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Introducing the Global Health and Equity section in the *British Journal of Dermatology*

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BLURB FOR ETOC:

The Section Editor and Associate Editors for the new British Journal of Dermatology Section on Global Health & Equity outline their vision for the Section and suggest topics for submission.

We are at a critical time in public health. The COVID-19 pandemic has highlighted glaring global health inequities in access to care, diagnostics, quality of treatment, freedom of information and vaccine access. Although research into health disparities dates back more than a century, the pandemic has given the world a renewed sense of urgency in addressing health inequities.

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In this setting, the *British Journal of Dermatology* is launching a new section, Global Health and Equity. The field has evolved from roots in tropical medicine and infectious disease into international health and community dermatology, and finally into global health dermatology. This shift in terms parallels a broader shift in philosophy that emphasizes the multidirectional flow of knowledge and collaborative practice.[1] Building on existing definitions of global health, we take global health dermatology to mean an area of research and practice 'that places a priority on improving health and achieving equity in health for all people worldwide',[1] on both an individual and public health level. Global health dermatology particularly prioritizes skin conditions affecting vulnerable people around the world.

So why title this section 'and equity'? Health equity is the 'commitment to reduce – and, ultimately, eliminate – disparities in health and in its determinants, including social determinants…striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk'. [2] Equity research plays a key role in this new section, regardless of country of origin or whether the research focuses on a small local community or the public health needs of an entire nation.

Therefore, the Global Health and Equity section of the *BJD* will showcase and cultivate rigorous equity-oriented research and scholarly work. As academic leaders in dermatology, we acknowledge our position of relative and often unspoken privilege, and will work to amplify voices that may not have previously been heard. Our editors span six regions of the globe, with expertise in refugee medicine, structural racism, neglected tropical diseases, sexually transmitted infections, HIV/AIDS, community health and global health partnerships.

Publications in dermatology often focus on resource-rich settings, and comparative efficacy of costly treatment regimens out of reach for patients living outside the global north. Knowledge generated in these settings defines practice and informs thinking sometimes to the detriment of knowledge systems in low- and middle-income countries (LMICs). According to the 2019 Global Burden of Disease analysis, the skin conditions with the highest disability-adjusted life-years (DALYs) were dermatitis, acne, scabies, viral skin diseases, urticaria, psoriasis, fungal skin diseases and bacterial skin diseases.[3] Publications do not mirror this global burden of disease – and even this list may not accurately represent the true burden in resource-limited settings. Data from these settings are limited, relying on extrapolation from relatively few data points. For example, estimates of the global burden of scabies come from 49 studies from North America, compared with only 16 studies for all of sub-Saharan Africa (which is made up of 46 different countries). Understanding the true burden of skin disease worldwide in resource-limited and under-represented settings is critical – and should be represented in the published dermatology literature.

The under-representation of dermatology research from resource-limited settings mirrors the distribution of dermatologists worldwide. In the USA, the ratio of dermatologists to population is 1.10 per 100 000 people.[4] In Southern and West Africa, the ratio is 0–3 per *million* people.[5] Even in high-resource settings like the USA, the higher ratio does not guarantee access; many majority African American, Hispanic American or Native American

communities have no dermatologists.[4] In areas with few dermatologists, existing physicians may be overburdened with clinical care, making it difficult for them to pursue research or build capacity.

Working in global health and equity, we must be prepared for uncomfortable but necessary conversations addressing the way that history has shaped our field. The legacy of colonialism is evident throughout medicine in funding, intervention design, training programmes, authorship and access to opportunities.[6] Acknowledgment of the legacy of former colonial relationships and their influence is increasing,[6] highlighting the need to develop culturally, ethnically and geographically appropriate resources.[5] Authors from LMICs are under-represented in articles on those same LMICs; a review of *The Lancet Global Health* authorship found that of 236 articles focusing on projects in LMICs, only 35% of authors were affiliated with or came from LMICs,[7] and the situation is even more stark when looking at first or senior authorship. This calls for greater investment in capacity building, incorporating practical clinical research training into residency programmes, and equitable research partnerships at every level of the global health community.[5]

Similarly, the history of structural racism affects access to and quality of care. Research has often excluded black, Latino and indigenous people. Teaching our trainees the full spectrum of skin disease, as it appears in all patients, regardless of skin tone, is critical.[8]

This section welcomes submissions from around the globe in all article categories, including original articles, systematic reviews, clinical trials, rapid responses, perspectives and letters, with an emphasis on including local partners and awareness of authorship order. All topics related to global health and equity research conducted in a rigorous and ethically sound manner are welcome, and include, but are not limited to, capacity building, race and health, sexual and gender minority health, indigenous health, climate change, healthcare policy, global burden of disease, infectious diseases, noncommunicable diseases including cancers, HIV/AIDS, neglected tropical diseases, telemedicine for access to care, training programmes, humanitarian crises, and global healthcare delivery and innovation.

We encourage authors to consider buy-in from local stakeholders prior to funding; ensuring sustainability; including true collaborators on the ground; understanding historical, cultural, political and sociological contexts; acknowledgment of efforts of local teams and community groups; and authorship inclusion and order.[9]

The recent COVID-19 pandemic has highlighted the tremendous inequities in healthcare access across the globe. According to the World Health Organization, by October 2021 only 4% of people in Africa had been fully vaccinated, compared with 55–66% in the USA and Europe. Even within high-resource settings, vaccine equity is a critical issue, with undervaccination of racial and ethnic minority groups. The pandemic has also emphasized our interconnectedness: the health of all people across the world affects each one of us. By creating a section focused on global health and equity, we aim to contribute to the goal of improving health for all.

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