

Published and interview evidence suggests that training for PCPs on psoriatic disease in South Africa remains limited and largely non-systematic. While some dermatology departments offer hospital-based bedside teaching and short online courses for medical and nursing professionals, dermatology nursing is not formally recognised as a specialty and workforce expertise is often insufficient (30). Education for GPs is generally sporadic and focused on basic recognition, mild management, comorbidities, and referral, with most providers relying on voluntary CME sessions, webinars, or self-directed resources such as DermNet or the EM Guidance app. Taken together, access to structured training is particularly constrained in public healthcare settings, leaving substantial gaps in frontline knowledge and consistent care delivery.

Recommendations for best practice from the WHO Global Report on Psoriasis

1. Specialist dermatologists are unavailable for the majority of people living with psoriasis, especially in low- and middle-income countries. The umbrella organizations of health-care providers should take the initiative to conduct education and training for physicians and other health-care providers such as nurses and community health workers.

2. Governments and nongovernmental organizations should provide education on common chronic skin conditions to health-care professionals, including undergraduate medical and nursing curricula and in service training for physicians in primary care. There is a great need to raise awareness and knowledge about psoriasis among general practitioners to increase early diagnosis and prevent disability.

3. All health professionals, especially clinicians working in primary health care, should be aware of psoriasis, its management and its co-morbidities. Health care professionals’ associations should provide training, for example, via the Internet for physicians from low- and middle-income countries, regarding prompt diagnosis and effective treatment of psoriasis. Patients with psoriasis need access to primary health care that responds to their individual needs and coordinates with any additional specialist care.

>>

4 The primary care provider, based on consultation with the patient, would seamlessly coordinate the inputs from various specialists, including dermatologists, rheumatologists, cardiologists and psychologists. Furthermore, if a dermatologist is not available, a general practitioner should monitor the progress of treatment, and in the case of relapse refer the patient to the appropriate specialists.

Source: WHO 2016 Global report on psoriasis (14)

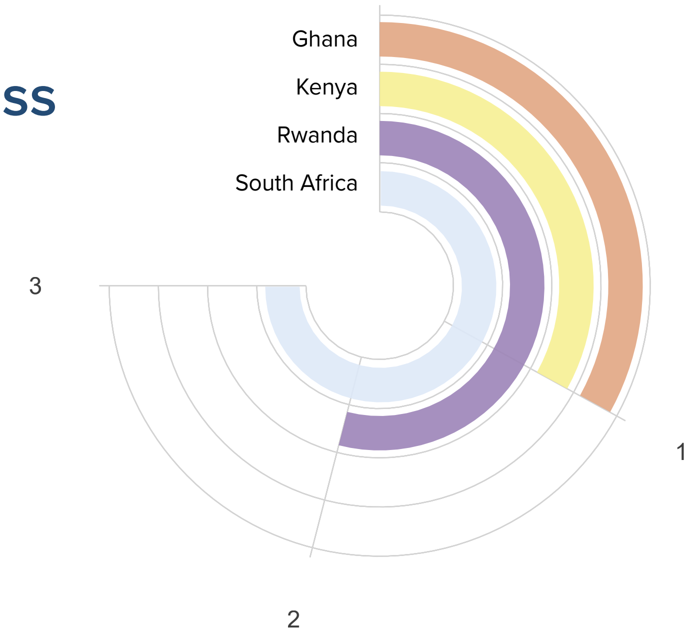
Treatment Guidelines

> “Evidence suggests that even in settings where such guidance exists, implementation in routine clinical practice is not always consistent.

Clinical treatment guidelines are a key component of effective psoriatic disease management, guiding GPs and specialists in achieving timely diagnosis, selecting appropriate therapies, and recognising the broader systemic complexity of the condition, including relevant comorbidities. Nonetheless, evidence suggests that even in settings where such guidance exists, implementation in routine clinical practice is not always consistent (34).

To strengthen patient outcomes, it is important that national or regional bodies responsible for clinical standards develop, adapt, and actively disseminate psoriatic disease guidelines to healthcare professionals involved in patient care. Research indicates that when clinicians incorporate guideline-based recommendations into everyday practice, the overall quality, coordination, and consistency of care for individuals living with psoriatic disease improves (39, 40).

Country progress



Ghana

1

No local treatment guidelines for Pso or PsA were identified in Ghana through either the literature review or stakeholder interviews. Interviewees reported that clinicians largely rely on international recommendations or limited external resources, including IFPA materials, although these are not always applicable given local constraints in specialist access and treatment availability. Stakeholders highlighted the need for updated, Ghana-specific guidance to support more consistent management, as care is often limited to symptomatic first-line treatment in primary settings with referral only when disease persists.

Kenya

1

No country-specific treatment guidelines for Pso or PsA were identified in Kenya through either the literature review or stakeholder interviews. Interviewees consistently reported that local or national guidelines are not formally available, particularly for PsA and newer therapeutic options, and that clinicians therefore rely on international guidance such as European League Against Rheumatism (EULAR), American College of Rheumatology (ACR), or other external dermatology and rheumatology recommendations. However, stakeholders noted that international guidelines are not always fully applicable in the Kenyan context due to differences in treatment availability, local market constraints, and population-specific considerations, including variation in skin types and disease presentation. Several respondents expressed a clear need for locally adapted guidance to support consistent clinical practice across healthcare settings. Limited references were made to Ministry of Health materials for mid-level hospitals that mention psoriasis primarily in terms of recognition and referral, rather than comprehensive treatment recommendations, underscoring an ongoing gap in standardized national guideline development

Rwanda 2

The available treatment guidance for Pso in Rwanda is currently limited. Available local guidance was embedded within broader general dermatology or multi-disease documents, with only brief and superficial coverage of psoriasis that may be outdated. Stakeholder perspectives highlighted the absence of clear, dedicated national protocols for psoriasis and a lack of locally specific guidance for PsA, resulting in frequent reliance on international or WHO-based recommendations among specialists. Several respondents expressed a need for more detailed Rwanda-specific psoriasis guidelines, noting that current practice is also shaped by constraints in medicine availability and supply continuity.

> **Apart from severity and location, the availability of medication and affordability are major considerations for treatment decision by clinicians**
>
> *Dermatologist in Rwanda*

South Africa 3

South Africa has locally developed treatment guidelines for both Pso and PsA, although their recency differs. Literature evidence identified recent PsA guidance aligned with international standards, including clear DMARD classification, multi-domain assessment, and a treat-to-target escalation approach using defined disease activity measures (41). In contrast, verbal accounts noted that available psoriasis guidelines are more than a decade old, having been published in 2010, and do not fully reflect newer therapies or current severity-based management, prompting calls for urgent updating. Several respondents indicated that revision efforts are underway, including initiatives to translate guidance into more patient-friendly formats, but psoriasis-specific protocols remain less current than those for PsA.

Recommendations for best practice from the WHO Global Report on Psoriasis

1. There is evidence that when health-care providers are aware of guidelines and implement them in daily practice, the quality of care for psoriasis patients is increased.

2. Guidelines on the treatment of psoriasis are required, including clinical protocols that can be implemented realistically in resource-poor primary care settings.

3. There is a great need to develop guidelines regarding the diagnosis of psoriasis and its treatment. Furthermore, certain standards relating to medical care such as adequate assessment of progress of therapy, using uniform tools to assess the severity of the disease and patient QoL should be implemented. Doctors should establish objectives of care and plan therapy in collaboration with their patients.

4. Health services research needs to be better used in identifying specific needs of health care, unmet patient needs and barriers of guideline-compliant treatment. Health services research should monitor and provide feedback on the actions taken to improve quality of care and investigate efficiency of care. PsO care could thus become a model for the management of other chronic (skin) diseases.

Source: WHO 2016 Global report on psoriasis (14)

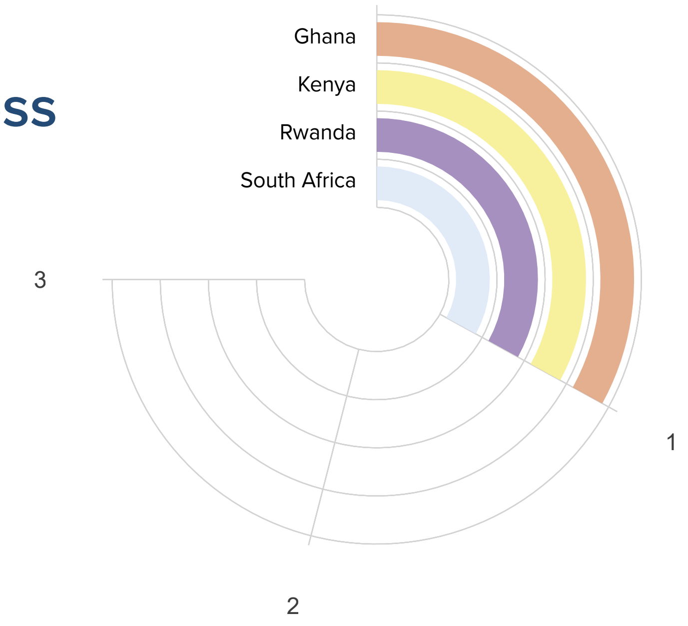
Support for medication adherence

> In the context of psoriatic disease, which requires long-term management, treatment discontinuation is common and often unavoidable.

Medication adherence is a key determinant of treatment effectiveness. In the context of psoriatic disease, which requires long-term management, treatment discontinuation is common and often unavoidable. Evidence consistently indicates that adherence rates among individuals with psoriatic disease remain suboptimal (42-45).

Non-adherence is frequently driven by reduced perceived efficacy, financial burden, concerns about adverse effects, and limited understanding of the disease or its treatment. Enhancing adherence therefore depends on ensuring access to appropriate, disease-specific information and supportive resources that enable informed and sustained treatment engagement.

Country progress



Ghana 1

No evidence on structured medication adherence support was identified in Ghana through the literature review. Verbal accounts indicate that adherence support in routine practice is limited to basic counselling and instructions from clinicians, sometimes reinforced by pharmacists or package directions, focusing on dosage, application, side effects, and the chronic nature of the disease. No dedicated adherence tools or programmes were reported. Stakeholders also noted that limited medicine availability and out-of-pocket treatment costs may further undermine sustained adherence in practice.

Kenya 1

Medication adherence support in Kenya is primarily delivered through direct counselling rather than formal tools or structured programmes. Stakeholder input indicated that clinicians, nurses, and pharmacists generally provide instructions on dosage, topical application, precautions, and potential side effects, but standardised educational resources such as leaflets are uncommon. Several respondents noted that high patient volumes and limited consultation time restrict the depth of adherence support, particularly in public care settings, with only brief reinforcement available at the pharmacy level. Although some providers described simple approaches such as pill organisers or linking treatment use to daily routines, dedicated adherence tools were generally not reported, and language barriers and limited follow-up may further challenge long-term adherence.

Rwanda

1

> We try at the first visit to both treat and educate the patient on how to adhere and why it is important to adhere. Sometimes we give the patients our number in case of any difficulties using the treatment.
>
> *Dermatologist, Rwanda*

In Rwanda, medication adherence support is primarily delivered through verbal counselling and basic instructions from clinicians at the time of prescribing. Interview findings suggest that pharmacists may occasionally reinforce written directions, and leaflets are provided for some treatments, but structured or disease-specific adherence tools are uncommon. Input from those interviewed highlighted that limited follow-up and variable patient understanding alongside the chronic nature of psoriatic disease may challenge sustained adherence, particularly where pharmacy-based support is inconsistent.

South Africa

1

Support for medication adherence in South Africa appears largely limited to informal clinical guidance rather than structured programmes or tools. Verbal accounts indicate that adherence support is mainly delivered through counselling and basic verbal or written instructions from clinicians, nurses, and occasionally pharmacists. No dedicated digital adherence tools or systematic tracking resources were reported, particularly within the public sector where services are overburdened and resources scarce. Some respondents noted that pharmaceutical company support programmes may be available for certain biologic or topical therapies, although these were described as limited in reach. Patient perspectives further highlighted gaps in ongoing support, with some individuals discontinuing prescribed treatment due to insufficient explanation or perceived lack of benefit and instead relying on self-directed use of over-the-counter products.

Recommendations for best practice from the WHO Global Report on Psoriasis

1 Low adherence is partly due to insufficient communication regarding instructions on how to use the drug, misperception of possible adverse events and mistaken expectations about the speed and degree of improvement.

2 Clinicians must inform patients about the possible consequences of the disease and collaborate with them to identify barriers to adherence and help address these barriers to achieve optimal management.

Source: WHO 2016 Global report on psoriasis (14)

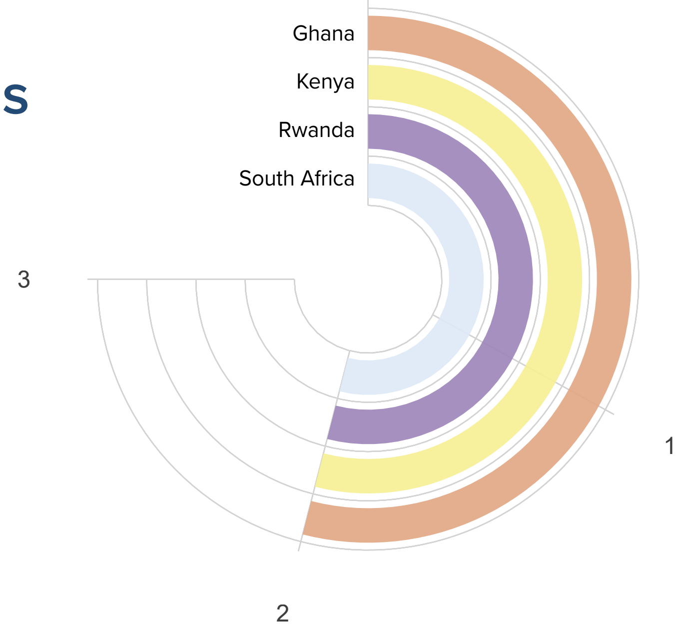
Patient-centric investigation of wellbeing

Health-related quality of life represents one of the most important outcomes for people living with psoriatic disease, reflecting the broader impact of the condition on daily functioning and overall well-being. Because generic quality of life measures are not disease-specific, they also provide a valuable basis for comparing the burden of different health conditions and informing resource allocation decisions.

Multiple dimensions of care can influence a person's quality of life. To ensure that management approaches reflect patients' needs and priorities, clinicians should routinely evaluate well-being using practical tools that capture both physical and mental health impacts. International guidelines recommend screening for common somatic and psychological comorbidities associated with psoriatic disease, alongside the use of patient-reported outcome measures such as the Dermatology Life Quality Index (DLQI).

> “Clinicians should routinely evaluate well-being using practical tools that capture both physical and mental health impacts.

Country progress



Ghana 2

The literature review yielded no country specific-evidence for this indicator. Insights from interviews suggest that physical well-being is routinely evaluated in clinical care, including monitoring of comorbidities and laboratory follow-up. Assessment of mental well-being appears more variable, occurring more often in private settings and typically prompted by visible psychological distress in high-volume public clinics. Structured patient-reported outcome measures and quality-of-life questionnaires were not described as being routinely implemented, with consultations often focused on clinical management rather than systematic well-being evaluation.

Kenya 2

Available published sources provided no evidence of formal well-being assessment approaches for psoriatic disease care in Kenya. Interview findings suggested physical assessments, including comorbidity screening and laboratory monitoring, are routinely conducted as part of follow-up care. Mental well-being evaluation appears less consistent, often limited by

> “Unfortunately, we do not use PROs. It's mainly because of a time constraint and high volume of patients.
>
> *Dermatologist in Kenya*

time constraints, stigma, and patient hesitancy, with referrals typically occurring only when distress is evident. Patient-reported outcome measures are not routinely used, although occasional DLQI or PASQoL application was noted in some tertiary settings.

Rwanda

2

The literature review did not identify published evidence on structured well-being assessment practices for psoriatic disease in Rwanda. Qualitative insights suggest that physical well-being assessments, including evaluation of comorbidities, are routinely incorporated into clinical care. In contrast, mental well-being assessment appears inconsistent, often limited by time constraints, high patient volumes, and persistent stigma surrounding mental health, with referrals typically made only when concerns are clearly evident. Patient-reported outcome measures and formal questionnaires were not described as routine practice, although occasional use of tools such as the DLQI was mentioned in some teaching hospital settings.

South Africa

2

Published literature did not yield evidence of structured well-being assessment practices for psoriatic disease in South Africa. Verbal accounts highlighted that physical monitoring is standard practice, but mental health assessment is variable and typically occurs only when distress is evident. PROs measures are not routinely used in general care, but are applied selectively in tertiary centres, particularly for biologic eligibility and monitoring, including tools such as the DLQI and rheumatology measures (PsAQoL, EQ-5D, pain VAS). Structured patient-centred assessment therefore appears largely confined to specialised settings that many people living with the disease do not regularly access.

Recommendations for best practice from the WHO Global Report on Psoriasis

1 Optimum treatment of psoriasis, and its comorbidities, require shifting to a model of people-centered and integrated health services. All people with psoriasis should have access to health services that are provided in a way that responds to their preferences, are coordinated around their needs and are safe, effective, timely, efficient and of an acceptable quality.

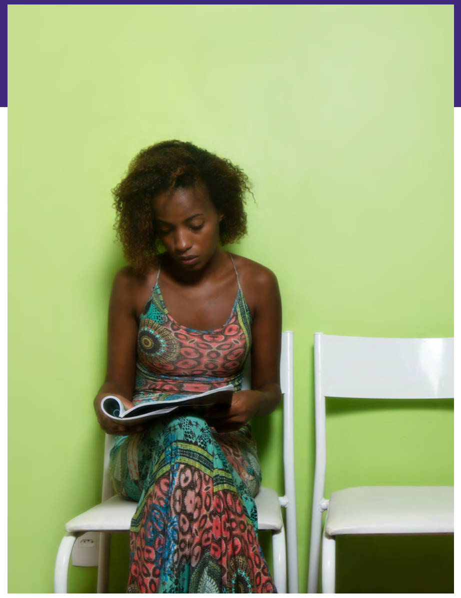
2 For research outcomes that are more reliable, the currently used clinical outcome parameters, including PASI and patient-reported outcomes such as DLQI, need to be improved.

3 Health services research needs to be better used in identifying specific needs of health care, unmet patient needs and barriers of guideline-compliant treatment. Health services research should monitor and provide feedback on the actions taken to improve quality of care and investigate efficiency of care. Psoriasis care could thus become a model for the management of other chronic (skin) diseases.

4 In settings with adequate resources, health-care professionals and health systems must strive to provide patients with comprehensive care from multidisciplinary teams of specialists, including dermatologists, rheumatologists, psychologists, psychiatrists, paediatricians, cardiologists and others.

Source: WHO 2016 Global report on psoriasis (14)

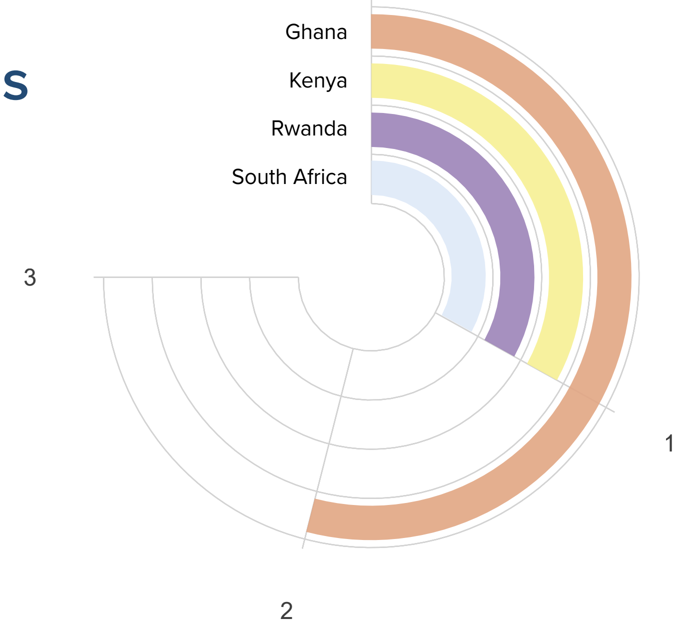
Time to diagnosis



Timely diagnosis of Pso and PsA is critical, as diagnostic delays can contribute to greater disease severity and poorer long-term health outcomes (42, 46-48). The interval between symptom onset and confirmed clinical diagnosis differs widely across healthcare systems and is shaped by multiple factors, including provider awareness, referral pathways, specialist availability, and patients' access to and engagement with care. Symptom severity and the pace of disease progression may further influence how quickly individuals are diagnosed. Reducing delays in diagnosis is therefore an important health system priority to improve outcomes and mitigate the overall burden of psoriatic disease.

> “Reducing delays in diagnosis is therefore an important health system priority to improve outcomes and mitigate the overall burden of psoriatic disease.

Country progress



Ghana

2

Published literature did not yield evidence on average time to diagnosis for Pso in Ghana. Interviews suggest diagnostic timelines vary considerably, with estimates ranging from 3–9 months for Pso and 2–12 months for PsA, reflecting delays in both recognition and referral. Several respondents rated time to diagnosis as slow in the public sector, often due to misdiagnosis at the pharmacy or primary care level and difficulties accessing specialist assessment, particularly for people living in rural areas. In contrast, private dermatology clinics were described as providing diagnosis within weeks, highlighting the influence of affordability and specialist availability. Overall, delays appear more pronounced for PsA, where limited awareness and referral pathways contribute to longer diagnostic intervals.

Kenya

1

The literature review did not identify published evidence on average time to diagnosis for psoriatic disease in Kenya. Verbal accounts suggest wide variation, from a few months in urban or specialist-access settings to several years in rural areas. Delays were attributed in part to individuals repeatedly seeking

> “Outcomes are better when patients get timely treatments across the board. Given that there is readily available treatment, the delay to diagnosis is unacceptable. Hospitals in public system are overrun and broken referral pathways as well as lack of awareness impact the delay.
>
> *Rheumatologist in South Africa*

pharmacy-based treatments before entering formal care, alongside slow referral pathways and general lack of awareness of the disease. Pso diagnosis was often estimated at several months but could extend to 3–5 years, while PsA was frequently described as taking years due to misdiagnosis and limited specialist availability.

Rwanda

1

Evidence from identified literature highlights substantial diagnostic delays in Rwanda, including reports of Pso diagnosis taking up to four years and rheumatology waiting times of around seven months (38), indicating barriers to timely PsA identification. Perspectives shared during interviews indicate that diagnosis commonly occurs after 6–12 months for psoriasis and 1–2 years for PsA, with extended delays more frequently described in rural settings. Contributors include limited specialist availability, low primary care awareness, misdiagnosis, and prolonged referral pathways. Delays were viewed as unacceptable by those consulted, particularly for PsA given the risk of irreversible disease progression.

South Africa

1

The literature review did not identify concrete published evidence on average time to diagnosis for psoriatic disease in South Africa. Verbal accounts described lengthy diagnostic pathways for both psoriasis and PsA, driven by slow referral processes, repeated primary care visits, and frequent misdiagnosis before reaching specialist care. Estimates for psoriasis diagnosis ranged from 6 months to 6 years, often exceeding one year in the public sector, while PsA was frequently reported to take even longer due to low awareness, osteoarthritis misclassification, and severe shortages of rheumatologists. Faster diagnosis was noted in private care settings where specialist access is less constrained.

Recommendations for best practice from the WHO Global Report on Psoriasis

1. It is essential that psoriasis is diagnosed as early as possible. Early diagnosis and appropriate therapy give the best chance to prevent patients from unnecessary suffering, uncontrolled disease, irreversible deformities of the joints and disability.
2. Patients with psoriasis should be screened for the presence of early joint symptoms and if diagnosed with psoriatic arthritis should start appropriate treatment to prevent disease progression and joint destruction.
3. The development of solutions such as tele-dermatology also can contribute to faster dermatological diagnosis in countries where there is a lack of skin care specialists.
4. There is a great need to raise awareness and knowledge about psoriasis among general practitioners to increase early diagnosis and prevent disability.
5. Health care professionals associations should provide training, for example, via the Internet for physicians from low- and middle-income countries, regarding prompt diagnosis and effective treatment of psoriasis.

Source: WHO 2016 Global report on psoriasis (14)

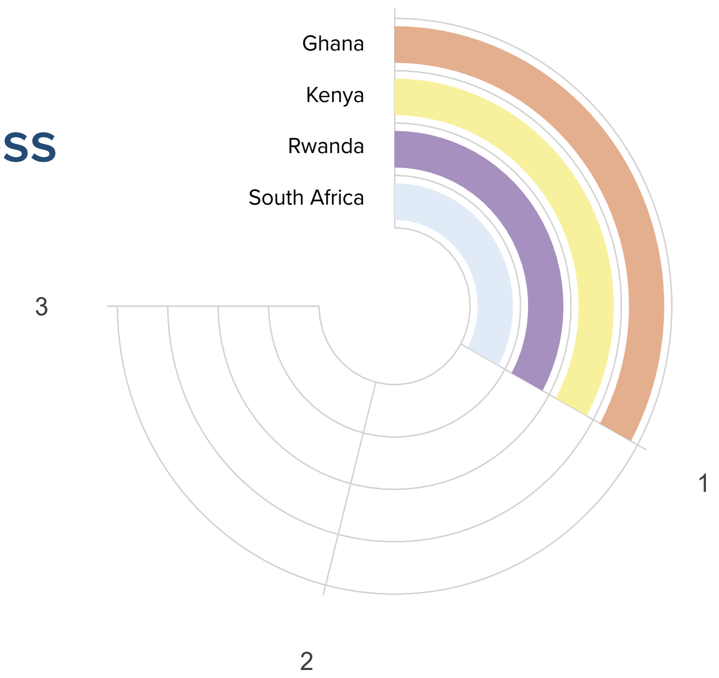
Access to medicines

> In systems where individuals must cover a significant portion of treatment costs, the risk of under-treatment increases, leading to an unnecessary burden on individuals.

Since psoriatic disease is a chronic condition, the cost of treatment can be substantial over a person's lifetime, especially for those with moderate to severe symptoms. In healthcare systems where individuals bear significant expenses, household budgets are often heavily strained (49), increasing the likelihood of people in need of care avoiding it. This can lead to uncontrolled disease and poorer outcomes, resulting in worse outcomes and QoL (50). Moreover, worsening symptoms can contribute to lost productivity and absenteeism among individuals with psoriatic disease, further affecting their families and access to necessary treatment (51). According to the WHO Global Health Expenditure Atlas, medical debt pushes over half a billion people into poverty (52). Therefore, ensuring that effective treatments remain affordable is crucial for individuals living with psoriatic disease, regardless of their location or socioeconomic background.

The cost of treatment varies and is closely linked to disease severity. Mild skin symptoms are usually managed with affordable topical treatments. Those with moderate to severe symptoms may require conventional systemic therapies, such as methotrexate or phototherapy, while others may be prescribed more expensive biologics or JAK inhibitors. Although biologic and JAK inhibitor treatments are both safe and effective, their high cost can impose a substantial financial burden (53, 54). As patents for branded biologics begin to expire, the introduction of biosimilars is expected to improve treatment accessibility for more people in need. The financial responsibility for treatment varies depending on the healthcare system, falling on either societal payers or patients. In systems where individuals must cover a significant portion of treatment costs, the risk of under-treatment increases, leading to an unnecessary burden on individuals.

Country progress



Additional obstacles to medication access include regulatory and payer-related challenges. The latter is often tied to cost, while regulatory barriers stem from local evaluations of efficacy and safety. Another factor affecting access is clinicians' experience and familiarity with newer treatments, as concerns about tolerability may persist (55), though these concerns are gradually decreasing. Moreover, indicator 7, time to diagnosis, serves as a temporal barrier to accessing treatment.

These challenges present themselves differently across regions, leading to disparities in access to optimal treatment for individuals living with psoriatic disease.

Ghana

1

Table 2 below provides details on the available treatments in Ghana. The primary barrier to accessing treatment for psoriatic disease in Ghana is cost (56). Interviewed clinicians and people living with the disease described a system in which public insurance coverage is limited, with many citizens either lacking coverage entirely or finding that their insurance does not cover key treatments. As a result, most medications must be purchased out-of-pocket, a burden that places even basic therapies out of reach for some. Access is notably tiered: topical medications like antihistamines and corticosteroids, are somewhat accessible, while systemic therapies and biologics remain virtually unavailable due to very high prices and limited availability at tertiary hospitals. Even among essential medicines, interviewees reported stock issues and inconsistent supply. Without access to specialty care or personal funds, individuals often rely on general care providers and are limited to what is locally available.

> “Most patients have to pay out of pocket. A lot of treatments are not covered by national insurance. Not everybody has public coverage. Because of distance, a lot of patients are in the villages, so access to coverage is bad.
>
> *Nurse in Ghana*

Table 2: Treatments available for Ghana

Treatment				For PsO	For PsA	Biosimilars?	Pediatric?	State subsidized?	Comment
Topical therapies									
Vitamin D analogues				x					
Corticosteroids (e.g., betamethasone)				x			x		
Anthralin / dithranol				x					
Topical retinoids									
Phototherapy									
UV-light therapy									Provided at special hospitals and very expensive
Conventional systemic therapies									
Methotrexate				x	x		x		
Ciclosporin				x					
Acitretin									
Oral small molecules (e.g., apermilast, deucravacitinib)									
Biologics	**Generic name**	**Target**	**Approved for:**						
Remicade	Infliximab	TNF	Pso & PsA	x	x		x		
Enbrel	Etanercept	TNF	Pso & PsA	x	x		x		
Humira	Adalimumab	TNF	Pso & PsA		x				
Raptiva	Efalizumab	CD11a	Pso						
Stelara	Ustekinumab	IL-12/23	Pso & PsA						
Cimzia	Certolizumab pegol	TNF	PsA						
Simponi	Golimumab	TNF	PsA						
Cosentyx	Secukinumab	IL-17A	Pso & PsA		x				Specialized hospitals and difficult to get for patients. Expensive as well
Taltz	Ixekizumab	IL-17A	Pso & PsA						
Xeljanz	Tofacitinib	JAK	PsA						
Siliq / Kyntheum	Brodalumab	IL-17A	Pso						
Tremfya	Guselkumab	IL-23	Pso & PsA						
Illumya	Tildrakizumab	IL-23	Pso						
Skyrizi	Risankizumab	IL-23	Pso & PsA						
Rinvoq	Upadacitinib	JAK	PsA						
Bimzelx	Bimekizumab	IL-17A/ 17F/17AF	Pso & PsA						

Key: CD11a = Cluster of Differentiation 11a, IL= Interleukin, IV = Intravenous, JAK = Janus kinase, PsA = Psoriatic arthritis, PsO = Psoriasis, TNF = Tumor necrosis factor, UV = Ultraviolet

Kenya

1

Table 3 on the next page provides details on the available treatments for Kenya. In Kenya, access to treatment is similarly constrained by cost at nearly every level of care. Both the cost of consultation and the medications themselves were identified by interviewees as significant barriers, particularly for uninsured or unemployed individuals. While conventional systemic treatments such as methotrexate are available at tertiary teaching hospitals, their reach does not extend to most people in need, and advanced therapies like biologics remain out of reach for most. Private insurance is available to a small segment of the population, but chronic condition coverage is often minimal, and patients reportedly often exhaust their benefits or face low claim ceilings (57, 58). Several stakeholders noted that even topical treatments are unaffordable for nearly half of individuals. Access remains strongly tied to one’s ability to pay or navigate the referral system, and many people never reach the level of care where more systemic options become available.

Table 3: Treatments available in Kenya

Treatment				For PsO	For PsA	Biosimilars?	Pediatric?	State subsidized?	Comment
Topical therapies									
Vitamin D analogues				x			x	Few*	*Less 10% of prescriptions. Topicals
Corticosteroids (e.g., betamethasone)				x			x	Few	Topical all strengths e.g. betamethasone clobetasone butyrate, mometasone may be in 3% salicylic acid or not, and orals
Anthralin / dithranol									
Topical retinoids									
Phototherapy									
UV-light therapy				x			x	Few	Inpatient support but not outpatient by state. PUVA, NB-UVB
Conventional systemic therapies									
Methotrexate				x	x		x	Few	Inpatient support but not outpatient by state. PUVA, NB-UVB
Ciclosporin				x	x		x	Few	Inpatient support but not outpatient by state
Acitretin				x	x				Private medical covers
Oral small molecules (e.g., apremilast)				x	x			Few	Inpatient support but not outpatient by state OR private med covers
Biologics	**Generic name**	**Target**	**Approved for:**						
Remicade	Infliximab	TNF	Pso & PsA	x		x			Private hospitals set up or private medical covers
Enbrel	Etanercept	TNF	Pso & PsA	x	x	x			Private hospitals set up or private medical covers
Humira	Adalimumab	TNF	Pso & PsA	x	x	x		Few	State may support under cancer treatment center
Raptiva	Efalizumab	CD11a	Pso						
Stelara	Ustekinumab	IL-12/23	Pso & PsA						
Raptiva	Efalizumab	CD11a	Pso						
Stelara	Ustekinumab	IL-12/23	Pso & PsA						
Cimzia	Certolizumab pegol	TNF	PsA						
Simponi	Golimumab	TNF	PsA		x			Few	State may support under cancer treatment center or private medical cover
Cosentyx	Secukinumab	IL-17A	Pso & PsA	x	x	x		Few	State may support under cancer treatment centers or private medical covers
Taltz	Ixekizumab	IL-17A	Pso & PsA						
Xeljanz	Tofacitinib	JAK	PsA		x	x			Private hospitals
Siliq / Kyntheum	Brodalumab	IL-17A	Pso						
Tremfya	Guselkumab	IL-23	Pso & PsA						
Illumya	Tildrakizumab	IL-23	Pso						
Skyrizi	Risankizumab	IL-23	Pso & PsA						
Rinvoq	Upadacitinib	JAK	PsA						
Bimzelx	Bimekizumab	IL-17A / 17F/17AF	Pso & PsA						

Key: C D11a = Cluster of Differentiation 11a, IL= Interleukin, JAK = Janus kinase, NB-UVB = Narrowband UV-B phototherapy, PsA = Psoriatic arthritis, PsO = Psoriasis, PUFA = Psoralen + UVA phototherapy, TNF = Tumor necrosis factor, UV = Ultraviolet.

Rwanda

1

Table 4 below provides details on the available treatments in Rwanda. Access to treatment in Rwanda is limited by affordability and the difficulty of reaching specialist care. Interviewees noted that access to certain essential treatments, including conventional systemics like methotrexate via the public system, is largely limited to patients seen at dermatology or rheumatology departments in tertiary hospitals (mainly in Kigali). However, for most people, particularly those in rural areas, such referrals are difficult to get and non-medical direct costs, such as the cost of transportation to the city and accommodation while seeking care further impact peoples' budgets. While Rwanda's community-based public insurance system provides some financial protection, it reportedly does not cover outpatient medications for psoriatic disease, leaving individuals to pay out-of-pocket for outpatient prescriptions received. Biologic therapies and other targeted agents are not included in national formularies, and while some newer treatments have been introduced through donor collaborations, they remain mostly inaccessible for routine care. As a result, many people rely on basic topicals from pharmacies, if they are available, and treatment access is sharply limited for those outside of urban centers (23, 24, 37).

Table 4: Treatments available in Rwanda

Treatment				For PsO	For PsA	Biosimilars?	Pediatric?	State subsidized?	Comment
Topical therapies									
Topical therapies				x					
Vitamin D analogues				x					
Corticosteroids (e.g., betamethasone)				x					
Anthralin / dithranol				x					
Topical retinoids									
Phototherapy									
UV-light therapy									
Conventional systemic therapies				x	x			Inpatient	
Methotrexate				x	x			Inpatient	
Ciclosporin				x	x			Inpatient	
Acitretin									
Oral small molecules (e.g., apremilast, deucravacitinib)									
Biologics	**Generic name**	**Target**	**Approved for:**						
Remicade	Infliximab	TNF	Pso & PsA	x	x				Very difficult to get
Enbrel	Etanercept	TNF	Pso & PsA	x	x				Very difficult to get
Humira	Adalimumab	TNF	Pso & PsA	x	x				Very difficult to get
Raptiva	Efalizumab	CD11a	Pso						
Stelara	Ustekinumab	IL-12/23	Pso & PsA						

Treatment				For PsO	For PsA	Biosimilars?	Pediatric?	State subsidized?	Comment
Biologics	**Generic name**	**Target**	**Approved for:**						
Cimzia	Certolizumab pegol	TNF	PsA		x				Very difficult to get
Simponi	Golimumab	TNF	PsA						
Cosentyx	Secukinumab	IL-17A	Pso & PsA						
Taltz	Ixekizumab	IL-17A	Pso & PsA						
Xeljanz	Tofacitinib	JAK	PsA	X	X				Very difficult to get
Siliq / Kyntheum	Brodalumab	IL-17A	Pso						
Tremfya	Guselkumab	IL-23	Pso & PsA						
Illumya	Tildrakizumab	IL-23	Pso						
Skyrizi	Risankizumab	IL-23	Pso & PsA						
Rinvoq	Upadacitinib	JAK	PsA						
Bimzelx	Bimekizumab	IL-17A/ 17F/17AF	Pso & PsA						

Key: CD 11a = Cluster of Differentiation 11a, IL= Interleukin, JAK = Janus kinase, PsA = Psoriatic arthritis, PsO = Psoriasis, TNF = Tumor necrosis factor, UV = Ultraviolet.

South Africa

1

Table 5 on the next page provides details on the available treatments in South Africa. Access to treatment for people living with psoriatic disease in South Africa is highly unequal and heavily dependent on whether people are served by the public or private sector. In the public system, access to psoriasis and PsA medications is largely limited to a small list of covered topicals and a few older systemics, with little to no coverage for newer or more expensive therapies. People in rural settings or without access to tertiary hospitals are particularly affected. In the private sector, individuals may have access to a broader range of treatments in theory. However, in practice, psoriasis treatments are not included under Prescribed Minimum Benefits (PMBs), which is the list of treatments that private insurers are required to cover. Thus, people with private coverage may either end up paying large out-of-pocket costs or might be stuck engaging in lengthy appeals to their insurer to receive coverage for biologics. PsA is more often recognized within benefit structures, but access is still not guaranteed (30, 59). Across both sectors, interviewed clinicians described significant disparities in access by geography, insurance status, and diagnosis subtype, with only a small proportion of their patients receiving advanced therapy for moderate to severe disease.

Table 5: Treatments available in South Africa

Treatment				For PsO	For PsA	Biosimilars?	Pediatric?	State subsidized?	Comment
Topical therapies									
Vitamin D analogues				x					
Corticosteroids (e.g., betamethasone)				x	x				
Anthralin / dithranol				x					
Topical retinoids				x					
Phototherapy									
UV-light therapy				x					
Conventional systemic therapies									
Methotrexate				x	x	x	x	x	Easily available
Ciclosporin				x	x		x	x	
Acitretin									
Oral small molecules (e.g., apremilast, deucravacitinib)									
Biologics	**Generic name**	**Target**	**Approved for:**						
Remicade	Infliximab	TNF	Pso & PsA		x	x	x	x	With strong motivation
Enbrel	Etanercept	TNF	Pso & PsA		x	x	x	x	With strong motivation
Humira	Adalimumab	TNF	Pso & PsA		x	x	x	x	With strong motivation
Raptiva	Efalizumab	CD11a	Pso	x		x			With strong motivation
Stelara	Ustekinumab	IL-12/23	Pso & PsA		x	x	x		With strong motivation
Cimzia	Certolizumab pegol	TNF	PsA	x		x			With strong motivation
Simponi	Golimumab	TNF	PsA	x	x	x	x		With strong motivation
Cosentyx	Secukinumab	IL-17A	Pso & PsA		x				
Taltz	Ixekizumab	IL-17A	Pso & PsA						
Xeljanz	Tofacitinib	JAK	PsA		x				With strong motivation
Siliq / Kyntheum	Brodalumab	IL-17A	Pso	x					
Tremfya	Guselkumab	IL-23	Pso & PsA						
Illumya	Tildrakizumab	IL-23	Pso	x					
Skyrizi	Risankizumab	IL-23	Pso & PsA	x					
Rinvoq	Upadacitinib	JAK	PsA		x				With strong motivation
Bimzelx	Bimekizumab	IL-17A/ 17F/17AF	Pso & PsA	x					

Key: CD11a = Cluster of Differentiation 11a, IL= Interleukin, JAK = Janus kinase, PsA = Psoriatic arthritis, PsO = Psoriasis, TNF = Tumor necrosis factor, UV = Ultraviolet.

Recommendations for best practice from the WHO Global Report on Psoriasis

1 Patients suffering from psoriasis should have access to comprehensive, individually adapted treatment. At a minimum, public and private facilities should provide the drugs included on the WHO Model List of Essential Medicines, including systemic therapies.

2 For newer biological therapies, more needs to be done to reduce the price of these medicines, if they are to present a sustainable and affordable treatment option for patients with psoriasis. The development of biosimilars may help in this regard.

3 Researchers should investigate the etiology of psoriasis and therapies to prevent as well as to manage the symptoms of the disease. It is vital to create low-cost effective treatment options that can be made widely available.

4 New treatments need to be affordable, effective and safe in the long term, stable in hot and humid climates and require minimal monitoring.

Source: WHO 2016 Global report on psoriasis (14)

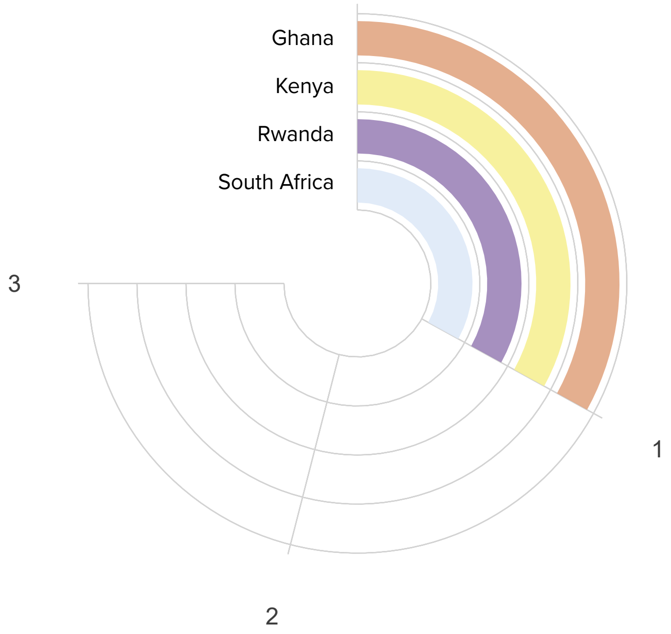
Access to specialist care

Across many health systems, dermatologists are primarily responsible for diagnosing and treating the cutaneous features of Pso, while rheumatologists manage musculoskeletal involvement such as PsA. Together, these specialists provide care for the most common physical manifestations of the disease. However, access to specialist services varies substantially between countries, which can delay diagnosis, limit timely initiation of appropriate treatment, and contribute to disease progression, including an increased risk of irreversible joint damage and disability.

Given the systemic nature of psoriatic disease, effective management also requires attention to associated comorbidities that affect overall health. Mental health is a particularly important yet frequently under-addressed component of care. People living with psoriatic disease have an increased risk of anxiety, depression, suicidal ideation, and other psychiatric conditions (60, 61), underscoring the need for access to psychological and psychiatric support. Psychological and psychiatric care is a key element of comprehensive psoriatic disease management, requiring both routine mental health assessment and open patient–clinician communication.

> “Psychological and psychiatric care is a key element of comprehensive psoriatic disease management, requiring both routine mental health assessment and open patient–clinician communication.

Country progress



Ghana

1

Evidence highlights major gaps in specialist access for psoriatic disease care in Ghana. Published sources report fewer than 40 dermatologists, largely concentrated in in the teaching hospitals in the big cities (Accra and Kumasi), leaving rural areas with minimal coverage, and reportedly only two rheumatologists nationwide, serving a population of nearly 35 million people (62). Stakeholder input aligned with these shortages, rating access at 2/5 for dermatology and 1/5 for rheumatology, with waits of several months and significant barriers for people living in rural areas, requiring travel and out-of-pocket payment. Mental health services were described as relatively more available through hospital-based mental health units.

Kenya

1

Evidence highlights major limitations in specialist access for Pso care in Kenya. Published sources report only around 30 dermatologists and approximately four rheumatologists serving a population of over 50 million, leaving most care to GPs and increasing risk of misdiagnosis, especially in rural areas (29). Stakeholder input suggested moderate dermatology access in major cities but very limited availability outside urban centres, with rural access often rated 1/5 due to travel and long waits. Rheumatology care was consistently described as scarce nationwide and largely confined to Nairobi or private services. Mental health services were generally perceived to be more accessible than dermatology or rheumatology care; however, persistent stigma and reluctance to seek psychological support may continue to limit their utilisation among some patients.

Rwanda

1

Specialist access for psoriatic disease care in Rwanda appears highly constrained. Collected records suggest only around 13 dermatologists and two rheumatologists, serving a population of over 14 million people. Specialists are largely concentrated in Kigali, leaving rural regions with minimal specialist coverage (23). Stakeholder input highlighted difficulty obtaining initial dermatology appointments and extremely limited access to rheumatology, particularly for people outside metropolitan centres or those reliant on community insurance. Public-sector waiting times of one month or longer were commonly reported, while private care may offer faster access but remains costly. Mental health services were viewed as comparatively more available through district-level psychiatric support and public coverage, although referrals are uncommon and stigma may limit utilisation.

> **“While there is a severe shortage of dermatologists across South Africa, this is even more profound in the public sector and rural areas like the Eastern Cape, where dermatologists are inaccessible to approximately 70% of the rural population**
>
> *Wright, 2025*

South Africa

1

Specialist access for Pso care in South Africa is constrained by workforce shortages, long waits, and pronounced urban–rural inequities. Published data show a very low public-sector dermatologist ratio (~1.2 per million) compared with private care (~20 per million). Reports indicate that around 70% of rural residents in the Eastern Cape lack access to dermatology services. Verbal accounts described public-sector waits of 3–6 months (up to one year), while private care may be faster but depends on affordability (63). Rheumatology access was consistently reported to be even more limited, with specialists concentrated in major-city tertiary hospitals and some regions lacking rheumatologists altogether. Tele-dermatology referral platforms were noted as a promising mitigation strategy, though they do not fully address underlying capacity gaps (64).

Recommendations for best practice from the WHO Global Report on Psoriasis

1. Lack of a sufficient number of health professionals to some extent also contributes to low public awareness of psoriasis and the exclusion and discrimination of patients diagnosed with the disease.
2. In settings with adequate resources, health-care professionals and health systems must strive to provide patients with comprehensive care from multidisciplinary teams of specialists, including dermatologists, rheumatologists, psychologists, psychiatrists, pediatricians, cardiologists and others.
3. Associations of medical specialists have a role in seeking consensus on the classification of psoriasis and standardization of the collection of epidemiological data using a unified methodology.
4. Member States should ensure that people suffering from psoriasis have access to professional medical care. Optimum therapy also reduces mental health and societal costs of the disease.

Source: WHO 2016 Global report on psoriasis (14)

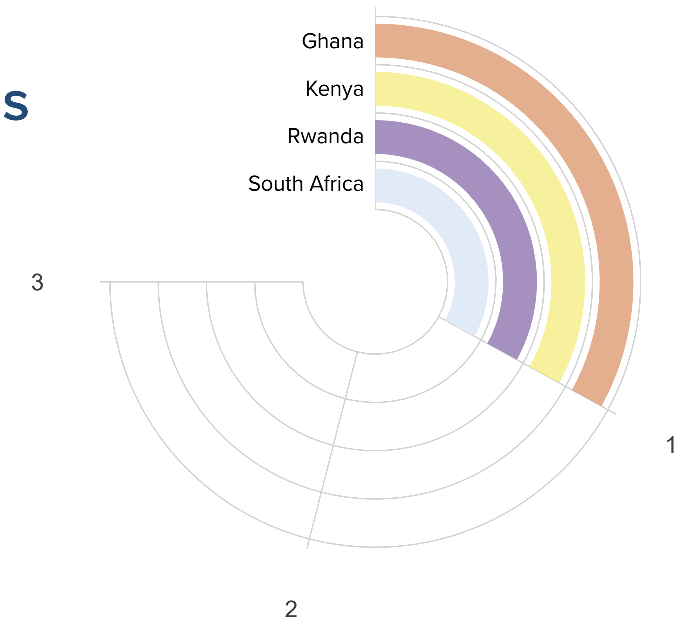
Direct and indirect costs to the economy

> Where public expenditure is limited, a greater share of costs is often borne out-of-pocket by individuals and house holds.

The economic burden of psoriatic disease comprises both direct and indirect costs that affect individuals, families, and health systems. Direct costs include medical and non-medical expenditures such as medications, clinical visits, hospital care, and transportation associated with accessing treatment. Indirect costs reflect the wider economic consequences of the disease, including productivity losses due to missed work, reduced work capacity, and the time and resources devoted by family members to caregiving.

Levels of public spending on Pso care can provide insight into the extent of state investment in addressing this burden. Where public expenditure is limited, a greater share of costs is often borne out-of-pocket by individuals and households. This shift can place significant financial strain on people living with psoriatic disease and their families, potentially influencing treatment adherence, access to care, and overall health outcomes.

Country progress



Ghana

1

Published information on the broader economic burden of psoriatic disease in Ghana is scarce; however, both literature sources and verbal accounts consistently highlight substantial out-of-pocket costs for individuals. Literature indicates that monthly treatment expenses can be prohibitively high, with estimates ranging from GHS 1,500–2,500 (roughly $136–227 in 2026 USD), often leading individuals to ration or discontinue therapy when funds are exhausted. Direct non-medical costs, including long travel distances and accommodation needs for specialist visits, further shape care-seeking behaviour, particularly for rural populations, and may delay timely access to appropriate diagnosis and treatment (19, 56). Stakeholders repeatedly identified cost as the primary barrier to both accessing care and sustaining treatment, compounded by gaps in national insurance coverage and limited affordability of specialist services.

> **I'm on medical aid, so they do help pay for it. But the aid is exhausted halfway through the prescription, so I have to use it sparingly. When you run out of medical aid then you pay full price.**
>
> *Person living with psoriatic disease*

Kenya

1

The economic burden of psoriatic disease in Kenya appears to fall largely on individuals through substantial out-of-pocket spending. No published evidence was identified on direct or indirect cost estimates, although limited literature suggests a notable proportion of people with skin manifestations of psoriatic disease may also have joint symptoms. Inputs from those interviewed indicate most people rely on public insurance; however, coverage is often restricted to inpatient services at higher-level referral hospitals, while outpatient visits, specialist consultations, and many medicines remain as out-of-pocket expenses. Interviewees described inconsistent reimbursement depending on facility type, limited drug subsidies, and high costs for advanced therapies such as biologics. Overall, these factors suggest minimal state subsidisation and a heavy financial burden on people living with psoriatic disease and their households.

Rwanda

1

The financial burden of psoriatic disease in Rwanda appears to be driven largely by high out-of-pocket costs and limited insurance coverage for treatment. Published sources note that while most of the population is insured, community-based schemes often do not fully cover outpatient care or psoriasis-specific medications, making therapies prohibitively expensive relative to national income levels (23, 24, 37). Verbal accounts indicated that an estimated 99% of individuals rely on community insurance, which may subsidise basic topical or conventional treatments but provides little support for advanced therapies, with frequent stock shortages further compounding costs. Overall, affordability remains a major barrier, shifting a substantial share of the economic burden onto individuals and households.

South Africa

1

Available evidence indicates that the economic burden of psoriatic disease in South Africa is driven mainly by treatment costs and limited insurance coverage, particularly for non-basic therapies, which few medical aid providers support (30, 63). Evidence from interviews suggest that most people rely on the public sector, where basic topical treatments may be subsidized, while private care often requires substantial out-of-pocket payment. People living in rural areas face additional direct non-medical costs related to travel and poor infrastructure when accessing specialist services. Ongoing “hidden” expenses, such as purchasing moisturizers and supportive skin products, were also highlighted as contributing to financial strain.

Recommendations for best practice from the WHO Global Report on Psoriasis

1. Having access to affordable basic health care, having their psoriasis diagnosed and receiving early and appropriate treatment as well as affordable long-term supply of medicines and treatments would significantly reduce the unnecessary burden of psoriasis.
2. Optimum therapy also reduces mental health and societal costs of the disease.
3. At a minimum, public and private facilities should provide the drugs included on the WHO Model List of Essential Medicines, including systemic therapies. Universal health coverage schemes should cover the costs of these treatments.
4. Governments should take cost-effectiveness of treatment options into account when developing national guidelines.
5. The most important step is to implement global commitments to achieve universal health coverage.

Source: WHO 2016 Global report on psoriasis (14)

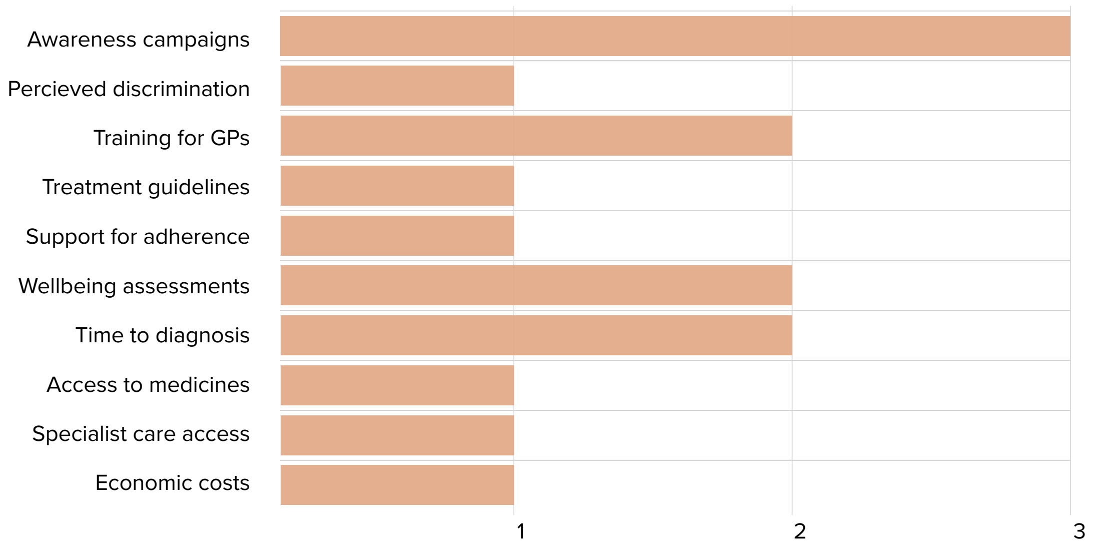
Limitations

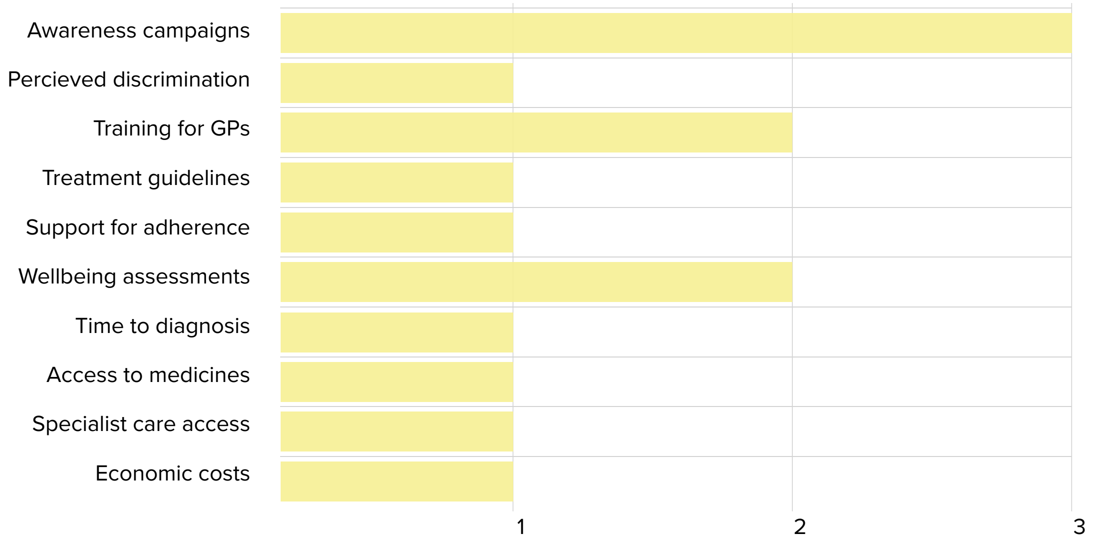
Africa is a highly diverse region in terms of health system organization, economic development, geography, and population needs. As such, it was not feasible to engage a large or fully representative sample of stakeholders across all relevant settings. This report serves as an initial assessment of the region's progress in implementing the recommendations outlined in the WHO Global Report on Psoriasis. While stakeholder interviews provided valuable insights, future work would benefit from broader engagement across additional countries and more diverse respondent profiles, including greater representation from rural areas, lower-income populations, and primary and secondary levels of care, where access barriers may be most pronounced. It is likely that many interviewees particularly clinicians and patient advocates, were relatively well connected to specialist services, and the challenges faced by more marginalized individuals living with psoriatic disease may therefore be underrepresented.

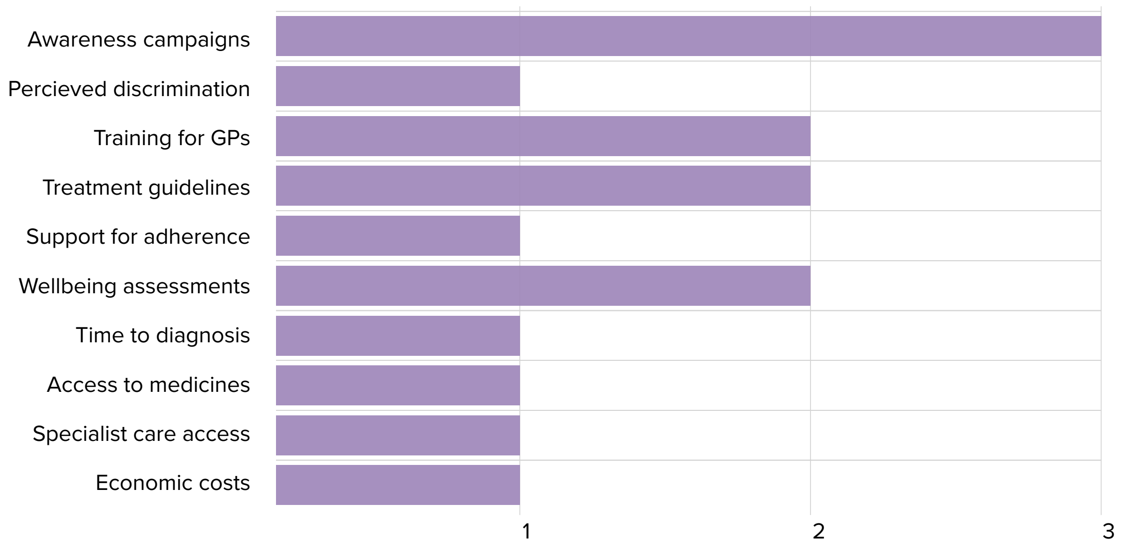
The literature review revealed substantial gaps in published and grey literature across many of the assessed indicators. For several indicators, particularly those related to perceived discrimination, access to medicines, access to specialist care, time to diagnosis, medication adherence support, quality of life and economic burden, evidence was sparse, fragmented, or entirely absent in some countries. As a result, conclusions for these indicators rely heavily on qualitative input from interviews. While these verbal accounts helped contextualize and supplement the limited literature, they cannot fully substitute for robust, population-level data. This finding aligns with the WHO Global Report on Psoriasis, which highlights the need for more health services and implementation research in low- and middle-income settings. Future studies should expand searches in local and regional sources, including government or institutional reports, which may capture additional relevant evidence.

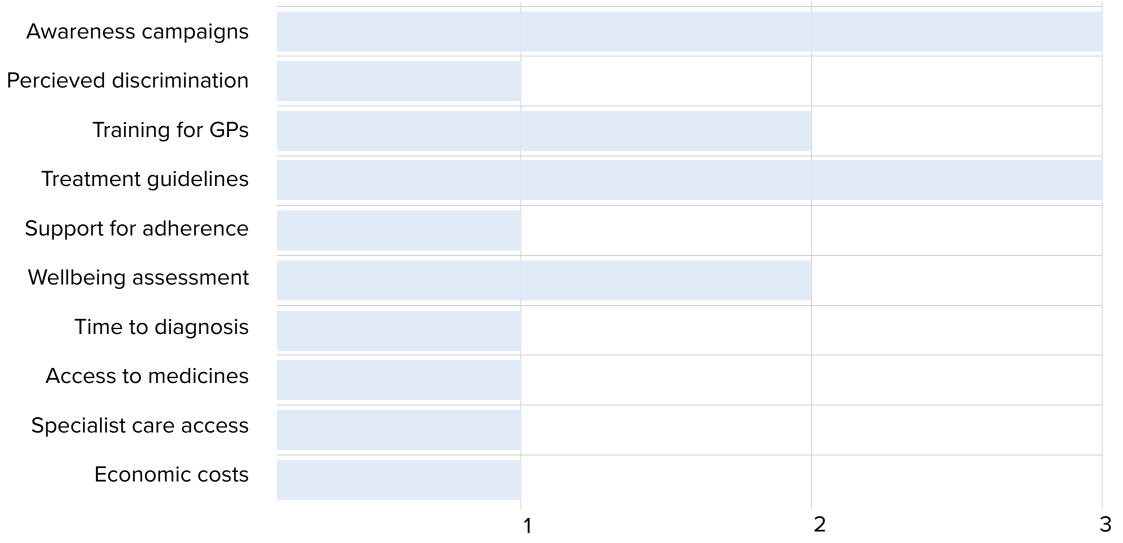
The indicators selected for this report reflect key priorities outlined in the WHO Global Report on Psoriasis and offer a structured overview of care delivery challenges across the region. However, these indicators do not capture all dimensions of psoriatic disease care, and additional indicators should be explored in future assessments. A coordinated effort to collect and assess the same information simultaneously across countries would enhance comparability within the region. Additionally, the rating scale of 1–3 used in this report is open to interpretation. Importantly, a rating of 3 does not indicate that a country has fully met the goal but rather that it has achieved the criteria outlined in this report.

Index scores by country


Ghana


Kenya


Rwanda


South Africa

Conclusions

This index report represents the first regional assessment of health-system responses to psoriatic disease in Africa, providing valuable insights for individuals living with Pso and PsA across diverse and often resource-constrained settings. Building on previous IFPA index analyses conducted in Europe, the Western Pacific Region, and the Americas, this report contributes to the global evaluation of progress in implementing the recommendations outlined in the WHO Global Report on Psoriasis. The findings support stakeholders in identifying priority gaps, shaping policies, and allocating resources to improve health and well-being for people living with psoriatic disease, with the long-term goal of reducing preventable disability, comorbidities, and stigma.

> **This index report represents the first regional assessment of health-system responses to psoriatic disease in Africa, providing valuable insights for individuals living with Pso and PsA across diverse and often resource-constrained settings.**

This report draws on a recent review of published and grey literature, supplemented by stakeholder and clinician input across four sample countries (Ghana, Kenya, Rwanda, and South Africa). Together, these sources informed an in-depth assessment of ten key indicators reflecting core dimensions of psoriatic disease care, including awareness, discrimination, healthcare capacity, diagnostic pathways, guideline availability, specialist access, treatment affordability, adherence support, wellbeing assessment, and economic burden.

Across the African region, evidence suggests that some progress has been made in implementing selected WHO recommendations, particularly through awareness campaigns led by patient organizations and periodic World Psoriasis Day activities. However, these efforts remain uneven in reach, with many initiatives concentrated in urban centres and limited outreach to the broader public, especially in rural communities.

Stigmatization and discrimination remain persistent challenges across all countries reviewed. Misconceptions, such as the belief that psoriasis is contagious or associated with a curse, continue to impact those living with the disease through social exclusion, workplace discrimination, strained family relationships, and/or substantial psychosocial burden. These experiences highlight the need for sustained public education and coordinated anti-stigma initiatives, implemented in partnership with patient organizations.

Training for PCPs in psoriatic disease was consistently described as limited across the sample countries. While some educational activities exist such as CME sessions, association-led webinars, and occasional hospital-based seminars, these opportunities are generally informal, concentrated in tertiary centres, and not routinely accessible to frontline clinicians in public or rural settings. As a result, PCPs often rely on self-directed learning, contributing to gaps in early recognition, misdiagnosis, and delayed referral, particularly for PsA where specialist knowledge is especially scarce.

> **Access to effective treatment is further shaped by affordability and health-system coverage.**

Across the countries assessed, access to clear, up-to-date national treatment guidelines for psoriatic disease remains inconsistent. In several settings, no formal local protocols were identified, and clinicians reported relying largely on international recommendations, which are not always adaptable to local treatment availability, health system structure, or population needs. Where guidelines do exist, they are often embedded within broader documents, outdated, or unevenly implemented. Stakeholder input repeatedly emphasized the need for context-specific, actively disseminated guidance to support consistent and evidence-based care across levels of the health system.

Support for medication adherence was broadly informal across countries, relying primarily on verbal counselling at the point of prescribing or dispensing. No structured, general or disease-specific tools were identified, and follow-up support remains limited in overstretched public systems. This reinforces the importance of strengthening care approaches alongside improvements in medicine availability.

In clinical practice, physical manifestations and comorbidities are generally assessed when patients reach specialist services, but mental wellbeing evaluation remains inconsistent. Although psychological burden was widely recognized, mental health discussions were often limited by time constraints, stigma, or lack of integrated services. Patient-reported outcome tools such as DLQI were rarely used outside tertiary hospitals or biologic eligibility contexts, suggesting that patient-centred wellbeing assessment is not yet routinely embedded in care pathways.

Timely diagnosis and early access to appropriate care remain constrained by limited frontline recognition and referral capacity. Many individuals begin care in pharmacies or primary care, where misdiagnosis is common and referral delays are substantial. Evidence on the time to diagnosis was very limited, with reported estimates ranging widely, often extending months to years. This is particularly the case for PsA, where awareness and specialist pathways are weakest. Such delays increase the risk of preventable joint damage and long-term disability.

Access to effective treatment is further shaped by affordability and health-system coverage. Across all four countries, access to medicines was described as highly unequal and strongly dependent on insurance status, geography, and above all, ability to pay. In Ghana and Kenya, most medications including basic therapies are often purchased out-of-pocket, placing systemic treatments and biologics out of reach for many. In Rwanda, community-based insurance provides partial financial protection, but outpatient medications for psoriatic disease are reportedly not covered, leaving individuals reliant on limited topicals or episodic tertiary referral. In South Africa, access differs sharply between public and private sectors, with newer therapies often excluded from both public formularies and private benefit structures, resulting in substantial barriers even for those with a health insurance. Overall, treatment access remains closely tied to socioeconomic capacity, contributing to under-treatment and avoidable disease burden.

> “Overall, the findings of this report highlight both emerging progress and significant unmet needs in psoriatic disease care across the African region.

Specialist access was consistently identified as a major structural barrier. Dermatologists and rheumatologists remain scarce across all sample countries, highly concentrated in major cities, and largely inaccessible to rural populations. These shortages contribute directly to delayed diagnosis, limited treatment escalation, and inequities in care. Although some tertiary centres provide multidisciplinary services and more rapid referral, these remain the exception rather than the norm. Emerging approaches such as tele-dermatology may help expand access for psoriasis care, although they do not yet offset broader specialist capacity gaps.

Finally, psoriatic disease places a significant financial strain on individuals and households across the four countries. High out-of-pocket spending for treatment, specialist visits, travel, and supportive care combined with limited insurance coverage for advanced therapies, continues to restrict access and disrupt long-term disease management. These findings highlight affordability as one of the most persistent barriers to effective care across the African region.

Overall, the findings of this report highlight both emerging progress and significant unmet needs in psoriatic disease care across the African region. Advancing equitable, patient-centred care will require coordinated action to improve awareness, reduce stigma, shorten diagnostic delays, expand specialist capacity, strengthen guideline implementation, and ensure affordable access to essential and advanced therapies, regardless of geography or socioeconomic status.

Recommendations

This report's findings highlight the following key recommendations to advance the implementation of the WHO Global Report on Psoriasis recommendations and enhance patient well-being in the Africa:

1. Pursue public awareness campaigns to reduce stigmatization in the general public
2. Reduce the patient/provider stigma associated with mental health care
3. Promote accessibility and equality of care for those who live in remote areas
4. Reduce out-of-pocket cost, in part by advancing universal health coverage
5. Increase the availability of specialists, or train GPs to support with care
6. Reduce waiting times for specialists
7. Raise awareness regarding the early diagnosis of psoriasis and the prevention of disability

Collaboration among various stakeholders, including people living with the disease and their representatives, caregivers, and decision-makers, is essential to effectively implement these recommendations and improve the well-being of individuals living with psoriatic disease in Africa.

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Appendix A

Additional information

Table 7: Eligibility criteria for included records from the literature review

Category	Inclusion criteria	Exclusion criteria
Population	People with Psoriatic Disease	
Outcomes	• Evidence of a public awareness campaign • Evidence of perceived discrimination • Information on Psoriatic Disease training programs for primary-care practitioners (PCPs) or general practitioners (GPs) • Existence of treatment guidelines for Psoriatic Disease • Evidence of tools or support for Psoriatic Disease medication adherence • Evidence of patient reported outcome (PRO) use in clinical setting • Estimates for time between presentation to health care and a Psoriatic Disease diagnosis • Measures of access to medicines • Measures of access to specialist care • Estimates of direct and indirect costs of Psoriatic Disease care to the economy • Estimates of health system spending on Psoriatic Disease care	
Study design	• Published literature: books and documents, classical article, evaluation study, government publication, guideline, news, observational study, patient education handout, periodical index, practice guideline, review, systematic review, validation study • Grey literature: reports, guidelines, campaign literature, official publications	Interventional studies
Language	English*	
Countries	Argentina, Canada, Colombia, Panama, United States	
Time limit	1st February 2019 - 31st October 2024**	
Text limit	Available in full text	

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*Note that the primary literature search included only English records. IFPA member associations provided additional records in languages other languages than English which were either translated by the local IFPA member organizations or through Google Translate; **Additional ad hoc searches were conducted through December 2024 to update gaps for some of the indicators.

Table 8: Outcomes of interest for data extraction in the literature review

Category	
Metadata	• QID (unique record identifier) • Title • Authors • Publication year • Journal / publishing institution
Study characteristics	• Study design • Location setting • Study objectives (description)/ Aim of the study • Comparator information
Involved indicators	• Binary variable for information on Public Awareness indicator • Binary variable for information on Provider Awareness indicators • Binary variable for information on Patient Engagement indicators • Binary variable for information on Health Systems indicators • Binary variable for information on Enabling Environment indicators
Public Awareness	• Evidence of previous public awareness campaign (yes/blank) • Name, promoter, and description of the campaign(s) • Evidence of current public awareness campaign (yes/blank) • Name, promoter, and description of the campaign(s) • Evidence of perceived discrimination
Provider Awareness	• Evidence of organization providing resources and training for PCPs on PsO management (yes/blank) • Evidence of core, professional curriculum training available for PCPs on PsO management (yes/blank) • Evidence of treatment guidelines incorporating topicals (yes//blank) • Evidence of treatment guidelines incorporating conventional systemics (yes//blank) • Evidence of treatment guidelines incorporating biologics (yes//blank) • Evidence of treatment guidelines incorporating severity (yes//blank) • Evidence of treatment guidelines incorporating features beyond severity (e.g., location) (yes/ /blank) • Evidence of treatment guidelines incorporating a stepped approach to therapy (yes/ /blank)
Patient Engagement	• Evidence of support for medication adherence in people with PsO (yes/ blank) • Evidence that patients' physical well-being (e.g., comorbidity) is / should be investigated in clinic (yes/blank) • Evidence that patients' mental well-being is / should be investigated in clinic (yes/blank) • Evidence of use of PROs in clinical settings (yes/blank)

Category	
Health Systems	• Estimated time to diagnosis (months) • Proportion of the WHO Model List of Essential Medicines indicated for PsO or PsA available • Proportion of biologic medicines available in formularies (reimbursed or insurance) compared to what was approved by the local regulatory body • Estimate for access to medicines, defined as those available in formularies (reimbursed or insurance) compared to what was approved by the local regulatory body • Proportion of patients who visit a dermatology specialist • Proportion of patients who visit a rheumatology specialist • Evidence describing access to treatment
Enabling Environment	• Direct costs used in estimate of economic burden (e.g., healthcare contacts, prescribed medication, OTC medication) • Estimate of direct costs to the economy (USD) • Indirect costs used in estimate of economic burden (e.g., work loss, transportation, etc.) • Estimate of indirect costs to the economy (USD) • Proportion of GDP spent on PsO healthcare (%, direct) • Proportion of GDP spent on PsO healthcare (%, indirect)

Key: GDP = Gross domestic product, PCPs = Primary care physicians, OTC = Over the counter, PROs = Patient reported outcomes, PsO = Psoriasis, QID = Quantify identification number, USD = United States dollar

Appendix B

Methods (details)

Literature reviews

A targeted literature review identified academically published literature and grey literature (defined as information not formally published in scholarly journals, such as guidelines or reports) to identify relevant evidence. Records were collected from the following sources for each country:

- A structured search of academic literature in PubMed
- Complementary Google searches to identify grey literature for each indicator category
- Grey literature material provided by local IFPA member associations

The review of academic literature utilized a set of Medline search facets based on a set of eligibility criteria specified beforehand in the study protocol (see appendix A, Table 7 for details).

The searches were implemented, all records were collected, and duplicates were removed before starting the review process. A reviewer screened each record's title and abstract (or equivalent summary text) for relevance. Relevant records were retained, and their full text reviewed. Information relevant to the indicators was extracted from each article into a data grid to facilitate the data synthesis process. The outcomes of interest for the extraction were specified in the study protocol (see appendix A, Table 8 for details).

The complementary Google searches utilized a set of 25 key-word searches based on the eligibility criteria, one for each of the five indicator categories in each of the five countries (5x5).

Stakeholder interviews

In addition to the literature review, a series of interviews were conducted to collect evidence about the progress towards implementing the recommendations listed in the WHO Global Report on Psoriasis for each indicator across each of the five countries. To provide a comprehensive perspective on each indicator, six types of stakeholders were identified for recruitment including people living with psoriatic disease, dermatologists with a clinical practice, rheumatologists with a clinical practice, nurse practitioners, academic researchers, and GPs.

Each country's local IFPA member organization recruited six stakeholders for an interview in each of the five countries (a total of 30 planned interviews). A total of 25 interviews were completed, including five people living with psoriatic disease, five academic researchers, five dermatologists, and five rheumatologists (100% of the target for each group), along with three nurses and two GPs.

A discussion guide was developed as part of the protocol, including standardized questions, tailored to each stakeholder type, which were asked to each stakeholder. The guide was used for each one-hour interview and subsequently used to validate the answers provided. Similar to the literature review, the stakeholders' interview responses were collected in a data grid for use in the data synthesis.

Key: GP = General practitioner

Index scoring

The scores applied in the index utilized a pragmatic 1 (lowest rating) to 3 (highest rating) scale to assess progress for each indicator. Table 9 provides the criteria for each of the indicators, which were applied to the evidence for each country in order to generate an index score.

Table 9: Criteria for index scores

#	Indicator title	Index scores
	Public awareness	
1	Existence of a public awareness campaign	1. A public awareness campaign does not exist 2. There has been a campaign, but not in the past 12 months 3. There is a public awareness campaign that is currently active, or has been active in the past 12 months
2	Discrimination	1. Patients perceive significant amounts of discrimination of those with psoriatic disease leading to emotional and/or economic harm 2. Patients experience some discrimination, but it is not pervasive in their life or causing significant emotional or economic harm 3. Patients experience little to no discrimination
	Provider awareness	
3	Availability of diagnostic and management training for PCPs (primary care professionals) on psoriatic disease	1. There is no training available for PCPs on psoriasis 2. An organization (e.g. patient society) provides resources and training for PCPs on psoriasis available that must be sought out 3. There is training for PCPs on psoriasis as part of the core professional curriculum or as part of continuing medical education
4	Availability of treatment guidelines	1. No treatment guidelines available 2. Treatment guidelines exist but do not include considerations beyond physician-rated severity 3. Treatment guidelines include topicals, conventional systemics and biologics. They are suitable for the treatments available in the country and include decision criteria beyond severity (e.g. location)
	Patient engagement	
5	Tools or support for medication adherence	1. No support for medication adherence exists 2. Support for medication adherence exists, but it's not specific to psoriatic disease 3. There is support specifically for medication adherence for people with psoriatic disease
6	Patient-centric investigation of well-being	1. Patient well-being is not investigated in clinics 2. Certain dimensions of patient well-being are assessed (e.g. screening for PsA but not mental health), possibly through the administration of PROs 3. Patient well-being is assessed through conversation with the patient including physical and mental dimensions, possibly through the administration of PROs
	Health systems	
7	Time to diagnosis	Time estimates and average ratings from physicians and patients, combined with estimates from the literature
8	Access to medicines	1. There are significant barriers to patients' access to medicines, including any of the following: a portion of essential treatments not approved or available for sale, high out-of-pocket costs, prescriber hesitation, long wait times for meeting a prescriber 2. There are some barriers to patients' access to medicines (e.g., higher costs, prescriber hesitation, long-wait times, missing treatments), but the majority of patients can access the desired treatments. 3. There are minimal barriers to patients' access to medicines. Though some complications exist (e.g., distance, supply issues, some costs), almost all patients can access the appropriate treatments for their disease.
9	Access to specialist care	1. There are significant barriers for patients to access specialist care, including: high costs, lack of available specialists, long wait times 2. There are some barriers for patients to access specialist care (e.g., costs, personnel shortages, long waits) but the majority of patients don't have issues 3. Patients can access dermatologists, rheumatologists, psychiatrists and/or psychologists with minimal barriers
	Enabling environment	
10	Direct and indirect costs for patients and the system	1. Low system-wide spending for psoriatic disease care and/or high economic burden for patients 2. Medium system-wide spending for psoriatic disease care and/or some economic burden for patients 3. High system-wide spending for psoriatic disease care and/or low economic burden for patients

Key: PCPs = Primary care physicians, PROs = Patient reported outcomes, PsO = Psoriasis

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