IFPA
FORUM
AFRICA 2026

Local strength, united action:

Advancing representation, rights, and research

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IFPA Forum

The IFPA Forum gathers regional stakeholders to address challenges related to psoriatic disease. Advocacy, knowledge sharing, and capacity building are in focus. The Forum aims to address the challenges that the regional and international psoriatic disease community faces in access to care, equal representation, and meaningful patient participation. Patient organizations bridge the gap between clinicians, policymakers, researchers, and the communities they serve. They bring lived experience into conversations where it is often missing. They translate needs into action and turn evidence into access.

In many settings, people with psoriatic disease still face delayed diagnosis, limited treatment options, and low awareness across both conventional and traditional care. Patient organizations help close these gaps by speaking with clarity, credibility, and persistence.

This briefing book supports that role. It provides context, shared language, and priority issues to guide informed discussion. It is designed to strengthen dialogue during the Forum and to support continued collaboration beyond it.

About the IFPA Forum Africa 2026

The IFPA Forum Africa is the first summit exclusively addressing psoriatic disease in the region.

The IFPA Forum Africa aims to:

- Foster collaboration to achieve the integration of psoriatic disease into the broader regional and national agendas
- Advance concrete advocacy priorities to influence research, policy, and care
- Formulate a unified call to action that strengthens the representation of people living with psoriatic disease.

Scan the QR code for
details on the **IFPA Forums**

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Foreword

Psoriatic disease is a chronic, non-communicable disease (NCD) for which there is no cure. It causes pain, disability, stigma, and economic harm. Yet across Africa, it remains underrecognized, under-diagnosed, and undertreated.

Psoriatic disease is a public health issue. Addressing it is not optional. It is part of building resilient, equitable health systems and achieving progress toward Sustainable Development Goal 3.

This briefing book sets out why that must change.

Across the continent, people living with psoriatic disease face delayed diagnosis, limited access to specialists, unaffordable treatments, and weak referral systems. Many live for years without answers. Some experience irreversible joint damage. Others are pushed out of work, education, and community life. Individuals and their families absorb the cost.

These challenges do not exist in isolation. Psoriatic disease intersects with the rising burden of NCDs, ongoing infectious disease pressures, fragile health systems, and limited social protection. It exposes gaps that affect many chronic conditions, but with consequences that are often visible, painful, and deeply stigmatizing.

This briefing book brings together evidence, lived experience, and regional insight to make one point clear.

IFPA is the only global organization working to unite people living with psoriatic disease. In Africa, our role is to listen, connect, and support collective action through our regional member organization, PsorAfrica, and all the national patient organizations across the region. Patient organizations play a central role in this effort. They bring lived experience into policy spaces. They turn data into advocacy. They ensure that decisions reflect real needs.

The path forward is clear. Better data strengthens advocacy. Advocacy drives policy change. Policy unlocks resources. Resources deliver care that restores health, dignity, and participation.

Local strength matters. United action matters more.

By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being

IFPA

Ingvar Ágúst Ingvarsson
President, IFPA

PsorAfrica
IFPA Region Africa

Pierre Celestin Habiyaremye
President, PsorAfrica

Key messages

Psoriatic disease cannot be cured, but effective therapies exist

Psoriatic disease is a lifelong inflammatory condition affecting the skin, joints, and overall health. It causes pain, disability, and psychological distress. With timely diagnosis and appropriate treatment, disease progression and complications can be reduced. In Africa, many people do not know about the disease itself and never receive that care.

The true burden in Africa is unknown

Despite low reported prevalence, widespread underdiagnosis is evident due to limited access to specialists, low awareness, and insufficient population data. The absence of dermatological and rheumatological specialties significantly affects diagnosis and long-term morbidity, with children and individuals with darker skin tones particularly at risk of being overlooked.

In Africa, fewer than one dermatologist is available for every million people, compared to 36 in the United States and 65 in Germany.[1]

The impact goes far beyond health

Psoriatic disease can significantly impact an individual's ability to work, earn an income, and participate in society. Out-of-pocket costs are high. Effective treatments are often unavailable. Stigma, discrimination, and misinformation drive isolation and mental distress. For many families, the disease becomes a pathway to poverty.

Psoriatic disease intersects with both NCDs and infectious diseases

People with psoriatic disease face higher risks of developing cardiovascular disease, diabetes, obesity, and mental health disorders. At the same time, infections such as HIV and tuberculosis (TB) can worsen disease severity, while some treatments increase infection risk. Care must reflect this reality.

Access to care is a systemic NCD challenge

Africa faces severe shortages of NCD specialists. Dermatologists and rheumatologists are concentrated in cities. Referral pathways are weak. Guidelines are limited. Medicine supply chains are fragile. These barriers delay diagnosis, weaken treatment, and worsen outcomes across many chronic diseases.

New care models offer a real opportunity
Telehealth, task-sharing with trained primary care and nursing staff, digital decision tools, and remote specialist support can enhance care access beyond urban areas. Improved primary care training and standardized referral pathways boost early detection. Exploring innovative partnerships can address health system gaps and support financing reforms for therapies, including biosimilars. Integrating these models within broader health system and NCD frameworks can amplify their impact, promoting sustainable improvements in access and outcomes for psoriatic disease.

African-led research is essential

Major gaps remain in epidemiology, clinical research, and economic data. African populations are underrepresented in trials. Local data are needed to guide policy, assess treatments, reduce stigma, and justify investment.

Advocacy must focus on three priorities

1. **Research** to generate local evidence
2. **Representation** to ensure that the voices of people living with the disease shape decisions
3. **Rights** to secure equitable access to diagnosis, treatment, and care

PSORIATIC **DISEASE**

Psoriatic disease is a **chronic**, **painful**, **disfiguring**, and **disabling** disease requiring long-term personalized treatment

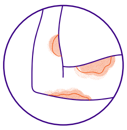
Psoriatic disease affects multiple parts of the body – it is a condition without a cure.[2] However, it can be effectively managed with treatment.

Psoriatic disease is characterized as a chronic, systemic, inflammatory NCD and a musculoskeletal disorder in which the immune system is triggered, and the resulting inflammation primarily damages the skin and joints.[3]

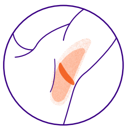
People of all sexes, ages, and races can develop psoriatic disease, and the disease is hereditary; as such, it often runs in families.[4] Psoriatic disease can manifest as skin symptoms (psoriasis) and joint inflammation (psoriatic arthritis), which may appear independently or together.[2]

Skin symptoms

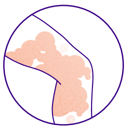
Psoriasis varies among individuals and includes several types. It is possible to have multiple types simultaneously or over a lifetime.[2,5]



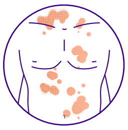
Plaque
Red patches or plaques with silvery scales and, the most common form



Inverse
Red shiny lesions found in skin folds



Erythrodermic
Severe form of psoriasis – fiery redness covering large areas; a widespread, red, peeling rash; and a medical emergency



Guttate
Small dot-like lesions often follow an infection like strep throat

Pustular
White pustules surrounded by red skin, and can be characterized by painful, pus-filled blisters that can be severe

Psoriasis and skin color

Psoriasis can affect people of all skin tones and may present differently for different skin types. Individuals with darker skin tones have a greater potential for disfigurement due to plaque psoriasis.[6] On darker skin tones, psoriasis lesions sometimes present as violet, dark brown, or grayish, with scales that may be gray rather than silvery white.[7] These differences can lead to delayed diagnosis, as healthcare guidelines and resources often focus on presenting symptoms in individuals with lighter skin.[8]

Inflammation of the joints

Psoriatic arthritis is a type of arthritis associated with psoriasis, distinguished by joint swelling, pain, and stiffness, as well as discomfort in the entheses, where tendons and ligaments attach to bones.[9] This condition can affect individuals of any age and can occur regardless of the severity of their skin symptoms. Even before a formal diagnosis, those with skin manifestations of psoriatic disease often report experiencing joint pain, stiffness, and fatigue.[10] People living with psoriatic arthritis have an increased risk of neurological issues like carpal tunnel syndrome, which worsens pain and functional ability.[11]

Delayed diagnosis drives irreversible joint damage

Timely diagnosis and effective treatment for psoriatic arthritis are essential in order to prevent irreversible joint damage and maintain a good quality of life. In Africa, limited rheumatology services and access barriers contribute to delayed diagnosis.[12] Photographs taken at a clinic in Ethiopia reveal that individuals with psoriatic disease frequently experience delayed diagnoses of psoriatic arthritis, resulting in deformities that could have been prevented or delayed.[13]

Personalized treatment is essential, but access gaps leave many untreated

Psoriatic disease requires personalized treatment.[14] Care choices depend on the disease type, severity, location, overall health, and response to previous therapies. In practice, many people live with persistent or worsening symptoms without formal assessment or timely treatment.[15] Pain and functional limitation tend to continue unchecked.

Although systemic and biologic therapies for psoriatic disease are highly effective, access remains limited for many, especially in low-resource settings.[16,17] High cost is a primary barrier, compounded by restrictive health policies, weak health systems, and limited coverage.[18]

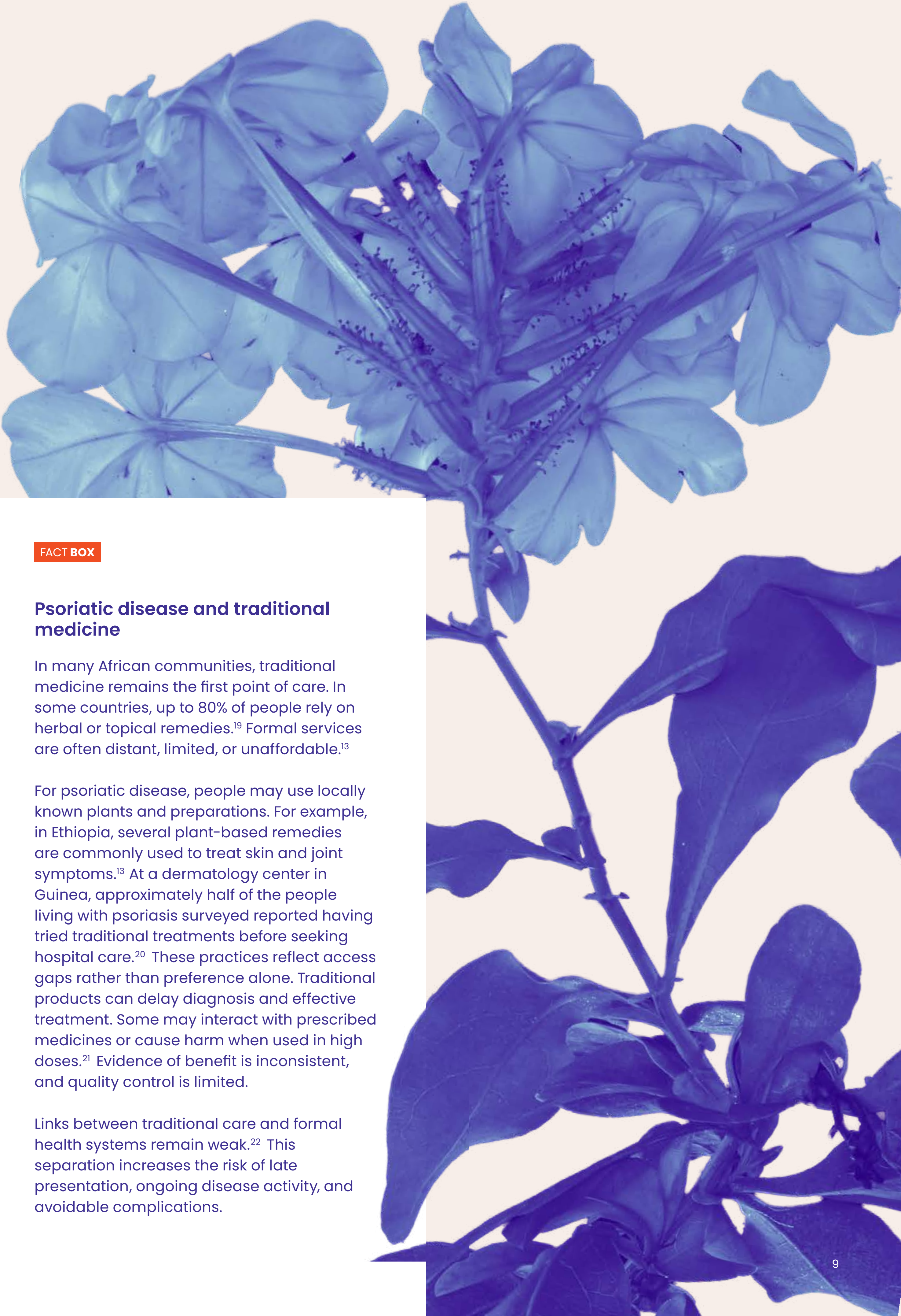
1 in 3
individuals with psoriasis also develops psoriatic arthritis.[2]

IFPA **AMBASSADOR STORY**

> *"The main problem impacting people with psoriatic disease is poor awareness. Even healthcare practitioners are not aware of psoriasis.* ***Doctors and nurses have asked me: 'What's happening to your skin?'***
>
> *The second problem is access to treatment. The last problem is that those who are affected by psoriatic disease take traditional medicines, and these medicines can cause a different set of issues in the body, without the person knowing about it."*

Pierre Celestin Habiyaremye
IFPA ambassador / Rwanda

Watch the interview online



FACT **BOX**

Psoriatic disease and traditional medicine

In many African communities, traditional medicine remains the first point of care. In some countries, up to 80% of people rely on herbal or topical remedies.[19] Formal services are often distant, limited, or unaffordable.[13]

For psoriatic disease, people may use locally known plants and preparations. For example, in Ethiopia, several plant-based remedies are commonly used to treat skin and joint symptoms.[13] At a dermatology center in Guinea, approximately half of the people living with psoriasis surveyed reported having tried traditional treatments before seeking hospital care.[20] These practices reflect access gaps rather than preference alone. Traditional products can delay diagnosis and effective treatment. Some may interact with prescribed medicines or cause harm when used in high doses.[21] Evidence of benefit is inconsistent, and quality control is limited.

Links between traditional care and formal health systems remain weak.[22] This separation increases the risk of late presentation, ongoing disease activity, and avoidable complications.

THE **BURDEN**

The true burden of psoriatic disease in Africa remains underestimated

Psoriasis affects an estimated **3.5 million people** across Africa, a region of more than 1.3 billion people.[23]

Globally, and in Africa, psoriasis prevalence varies across geographic regions. For example, Eastern sub-Saharan Africa has a similar population size to that of North Africa, but reports only half the number of cases.[23] The distribution of cases points to a north–south divide, shaped by genetics, health system capacity, environmental exposure, and disease awareness.

Countries in the East African region – namely Kenya, Tanzania, Uganda, Rwanda, and Burundi – face considerable socioeconomic constraints that restrict access to both diagnosis and routine dermatological care.[24,25] In fact, physician-/dermatologist-diagnosed prevalence rates for adults in the region and also across West, Central, and Southern Africa are reported to be as low as 0.06%.[23] **These figures likely reflect a substantial number of missed diagnoses due to various systemic issues.[13]**

In stark contrast, Australia, a high-income country with a robust and well-resourced primary care system, reports a considerably higher prevalence of psoriasis of 3.78% among adults.[23] This disparity tends to highlight the significant impact of healthcare infrastructure on the diagnosis and treatment of the condition. The wide variation in prevalence rates suggests that inadequate access to primary care, a shortage of trained healthcare professionals, and lower levels of health literacy contribute to underdiagnosis and misdiagnosis of psoriasis in Africa.[24,26]

Reliable data are scarce and mask the extent of the disease burden

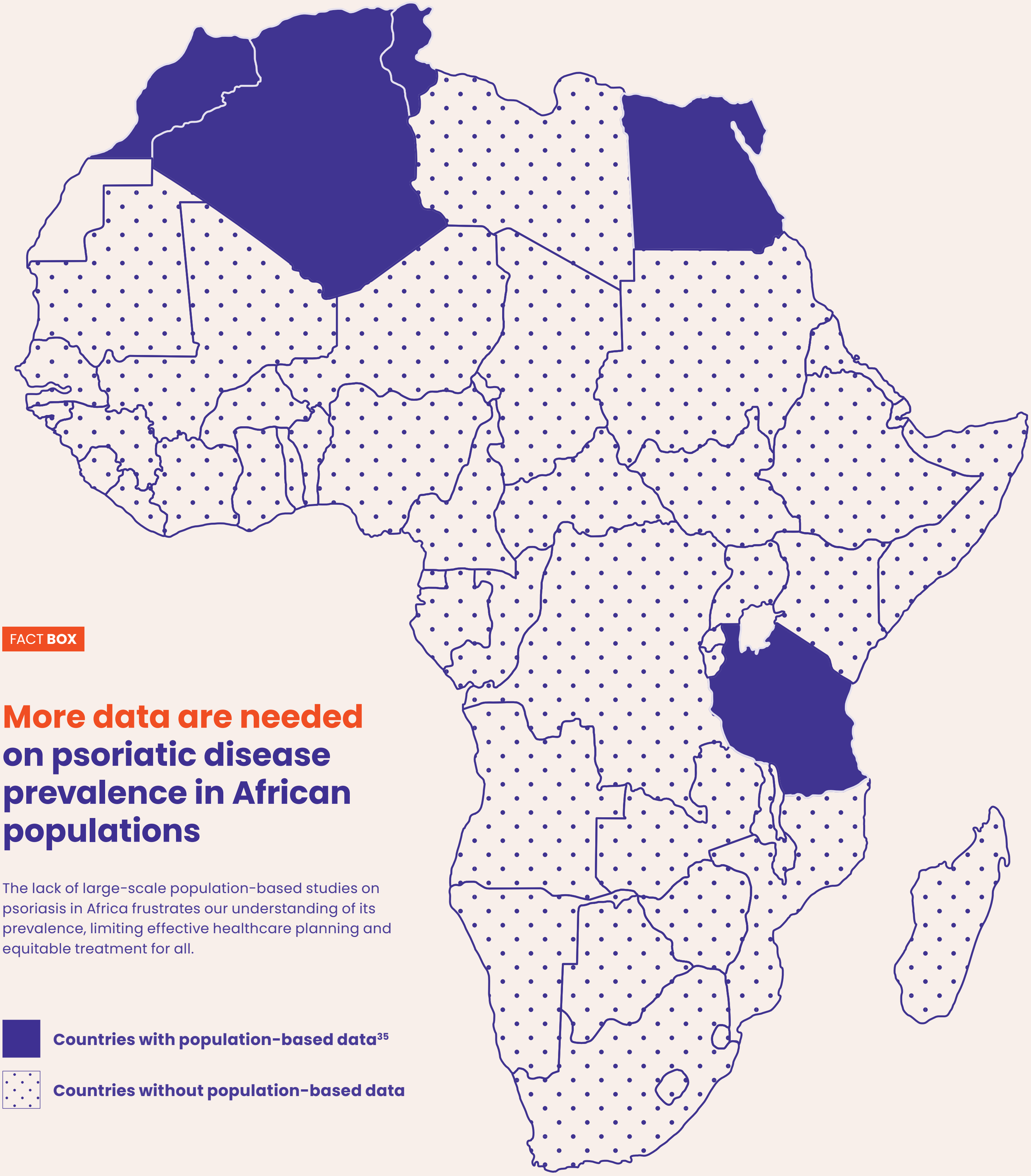
Considerable gaps still exist in the geographical areas reporting data on the incidence and prevalence of psoriasis. Only 41 of the more than 220 countries and territories in the world have epidemiological data on psoriasis in the general population.[23] Prevalence studies in people with darker skin are especially limited worldwide, and population-based research in Africa is sparse (see fact box).[7]

Data on psoriatic arthritis are even less frequent. Few global analyses include African populations, largely due to the lack of population-level data.[27,28] One estimate suggests that 15.5% of patients with psoriasis living in Africa have psoriatic arthritis, which is lower than reported in Europe.[29] However, clinic-based studies tell a different story, with rates of 28% in Kenya and 25% in Nigeria.[30,31] These findings suggest that joint disease may be more common than current estimates imply.

Psoriatic disease in children is rising, but remains poorly understood in Africa

Children and adolescents are also impacted. Psoriasis is less common in children than in adults, with a physician-/dermatologist-diagnosed prevalence of less than 1% in all countries and onset typically occurring during adolescence.[23,32] Although there are just over 600,000 pediatric cases worldwide, rates have increased in all regions over the past three decades.[33] Over this period, sub-Saharan Africa experienced the greatest increase in pediatric psoriasis cases globally.[33]

Globally, psoriatic arthritis affects an estimated 3.3% of children and adolescents with psoriasis.[29] Yet its epidemiology in children remains poorly described, with minimal information from African populations.[34]



FACT **BOX**

More data are needed on psoriatic disease prevalence in African populations

The lack of large-scale population-based studies on psoriasis in Africa frustrates our understanding of its prevalence, limiting effective healthcare planning and equitable treatment for all.

■ **Countries with population-based data[35]**

⁘ **Countries without population-based data**

Global prevalence data

The Global Psoriasis Atlas (GPA) is the world's most extensive review of the global burden of psoriasis, with data from 41 countries across 14 regions, including Africa.[23]

The GPA began differentiating between physician-/dermatologist-diagnosed cases and self-reported cases when reporting data in order to address global prevalence variations, improve epidemiological accuracy, and acknowledge the burden of undiagnosed or misdiagnosed psoriasis. This distinction seeks to clarify the verified disease burden versus suspected cases.

Physician/dermatologist diagnosis

Cases reported as diagnosed by a physician or dermatologist confirm psoriasis through formal clinical assessment. Many individuals with psoriasis may not seek treatment, potentially resulting in underreporting in studies relying solely on medical records.

Countries with missing data

Many countries, particularly those in Africa, lack prevalence data on psoriasis. For these nations, the GPA uses a statistical model based on available data for estimates, which are less reliable than those derived from original data sources and should be interpreted with caution.

THE **BURDEN**

Psoriatic disease **impacts far more than the skin and joints**

Psoriatic disease significantly affects physical, mental, and social well-being, especially in Africa.[4]

The burden is often higher than in wealthier regions, mainly because of limited access to dermatology and rheumatology services. Diagnosis is often delayed, and many people live for years without clear information or effective treatment.[13,36] As a result, disease activity worsens without control, leading to increased disability and long-term effects.[13]

Misunderstanding and stigma amplify the social burden of disease

Psoriatic disease is widely misunderstood and often mistaken for an infectious, fungal, or hygiene-related condition.[37] Visible skin changes can lead to avoidance, discrimination, and exclusion from social and community life.[4,38] Many individuals withdraw socially due to shame or fear of judgment.[38] These experiences erode self-esteem and reinforce isolation.[38]

Women and socioeconomically disadvantaged groups face the greatest challenges

Women often experience a higher psychosocial burden due to cultural expectations related to appearance, marriage, and caregiving roles.[39,40] Psoriatic disease may affect marriage prospects or strain existing relationships.[41,42] At the same time, caregiving responsibilities and limited financial autonomy can restrict access to care.

Psychological distress is common but rarely recognized or treated

Depression, anxiety, and emotional distress are frequent among people living with psoriatic disease.[38] These impacts are compounded by stigma, chronic symptoms, and financial stress. Mental health services are scarce in many settings, and psychosocial support is rarely integrated into chronic disease management.[43]

Myths and misinformation hinder effective management and care

Widespread myths about contagion, spiritual causes, or lifestyle factors continue to shape perceptions of psoriatic disease.[37] In the absence of accessible, trusted health information, people with skin or joint symptoms of psoriatic disease may delay seeking care or rely on ineffective treatments. These beliefs complicate communication with healthcare providers and reduce adherence to long-term treatment plans.[37]

Symptoms directly affect the ability to work, generate an income, and pay for care

Chronic pain, joint stiffness, and skin lesions limit the ability to work and earn an income.[44] This is especially damaging in settings where livelihoods depend on manual or informal work. Lost productivity and missed workdays are common.[45]

Financial impact is compounded by health system design. Most people in Africa pay for care out of pocket.[46] While universal health coverage (UHC) and social health insurance schemes exist, coverage of low-income populations remains limited.[46] Private insurance is rare, and many people pay in cash for medicines.[47]

Effective treatments are often unaffordable. High-cost therapies, including biologics, are typically not covered by insurance. In rural Cameroon, annual biologic costs range between 30,000 and 80,000 US dollars, placing them far beyond the reach of most people with psoriatic disease.[36]

Psoriatic disease can be a pathway to poverty

Psoriatic disease often starts as a health problem. It quickly becomes an economic one.

Across Africa, diagnosis is frequently delayed, treatment options are limited, and medical costs can be prohibitive. As a result, people often seek care only when the disease is severe. Severe disease costs more, lasts longer, and disrupts work and family life.[48]

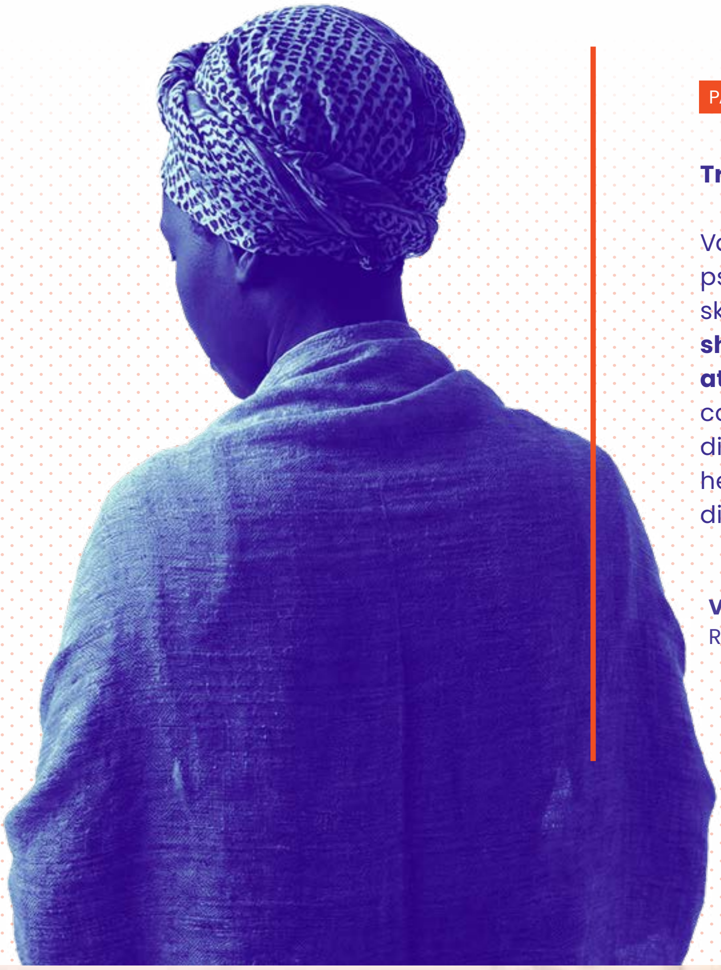
Psoriatic disease does not act alone. It interacts with fragile health systems and limited social protection. Even people in formal employment can fall behind. Left untreated or poorly managed, psoriatic disease becomes a driver of poverty, not just a consequence of it.[48]

As disease severity increases, so do costs. Medicines, clinic visits, travel, and lost workdays accumulate. Caregivers may also lose income.

CASE **EXAMPLE**

The annual treatment costs for psoriasis in Nigeria[49]

Treatment costs in Nigeria (US dollars)*



PATIENT **STORY**

Traditional beliefs and stigma

Valentine Murakatete, a 31-year-old Rwandan woman with psoriatic disease, initially felt a burning sensation on her skin that spread in patches. **Before seeking a diagnosis, she relied on local remedies suggested by friends who attributed her condition to witchcraft.** Misbeliefs in her community led to accusations of HIV or other contagious diseases, resulting in ostracism. This stigma, coupled with her physical symptoms, caused significant emotional distress, including suicidal thoughts and attempts.[50]

Valentine Murakatete,
Rwanda

Her full story can be read
online at **AllAfrica.com**

NIGERIA

30%
of income

For a graduate in a federal job in Abuja, the cost of treating severe psoriasis can consume nearly 30% of their annual earnings.[49]

NIGERIA

$16.4 million
is spent

each year on psoriasis treatment,
nearly 2% of the national health budget.[49,*]
A large share of this cost is paid directly by
people living with the disease and their families.

* Government spend on treatment costs was converted from Nigerian naira to US dollars. Rates were calculated at the time of the study in 2016.

THE **BURDEN**

Psoriatic disease sits at the **crossroads of NCDs and infectious diseases**

NCDs now account for about a third of deaths across the continent, and sub-Saharan Africa is experiencing the fastest increase in NCD mortality globally, despite limited resources to manage this growing dual health challenge.[51-53]

Psoriatic disease closely co-exists with other NCDs, increasing health risks and care complexity. People living with psoriatic disease have a higher risk of developing cardiovascular disease, diabetes, obesity, mental health disorders, inflammatory bowel disease, and some cancers.[54] When these conditions are not identified early, the overall disease burden increases, and management becomes more challenging.

Data from North Africa illustrate the scale of this challenge. In a multicenter hospital study across Algeria, Tunisia, and Morocco, cardiometabolic risk factors were widespread among people with psoriatic disease.[55] Nearly one in three had dyslipidemia. Almost one in four lived with obesity or hypertension. Over one in five had diabetes. More than a third met the criteria for metabolic syndrome.

Systemic inflammation provides a biological link.[56,57] Elevated inflammatory markers associated with cardiovascular risk have been observed in a North African population.[58] In South Africa, signs of atherosclerosis were more common in people with psoriasis than in those without the disease.[59]

Obesity further worsens outcomes. More than half of the people with psoriatic arthritis in Africa are also estimated to live with obesity.[60] Excess body weight increases the risk of earlier disease onset, worsens symptoms, reduces treatment response, and adds to cardiometabolic risk.[61]

Achieving the **UN Sustainable Development Goal 3** on health and well-being requires health systems to address the full burden of NCDs. Psoriatic disease must be included in this effort.

Psoriatic disease does not exist in isolation from infectious disease

Infections can trigger or worsen disease flares. At the same time, psoriatic disease and its treatments can increase susceptibility to serious communicable diseases.[62]

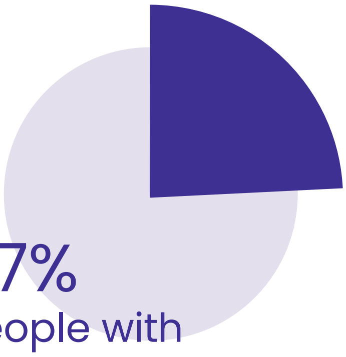
This overlap is especially important in Africa, where infectious diseases remain a major cause of illness and death.[63] TB and HIV continue to place a heavy strain on health systems, particularly in southern and eastern Africa.[63] Other infections, including viral hepatitis and endemic fungal diseases, also pose risks.[62] Chikungunya virus, which is endemic to certain regions and recently broke out in Réunion, Mayotte, Mauritius, Madagascar, Kenya, and Somalia, adds further complexity, as its severe joint pain can mimic or worsen psoriatic arthritis, complicating diagnosis and care (see fact box).[64,65]

HIV significantly alters the course of psoriatic disease. In people living with HIV, psoriasis often presents with greater severity, atypical patterns, and poorer response to standard therapies.[66,67] Psoriasis affects an estimated 2% to 5% of people living with HIV, a higher prevalence than in the general population.[68]

Evidence from West Africa highlights the consequences. In Conakry, Guinea, nearly 40% of people with HIV-positive psoriasis also had psoriatic arthritis.[20] Around 43% developed erythroderma, a severe and potentially life-threatening complication. A similiar pattern of more severe disease was also reported in Nigeria among HIV-positive people.[69]

Treatment further increases infection risk. Systemic therapies and biologic agents suppress immune responses and raise the risk of infections such as TB and viral hepatitis, both common in endemic settings.[70] TB screening before starting biologic therapy, followed by regular monitoring, is essential. Diabetes, a common comorbidity in psoriatic disease, further increases TB risk, reinforcing the need for integrated screening and coordinated care.[71]

Addressing psoriatic disease requires alignment with infectious disease prevention and control. Without this, people remain exposed to avoidable risks from both conditions.



GUINEA

24.7%

of people with psoriasis tested positive for HIV.[20]

Psoriasis was the first indication of HIV infection in more than half the cases.

FACT BOX

Chikungunya virus

A mosquito-borne viral infection common in parts of Africa.[65] It spreads through bites from infected Aedes mosquitoes.[65] The virus causes sudden fever and severe joint pain.[64] Joint symptoms can last for months or longer. Swelling and stiffness are common. Because chikungunya affects the joints, it can resemble or worsen inflammatory arthritis.[64] This overlap can delay diagnosis and complicate care for people with joint manifestations of psoriatic disease.

THE **BURDEN**

Limited access to care delays diagnosis and weakens treatment

The path from identifying symptoms to achieving successful treatment for individuals living with psoriatic disease in Africa is rarely simple: **challenges can arise throughout the patient care journey.**

01

First sign of symptoms

Individual seeks help

Psoriasis often develops as subtle, itchy, or sore scaly patches that cause a person to seek care from a pharmacist or general practitioner.[36] These symptoms are frequently missed or confused with dandruff, dry skin, eczema, or more familiar infections. A lack of public awareness of the disease, and specifically among healthcare professionals, contributes to misdiagnosis or late diagnosis.[26,37]

02

Symptoms worsen, disease progresses

Delays in diagnosis

Poor awareness of the disease and a failure to receive a proper diagnosis can cause a person to become stuck in primary care or turn to alternative remedies when that care fails to meet their needs.[36,70,72] Patients often only get an accurate diagnosis after being referred to a dermatologist, which can take years in some cases.[13,36] Many countries lack national guidelines or clear care pathways for psoriatic disease and other NCDs. South Africa remains one of the few countries with formal guidelines and specialist referral centers.[73] Unclear or fragmented referral pathways directing patients toward specialist care can further stagnate the process. During this time, the disease progresses, and complications develop.

In Rwanda, only **12 dermatologists** serve a population of **13 million people**.

All of them are based in Kigali.[74]

03

Referral to a specialist

Extended waiting times for an appointment

Health systems face widespread shortages of professionals providing advanced care for autoimmune diseases and NCDs, including dermatologists, rheumatologists, cardiologists, and endocrinologists.[1,75,76] Most are concentrated in large cities.[1] In Nigeria, for example, only 30 rheumatologists serve a population of about 200 million people.[76] For people living in rural or peri-urban areas, it can take weeks or months to get an appointment, followed by long travel and waiting times to see the specialist, or no access at all.[76] This pattern affects many chronic conditions, but its impact is especially severe for psoriatic disease, which requires early recognition and coordinated care.[76]

> *"Training more primary care practitioners would be useful because, the truth is, **most of them can't recognize the disease**, and keep treating it as a fungal infection. In psoriasis, timely intervention is very important. Early diagnosis and treatment are key."*

Dermatologist in Ghana – discussing psoriatic disease-specific training and resources for primary care providers.

> *"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 the public system are overrun** and have broken referral pathways, as well as a lack of awareness."*

Rheumatologist in South Africa – discussing time to diagnosis for psoriatic arthritis (they estimated a delay of six to 12 months)

> *“Most patients have to pay out of pocket.* ***Many treatments aren’t covered by national insurance****. Not everyone has public coverage. Because of distance, a lot of patients are in the villages, so access to coverage is bad.”*
>
> **Nurse in Ghana** – discussing barriers to treatment access

04

Treatment begins

Medicines unaffordable or unavailable

In Africa, affordable, older medications are preferred due to their cost-effectiveness and familiarity, while newer treatments are seldom included in essential medicines lists or UHC packages.[12] Even when patients are prescribed less expensive treatment options, families still likely face high out-of-pocket costs, limited insurance, and the risk of catastrophic expenditures.[12,77] Added to the cost challenges are availability issues. Fragile supply chains, reliant on imports with minimal local production, lead to frequent drug shortages and counterfeit products.[78] Weak forecasting and regulatory issues further exacerbate access problems, resulting in treatment interruptions that increase long-term health costs and reduce overall quality of life.[78,79]

05

Psoriatic disease-related complications

Inadequate chronic NCD disease care

Primary care providers lack sufficient training in chronic inflammatory conditions like psoriatic disease, an NCD that can lead to others.[4,80] This gap may result in missed screenings for preventable conditions such as type 2 diabetes and cardiovascular disease or appropriate coordinated care with a multidisciplinary team. Overcoming challenges in NCD care requires innovative solutions like telehealth, task-sharing, and remote specialist consultations to improve access in underserved areas.[81] Standardizing care pathways and enhancing training for primary care practitioners can facilitate earlier detection and referrals, ultimately improving access to effective treatment.

FACT **BOX**

Recognition of psoriatic disease as an important NCD strengthens support at primary care

Governments and NGOs are beginning to incorporate psoriatic disease into UHC and NCD action plans. Successful advocacy in countries like Panama and the Philippines provides a valuable model for local efforts.[82,83]

The inclusion of psoriatic disease within these frameworks engages systemic support and resources that enable primary care to deliver timely, comprehensive, and affordable care for people living with psoriatic disease.

IFPA **ADVOCACY**

Advocating for a better future

To overcome the myriad of challenges that people living with psoriatic disease in Africa encounter, **the way forward must be practical and interdependent**: better data unlock advocacy and policy action, policy unlocks resources, and resources deliver care that restores health, dignity, and economic participation for people living with psoriatic disease in Africa.

IFPA **AMBASSADOR STORY**

> *"I became an advocate to* ***become more involved in my community****, get access to better training workshops and tools to* ***empower myself, and empower other people*** *in our community."*

Zakieyah Ajouhaar
IFPA ambassador / South Africa

Watch the interview online

Advocates in every African country demand action in **three key areas:**

Research

Unlock local knowledge and solutions

We can only effectively manage what we measure. Data on every aspect of psoriatic disease in African populations are the key to informed decisions and solutions that can improve the everyday lives of those affected.

Our advocacy priorities:

Establish **national registries** across Africa

Conduct **prevalence studies** to close the data gap

Ensure **inclusion** in global clinical trials

Representation

Nothing about us, without us

People-centered care must be at the forefront of all decisions. That means that people living with psoriatic disease must be present in rooms when decisions about them are being made. Moreover, we must be included in research, policy, and leadership.

Our advocacy priorities:

Secure a seat for people living with psoriatic disease in NCD and UHC decision-making arenas

Achieve formal recognition of patient organizations as partners in health system design

Rights

Health is not a privilege

Access, equity, and stigma-free care – ensuring medicine availability, affordability, and quality care for all with psoriatic disease – must be non-negotiable. Recognizing psoriatic disease as a chronic systemic NCD and integrating it into national NCD policies, UHC packages, and health strategies requires unwavering political commitment.

Our advocacy priorities:

Advocate for the inclusion of medicines for psoriatic disease in **national essential medicines lists**

Ensure **coverage of treatments** in UHC schemes

Push for **anti-stigma legislation**

More research and more data can drive improvements in health outcomes

Better care for psoriatic disease in Africa depends on better evidence. High-quality research supports advocacy demands for improved care, equal representation, and policies that safeguard the rights of people living with psoriatic disease. That said, today, there are still research gaps that deter the planning, treatment, and implementation of effective policies. Yet these gaps are bridgeable.

Basic epidemiological data are missing across much of the continent. Few population studies track the number of people living with psoriatic disease, the time when symptoms first appear, or the progression of the disease. Without this information, policymakers cannot plan services or allocate resources. Representative population surveys, standardized case definitions, and shared clinic registries would allow countries to estimate burden and plan care with confidence.

Clinical research in psoriatic disease remains heavily skewed toward high-income regions. African populations are rarely included in trials, raising questions about how well existing evidence applies in settings with different genetics and high HIV prevalence.

Including African sites in global trials and pharmacogenomic studies would improve confidence in dosing, safety, and effectiveness.

Little is known about the economic burden of psoriatic disease in Africa. Almost no formal cost-of-illness studies exist, and data on disability and lost productivity are scarce. Clear economic evidence could shift policy debates. Showing that effective treatment reduces long-term costs, disability, and income loss would strengthen the case for investment.

Few countries have national strategies or clinical guidelines for psoriatic disease. This limits the consistency of care and leaves people dependent on where they live or who they see. Developing local guidelines and embedding psoriatic disease within existing NCD and disability frameworks would support more person-centered and equitable care.

Limited awareness fuels stigma and delays care. Psoriatic disease is still misunderstood by the public and some health workers, and is sometimes confused with infectious diseases such as HIV.

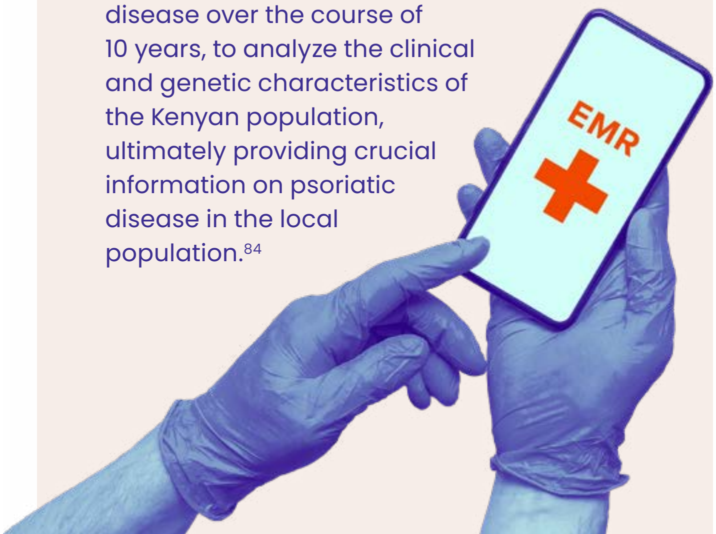
Research into local beliefs and cultural perceptions can guide targeted education and anti-stigma efforts. Better understanding leads to earlier care, better adherence, and improved quality of life.

Better research is not only an academic exercise. It is a practical tool to improve care, guide policy, and protect lives.

FACT **BOX**

Registry to collect psoriatic disease data in Kenya

The first psoriasis patient registry in Kenya has recently been established. The registry aims to enroll people with psoriatic disease over the course of 10 years, to analyze the clinical and genetic characteristics of the Kenyan population, ultimately providing crucial information on psoriatic disease in the local population.[84]



ABOUT **IFPA**

Our vision and mission

Founded in 1971, IFPA is the International Federation of Psoriasis Associations. It is the only global organization representing and uniting all people living with psoriatic disease – regardless of where they live, the type of psoriatic disease they have, or how it impacts their lives.

Vision

A future where all people living with psoriatic disease enjoy good health and well-being, free from stigma and preventable disability and comorbidities.

Mission

Unite, strengthen, and lead the global psoriatic disease community to improve the lives of all people affected by psoriatic disease.

IFPA MEMBER ORGANIZATIONS IN THE AFRICA REGION

PsorAfrica
Psoriasis Africa (PsorAfrica) champions dignity, access to care, and inclusion for people living with psoriatic disease in Africa, moving from silence and stigma toward visibility, treatment, and empowerment.

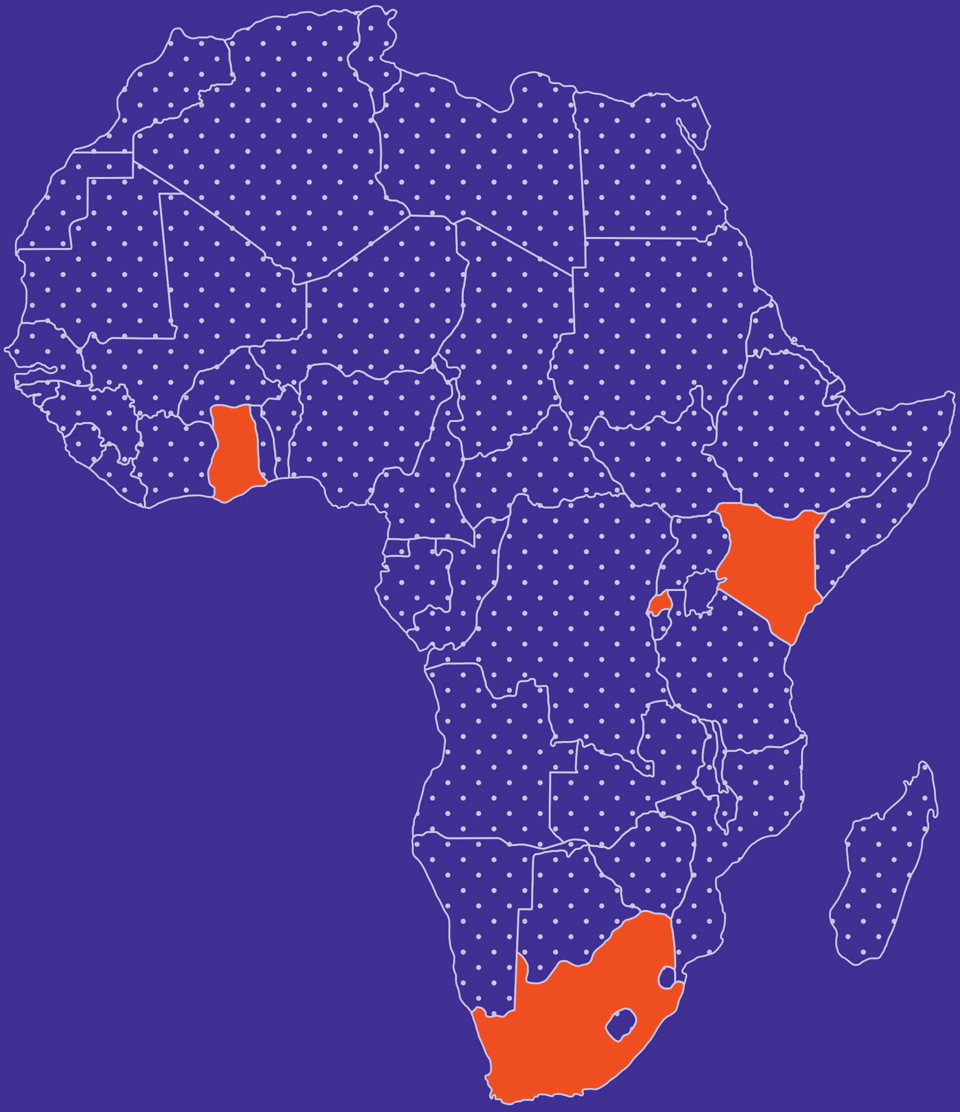
MEMBERS

GHANA
Ruth Abekah
Psoriasis Association of Ghana

KENYA
Dr Evanson Njoroge Kamuri
Psoriasis Association of Kenya

RWANDA
Pierre Celestin Habiyaremye
Rwanda Psoriasis and Psoriatic Arthritis Organization

SOUTH AFRICA
Judy Wallace
South African Psoriasis Association (SAPSA)



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IFPA

GLOBAL LEADER IN FIGHTING
PSORIATIC DISEASE