GLOBAL ACTION PLAN ON SKIN DISEASES (GAP-SKIN) 2026–2035

Training and Competency Policy Framework for Integrated Skin Health

A competency-based, adopt-and-adapt model for national health workforce policy, education and quality assurance

PRE-PUBLICATION DRAFT | VERSION 1.0
Prepared for technical review, clearance and national adaptation

Status	Pre-publication technical draft. Not official WHO guidance.
Alignment	WHA78.15 and the draft GAP-SKIN 2026–2035, with direct linkage to Strategic Objective 4.
Primary audience	Ministries of Health, education and regulatory bodies, training institutions, professional societies, programme managers and implementation partners.
Date	20 July 2026
Document version	Version 1.0, clean pre-publication copy prepared for technical review and clearance.

Pre-publication status
This document is a pre-publication technical draft prepared to support technical review, clearance and national adaptation. It translates the workforce and competency direction of GAP-SKIN into a proposed policy architecture. The draft GAP-SKIN and internal indicator compendium used in its preparation remain subject to validation and approval. This document is not official WHO guidance and should not be cited as such until formally cleared and published.

Executive summary

WHA78.15 calls for competency-based education of the primary health care workforce in the identification and management of skin diseases and their comorbidities, together with self-care education and support for digital assessment and remote specialist advice [1]. The draft GAP-SKIN 2026–2035 develops this mandate through Strategic Objective 4, which emphasizes cadre-specific competencies, pre-service and in-service education, assessment, certification, continuing professional development, mentorship, supportive supervision, task-sharing, referral systems and digital support [2].

The targeted framework review undertaken for this draft did not identify a single global instrument covering the complete integrated skin health policy, competency, curriculum, assessment and support system. Several mature frameworks can, however, be combined without constructing a new architecture from bare ground. The recommended model is therefore an adopt-and-adapt hybrid rather than a stand-alone invention.

Recommended adoption decision
Adopt the WHO Rehabilitation Competency Framework as the structural model for contextualization; use the WHO Global Competency and Outcomes Framework for Universal Health Coverage as the transversal competency spine; and populate the model with skin-specific practice activities, behaviours and learning content drawn from GAP-SKIN, the WHO skin NTD strategic framework, the WHO front-line skin NTD training guide, the national classification of common skin diseases, and locally relevant clinical guidance. Use the WHO self-care and community health worker frameworks for role-specific pathways. [2–11]

The proposed Integrated Skin Health Training and Competency Policy Framework consists of nine competency domains, ten practice activities, four proficiency levels and five workforce pathways. It establishes minimum policy standards for national endorsement, curriculum development, assessment, certification, supervision, digital governance, service implementation and monitoring. It also includes a staged specialist-development route for countries that currently have no dermatologist, combining immediate regional referral and teledermatology support with the deliberate creation of nationally regulated dermatology specialist capacity.

The framework is designed to operationalize proposed GAP-SKIN core indicator C4 in the internal indicator compendium: the proportion of Member States with an approved competency-based skin health workforce framework implemented through at least one relevant education, training, supervision or mentoring channel [17]. Final global reporting requirements remain subject to approval of the GAP-SKIN monitoring framework. The document also aligns workforce competencies with the three PHC management categories in the draft classification of common skin diseases: manage at PHC, recognize and consider referral, and urgent referral [18].

Relationship and functional boundary. This framework is the workforce and competency companion document for GAP-SKIN. It defines competency, education, assessment, certification, supervision, mentorship and workforce implementation architecture. It should be used with the PHC classification, NAP-Skin Guidance, the Indicator Compendium, the Two-Phase Prioritization Framework and SHRIEF. It does not replace national clinical guidelines, disease-priority setting, professional regulation, indicator metadata or national planning processes.

Key policy outputs

- A nationally endorsed competency framework defining the expected behaviours, knowledge and skills for each relevant cadre.
- Cadre-specific scopes of practice linked to the national skin health service package and referral system.
- Competency-based curricula and learning pathways covering pre-service, induction, in-service and continuing professional development.

- A standardized but nationally adaptable PHC training package comprising learner, facilitator, decision-support, image, assessment and supervision products.
  - Valid assessment and certification arrangements, with remediation and periodic reassessment.
  - Structured supportive supervision, mentorship and access to specialist advice, including teledermatology where appropriate.
  - A monitoring system that measures competence, coverage, retention, quality, equity and service outcomes rather than counting training events alone.
- A national specialist-development pathway for countries with no dermatologist, including interim referral arrangements, regional training partnerships, accreditation, retention and eventual domestic programme development.

Contents

1. Background and policy mandate

Skin diseases are common across the life course and may cause pain, itch, infection, disability, disfigurement, stigma, mental distress, reduced participation in education and work, and avoidable mortality. Integrated skin health requires a workforce that can manage common conditions close to where people live, recognize serious or uncommon disease, provide respectful and inclusive care, and connect patients to diagnostic, specialist, rehabilitation and psychosocial services.

In May 2025, the Seventy-eighth World Health Assembly adopted resolution WHA78.15, recognizing skin diseases as a global public health priority. The resolution urges Member States to strengthen competency-based education in PHC, including identification and management of skin diseases and comorbidities, self-care education, laboratory capacity, mental health and rehabilitation integration, and digital assessment and telemedicine [1].

The draft GAP-SKIN 2026–2035 translates this mandate into seven strategic objectives. Strategic Objective 4 calls for an integrated workforce approach tailored by cadre, setting and epidemiology. It proposes standardized competencies, blended learning, pre-service and in-service integration, formal certification, continuing professional development, mentorship, supportive supervision, skills assessment, task-sharing with clear scopes and referral pathways, specialist support, and digital technologies [2].

The internal GAP-SKIN indicator compendium defines core global indicator C4 as the proportion of Member States with an approved competency-based skin health workforce framework implemented through at least one relevant education, training, supervision or mentoring channel. Its operational definition requires an endorsed framework or curriculum, documented implementation, competency assessment and supervision, mentorship or specialist support. It explicitly excludes one-off awareness training as sufficient evidence [17].

The policy challenge is therefore not simply to produce training materials. It is to build a functioning competency system in which education, scope of practice, supervision, assessment, regulation, service standards and health workforce planning pull in the same direction.

1.1 Policy problem addressed

- Fragmented, disease-specific training that duplicates content and misses common diagnostic and service-delivery skills.
- Uneven exposure to dermatology in pre-service education and limited opportunities for continuing professional development.
- Training models that measure attendance or knowledge but do not verify performance in practice.
- Unclear task-sharing, scope-of-practice and referral arrangements for community and PHC providers.
- Insufficient training for recognition across different skin tones, ages, disabilities and local epidemiological patterns.
- Weak supervision, mentorship and specialist access after training, especially in rural and underserved areas.
- Absence of a national dermatologist or accredited specialist-training route in some countries, creating referral, governance, education and succession gaps.
- Limited integration of psychosocial care, stigma reduction, self-care, rehabilitation, surveillance, laboratory pathways and digital health.

1.2 Theory of change

Policy logic
When countries define role-appropriate competencies, embed them in education and scopes of practice, assess them through valid methods, and sustain performance through supervision, referral and specialist support, the workforce is more likely to deliver safe, equitable and people-centred skin health services. Better workforce performance should improve diagnostic and management quality, timely referral, continuity of care, data quality and patient experience, which in turn supports GAP-SKIN service and health outcomes.

2. Purpose, scope and intended users

2.1 Purpose

The purpose of this framework is to provide a common policy and technical foundation for developing, approving, implementing and monitoring competency-based education and workforce systems for integrated skin health. It is designed for national adaptation rather than direct use as a universal curriculum.

2.2 Scope

The framework covers population and individual care across promotion, prevention, early recognition, assessment, basic diagnosis, treatment, wound and disability care, self-care support, referral, follow-up,

surveillance, outbreak response, quality improvement and service leadership. It applies to common skin diseases, skin NTDs, inflammatory and chronic dermatoses, pigmentary disorders, wounds and lymphatic conditions, benign lesions, pre-cancerous and malignant conditions, and systemic, drug-related and severe presentations, as prioritized nationally [18], including workforce development in settings with no nationally available dermatologist.

The framework does not replace disease-specific clinical guidelines, national formularies, licensing standards or emergency protocols. Clinical content and authorized tasks must be adapted to national epidemiology, health-system capacity, medicines and diagnostics, professional regulation and referral resources.

2.3 Intended users

User group	Primary use
Ministries of Health	Policy endorsement, workforce planning, service-package alignment, financing and national monitoring.
Education ministries and training institutions	Curriculum design, faculty development, learning delivery and assessment.
Professional councils, regulators and accreditation bodies	Scope of practice, standards, credentialing and continuing competence.
National skin health, NTD, NCD, cancer, mental health, rehabilitation and PHC programmes	Technical content, integration, implementation and quality improvement.
Health service managers and supervisors	Deployment, workplace learning, supervision, performance review and referral support.
Professional societies and specialist networks	Technical validation, mentorship, teleconsultation and advanced-role development.
People affected, caregivers and civil society	Co-design, rights and stigma safeguards, patient experience and accountability.
Implementation partners and funders	Aligned investment, technical assistance and evaluation.

2.4 Terminology and definitions

Term	Working definition used in this framework
Accreditation	Formal recognition by an authorized body that an education programme, institution or assessment system meets specified standards.
Assessment	A structured process for collecting and judging evidence of learning or performance against explicit criteria.
Certification	Formal confirmation by the national competent authority, or its designated body, that a person has met specified competency requirements.
Competence	Demonstrated ability to integrate knowledge, skills, judgement, values and behaviours to perform safely and effectively in a defined context.
Competency	A defined capability or expected area of performance. A competency framework describes the competencies required; assessment determines whether competence has been demonstrated.
Credentialing	A process that verifies qualifications, competence and other requirements and authorizes a person to perform specified activities within an institution or system.
Entrustment	A supervised decision that a learner or practitioner may perform a specified professional activity with a defined level of supervision.
Proficiency level	The expected degree of independence, complexity, consistency and leadership for a specific practice activity.
Proficiency testing	External comparison of laboratory performance using unknown samples or equivalent material. In this framework, the term is reserved for laboratory quality assurance.

Term	Working definition used in this framework
Revalidation or renewal	Periodic confirmation that a practitioner continues to meet applicable professional, competency and practice requirements.
Scope of practice	The activities a cadre or practitioner is legally, professionally and organizationally authorized and competent to perform.
Counter-referral	Communication from the receiving service back to the referring provider or facility, documenting findings, actions, follow-up and responsibility for continuing care.
National competent authority	The ministry, regulator, council, accreditation body or formally designated institution with legal or policy authority for the relevant decision.
Dermatologist	A physician who has completed a nationally recognized postgraduate specialist qualification in dermatology and is entered on the appropriate specialist register, where such a register exists.
Extended-role provider	A non-specialist clinician or other regulated practitioner credentialed to perform a defined set of skin health activities beyond the usual generalist scope, with explicit boundaries and specialist support.
Teledermatology	Delivery of dermatology advice or care at a distance through approved synchronous or asynchronous communication, with defined accountability, consent, privacy, response and follow-up arrangements.
Proposed ESHP	The proposed Essential Skin Health Package described in internal working materials, or the nationally defined minimum integrated skin health service package used for adaptation. It is not presented as finalized WHO guidance.
Referral urgency	Immediate emergency action, urgent or rapid assessment, priority or expedited referral, or routine referral/follow-up, as defined in national protocols.

3. Review of existing frameworks and adoption decision

The review prioritized WHO and other authoritative frameworks that provide a reusable architecture, role-specific competency content, curriculum development methods, assessment approaches or dermatology-specific examples. The central finding is that the building blocks exist, but they must be assembled into a coherent integrated skin health system.

Review scope. This was a targeted technical review of authoritative and operationally relevant frameworks, not a systematic review. Statements about framework suitability therefore refer to the sources reviewed for this draft and should be updated if additional authoritative instruments are identified during consultation.

3.1 Frameworks suitable for adoption or adaptation

Framework	Best function	Decision	Rationale
WHO Rehabilitation Competency Framework (RCF) [5]	Structural model	Adopt and adapt	Explicitly designed for adaptation across professions, specializations and settings. Provides values, competencies, behaviours, knowledge and skills, and links to education, regulation, performance appraisal and gap analysis.
WHO UHC competency and outcomes frameworks [3,4]	Transversal competency spine	Adopt	Provides six common domains and a practice-activity approach for competency-based pre-service and in-service outcomes.
Draft GAP-SKIN 2026–2035 [2]	Policy mandate and skin-health direction	Align	Defines Strategic Objective 4 and expectations for cadre tailoring, assessment, CPD, mentorship, task-sharing, digital support and equity.
WHO skin NTD strategic framework [8]	Integrated service and workforce content	Adapt	Provides integrated skin NTD activities, basic dermatology training, active case detection, wound and lymphoedema care, reporting, apps and teledermatology.
WHO front-line skin NTD training guide [9]	Front-line clinical learning content	Adapt	Provides visual recognition and management content for skin NTDs and common skin problems.
WHO self-care competency framework [10]	Self-care support	Integrate	Defines measurable behaviours for supporting safe, informed and person-centred self-care.

Framework	Best function	Decision	Rationale
WHO global CHW curriculum guide [11]	Community workforce pathway	Integrate	Provides a context-adaptable curriculum approach for role-specific CHW competencies within PHC.
ILDS Skin Health Training Hub [12]	Learning-resource repository	Use as resource	Free global platform with practical courses and expert-developed content. It is a delivery resource, not a normative competency architecture.
BDNG and GPwER dermatology frameworks [13,14]	Advanced-role examples	Optional benchmark	Provide portfolio, workplace assessment and progressive dermatology competence examples for advanced nursing and primary-care roles. Country- and profession-specific, so not suitable as the global base.

3.2 Why the WHO RCF is the preferred structural model

Among the frameworks reviewed, the WHO Rehabilitation Competency Framework was considered the most suitable structural model for integrated skin health. WHO describes the RCF as a framework that can be adopted and adapted by a professional group, specialization or setting and provides companion guides for contextualization and curriculum development [5–7]. Its design is therefore a stronger structural shell for this purpose than a disease-specific course or a profession-specific dermatology framework.

The proposed framework does not copy rehabilitation competencies into dermatology. It adopts the RCF design logic: common values, competency domains, behaviours, knowledge and skills, proficiency levels, contextualization, and multiple applications across education, regulation and workforce management. The skin-specific content is newly mapped to GAP-SKIN and skin health service functions.

3.3 Adoption decision

Layer	Source to adopt/adapt	Result in this framework
Policy mandate	WHA78.15 and draft GAP-SKIN	National requirement for a competency-based, assessed and supported workforce system.
Architecture	WHO RCF and adaptation guide	Values, domains, behaviours, proficiency, contextualization and implementation process.
Transversal competencies	WHO UHC framework	People-centredness, decision-making, communication, collaboration, evidence-informed practice and personal conduct.
Skin-specific functions	Draft GAP-SKIN, skin NTD framework and PHC classification	Integrated practice activities, clinical scope, referral and health-system competencies.
Role-specific pathways	WHO self-care and CHW frameworks	Community, self-care and workforce pathway adaptations.
Learning resources	WHO training guide and ILDS Training Hub	Course content, clinical images and learning activities subject to national validation.
Advanced-role benchmarks	BDNG and GPwER frameworks	Optional portfolio and workplace assessment models for extended roles.

4. Policy goal, objectives and guiding principles

4.1 Policy goal

Goal
All people have equitable access to health workers who possess, maintain and apply the competencies required to promote skin health, recognize and manage common and priority skin conditions safely, provide compassionate and stigma-responsive care, and ensure timely referral and continuity across the health system.

4.2 Policy objectives

1. Create a nationally endorsed, role-based competency framework aligned with the minimum integrated skin health service package.
2. Integrate skin health competencies into pre-service, induction, in-service and continuing professional development pathways.
3. Enable safe task-sharing through explicit scopes of practice, referral thresholds, supervision and access to specialist support.
4. Establish valid and equitable competency assessment, certification, remediation and periodic reassessment.
5. Strengthen faculty, clinical supervisors, mentors and training institutions to deliver and sustain competency-based education.
6. Ensure competence in people-centred care, stigma reduction, mental health, disability, self-care, data use, laboratory pathways and digital health.
7. Monitor workforce capacity and performance using disaggregated indicators linked to GAP-SKIN C4 and national service outcomes.

4.3 Guiding principles

Principle	Policy meaning
People-centred and rights-based	Respect dignity, autonomy, privacy, informed consent and shared decision-making.
Equity and inclusion	Prioritize rural, underserved and stigmatized populations and ensure accessibility across age, gender, disability, language, ethnicity and socioeconomic context.
Integrated, not disease-siloed	Teach common clinical patterns and system functions while retaining disease-specific safety requirements.
Competence, not attendance	Use observable behaviours and valid assessment. Course completion alone does not demonstrate safe performance.
Role and context appropriate	Match competencies to authorized tasks, epidemiology, resources, referral capacity and service level.
Patient safety and quality	Set non-negotiable red-flag, medicine, infection-prevention, referral and documentation standards.
Continuum of learning	Connect pre-service education, workplace induction, CPD, supervision and career progression.
Co-designed and culturally responsive	Engage people affected, community representatives, local educators and frontline workers.
Evidence-informed and adaptive	Review competencies and learning resources as evidence, technology and epidemiology evolve.
Sustainable and interoperable	Use existing education, accreditation, HRH, HMIS and supervision systems rather than parallel structures.

5. Framework architecture

The framework is organized as a nested system. Each layer answers a different policy question and prevents the common failure mode in which a curriculum floats free from scope of practice, assessment and service delivery.

Relationship with PHC management categories. The categories manage at PHC level, recognize and consider referral, and urgent referral define what health workers need to recognize, manage or refer. They should structure competency-based learning, assessment and supervision, but they are not a substitute for national disease-priority setting.

Framework layer	Policy question
1. Values and principles	What standards govern behaviour and decision-making?
2. Competency domains	What broad capabilities are required across the workforce?
3. Practice activities	What integrated work must providers be able to perform?
4. Proficiency levels	How much independence, complexity and leadership are expected?

Framework layer	Policy question
5. Workforce pathways	Which competencies and activities apply to each cadre and service level?
6. Assessment and credentials	How will competence be demonstrated, certified and maintained?
7. Learning and support system	How will education, supervision, mentorship and specialist support sustain performance?
8. Governance and monitoring	Who is accountable, and how will implementation and outcomes be measured?

5.1 Definition of competence

Working definition
Integrated skin health competence is the demonstrated ability to combine knowledge, skills, judgement, communication, professional behaviours and system awareness to perform defined skin health activities safely, effectively, respectfully and consistently within an authorized scope of practice and local service context.

5.2 Competency statement format

Each national competency should be specified using four linked elements:

- Competency statement: the broad capability expected.
- Observable behaviours: what a competent worker does in practice.
- Enabling knowledge and skills: what supports the behaviour.
- Conditions and boundaries: level of independence, authorized tasks, referral threshold and resources required.

5.3 Proposed Essential Skin Health Package or national minimum service-package alignment

The proposed Essential Skin Health Package (ESHP), or a nationally defined minimum integrated skin health service package, should serve as the service-delivery foundation for national adaptation. The public GAP-SKIN draft refers to essential services and UHC benefit packages but does not yet establish a finalized ESHP. Accordingly, this framework uses the proposed ESHP as an adaptable planning model rather than as approved WHO guidance. The service package defines what should be delivered; this framework defines who delivers it, the required competencies and proficiency, and the education, assessment, supervision and governance systems that enable safe delivery [2,8].

National adaptation should map each component of the proposed ESHP or national minimum service package to the responsible workforce pathway, authorized practice activities, curriculum modules, assessment evidence, supervision arrangements, referral routes, commodities and indicators. The implementation logic is summarized in Figure 1.

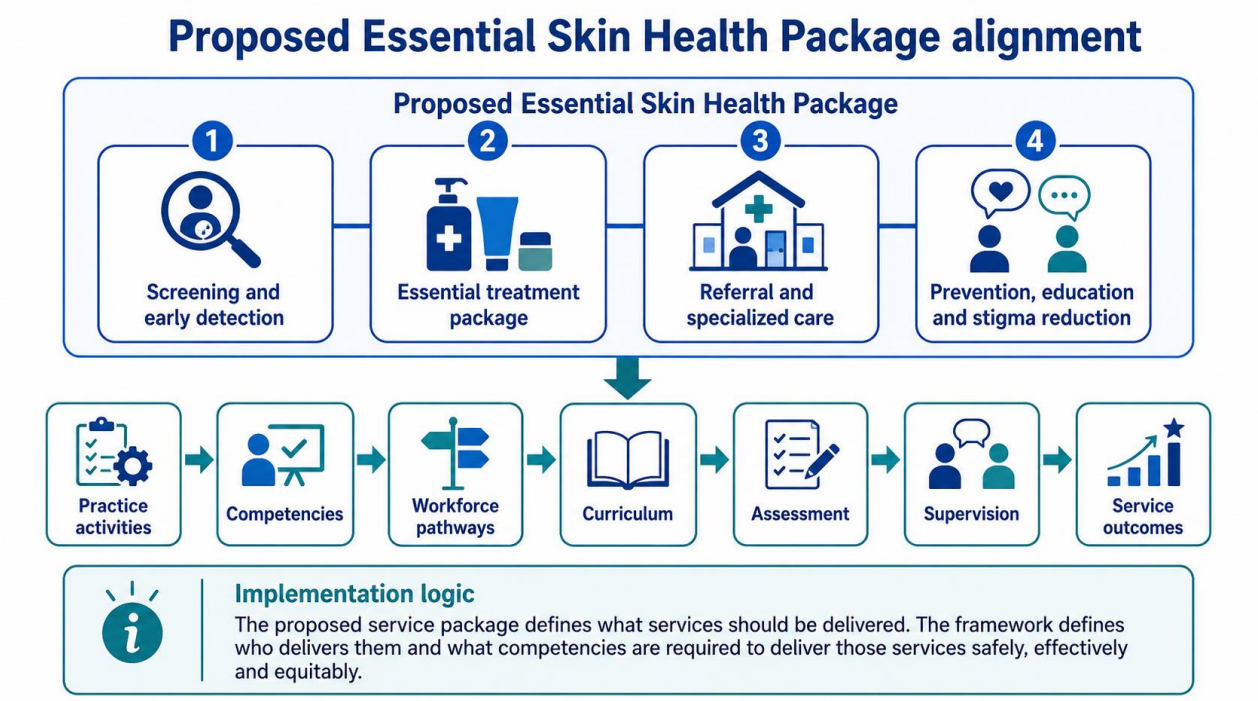

Figure 1. Proposed Essential Skin Health Package alignment and implementation logic. Source: developed for this framework.

Proposed ESHP or national service-package pillar	Required competencies	Primary workforce contribution	Implementation tools
1. Screening and early detection	Promotion, structured assessment, recognition of common and priority conditions, danger-sign identification and case finding.	Community recognition and referral; PHC assessment and classification; district support for uncertainty.	CHW job aids, PHC assessment algorithm, image library, screening and referral forms.
2. Essential treatment and supportive care	Safe management within scope, wound care, medicines counselling, self-care support, infection prevention, follow-up and treatment-failure recognition.	PHC management of authorized uncomplicated conditions; district extended-role support; specialist advice for complex disease.	National treatment guidance, essential medicines list, wound-care tools, counselling aids and monitoring checklists.
3. Referral and specialized care	Triage, stabilization, routine/priority/urgent referral, counter-referral, teleconsultation, rehabilitation and continuity of care.	All pathways, with district and specialist levels providing consultation, procedures, escalation and quality assurance.	Referral directory, escalation protocol, teledermatology SOP, counter-referral form and transport arrangements.
4. Prevention, education and stigma reduction	Health promotion, occupational and environmental prevention, community engagement, mental-health support, rights-based communication and stigma reduction.	Community, PHC, programme and specialist workforces working with affected people and civil society.	Community messages, school/workplace materials, self-care resources, stigma tools and community feedback mechanisms.

6. Integrated skin health competency domains

Nine domains are proposed. The first six are informed by the transversal logic of the WHO UHC framework but are not a one-to-one reproduction of its domains. The remaining three address surveillance and quality, digital information governance, and leadership, workforce development and climate-responsive system resilience emphasized in GAP-SKIN.

Domain	Core competency statement
D1. People-centred, compassionate and stigma-responsive care	Provides respectful, rights-based and culturally safe care; recognizes psychosocial impact, discrimination and barriers; involves people and caregivers in decisions; protects privacy, dignity and consent, including for clinical images.
D2. Prevention, health promotion, community engagement and self-care	Promotes hygiene, skin protection, early care-seeking and transmission prevention; supports safe self-care, adherence and chronic disease management; engages communities and affected-person organizations.

Domain	Core competency statement
D3. Clinical assessment, pattern recognition and decision-making	Takes a focused history; performs a whole-person skin examination; describes lesions accurately; recognizes presentations across skin tones; considers differentials and comorbidities; identifies diagnostic uncertainty and red flags.
D4. Safe management, diagnostics and medicine stewardship	Delivers evidence-informed initial management within scope; uses topical and systemic medicines safely; applies infection prevention, antimicrobial stewardship and basic diagnostic techniques; collects and transports specimens when authorized.
D5. Referral, continuity, wound care, disability and rehabilitation	Triages urgency; stabilizes and refers; uses referral and counter-referral systems; provides follow-up; supports wound, lymphoedema, disability and rehabilitation care; coordinates with mental health and social services.
D6. Communication, collaboration and professional conduct	Communicates clearly and compassionately; collaborates across cadres and sectors; practices within competence and legal scope; manages boundaries and conflicts; protects confidentiality and patient safety.
D7. Surveillance, recording, reporting, evidence and quality improvement	Documents diagnoses and management; uses standard terminology and coding; notifies priority diseases; contributes to outbreak response; interprets data; audits care; applies evidence and improves services.
D8. Digital health, teledermatology and information governance	Captures, transmits, stores and uses clinical information safely; uses teledermatology and digital decision support appropriately; understands limitations, bias and escalation; protects consent, privacy, security and human clinical oversight.
D9. Leadership, workforce development, system resilience and climate-responsive skin health	Leads learning, supervision, quality and service development; plans and supports the workforce; strengthens referral and multidisciplinary networks; anticipates climate-, occupational- and emergency-related shifts in disease and service disruption; promotes continuity, adaptation and equitable access.

6.1 Minimum cross-cutting behaviours

Cross-cutting area	Expected behaviour
Equity	Assesses barriers to access and adapts communication, examination, treatment and follow-up for underserved groups.
Skin tone competence	Recognizes that erythema, inflammation, pallor and pigment change may present differently; uses diverse validated images and avoids color-dependent shortcuts.
Mental health and stigma	Screens for distress or functional impact when relevant; provides first-line support; refers for psychosocial or mental health care; avoids stigmatizing language.
Self-care	Explains benefits, risks, warning signs and follow-up; checks understanding and feasibility; avoids transferring inappropriate clinical burden to patients.
Patient safety	Recognizes severe drug reactions, necrotizing infection, rapidly progressive disease, sepsis, severe pain, ocular involvement and suspected malignancy according to national guidance.
Data protection	Obtains consent and follows national rules for clinical images, teleconsultation, storage, access and secondary use.
Antimicrobial stewardship	Uses antibiotics, antifungals and antiparasitic medicines according to national guidance; recognizes treatment failure and resistance concerns.
Interprofessional practice	Uses clear roles, handover, referral, counter-referral and escalation; seeks help early when limits are reached.

6.2 Relationship to the WHO UHC domains

The mapping below demonstrates conceptual alignment rather than equivalence. Each WHO UHC domain contributes to several integrated skin health domains, and the skin-specific framework adds clinical, surveillance, digital-governance and system-resilience requirements.

WHO UHC domain	Primary integrated skin health links
People-centredness	D1 people-centred care; D2 prevention, community engagement and self-care.
Decision-making	D3 assessment and decision-making; D4 management and diagnostics; D5 referral and continuity.
Communication	D1 rights-based communication; D6 communication, collaboration and professional conduct.
Collaboration	D5 care coordination; D6 teamwork and professional conduct; D9 leadership and system development.
Evidence-informed practice	D4 safe management and stewardship; D7 surveillance, evidence and quality; D8 digital information governance.
Personal conduct	D1 dignity and consent; D6 ethics, scope and accountability; D8 privacy and responsible technology use.

7. Practice activities and proficiency levels

7.1 Integrated skin health practice activities

ID	Practice activity	Description
PA1	Promote skin health and prevention	Deliver culturally appropriate prevention, early care-seeking and stigma-reduction messages at individual and community levels.
PA2	Conduct a respectful skin assessment	Take a focused history, assess comorbidities and impact, examine skin, hair, nails and mucosa as appropriate, and document findings.
PA3	Recognize and classify presentations	Use morphology, distribution, symptoms and epidemiology to identify common patterns, formulate differentials and assign the national PHC management category.
PA4	Identify referral urgency and triage	Recognize immediate emergencies, urgent and priority conditions, suspected malignancy, disability risk, diagnostic uncertainty and treatment failure; stabilize, safety-net and escalate according to national time standards.
PA5	Manage uncomplicated conditions within scope	Provide evidence-informed treatment, wound care, counselling and follow-up for defined common and priority conditions.
PA6	Use diagnostics and medicines safely	Perform or arrange authorized tests, collect specimens, interpret basic results, prescribe or administer medicines safely, and apply stewardship.
PA7	Support self-care, adherence and chronic care	Co-create feasible care plans, teach skin and wound care, address adherence and psychosocial barriers, and monitor outcomes.
PA8	Refer, counter-refer and coordinate continuity	Prepare a complete referral, use teleconsultation appropriately, track completion, act on specialist advice and coordinate rehabilitation and mental health support.
PA9	Record, report and respond	Use standard terminology and ICD-11 where implemented, notify priority diseases, contribute to surveillance and outbreaks, and protect data.
PA10	Improve quality and develop others	Use audit and data for improvement, participate in supervision and CPD, provide feedback, mentor within competence and support service readiness.

7.2 Four proficiency levels

Proficiency level	General descriptor
Level 1: Awareness and recognition	Performs limited, low-risk activities under protocol; recognizes common presentations and danger signs; provides basic prevention messages; refers or seeks support. Requires ready access to supervision.

Proficiency level	General descriptor
Level 2: Foundation practitioner	Independently manages a defined package of uncomplicated conditions using national guidance; performs basic assessment, treatment, counselling, documentation and referral; consults for uncertainty or complexity.
Level 3: Advanced practitioner or supervisor	Manages broader complexity within regulated scope; performs selected procedures or diagnostics; provides consultation, supervision, quality improvement and training; coordinates district referral networks.
Level 4: Expert, educator or system leader	Provides specialist diagnosis and management; leads advanced services, curriculum and assessment standards, research, referral networks, policy, quality assurance and workforce development.

7.3 Proficiency is activity-specific

A worker may hold different proficiency levels across practice activities. For example, a community health worker may be Level 2 in prevention and referral follow-up but Level 1 in lesion classification. A PHC nurse may be Level 2 in management of common infections and wound care but Level 1 in suspected skin cancer assessment. National frameworks should avoid assigning a single blanket level that implies competence beyond the authorized role.

7.4 Standardized service workflows, presentation groups and referral urgency

Countries should use simple, common workflows that can be translated into algorithms, teaching cases, assessment stations and supervision checklists. These workflows standardize the clinical reasoning process without replacing disease-specific national guidance. Figures 2–4 present the recommended workflow and competency boundary for community, primary health care and district or extended-role personnel.

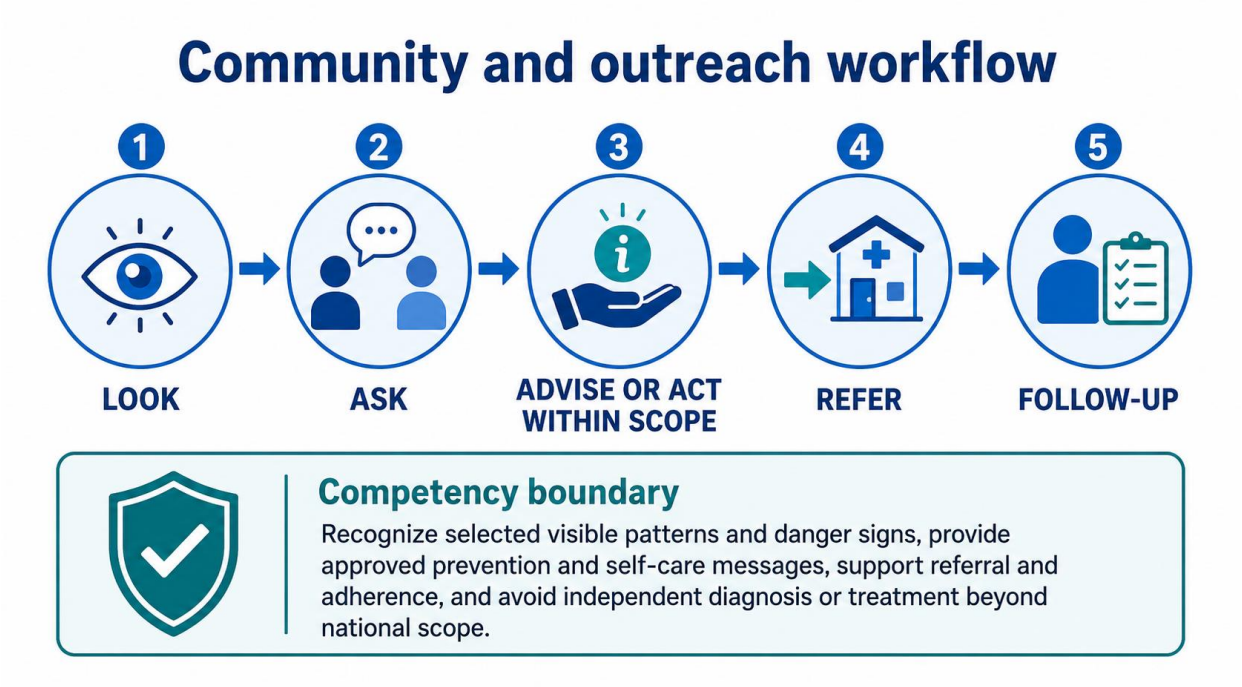

Figure 2. Recommended community and outreach workflow and competency boundary. Source: developed for this framework.

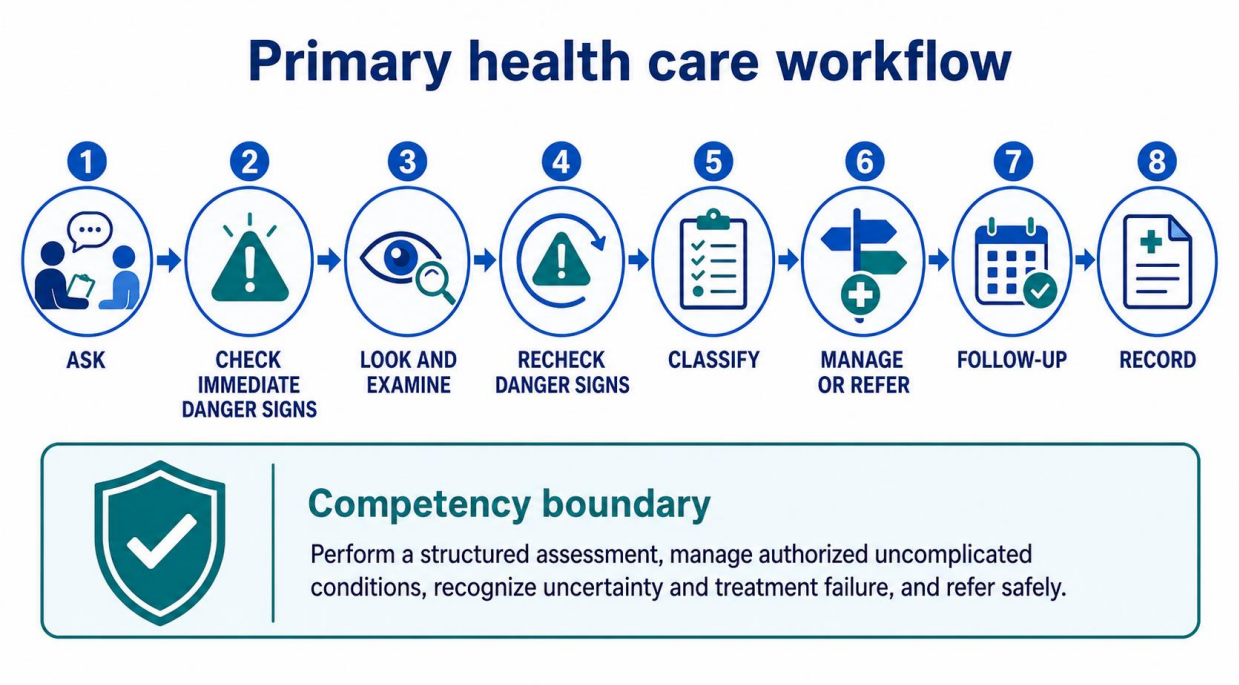

Figure 3. Recommended primary health care workflow and competency boundary. Source: developed for this framework.

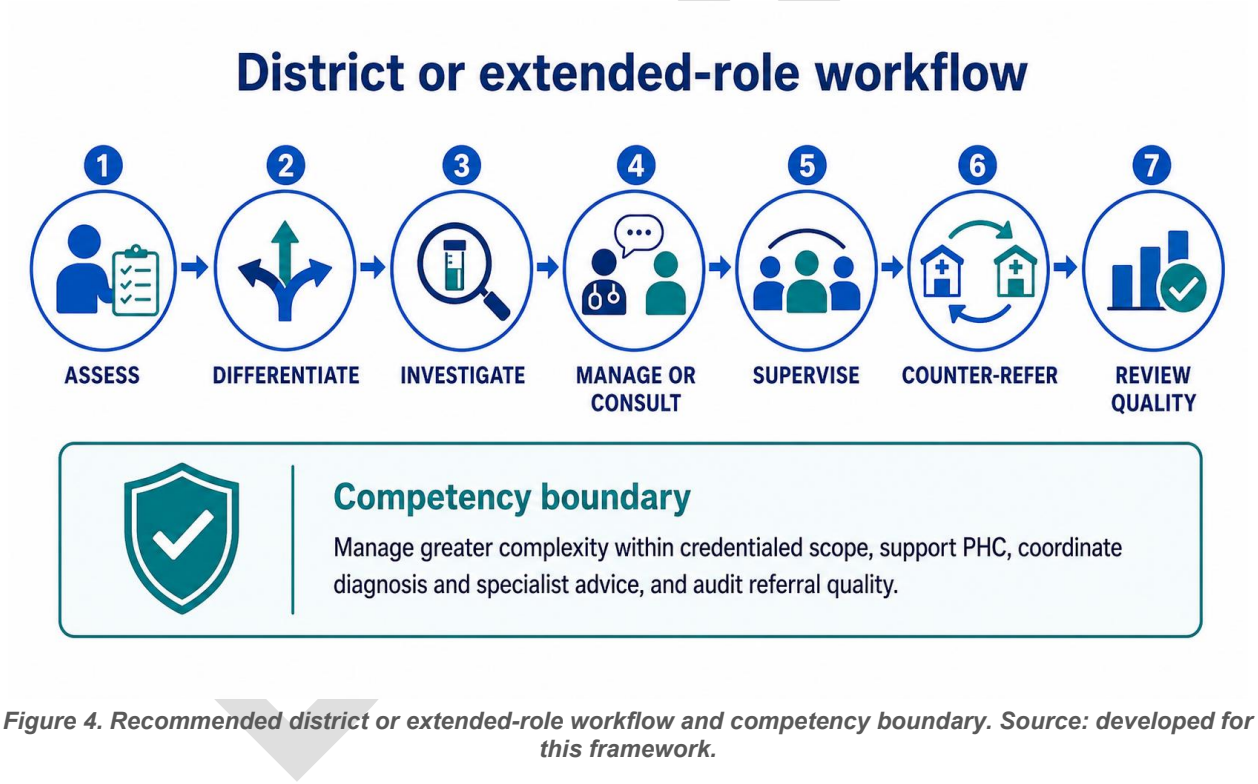

Figure 4. Recommended district or extended-role workflow and competency boundary. Source: developed for this framework.

Minimum presentation groups. PHC curricula and assessments should sample the following integrated presentations, adapted to national epidemiology:

- Wounds and ulcers, including infection, chronicity, pain, disability risk and referral triggers.
- Patches and pigmentary change, including sensory testing and possible nerve involvement where relevant.
- Rash, itching and scaling, including common infections, infestations, inflammatory disease and treatment failure.
- Nodules, swellings and tumours, including rapidly enlarging lesions, suspected malignancy and deep infection.
- Limb swelling, lymphoedema, functional impairment and disability, including self-care and rehabilitation needs.

- Severe, systemic and drug-related presentations requiring immediate stabilization and urgent referral.

Standardized referral urgency. All cadres should use a nationally approved urgency framework. Failure to identify or act correctly on an immediate emergency or other safety-critical presentation should be a non-compensable assessment error. National protocols should define exact response times, destinations and stabilization actions.

Referral urgency category	Illustrative triggers	Required action
Immediate emergency action	Severe drug reaction or skin failure; widespread blistering or epidermal detachment; sepsis or systemic toxicity; necrotizing or rapidly spreading deep infection; altered consciousness; major ocular or mucosal involvement; uncontrolled bleeding; severe pain out of proportion.	Provide immediate stabilization within scope, activate emergency communication and arrange immediate transfer to the designated emergency or referral service.
Urgent or rapid assessment	Rapid clinical progression; deep infection without shock; new sensory loss, nerve impairment, weakness or rapidly worsening disability; rapidly enlarging swelling; extensive disease with systemic manifestations; severe uncontrolled pain.	Arrange same-day or nationally defined rapid assessment, provide safe interim care, document escalation and confirm transfer or specialist response.
Priority or expedited referral	Suspected malignancy; non-healing or deteriorating ulcer; persistent treatment failure; significant diagnostic uncertainty; progressive functional impairment; need for specialist diagnostics or multidisciplinary care.	Refer within the nationally defined expedited interval, provide safety-netting and interim care, and track completion and counter-referral.
Routine referral or planned specialist review	Stable conditions beyond PHC scope, planned diagnostic review, chronic disease requiring specialist input, or rehabilitation needs without rapid deterioration.	Use the routine referral pathway, maintain management within scope and document follow-up responsibility.
Risk modifiers	Newborn or young child, pregnancy, older age, immunosuppression, major comorbidity, disability, inability to ensure follow-up, remoteness or social vulnerability.	Lower the threshold for escalation and adapt care, but do not treat the characteristic alone as an automatic emergency without clinical assessment.

8. Workforce pathways and scopes of practice

Countries should map competencies to existing cadres rather than creating a parallel skin workforce. The five pathways below provide a common planning model that can be translated into national job categories.

Pathway	Illustrative cadres	Minimum scope
Pathway A: Community and outreach workforce	Community health workers, community volunteers, school health, traditional or community actors where formally engaged	Promotion, stigma reduction, early recognition, active case finding where authorized, basic self-care support, adherence, referral and follow-up, community surveillance. No independent diagnosis or treatment beyond national scope.
Pathway B: PHC generalist workforce	Nurses, midwives, clinical officers, general practitioners, medical officers and other PHC providers	Focused assessment, management of defined uncomplicated conditions, basic wound care, medicine counselling, referral, follow-up, recording and reporting. Requires protocol and specialist access.
Pathway C: District or extended-role workforce	Dermatology-trained nurses, advanced clinical officers, GP extended roles, district clinicians	Broader differential diagnosis, selected diagnostics and procedures, management of moderate complexity, teleconsultation triage, supervision, audit and counter-referral.
Pathway D: Specialist and referral workforce	Dermatologists and relevant specialists in infectious disease, surgery, oncology, pathology, rehabilitation, mental health and laboratory medicine	Complex and severe care, advanced diagnostics and procedures, consultation, referral governance, supervision, training, quality assurance and research.
Pathway E: Programme, education and system leadership	Programme managers, educators, regulators, accreditors, data managers and service leaders	Policy, curriculum, assessment, workforce planning, financing, surveillance, quality improvement, research, digital governance and implementation oversight.

8.1 Scope-of-practice policy requirements

- List authorized activities and prohibited or specialist-only activities for each cadre.
- Link each authorized clinical activity to required competency, assessment method and supervision level.
- Define red flags, referral thresholds, stabilization actions and expected referral time.
- Specify medicines, diagnostics, procedures and digital tools that may be used and under what conditions.
- Define direct, indirect and remote supervision arrangements, including escalation when connectivity fails.
- Align task-sharing with legislation, professional regulation, indemnity, job descriptions and remuneration.
- Review scope when epidemiology, medicines, diagnostics, technology or referral capacity changes.

8.2 Alignment with PHC management categories

PHC category	Workforce implication	Competency requirement
Manage at PHC level	Authorized PHC cadres may diagnose and manage defined uncomplicated presentations.	Demonstrated assessment, treatment, counselling, follow-up and treatment-failure recognition.
Recognize and consider referral	PHC provider recognizes and provides initial or supportive care, with referral determined by severity and local capacity.	Differential recognition, severity assessment, scope awareness, referral decision and safe interim care.
Urgent referral	Provider identifies a time-critical condition and initiates emergency action and transfer.	Non-negotiable red-flag recognition, stabilization within scope, communication and rapid referral.

Referral-urgency categories in Section 7.4 operate within these three PHC management categories. “Recognize and consider referral” may lead to routine, priority or urgent referral according to severity, risk and local capacity; “urgent referral” includes time-critical emergency action.

8.3 Illustrative planning ranges by workforce pathway

Training duration should be determined by the competencies, practice activities, proficiency level and authorized scope of practice assigned to each workforce pathway. Duration should not be used as a substitute for demonstrated competence. Countries should define the training dose across structured learning, supervised workplace practice, competency assessment and continuing professional development. WHO competency and community health worker guidance supports tailoring education to expected roles, baseline competence, context and assessment requirements [5,11].

The ranges below are illustrative planning parameters proposed by this framework; they are not WHO-mandated course durations or evidence-based minimums. National authorities may shorten or extend them according to prior qualifications, epidemiology, scope of practice, service readiness, clinical exposure and assessment results. The ranges should be validated through national curriculum mapping, consultation, piloting and competency-assessment findings.

Workforce pathway	Illustrative initial structured-learning range	Supervised practice and competency assessment	Continuing learning
Pathway A: Community and outreach workforce	8–12 hours, normally 1–2 days.	At least 3–5 observed or simulated referral and counselling cases within 4–6 weeks.	4–6 hours annually, with brief supervisor reinforcement every 3–6 months.
Pathway B: PHC generalist workforce	24–40 hours, normally 3–5 days.	20–30 documented or supervised clinical cases over approximately 8–12 weeks, followed by workplace competency verification.	At least 8 hours annually, supported by case review, mentorship or digital refreshers.
Pathway C: District or extended-role workforce	80–120 hours, normally 2–3 weeks, delivered continuously or in modules.	A supervised portfolio of approximately 40–60 cases over 3–6 months, including complex cases, referrals, diagnostics and supervision activities.	12–16 hours annually, quarterly case review and reassessment approximately every 3 years.

Workforce pathway	Illustrative initial structured-learning range	Supervised practice and competency assessment	Continuing learning
Pathway D: Specialist and referral workforce	12–24 hours of GAP-SKIN and integrated-service orientation.	No repetition of specialist clinical qualification. Trainers, mentors and assessors should complete an additional 16–24 hours of faculty and assessor preparation.	At least 8 hours annually for assessor calibration, guideline updates, referral review and quality assurance.
Pathway E: Programme, education and system leadership	16–24 hours of integrated skin health policy, planning, monitoring and governance training.	An additional 16–40 hours relevant to the assigned function, such as curriculum, accreditation, assessment, data or implementation leadership, with an applied work product.	4–8 hours annually for policy, data, indicator and implementation updates.

8.3.1 Interpretation by pathway

Pathway A: Community and outreach workforce. The 8–12-hour package should remain tightly bounded to promotion, visible-pattern recognition, danger signs, stigma reduction, referral, adherence and basic self-care support. It should be highly visual and practical. Completion does not authorize independent diagnosis or treatment beyond the nationally approved community scope.

Pathway B: PHC generalist workforce. The 24–40-hour package should serve as the principal integrated skin health course for nurses, clinical officers, general practitioners and other PHC providers. It may be delivered as a 3–5-day course or in modules and should include structured assessment, image-based reasoning, management of authorized common conditions, skin NTDs, danger signs, referral, counselling, documentation and practical competency assessment.

Pathway C: District or extended-role workforce. The 80–120-hour programme is intended for personnel with a broader clinical, diagnostic, procedural or supervisory scope. It may be organized as two intensive blocks, a continuous 2–3-week programme or a blended modular pathway. Credentialing should require a supervised portfolio, direct observation and evidence of safe performance across more complex cases, referral decisions and mentorship functions.

Pathway D: Specialist and referral workforce. Specialists should receive focused orientation to GAP-SKIN, integrated PHC service organization, referral and counter-referral, task-sharing governance, teleconsultation, supervision, surveillance and quality assurance. Those serving as trainers, assessors or moderators require additional preparation in competency-based education, standard setting, scoring, feedback, calibration and conflict-of-interest management.

Pathway E: Programme, education and system leadership. The core programme should cover policy, workforce planning, curriculum and accreditation requirements, regulation, financing, monitoring, equity, digital governance and implementation evaluation. Personnel responsible for specialized functions should complete additional role-specific learning and produce an applied output, such as a curriculum map, assessment blueprint, accreditation protocol, costed implementation plan or monitoring framework.

8.4 Recommended modes of training delivery

Training should use a blended portfolio of methods selected according to the competency being developed, learner access, available faculty, clinical risk and infrastructure. Knowledge may be developed remotely, but competencies that require examination, procedures, counselling or clinical decision-making should include observed practice, simulation or workplace-based assessment.

Training mode	Best use	Minimum delivery and quality safeguards
Interactive face-to-face learning	Foundations, local protocols, facilitated case discussion, communication and team learning.	Use active learning, representative images and cases, clear objectives and sufficient time for questions; avoid lecture-only delivery.
Skills laboratory and simulation	Skin examination, lesion description, wound care, specimen procedures, danger-sign response, referral and counselling.	Use standardized checklists, safe simulation materials, trained facilitators, structured feedback and repeat practice.

Training mode	Best use	Minimum delivery and quality safeguards
Supervised clinical or workplace learning	Transfer of skills to real consultations, documentation, treatment, referral and continuity of care.	Obtain consent, ensure appropriate supervision ratios and case mix, document encounters and verify performance against explicit standards.
Blended learning	Combining online or self-directed theory with practical sessions, clinical exposure and assessment.	Maintain equivalent learning outcomes, accessibility and assessment integrity; schedule practical components and learner support in advance.
Self-paced digital, mobile or offline learning	Pre-course preparation, image practice, knowledge modules, refreshers and low-bandwidth access.	Provide accessible and offline options where needed. Do not use as the sole basis for certifying clinical competence.
Live virtual learning and case conferences	Expert teaching, difficult-case discussion, guideline updates and cross-site peer learning.	Protect patient privacy, use de-identified information, document decisions and provide a contingency plan for connectivity failure.
Mentorship, case review and teledermatology-supported learning	Post-training reinforcement, referral support, feedback, retention and progressive responsibility.	Define mentor qualifications, review frequency, escalation routes, image consent and governance, response times and documentation requirements.
Training of trainers and faculty development	National scale-up, curriculum fidelity, assessment quality and supervisor preparation.	Use standardized materials, observed facilitation, assessor calibration, moderation, periodic recertification and monitoring of cascade quality.

Minimum modality rule: No single mode is sufficient for every competency. Fully online or self-directed learning may support knowledge and image-recognition outcomes, but certification for clinical practice should also include observed or simulated performance and, where feasible, workplace verification.

8.5 Dermatology specialist-development pathway where no dermatologist is available

Some countries have no dermatologist or no nationally accessible dermatology specialist. The absence of a specialist should not delay PHC strengthening, but it requires a deliberate bridge from immediate service continuity to a regulated and sustainable specialist workforce. WHO has documented countries with no dermatological specialists, and GAP-SKIN calls for expanded education, digital support and international collaboration where specialist training remains inaccessible [2,21].

The recommended approach is a staged national pathway. It combines task-sharing within protected boundaries, regional or international referral and teledermatology, formal postgraduate training of an initial national cohort, development of local faculty and services, and eventual accreditation of a domestic programme where feasible. A dermatologist is a physician who has completed a nationally recognized postgraduate specialist qualification in dermatology and, where applicable, is entered on the national specialist register. Dermatology-trained nurses, clinical officers and general practitioners with extended roles are essential bridge providers but should not be titled or registered as dermatologists.

Phase and timing	Core actions	Minimum output
Phase 0: Immediate bridge, 0-12 months	Designate a national skin-health clinical lead; map emergency, urgent and priority referral options; establish formal regional or supra-national referral, teledermatology and visiting-specialist agreements; define licensure, indemnity, prescribing responsibility, clinical accountability, data transfer, response times, pathology routes and emergency transfer; train PHC and district extended-role providers.	A functioning interim referral network, named clinical accountability, minimum PHC capacity and access to external specialist advice.
Phase 1: National plan and regulatory foundation, 0-18 months	Assess burden, service gaps and workforce need; define the protected specialist title and scope; agree accreditation and specialist-register arrangements; confirm that the regulator will recognize each proposed external qualification before candidates enrol; cost the plan; identify training partners and posts; approve lawful retention and return-of-service measures.	A costed national dermatology workforce plan endorsed by health, education, finance and regulatory authorities.

Phase and timing	Core actions	Minimum output
Phase 2: Train the first national specialist cohort, approximately years 1-5	Select physicians through transparent criteria; use an accredited regional programme, twinning arrangement or sandwich model combining external rotations with supervised national service; guarantee funded training posts, mentorship, examination and return positions.	An initial cohort of at least two nationally sponsored trainees, or another justified size for a small state or pooled regional model, progressing through recognized postgraduate specialist education without creating single-person dependency.
Phase 3: Establish the national specialist service and faculty base, approximately years 3-7	Appoint returning specialists; create a national referral service; build dermatopathology/laboratory, surgery, pharmacy, rehabilitation and mental-health links; formalize outreach and teleconsultation; develop teaching and assessor skills; collect case-volume and outcomes data.	A stable national dermatology service with more than one specialist, multidisciplinary support and protected education time.
Phase 4: Develop an accredited domestic or joint programme, approximately years 5-10	Undertake programme feasibility review; adopt or adapt competency-based curriculum and postgraduate standards; accredit training sites; appoint programme leadership, supervisors and external examiners; ensure adequate case mix, facilities, trainee support and quality improvement.	An accredited national or jointly governed postgraduate dermatology programme, or a durable regional training agreement if domestic volume is insufficient.
Phase 5: Sustain, distribute and deepen capacity, approximately years 7-15	Expand annual training pipeline; develop dermatology nursing and allied pathways; add subspecialty functions such as dermatopathology where needed; maintain CPD and revalidation; use rural recruitment and retention bundles; establish research, surveillance and professional networks.	A resilient specialist workforce with succession, geographic distribution, continuing competence and national leadership.

8.5.1 Minimum conditions before starting a domestic specialist programme

- A legally recognized specialist title, regulator or competent authority, accreditation route and specialist register.
- Formal confirmation, before enrolment, that the national regulator or competent authority will recognize the selected external, regional or joint qualification and define any additional registration requirements.
- A curriculum based on population needs and nationally defined competencies, with protected training time and progressive entrustment.
- A sufficient and diverse clinical case load, including inpatient, outpatient, emergency, infectious, inflammatory, oncological, paediatric and procedural exposure, supplemented by accredited external rotations where needed.
- At least a small faculty team rather than dependence on one individual, with external supervisors and examiners during the development period.
- Access to essential diagnostics, dermatopathology or reliable external pathology services, medicines, procedures, rehabilitation, mental-health support and referral care.
- A valid assessment programme, trainee support, patient-safety system, quality-improvement process and periodic external review. The WFME postgraduate medical education standards may be adapted as a principles-based quality benchmark [26].
- A funded workforce plan that creates posts for graduates and includes retention, rural access and succession measures [20,25].

8.5.2 Candidate selection and retention safeguards

- Sponsor an initial cohort of at least two trainees wherever feasible, or document another justified size for a small state or pooled regional model, to reduce professional isolation and service fragility.
- Use transparent selection based on national workforce need, clinical aptitude, commitment to public service and equitable representation.
- Secure written agreements on salary, tuition, supervision, return post, recognized qualification and career progression before departure.
- For cross-border training, referral or teledermatology, define licensure, indemnity, clinical accountability, prescribing authority, data transfer, complaint handling and patient-safety incident management in binding agreements.
- Prefer training partnerships that expose trainees to conditions, technologies and resource constraints relevant to their home setting.

- Maintain structured contact during external training through national projects, teleconsultation, research and periodic service placements.
- Use a bundled retention strategy, including appropriate remuneration, professional development, safe working conditions, housing or rural incentives where relevant, family support and opportunities for teaching and research [25].

Decision rule: a country should not wait to open a full domestic residency before developing specialist capacity. It should first secure an accredited regional training route and external referral network, train an initial cohort, establish a national service and faculty base, and open a domestic or joint programme only when accreditation, case volume, supervision and resources are sufficient. Regional hubs such as the Regional Dermatology Training Centre illustrate the value of supra-national training and continuing professional networks in low-resource settings [22].

9. Education, training and faculty standards

9.1 National learning continuum

Countries should institutionalize skin health education across pre-service, induction, in-service and continuing professional development pathways, aligning education capacity with national workforce needs, service-delivery priorities and quality-assurance systems [19].

Channel	Purpose	Minimum standard
Pre-service education	Build foundational competence before entry to practice.	Required competencies mapped to curriculum, clinical exposure and exit assessment.
Workplace induction	Translate competence to local protocols, service package, medicines, referral and reporting.	Completed before independent performance of local skin health tasks.
In-service upskilling	Close identified service or workforce gaps and support task-sharing.	Needs-based, practice-oriented, assessed and linked to supervision.
Continuing professional development	Maintain and update competence.	Accredited learning, reflective practice, audit, case review and periodic reassessment.
Advanced or extended-role training	Authorize greater complexity or procedures.	Formal selection, supervised practice, portfolio, workplace assessment and credentialing.
Faculty and supervisor development	Ensure educators can teach and assess competence.	Training in competency-based education, feedback, assessment quality, equity and clinical image ethics.

9.2 Curriculum design standards

- Begin with national service needs, epidemiology, workforce roles and referral capacity, not with a fixed course duration.
- Map each learning outcome to a competency, practice activity, proficiency level and assessment method.
- Use symptom- and pattern-based learning alongside disease-specific content to support integrated decision-making.
- Include common conditions, priority skin NTDs, severe and urgent presentations, suspected malignancy, drug reactions, wounds, disability, mental health, stigma and self-care.
- Use diverse, ethically sourced and consented clinical images representing different skin tones, ages and stages of disease.
- Combine case-based learning, guided image interpretation, simulation, skills practice, supervised clinical encounters and workplace feedback.
- Use local medicines, diagnostics, referral pathways, reporting tools and language adaptations.
- Plan for accessibility, low-bandwidth delivery and offline alternatives where needed.
- Pilot and revise the curriculum using learner performance, patient safety and service data.

Training package alignment. National skin health training packages should be based on the country's agreed service package, priority conditions, referral pathways and competency expectations. Integrated competencies should be used where they can achieve the required learning outcomes safely and

efficiently, while disease-specific modules should be retained where distinct technical or safety requirements apply.

9.3 Core PHC curriculum requirements

Module	Core content
M1	Integrated skin health, burden, rights, stigma and people-centred care
M2	Skin structure, lesion description, distribution and assessment across skin tones
M3	Common infectious and infestational skin conditions and antimicrobial stewardship
M4	Skin NTD recognition, reporting, referral and integrated care
M5	Inflammatory, chronic and pigmentary conditions, comorbidities and self-management
M6	Wounds, ulcers, lymphoedema, disability prevention and rehabilitation
M7	Benign, pre-cancerous and malignant lesions and early referral
M8	Systemic, drug-related, severe and emergency presentations
M9	Diagnostics, specimens, medicines, infection prevention and laboratory pathways
M10	Communication, mental health, stigma reduction, counselling and self-care support
M11	Referral, counter-referral, teledermatology and clinical image governance
M12	Recording, standardized national terminology and coding, including ICD-11 where implemented; surveillance, outbreak response, data use and quality improvement

The twelve modules above constitute the minimum PHC curriculum architecture and use the same numbering and titles as Annex F. They should be delivered through a core-plus-adaptation model: a common core protects safety, integration and comparability, while national adaptation aligns disease coverage, medicines, diagnostics, scopes of practice, terminology and coding, language, referral routes and digital tools with the local health system.

Curriculum layer	Minimum content	National decision
Global core	Structured assessment; common clinical presentations; safe PHC management; danger signs; skin NTD detection; communication and stigma reduction; documentation; referral; and competency assessment.	Retain the competency intent and safety-critical outcomes across all settings.
Country-adaptable content	Priority diseases, locally authorized treatments and procedures, diagnostic pathways, reporting requirements, teaching cases, languages and delivery arrangements.	Specify through national clinical guidance, epidemiology, workforce policy, essential medicines and referral capacity.

9.4 Recommended integrated skin health training package

Countries should develop or adapt a competency-based training package for PHC and community-level personnel. The package should function as a connected implementation system rather than as a stand-alone manual and should be aligned with national scopes of practice, epidemiological priorities, clinical guidelines, the essential medicines list, referral pathways and workforce education systems.

Product	Purpose and minimum requirement
1. Core curriculum and competency map	Maps each learning outcome to the relevant competency domain, practice activity, proficiency level, cadre, scope of practice and assessment method.
2. Participant learning manual	Provides concise, clinically validated content organized around practical presentations, management boundaries, self-care, follow-up and referral.
3. Facilitator or trainer guide	Includes session plans, preparation requirements, facilitation methods, clinical cases, debriefing guidance and standard answers.
4. Clinical decision-support and referral tools	Provides point-of-care algorithms, referral-urgency checklists, treatment and follow-up prompts, and emergency, urgent, priority and routine referral pathways.

Product	Purpose and minimum requirement
5. Clinical image and case library	Uses ethically sourced, consented and technically validated images representing different skin tones, ages, disease stages and common mimics.
6. Competency assessment package	Combines knowledge, image-based reasoning, structured clinical scenarios, observed skills and workplace evidence, with separate pass requirements for safety-critical competencies.
7. Supportive supervision and mentorship toolkit	Provides observation checklists, case-review templates, feedback tools, escalation routes, supervision schedules and mechanisms for specialist support.
8. Digital or blended learning version	Supports low-bandwidth, offline or mobile delivery where feasible and maintains equivalent learning outcomes, assessment integrity, privacy and accessibility.

Completion or attendance alone should not be treated as evidence of competence. National implementation should require successful competency assessment and, for clinical tasks, post-training supervision or workplace verification.

9.5 Training sequencing and delivery pathways

Sections 8.3 and 8.4 provide illustrative planning ranges, supervised-practice expectations and recommended delivery modes. These are planning parameters rather than mandatory global course lengths. National programmes should sequence learning so that knowledge preparation, practical instruction, supervised application, competency assessment and continuing support form one connected pathway.

Training intensity and modality should be proportionate to the learner's role, baseline competence and clinical risk. The following summary should be read together with the five-pathway specifications in Section 8.

Learner pathway	Primary emphasis	Recommended delivery model
Community and outreach personnel	Promotion, recognition of visible problems and danger signs, stigma reduction, referral, adherence and follow-up.	Short modular learning with demonstrations, image-based cases, referral practice and periodic supervisor reinforcement.
PHC clinical personnel	Structured assessment, pattern recognition, management of authorized common conditions, referral, skin NTDs, emergencies and documentation.	Blended learning with guided cases, simulation or skills stations, supervised clinical encounters and competency assessment.
PHC skin health focal persons, trainers and supervisors	Advanced reasoning, mentoring, difficult referrals, quality improvement, assessment and training facilitation.	Additional faculty and mentorship preparation, standardized assessment practice, case review and ongoing specialist linkage.

9.5.1 Role of the WHO Academy and other educational platforms

The WHO Academy and other educational platforms can support implementation of this framework by enabling scalable, quality-assured and equitable access to integrated skin health learning. The WHO Academy may serve as a global platform for hosting, curating and signposting core learning modules, digital refresher courses, faculty-development and training-of-trainers resources, case-based learning activities, communities of practice and learning analytics [27]. Other WHO, regional, national, academic and professional learning platforms may complement this role by delivering nationally adapted content, supporting pre-service and in-service education, tracking continuing professional development and facilitating supervised workplace learning.

The use of the WHO Academy or any other digital learning platform should remain aligned with the competency principles of this framework. Completion of online learning may contribute to knowledge acquisition, continuing professional development and periodic refresher training, but should not by itself be considered evidence of clinical competence. Authorization for independent clinical practice should require nationally approved assessment of knowledge, image-based reasoning, clinical judgement, communication, practical skills and safety-critical behaviours, with workplace verification where feasible. National competent authorities remain responsible for defining scopes of practice, assessment standards, certification, revalidation and authorization to perform clinical activities.

Countries should adopt a connected learning ecosystem in which global platforms provide high-quality and adaptable learning resources; national systems contextualize, accredit and monitor learning; training institutions deliver and assess role-specific curricula; supervisors verify competence in practice; and ministries, regulators and professional councils maintain certification and continuing competence systems. This approach enables WHO Academy-supported learning to accelerate workforce scale-up while preserving national ownership, regulatory accountability, patient safety, equity and alignment with national service-delivery priorities.

Learning analytics generated through digital platforms may be used to identify learning gaps, target refresher training, support supervision planning and inform workforce-development strategies, subject to national data-protection and governance requirements.

9.6 Cross-cutting curriculum and faculty requirements

National curricula should integrate the following topics across relevant pathways rather than leave them as optional add-ons. The depth should match the learner's role and scope of practice.

Cross-cutting topic	Minimum curriculum requirement
Climate, environment, occupational health and One Health	Recognize climate-sensitive and emerging patterns; assess occupational and household exposures; integrate WASH, housing, heat, ultraviolet radiation, vector and zoonotic risks; adapt outreach and referral during emergencies.
Patient safety and clinical stewardship	Infection prevention and control; safe prescribing; antimicrobial and antifungal stewardship; medicine interactions and contraindications; pharmacovigilance; procedural safety; incident reporting and diagnostic safety [23].
Life-course and priority populations	Adapt assessment, communication, consent, safeguarding, treatment and referral for newborns, children, adolescents, pregnancy, older people, immunocompromised people, people with disability, displaced populations and underserved groups.
Laboratory and diagnostic workforce	Specimen selection and collection; microscopy or locally available tests; packaging and transport; biosafety; result interpretation; dermatopathology referral; internal quality control; external quality assessment and proficiency testing.
Allied and multidisciplinary workforces	Define competencies for pharmacy, wound care, rehabilitation, mental health, pathology, surgery, oncology, public health, surveillance and education personnel, with clear handovers and team-based practice.
Faculty, trainer and assessor quality	Transparent selection; clinical currency; competency-based education skills; safe use of patients and images; observed facilitation; assessor calibration; conflict-of-interest management; moderation; feedback; periodic review and renewal.
Visual and point-of-care learning tools	Validated image sets across skin tones and ages; CHW flipcharts; PHC algorithms; portable danger-sign and referral tools; accessibility and low-literacy design; version control linked to national guidance.

10. Assessment, certification and continuing competence

10.1 Assessment policy

Assessment must generate credible evidence that a learner can perform the authorized activity, not merely recall facts. A programmatic approach should combine several methods because no single test captures clinical judgement, communication, technical skill and workplace consistency.

Method	Best use
Knowledge and image-based assessment	Core concepts, pattern recognition, red flags, medicines, referral and data requirements. Images must reflect local conditions and skin-tone diversity.
Objective structured clinical examination or simulation	History, examination, lesion description, counselling, triage, wound care, image capture, referral and emergency response.
Direct observation in practice	Real or standardized encounters using structured checklists and narrative feedback.

Method	Best use
Case-based discussion	Reasoning, differential diagnosis, uncertainty, comorbidity, treatment choice, referral and ethical issues.
Case log or portfolio	Breadth, repeated performance, reflective learning, audit, feedback and completion of required activities.
Referral and documentation audit	Completeness, appropriateness, timeliness, counter-referral and data quality.
Patient or caregiver feedback	Respect, communication, stigma, shared decisions and self-care support, with safeguards against coercion.
Quality improvement task	Use of local data to identify and address a service problem.

10.2 Pass standards and safety rules

- Use criterion-referenced standards linked to required behaviours rather than ranking learners against one another.
- Define critical safety failures that cannot be compensated by a high overall score, such as missing an emergency, unsafe medicine use, failure to refer suspected malignancy, or breach of consent and privacy.
- Require sufficient sampling across conditions, age groups, skin tones and practice activities.
- Use trained assessors, standardized tools, moderation and periodic review of reliability and fairness.
- Provide structured feedback, remediation and reassessment pathways.
- Record assessment evidence in a verifiable credential, portfolio or HRH system consistent with national policy.

10.3 Certification and continuing competence

Certification should state the competency set, proficiency level, authorized activities, date, issuing authority and reassessment requirements. It should not imply a professional title or clinical scope beyond national regulation. Continuing competence should combine CPD, case review, supervision, service audit and reassessment based on risk, role and frequency of practice.

Risk tier	Illustrative activities	Suggested maintenance approach
Lower risk	Promotion, basic recognition, counselling and referral follow-up	Annual update or supervisor review; focused reassessment when guidance changes.
Moderate risk	Independent management of common conditions, wound care, prescribing within protocol	Regular case review and workplace observation; formal reassessment every 2–3 years or per regulator.
Higher risk	Procedures, advanced diagnostics, complex prescribing, extended-role practice	Credentialing, minimum practice volume, direct observation, portfolio and periodic revalidation.

10.4 Certification and competency assessment authority

Certification of competency in integrated skin health should be governed by the national competent authority. The Ministry of Health, relevant statutory professional councils and national education or accreditation bodies should define the certification arrangements applicable to each health workforce cadre.

Training may be delivered by accredited universities, health training institutions, teaching hospitals or other authorized providers. A certificate of attendance or course completion should not be considered equivalent to competency certification.

Competency certification should be awarded only following successful completion of nationally approved knowledge, image-based, clinical reasoning, practical and safety-critical assessments. Workplace verification should be included where feasible.

Clinical competency assessments should be administered by trained and calibrated assessors. To reduce conflicts of interest, at least one assessor or moderator should be independent of the immediate training team. National dermatology, primary health care, nursing, public health and skin NTD expertise should be represented in assessment development and quality assurance. The term “proficiency testing” is reserved for laboratory external quality assessment.

WHO and international partners may provide normative guidance, adaptable tools and technical assistance but should not normally serve as the authority certifying individual health workers.

Operational principle: Training providers teach; authorized assessors assess competence; national authorities certify; and supervisors verify continuing competence in practice.

11. Supportive supervision, mentorship and digital support

11.1 Supportive supervision standard

Training should be followed by a structured period of supported practice. Supervision should combine clinical coaching, problem-solving, quality review and service readiness rather than operate as fault-finding inspection.

- A named supervisor or support team for each participating provider or facility.
- A standard supervision tool linked to the competencies and practice activities.
- Case review, direct observation, medicine and supply checks, referral review and data-quality feedback.
- Escalation routes for diagnostic uncertainty, severe disease and treatment failure.
- Documented action plans, follow-up and recognition of improvement.
- Adapted frequency based on provider experience, service volume, remoteness and risk.

11.2 Mentorship and communities of practice

Mentorship should support professional growth beyond compliance. District case conferences, image-review sessions, specialist outreach, peer groups and communities of practice can sustain learning and reduce professional isolation. Mentors must work within data protection, consent and clinical governance requirements.

11.3 Teledermatology and digital decision support

WHA78.15 and the draft GAP-SKIN identify telemedicine and digital assessment as mechanisms to extend specialist support, especially in remote settings [1,2]. Digital tools should augment, not replace, clinical accountability and referral systems.

Minimum governance requirement	Operational standard
Consent and purpose	Obtain informed consent for image capture and transmission and explain who will view the information and why.
Image quality and context	Use standardized views, scale and lighting; include relevant history and avoid unnecessary identifying features.
Privacy and security	Use approved platforms, role-based access, secure storage, retention rules and breach procedures.
Clinical accountability	Define responsibility for interim care, response time, documentation, follow-up and escalation.
Equity and access	Provide non-digital alternatives and avoid excluding people with low connectivity, disability or low digital literacy.
Tool validation	Evaluate accuracy, bias across skin tones and settings, usability and safety before scale-up, especially for AI.
Learning use	De-identify and obtain appropriate consent or authorization before using cases for teaching or research.

11.4 Digital, clinical-image and artificial-intelligence governance

Digital tools, clinical photography and artificial intelligence may expand access and learning, but they create distinct clinical, ethical and data-governance risks. National programmes should apply WHO principles that place ethics, human rights, transparency and human oversight at the centre of design and deployment [24].

Learning and innovation link. Implementation of digital support, teledermatology and AI-enabled tools should generate SHRIEF-aligned learning questions, including which models improve competence, referral quality, patient experience, equity and service outcomes in different settings. Research activity should remain connected to clinical governance and routine quality improvement.

Governance domain	Minimum requirement
Purpose and authorization	Approve a defined use case, intended users, clinical boundary and accountable owner before deployment.
Consent and lawful processing	Use understandable consent or another valid legal basis; explain image capture, transmission, storage, teaching and secondary use separately.
Data minimization and security	Collect only necessary information; remove identifiers where possible; use approved devices and platforms; define access, retention, deletion, breach and cross-border transfer rules.
Clinical validation and equity	Validate performance in the target setting across skin tones, ages, sex, disease severity, devices and connectivity conditions; assess false reassurance and referral harms.
Human oversight and accountability	The health worker remains responsible for clinical decisions; define when the tool must not be used, how uncertainty is displayed and how cases are escalated.
Transparency and explainability	Inform users and patients when algorithmic support is used; document version, limitations, provenance and changes that affect performance.
Monitoring and incident response	Monitor accuracy, bias, downtime, inappropriate recommendations, privacy incidents and user workarounds; suspend or correct unsafe tools promptly.
Training and competence	Train users in image quality, consent, limitations, bias, cybersecurity, documentation and safe override; assess competence before authorization.
Equity and offline alternatives	Maintain non-digital routes for people and facilities without connectivity, devices, language access or digital literacy.

12. Governance, regulation and financing

12.1 National governance mechanism

The Ministry of Health should designate an accountable unit and establish a multidisciplinary technical group for adaptation and implementation. The group should connect health workforce policy with service delivery and include affected communities.

- Ministry of Health units responsible for PHC, HRH, education, quality, NTDs, NCDs/cancer, mental health, rehabilitation, laboratories, pharmacy, surveillance and digital health.
- Ministries or agencies responsible for education, professional regulation, accreditation and public service employment.
- Dermatology, primary care, nursing, allied health, laboratory, pharmacy and public health professional bodies.
- Training institutions and faculty from different regions and service levels.
- People affected by skin diseases, caregivers, patient organizations and civil society.
- Implementation partners, funders and private-sector actors subject to conflict-of-interest safeguards.

12.2 Accountability roles

Actor	Core responsibilities
Ministry of Health	Endorse framework; define service package and national standards; finance implementation; coordinate data and review.
Education and training authorities	Embed competencies in curricula; approve programmes; ensure faculty, placements and assessment quality.
Regulators and professional councils	Align scope of practice, licensing, credentialing and continuing competence.
Service managers	Deploy competent staff, enable practice, provide supplies, referral, supervision and protected learning time.
Specialist and professional networks	Validate content, train assessors, provide mentorship, referral support and advanced-role standards.
Communities and people affected	Co-design standards and learning; assess acceptability, dignity, accessibility and patient experience.
WHO and partners	Provide technical guidance, shared resources, country support and learning across settings within mandates and resources.

12.2.1 Recommended responsibility model for certification and competency assessment

The model below should be adapted to national legislation and institutional mandates. Where functions are distributed across several bodies, a regulation, memorandum of understanding or standard operating procedure should define decision rights, data exchange, appeals, conflict-of-interest controls and quality assurance.

Function	Recommended responsible body
Approve the national competency standards	Ministry of Health, with the national professional councils and relevant technical programmes.
Accredit the training programme	National accreditation authority, Ministry of Health, Ministry of Education or statutory professional council.
Deliver training	Accredited universities, nursing or medical schools, national training institutes, teaching hospitals or authorized training centres.
Issue a certificate of course completion	The accredited training provider.
Award competency certification	Ministry of Health or the relevant statutory professional council, directly or through a formally designated institution.
Conduct knowledge and image-based tests	Accredited training institution or national examination body.
Conduct practical and clinical competency assessments	Trained and calibrated assessors appointed by the national certification authority.
Verify workplace competence	Designated PHC supervisors, district clinical mentors or skin health focal persons.
Provide external quality assurance	National technical working group, university, dermatology society or independent examination body.
Reassess and renew certification	The original certification authority, supported by accredited assessment centres.

National arrangements may combine roles in resource-constrained settings, but the functions of training delivery, assessment, certification and external quality assurance should remain explicitly assigned and documented.

12.3 Financing principles

- Cost the full competency system, including adaptation, faculty, clinical placements, assessment, supervision, digital support, data systems and periodic review, not only classroom delivery.
- Use domestic health workforce and education budgets where possible and align partner funding with the national plan.
- Protect time for learning and supervision and avoid shifting training costs to low-paid workers.
- Link training expansion to medicines, diagnostics, referral and staffing readiness so competence can be applied.
- Use regional hubs, open resources and shared digital infrastructure to reduce duplication while preserving national ownership.

13. National adaptation and implementation roadmap

National adaptation should follow a transparent, evidence-informed process based on the WHO RCF adaptation cycle and curriculum development guidance [6,7]. The proposed roadmap aligns this process with GAP-SKIN implementation phases.

Phase	Indicative timing	Key outputs
Phase 0: Mandate and governance	0–3 months	Designate lead; form technical group; agree scope, stakeholders, decision rules and consultation plan.
Phase 1: Situational analysis	3–6 months	Map burden, services, cadres, existing curricula, scopes, training resources, supervision, referral, digital capacity and equity gaps; establish C4 baseline.

Phase	Indicative timing	Key outputs
Phase 2: Draft and map competencies	6–10 months	Select national priority conditions and service activities; tailor domains, behaviours, proficiency and pathways; map to PHC classification and clinical guidance.
Phase 3: Validate and approve	10–14 months	Conduct technical, regulatory, educator and community review; field-test terminology and feasibility; revise and secure formal endorsement.
Phase 4: Build curriculum and assessment	12–20 months	Develop or revise curricula, faculty preparation, assessment blueprint, clinical placements, credentials and supervision tools.
Phase 5: Pilot implementation	18–30 months	Pilot in diverse settings; measure learning, workplace performance, patient safety, acceptability, equity, costs and service effects.
Phase 6: Scale and institutionalize	2028–2030	Integrate into pre-service, CPD, HRH, regulation and national service systems; expand supervision and specialist support.
Phase 7: Optimize and sustain	2031–2035	Review outcomes, update competencies, strengthen advanced roles, digital learning, climate resilience, research and quality improvement.

13.1 Minimum adaptation evidence

- National epidemiological and service-needs analysis.
- Inventory of existing education, competency, scope-of-practice and supervision instruments.
- Competency-to-service-package and competency-to-cadre mapping.
- Consultation record including people affected and rural/underserved workforce representatives.
- Assessment and certification plan with responsible authority.
- Implementation, financing and monitoring plan with equity disaggregation.
- Formal endorsement and version-control process.

14. Monitoring, evaluation and learning

14.1 Core GAP-SKIN alignment

> **Core indicator C4**
> Proportion of Member States with an approved competency-based skin health workforce framework implemented through at least one relevant education, training, supervision or mentoring channel. A country should be counted only when the framework is nationally endorsed, implemented through a documented channel, and includes competency assessment plus supervision, mentorship or specialist support arrangements. One-off awareness training does not meet the standard. [17]

Indicator alignment. Workforce indicators in this framework should be mapped to the GAP-SKIN Indicator Compendium. Countries may use additional workforce indicators for national management and implementation learning, but global reporting should remain aligned with the compendium and should not treat training attendance alone as evidence of competence, supervision or service quality.

14.2 Tiered national indicator set

Countries should begin with eight core indicators and add recommended indicators as systems mature. Developmental indicators should be piloted before routine use. Applicability must be reported, and “not applicable” should not be treated as non-performance.

ID	Tier	Indicator	Unit	Purpose
ISH-W1	Core	Approved framework and implementation maturity	Maturity level 0–4	Assesses policy development, endorsement, implementation, practice support and routine improvement.
ISH-W2	Core	Curriculum integration	% of relevant programmes	Measures integration of the approved competency set in applicable pre-service and in-service programmes.

ID	Tier	Indicator	Unit	Purpose
ISH-W3	Core	Competency attainment	%	Measures learners or providers meeting the defined pass standard, by cadre and proficiency level.
ISH-W4	Core	Facility competence coverage	% of expected PHC facilities	Measures facilities with at least one currently competent provider for the nationally defined minimum service package.
ISH-W5	Core	Supervision and mentorship coverage	%	Measures competent providers receiving required supervision or mentorship during the reporting period.
ISH-W6	Recommended	Competency retention	%	Measures certified providers retaining selected competencies at the nationally defined interval.
ISH-W7	Core	Referral quality	%	Measures reviewed referrals meeting completeness, appropriateness, urgency, timeliness and continuity standards.
ISH-W8	Recommended	Clinical quality concordance	%	Measures audited cases consistent with current national assessment and management guidance.
ISH-W9	Recommended	Patient experience and stigma-responsive care	%	Measures service users reporting all specified respectful-care, privacy, involvement and stigma-responsive criteria.
ISH-W10	Core	Equitable deployment	Density ratio	Compares competent provider density in underserved areas with the national or agreed reference density.
ISH-W11	Recommended where used	Digital consultation quality	% of eligible consultations	Measures teledermatology cases meeting consent, image, documentation, response and follow-up standards.
ISH-W12	Recommended	Faculty, supervisor and assessor capacity	Number and % of planned positions	Measures active trained personnel available by role, region and institution.
ISH-W13	Core	National minimum integrated skin health service coverage	% of expected PHC facilities	Measures whether trained workers can deliver the nationally defined minimum service package with required readiness.
ISH-W14	Recommended	Approved algorithm implementation	% of eligible facilities	Measures availability and documented use of current approved integrated assessment and referral algorithms.
ISH-W15	Recommended	Community job-aid access and use	% of active trained community personnel	Measures access to and documented use of approved, current visual tools.
ISH-W16	Recommended where relevant tests are performed	Laboratory quality assurance coverage	% of all eligible laboratories	Measures satisfactory participation in relevant external quality assessment or proficiency testing.
ISH-W17	Developmental/pilot where images or AI are used	Digital image and AI governance compliance	% of all eligible facilities/programmes	Measures compliance with an auditable consent, privacy, validation, oversight and incident-management standard.
ISH-W18	Recommended for countries without sustainable specialist access	Specialist-development pathway progress	Verified milestone M0–M5	Tracks planning, training, return, service establishment and a sustainable accredited or regional pathway.

ISH-W1 maturity scale. A country reaches the proposed C4 implementation threshold at Level 3 or Level 4, subject to final GAP-SKIN indicator approval.

Level	Verification standard
0. Not initiated	No documented national process or approved framework.
1. In development	Situation analysis or draft framework exists and consultation is under way.
2. Approved	Framework is formally endorsed and defines role-specific competencies, scopes, assessment and support requirements.
3. Implemented	Approved standards are used through at least one documented channel with competency assessment and structured practice support.
4. Institutionalized and improving	Implementation is scaled or routinely embedded, monitored with equity and quality data, financed and periodically improved.

14.3 Data sources and review cycle

Countries should use existing education, HRH, licensing, facility, supervision and routine health information systems where feasible. Data sources may include approved curricula, student information systems, examination records, CPD platforms, credential registers, HRH information systems, supervision records, facility assessments, referral registers, clinical audits, patient-experience surveys and teledermatology logs. Denominators and reporting coverage should be reported transparently.

A national annual review should examine implementation status, equity, competence gaps, supervision findings, referral quality and service outcomes. A more comprehensive framework review should occur every three to five years or earlier when clinical guidance, technology, regulation or epidemiology changes substantially.

14.4 Evaluation questions

- Does the framework improve provider competence beyond knowledge gain?
- Are skills retained and applied in routine practice?
- Does training improve safe management, referral, continuity and patient experience?
- Are benefits equitable across geography, cadre, gender and underserved populations?
- Does task-sharing expand access without increasing safety failures or inappropriate treatment?
- Are supervision and teledermatology feasible, timely and cost-effective?
- What implementation adaptations explain variation in outcomes?

15. Risk management and safeguards

Risk	Potential effect	Safeguard
Training without service readiness	Providers cannot apply competence because medicines, diagnostics, referral or time are unavailable.	Link training rollout to facility readiness and service-package implementation.
Scope expansion without regulation	Task-sharing creates legal uncertainty or unsafe practice.	Secure regulatory approval, explicit boundaries, supervision and credentialing before independent practice.
Overdiagnosis or inappropriate treatment	Pattern-recognition training may encourage false certainty.	Teach uncertainty, differential diagnosis, reassessment and referral; use workplace audit.
Failure to recognize emergencies or cancer	Serious cases are delayed.	Use critical-fail assessment standards, stratified emergency/urgent/priority referral protocols and rapid escalation.
Bias across skin tones and populations	Learning resources perform poorly or reinforce inequity.	Use representative images, diverse assessors, subgroup performance analysis and local validation.
Digital privacy or AI harm	Images are shared insecurely or biased tools influence decisions.	Use consent, approved platforms, validation, human oversight, audit and non-digital alternatives.
One-off training decay	Competence erodes without practice and feedback.	Require supervision, case review, CPD, refresher learning and periodic reassessment.
Vertical programme fragmentation	Multiple disease courses duplicate effort and burden staff.	Use a shared integrated competency core with disease-specific modules only where necessary.
Exclusion of affected people	Standards overlook stigma, access and lived experience.	Include affected-person representatives in governance, curriculum, assessment and evaluation.
Unsustainable external financing	Training stops after a project cycle.	Integrate costs into domestic workforce, education and service budgets and use existing systems.

Risk	Potential effect	Safeguard
No national dermatologist or specialist access	Unsafe referral delays, professional isolation, overextension of PHC or extended-role workers.	Apply Section 8.5: formal cross-border governance, regional referral and teledermatology, protected task-sharing boundaries, a regulator-recognized initial specialist cohort and sustainable national or pooled regional capacity.
Training one specialist without succession or retention plan	Single-person dependency, burnout, migration and collapse of the service.	Train a cohort, fund posts and career progression, use bundled retention measures, external networks and succession planning.
Unvalidated AI or image tools	Bias, missed diagnosis, privacy breach and false reassurance.	Apply Section 11.4 governance, local validation, human oversight, incident monitoring and non-digital alternatives.

15.1 Minimum national standard for proposed GAP-SKIN C4 implementation

For national monitoring, and for any future GAP-SKIN reporting subject to final indicator approval, a country should be considered to have an implemented competency-based skin health workforce framework only when all minimum criteria below are documented. This corresponds to ISH-W1 maturity Level 3 or 4 and intentionally distinguishes demonstrated competence and system support from course attendance alone.

Minimum safeguard. A workforce programme should not be considered implementation-ready if it consists only of short training or awareness sessions. Minimum implementation includes defined competencies, role-appropriate learning, assessment, supervision or mentorship, referral support, quality monitoring and an equity-sensitive deployment approach.

Minimum criterion	Verification requirement
1. Formal endorsement	The framework or curriculum is approved by the competent national authority and remains current.
2. Role-specific standards	Competencies, scopes of practice, referral boundaries and supervision requirements are defined for the relevant cadres.
3. Operational delivery	The approved framework is used through at least one documented pre-service, in-service, CPD, supervision or mentoring channel.
4. Competency assessment	Learners or providers are assessed against explicit standards using methods appropriate to knowledge, clinical skills, communication and workplace performance; critical safety failures cannot be compensated by aggregate scores.
5. Practice support	Supportive supervision, mentorship, specialist advice or another structured escalation mechanism is operational and documented.
6. Monitoring and improvement	Implementation coverage, competency attainment, equity, referral quality and retention are reviewed, with findings used to improve curricula and services.
7. Service readiness and financing	Training is linked to the minimum PHC service package, medicines, supplies, referral capacity and a costed implementation pathway.
8. Participation and safeguards	People affected by skin diseases contribute to design or review, and the framework addresses stigma, privacy, consent, inclusive imagery and digital safety.

Interpretation rule
A certificate of attendance, isolated awareness session or unassessed online module does not by itself constitute competency-based implementation. Evidence must show approved standards, assessment and structured practice support.

Annex A. Existing framework adoption matrix

This matrix distinguishes the normative or structural function of each source from the way it should be used in national adaptation. “Adopt” means retain the core architecture or domain model; “adapt” means tailor content and implementation; “resource” means use learning content subject to technical and contextual validation.

Source	Function	Recommended use	Caution
WHA78.15 [1]	Political and policy mandate	Retain requirements for competency-based PHC education, self-care, digital support, mental health, rehabilitation and capacity-building.	Resolution does not provide a competency architecture or assessment specification.
Draft GAP-SKIN [2]	Strategic policy direction	Use SO4 as the primary alignment standard for training, competence, task-sharing and support systems.	Draft for consultation; final text and targets may change.
WHO UHC frameworks [3,4]	Transversal competency domains and outcomes	Adopt six domains and practice-activity logic; tailor outcomes to skin health.	Developed mainly through pre-service pathways; additional workplace and system detail is required.
WHO RCF [5]	Framework architecture	Adopt values, competency-behaviour-knowledge-skill logic, proficiency and multi-use design.	Rehabilitation content itself is not transferred unless relevant to wounds, disability or functioning.
WHO RCF adaptation guide [6]	Contextualization process	Adopt five phases: planning, drafting, review, finalization and dissemination.	Add GAP-SKIN governance, community co-design and regulatory steps.
WHO curriculum guide [7]	Education programme development	Adopt planning, construction, sequencing, assessment and implementation cycle.	Tailor clinical exposure and assessment to skin health roles.
WHO skin NTD strategic framework [8]	Integrated programmatic content	Adapt workforce tasks, active case detection, wound/lymphoedema care, reporting, apps and teledermatology.	Expand beyond NTDs to common, chronic, malignant and severe skin conditions.
WHO front-line training guide [9]	Visual clinical learning	Use for recognition and common-problem content.	Update to national guidance, local epidemiology and broader GAP-SKIN scope.
WHO self-care framework [10]	Self-care support competencies	Integrate behaviours into patient counselling and chronic care.	Must not shift inappropriate responsibility or cost to patients.
WHO CHW curriculum guide [11]	Community pathway curriculum	Adapt to national CHW role, integration and system support.	CHW tasks vary substantially and must remain within national authorization.
ILDS Training Hub [12]	Open learning resources	Use selected validated courses to reduce duplication.	Not a policy, regulatory or competency assessment framework.
BDNG framework [13]	Advanced nursing example	Use portfolio, direct observation and staged competence concepts where relevant.	Older and UK-specific; requires current national and professional validation.
GPwER dermatology [14]	Extended primary-care role example	Use as optional benchmark for portfolio and advanced-scope credentialing.	UK-specific and not designed for global PHC or low-resource implementation.
Mali implementation studies [15,16]	Evidence for integrated PHC training and teledermatology	Use to inform implementation research and evaluation designs.	Context-specific evidence; outcomes should not be generalized without local evaluation.

Annex B. Competency matrix by workforce pathway

The matrix provides minimum expectations. Countries should replace illustrative cadre groupings with national roles and specify exact authorized activities, supervision and assessment.

Domain	A Community	B PHC generalist	C District/extended role	D Specialist	E System/education
D1 People-centred and stigma-responsive care	L1–2: respectful communication, privacy, stigma recognition, referral for distress	L2: shared decisions, psychosocial screening, inclusive care	L3: complex counselling, supervision, service accessibility	L4: specialist care, standards and system leadership	L3–4: policy, co-design and accountability
D2 Prevention, community and self-care	L2: community messages, early care-seeking, adherence and referral follow-up	L2: prevention, counselling, self-care planning	L3: programme design and supervisor coaching	L4: technical standards and specialist prevention advice	L3–4: communication strategy, community partnerships and evaluation
D3 Assessment and decision-making	L1: recognize selected patterns and red flags	L2: history, examination, lesion description, common differentials	L3: broader complexity, selected diagnostics and consultation	L4: specialist diagnosis and complex decision-making	L2–3: understand clinical workflow for policy, training and data quality
D4 Management, diagnostics and stewardship	Protocol-limited tasks only where authorized	L2: manage defined uncomplicated conditions and basic wounds	L3: moderate complexity, selected procedures or diagnostics, supervision	L4: advanced treatment, procedures and diagnostic governance	L2–4: formulary, laboratory, quality and workforce standards
D5 Referral, continuity and rehabilitation	L2: refer, track and support adherence	L2: triage, initial care, referral and follow-up	L3: counter-referral, district coordination and disability care	L4: complex referral and multidisciplinary leadership	L3–4: referral network, rehabilitation and service planning
D6 Collaboration and professional conduct	L1–2: role boundaries, confidentiality and teamwork	L2: interprofessional care and scope awareness	L3: supervision, conflict management and team leadership	L4: specialist collaboration and ethics leadership	L3–4: regulation, governance and accountability
D7 Surveillance, evidence and quality	L1–2: community alerts and required records	L2: coding, notification, registers and basic audit	L3: data review, outbreak support and quality improvement	L4: research, standards and advanced audit	L3–4: M&E, HMIS, research and policy learning
D8 Digital health, teledermatology and information governance	L1–2: approved communication, referral and privacy practices	L2: safe image capture, teleconsultation, documentation and escalation	L3: tele-triage, digital mentorship, governance and incident response	L4: specialist digital governance, validation and innovation oversight	L3–4: digital policy, security, interoperability, validation and equity
D9 Leadership, workforce development and system resilience	L1–2: contributes to continuity, local preparedness and feedback	L2: participates in supervision, quality and climate-responsive continuity	L3: leads teams, district networks, adaptation and workforce support	L4: leads specialist services, education, research and resilient referral systems	L3–4: workforce planning, financing, emergency continuity and climate adaptation

Annex C. Assessment blueprint

Practice activity	Recommended evidence	Critical criteria
PA1 Promotion and prevention	Knowledge/case assessment; observed counselling; community plan	Accuracy, cultural fit, stigma-free language, feasibility and referral advice
PA2 Skin assessment	OSCE or direct observation; structured note review	Consent, history, full appropriate examination, morphology, distribution, impact and documentation
PA3 Recognition and classification	Image/case test; case-based discussion	Pattern recognition across skin tones, differential, uncertainty and management category
PA4 Referral urgency and triage	Simulation/OSCE with emergency, urgent and priority scenarios and critical-fail items	Correct urgency category, immediate action, stabilization, communication, safety-netting and timely escalation
PA5 Uncomplicated management	Observed encounter; case log; audit	Correct treatment, counselling, safety-netting, follow-up and treatment-failure plan
PA6 Diagnostics and medicines	DOPS/simulation; prescription audit	Technique, specimen quality, interpretation, contraindications, stewardship and documentation
PA7 Self-care and chronic care	Observed counselling; patient feedback; care-plan review	Shared plan, teach-back, adherence barriers, warning signs and respectful support
PA8 Referral and continuity	Referral-note audit; simulation; tracking audit	Appropriateness, completeness, urgency category, interim care, timeliness, completion and counter-referral
PA9 Recording and reporting	Data task; register audit; outbreak scenario	Correct terminology/coding, notification, completeness, privacy and action
PA10 Quality and development	QI project; supervision observation; portfolio	Data use, feedback, change testing, reflection, mentorship within scope

Annex D. National readiness and implementation checklist

Governance and mandate

Criterion	Status	Evidence/action
A lead ministry unit and multidisciplinary technical group are designated.	☐ Not started ☐ Partial ☐ Complete	
People affected and frontline workers are represented.	☐ Not started ☐ Partial ☐ Complete	
The framework scope, approval pathway and version-control process are agreed.	☐ Not started ☐ Partial ☐ Complete	

Situation analysis

Criterion	Status	Evidence/action
National priority conditions, burden and equity gaps are documented.	☐ Not started ☐ Partial ☐ Complete	
Cadres, service levels, scopes, curricula, training, supervision and specialist capacity are mapped.	☐ Not started ☐ Partial ☐ Complete	
Facility readiness, referral, laboratory, medicines, data and digital systems are assessed.	☐ Not started ☐ Partial ☐ Complete	

Competency framework

Criterion	Status	Evidence/action
Domains, behaviours, practice activities and proficiency levels are contextualized.	☐ Not started ☐ Partial ☐ Complete	
Competencies are mapped to the national minimum skin health package and PHC management categories.	☐ Not started ☐ Partial ☐ Complete	
Cadre-specific scope, supervision and referral boundaries are explicit.	☐ Not started ☐ Partial ☐ Complete	

Education and assessment

Criterion	Status	Evidence/action
Pre-service, induction, in-service and CPD channels are identified.	☐ Not started ☐ Partial ☐ Complete	
Curriculum, faculty and clinical-placement plans are approved.	☐ Not started ☐ Partial ☐ Complete	
Assessment blueprint, pass standards, critical failures, remediation and credentials are defined.	☐ Not started ☐ Partial ☐ Complete	

Implementation support

Criterion	Status	Evidence/action
Supervision, mentorship and specialist support are operational.	☐ Not started ☐ Partial ☐ Complete	
Medicines, diagnostics, wound supplies and referral systems are available.	☐ Not started ☐ Partial ☐ Complete	
Digital and clinical image governance is approved, with offline alternatives.	☐ Not started ☐ Partial ☐ Complete	

Monitoring and sustainability

Criterion	Status	Evidence/action
C4 baseline and national indicators are defined with denominators and equity disaggregation.	☐ Not started ☐ Partial ☐ Complete	
Implementation is costed and financed beyond pilot delivery.	☐ Not started ☐ Partial ☐ Complete	
Annual review and periodic framework update mechanisms are established.	☐ Not started ☐ Partial ☐ Complete	

Specialist capacity where no dermatologist is available

Criterion	Status	Evidence/action
Interim regional referral, teledermatology and visiting-specialist arrangements are formally documented.		
A costed national dermatology workforce and retention plan has been approved.		
The protected specialist title, accreditation route and specialist register are defined.		
An initial cohort of at least two candidates, or another justified size for a small state or pooled regional model, has a funded recognized training route, regulator confirmation and return posts.		
Domestic programme feasibility has been assessed against faculty, case volume, diagnostics, resources and external quality requirements.		
A succession, rural access, continuing competence and distribution strategy is in place.		

Annex E. Tiered national indicator reference sheets

These reference sheets provide a complete, internally consistent specification for ISH-W1 to ISH-W18. Countries should adapt definitions and intervals before implementation, document applicability and denominator coverage, and retain the tier designation unless national priorities justify a transparent change.

ISH-W1: Approved framework and implementation maturity

Field	Specification
Tier	Core
Applicability	All countries
Definition	Highest verified national maturity level (0–4) achieved for the integrated skin health workforce framework.
Numerator	Not applicable; report one verified maturity level.
Denominator	Not applicable.
Disaggregation	National; optionally by subnational implementation stage.
Preferred data source	Approval instruments, framework, implementation records, assessment and supervision evidence, annual review report.
Frequency	Annual
Data-quality notes	Use the maturity scale in Section 14.2. Level 3 or 4 meets the proposed C4 implementation threshold; retain dated documentary evidence.

ISH-W2: Curriculum integration

Field	Specification
Tier	Core
Applicability	Countries with relevant education or training programmes
Definition	Percentage of relevant programmes that integrate the approved competency set, scopes and assessment requirements.
Numerator	Number of relevant programmes meeting the national integration standard.
Denominator	Total number of relevant programmes expected to integrate the competency set.
Disaggregation	Programme type; cadre; pre-service/in-service/CPD; public/private; region.
Preferred data source	Accreditation records, curricula, programme inventories and review reports.
Frequency	Annual or biennial
Data-quality notes	Define “relevant programme” and the minimum integration standard before measurement; verify content and assessment, not course title alone.

ISH-W3: Competency attainment

Field	Specification
Tier	Core
Applicability	All implemented training or assessment pathways
Definition	Percentage of eligible learners or providers meeting the complete defined pass standard.
Numerator	Number meeting all knowledge, performance and safety-critical pass requirements.
Denominator	Number completing the required assessment.
Disaggregation	Cadre; pathway; proficiency; sex; age where appropriate; geography; training provider; skin-tone case coverage.

Field	Specification
Preferred data source	Assessment system, examination records, competency portfolio or credential register.
Frequency	Each cohort; annual aggregation
Data-quality notes	Report non-completion separately; do not combine incompatible standards without stratification; critical-fail rules must be explicit.

ISH-W4: Facility competence coverage

Field	Specification
Tier	Core
Applicability	PHC facilities expected to deliver the national minimum service package
Definition	Percentage of expected PHC facilities with at least one currently competent provider for the defined service package and shift coverage standard.
Numerator	Number of expected facilities meeting the competent-provider coverage standard.
Denominator	Total expected PHC facilities in scope.
Disaggregation	Facility type; ownership; urban/rural; region; remoteness.
Preferred data source	HRH information system, credential register, facility assessment and staffing roster.
Frequency	Annual
Data-quality notes	Define currency and minimum shift/leave coverage; avoid counting a provider who is not deployed, available or authorized at the facility.

ISH-W5: Supervision and mentorship coverage

Field	Specification
Tier	Core
Applicability	Providers or facilities for which supervision/mentorship is required
Definition	Percentage receiving the nationally specified support during the reporting period.
Numerator	Number receiving all required contacts or documented support.
Denominator	Number expected to receive support.
Disaggregation	Cadre; pathway; facility; geography; modality; supervisor type.
Preferred data source	Supervision platform, mentorship register, teleconsultation log or district report.
Frequency	Quarterly; annual aggregation
Data-quality notes	Measure meaningful documented support, not attendance at a mass meeting; report missed contacts and reasons.

ISH-W6: Competency retention

Field	Specification
Tier	Recommended
Applicability	Certified providers selected for follow-up
Definition	Percentage continuing to meet selected competency standards at the national follow-up interval.
Numerator	Number meeting the retention standard.
Denominator	Number reassessed at the specified interval.
Disaggregation	Cadre; pathway; domain/activity; geography; time since certification.

Field	Specification
Preferred data source	Reassessment, direct observation, audit, portfolio or standardized case review.
Frequency	At 6–12 months or national interval
Data-quality notes	Report follow-up coverage and attrition; use the same or equated standards; interpret low case volume separately.

ISH-W7: Referral quality

Field	Specification
Tier	Core
Applicability	Eligible skin health referrals
Definition	Percentage meeting national completeness, appropriateness, urgency, timeliness and continuity criteria.
Numerator	Number of reviewed referrals meeting all specified criteria.
Denominator	Total eligible referrals reviewed.
Disaggregation	Urgency; condition group; referring cadre; facility; geography; completion and counter-referral status.
Preferred data source	Referral register, counter-referral record, electronic referral or audit.
Frequency	Quarterly or annual
Data-quality notes	Define timeliness by urgency; do not penalize clinical appropriateness for transport or access barriers outside provider control; analyze completion separately.

ISH-W8: Clinical quality concordance

Field	Specification
Tier	Recommended
Applicability	Facilities or services conducting clinical audit
Definition	Percentage of audited cases concordant with current national assessment and management guidance.
Numerator	Number of audited cases meeting all specified concordance criteria.
Denominator	Total eligible cases audited.
Disaggregation	Condition/presentation; cadre; facility; region; referral category; patient group.
Preferred data source	Clinical records, prescription audit, standardized case audit or electronic health record.
Frequency	Quarterly or annual
Data-quality notes	Use current version-controlled criteria, risk-adjust interpretation and report audit sampling methods.

ISH-W9: Patient experience and stigma-responsive care

Field	Specification
Tier	Recommended
Applicability	Services able to obtain safe voluntary feedback
Definition	Percentage of respondents meeting all specified respectful-care and stigma-responsive experience criteria.
Numerator	Number of eligible respondents reporting all required positive criteria.
Denominator	Total eligible respondents completing the defined measure.
Disaggregation	Age group; sex; disability; condition group; geography; facility; language.
Preferred data source	Validated patient-experience survey, exit interview or confidential feedback system.

Field	Specification
Frequency	Annual or periodic survey
Data-quality notes	Use accessible, non-coercive collection; protect confidentiality; document response rate and avoid facility staff administering sensitive items where possible.

ISH-W10: Equitable deployment

Field	Specification
Tier	Core
Applicability	All countries
Definition	Ratio of competent provider density in nationally defined underserved areas to the agreed national or reference density.
Numerator	Competent providers per defined population in underserved areas.
Denominator	Competent providers per the same population unit in the national or agreed reference area.
Disaggregation	Region; rural/urban; remoteness; facility type; cadre; sex where relevant.
Preferred data source	HRH information system, credential register, population estimates and facility mapping.
Frequency	Annual
Data-quality notes	Define underserved areas and population denominator consistently; report absolute densities alongside the ratio.

ISH-W11: Digital consultation quality

Field	Specification
Tier	Recommended where used
Applicability	All eligible teledermatology consultations
Definition	Percentage meeting consent, image/context, documentation, response-time, clinical-action and follow-up standards.
Numerator	Number of eligible consultations meeting all criteria.
Denominator	Total eligible consultations reviewed.
Disaggregation	Platform; synchronous/asynchronous; cadre; urgency; region; outcome; skin-tone group where ethically and methodologically appropriate.
Preferred data source	Teledermatology platform, clinical record and quality audit.
Frequency	Quarterly or annual
Data-quality notes	Audit both technical and clinical quality; report exclusions, failed transmissions and cases redirected to non-digital care.

ISH-W12: Faculty, supervisor and assessor capacity

Field	Specification
Tier	Recommended
Applicability	Countries implementing education, supervision or assessment
Definition	Number of active trained personnel and percentage of planned positions filled for each function.
Numerator	Number of active trained faculty, supervisors and assessors meeting national criteria.
Denominator	Number of positions required in the approved workforce or implementation plan.
Disaggregation	Function; cadre; institution; region; sex; active/inactive status.

Field	Specification
Preferred data source	Faculty register, assessor authorization, supervision roster and HRH plan.
Frequency	Annual
Data-quality notes	Avoid double-counting individuals across roles; define active status and minimum annual activity.

ISH-W13: National minimum integrated skin health service coverage

Field	Specification
Tier	Core
Applicability	PHC facilities expected to deliver the national minimum service package
Definition	Percentage meeting all nationally defined service-readiness and delivery criteria.
Numerator	Number of expected PHC facilities meeting all minimum service-package criteria.
Denominator	Total expected PHC facilities in scope.
Disaggregation	Facility type; ownership; region; rural/urban; service component.
Preferred data source	Facility assessment, routine service data, commodity records and clinical audit.
Frequency	Annual
Data-quality notes	Use an auditable checklist covering competent staff, medicines/supplies, tools, referral and actual service delivery; report component gaps.

ISH-W14: Approved algorithm implementation

Field	Specification
Tier	Recommended
Applicability	Facilities expected to use approved algorithms
Definition	Percentage with the current approved algorithm available and documented evidence of appropriate use.
Numerator	Number of eligible facilities meeting availability, currency and use criteria.
Denominator	Total eligible facilities assessed.
Disaggregation	Algorithm type; facility; region; cadre; digital/paper.
Preferred data source	Facility assessment, record audit, supervision checklist or digital log.
Frequency	Annual
Data-quality notes	Presence alone is insufficient; verify version, accessibility and use without encouraging mechanical application beyond scope.

ISH-W15: Community job-aid access and use

Field	Specification
Tier	Recommended
Applicability	Active trained community personnel expected to use job aids
Definition	Percentage with access to a current approved job aid and documented use or demonstration of use.
Numerator	Number meeting both access and use criteria.
Denominator	Total active trained community personnel expected to use the aid.
Disaggregation	Cadre; district; language; format; sex; rural/urban.
Preferred data source	CHW register, supervision observation, stock/distribution record or digital use log.

Field	Specification
Frequency	Annual
Data-quality notes	Distinguish distribution from access and correct use; account for replacement, language and accessibility needs.

ISH-W16: Laboratory quality assurance coverage

Field	Specification
Tier	Recommended where relevant tests are performed
Applicability	All eligible laboratories performing the specified skin-related tests
Definition	Percentage with satisfactory participation in relevant external quality assessment or proficiency testing during the interval.
Numerator	Number of eligible laboratories with a satisfactory result or completed corrective action under the national standard.
Denominator	All laboratories performing the relevant test(s), whether or not initially enrolled in the scheme.
Disaggregation	Test; laboratory level; ownership; region; initial result/corrective action.
Preferred data source	EQA or proficiency-testing provider, laboratory quality system and national reference laboratory.
Frequency	Per EQA cycle; annual aggregation
Data-quality notes	Report laboratories lacking access to a scheme separately; do not restrict the denominator to voluntary participants.

ISH-W17: Digital image and AI governance compliance

Field	Specification
Tier	Developmental/pilot where images or AI are used
Applicability	All facilities, programmes or tools using clinical images or AI for skin health
Definition	Percentage meeting every required item in the approved governance checklist.
Numerator	Number of eligible facilities/programmes meeting all required consent, privacy, validation, oversight and incident-management criteria.
Denominator	All eligible facilities/programmes using clinical images or AI.
Disaggregation	Use case; tool/version; facility; region; public/private; AI/non-AI.
Preferred data source	Governance audit, data-protection review, tool register and incident log.
Frequency	Before deployment and at least annually
Data-quality notes	Use an auditable checklist; report serious incidents and suspended tools separately; pilot reliability before routine performance comparison.

ISH-W18: Specialist-development pathway progress

Field	Specification
Tier	Recommended for countries without sustainable specialist access
Applicability	Countries with no dermatologist or no sustainably accessible national specialist service
Definition	Highest independently verified milestone M0–M5 achieved in Annex G.
Numerator	Not applicable; report the highest verified milestone.
Denominator	Not applicable.
Disaggregation	National; optionally by referral region and trainee cohort.

Field	Specification
Preferred data source	Workforce plan, regulator decisions, partnership agreements, trainee records, appointments, accreditation and service data.
Frequency	Annual
Data-quality notes	A milestone is achieved only when all verification requirements are met; report attrition, delayed return and regional pooled arrangements transparently.

Annex F. PHC curriculum blueprint and training package specification

This annex translates the policy framework into a minimum curriculum blueprint for PHC development teams. It is not a condition-specific clinical guideline. National clinical guidance must define diagnosis, medicines, procedures, follow-up intervals and referral thresholds.

F.1 Curriculum development principles

- Start from the national skin health service package, workforce roles, epidemiology and referral capacity.
- Organize learning around practical presentations and clinical decisions, while retaining disease-specific content where required.
- Define observable learning outcomes and map them to competencies, authorized activities and assessment evidence.
- Use diverse and ethically governed clinical images and teaching cases, including common mimics and atypical presentations.
- Design for transfer to practice through simulation, supervised encounters, feedback, mentorship and job aids.
- Pilot with intended learners and revise using performance, usability, patient-safety and equity findings.

F.2 Minimum PHC curriculum blueprint

Countries may combine or subdivide modules, but the M1–M12 numbering below is intentionally identical to Section 9.3. Cross-cutting requirements in Section 9.6, including climate and occupational health, patient safety, life-course adaptation, allied workforce roles, faculty quality and visual-tool standards, should be integrated across the relevant modules rather than taught as optional add-ons.

Module	Minimum PHC learning outcomes	Minimum assessment evidence
M1. Integrated skin health, burden, rights, stigma and people-centred care	Explain the public health importance of skin diseases; apply person-centred, rights-based and non-discriminatory care; recognize links with disability, mental health, stigma and social participation.	Knowledge or case-based assessment plus observed communication behaviour.
M2. Skin structure, lesion description, distribution and assessment across skin tones	Take a focused history; conduct a safe and respectful examination; describe lesions, distribution and extent; examine hair, nails and mucosa when indicated; document findings across different skin tones.	Observed structured examination or simulation and lesion-description exercise.
M3. Common infectious and infestational skin conditions and antimicrobial stewardship	Recognize common infections and infestations and important mimics; manage authorized uncomplicated conditions; apply infection prevention and antimicrobial, antifungal and antiparasitic stewardship; recognize treatment failure.	Image-based cases, medicine-safety scenarios and observed or simulated management.
M4. Skin NTD recognition, reporting, referral and integrated care	Recognize nationally relevant skin NTDs; follow diagnostic, reporting, contact, treatment or referral protocols; support disability prevention, wound or lymphoedema care, stigma reduction and community follow-up.	Image and case-based assessment plus observed or simulated reporting and referral.
M5. Inflammatory, chronic and pigmentary conditions, comorbidities and self-management	Recognize common inflammatory, chronic and pigmentary presentations; assess impact and comorbidities; provide authorized treatment, counselling and self-management support; identify uncertainty and referral needs.	Case-management scenarios, observed counselling and follow-up planning.
M6. Wounds, ulcers, lymphoedema, disability prevention and rehabilitation	Assess wounds, ulcers and swelling; provide authorized wound and self-care; identify infection, ischemia, nerve impairment, disability and non-healing; coordinate rehabilitation and referral.	Practical wound-care station, structured case and referral assessment.
M7. Benign, pre-cancerous and malignant lesions and early referral	Differentiate common benign patterns from suspicious lesions; recognize malignancy indicators; document accurately; select priority or urgent referral and provide safety-netting.	Image-based assessment and referral decision scenario with critical criteria.

Module	Minimum PHC learning outcomes	Minimum assessment evidence
M8. Systemic, drug-related, severe and emergency presentations	Recognize severe drug reactions, skin failure, sepsis, rapidly spreading infection, major ocular or mucosal involvement and other nationally defined emergencies; stabilize within scope and activate immediate referral.	Safety-critical simulation or structured scenario with a separate mandatory pass standard.
M9. Diagnostics, specimens, medicines, infection prevention and laboratory pathways	Select and perform or arrange authorized tests; collect, label, package and transport specimens safely; interpret basic results; prescribe or administer medicines safely; use laboratory and dermatopathology referral pathways.	Observed or simulated specimen/medicine task, prescription audit and results-interpretation case.
M10. Communication, mental health, stigma reduction, counselling and self-care support	Explain diagnosis and treatment clearly; address misconceptions and stigma; support adherence and self-care; recognize distress; involve caregivers appropriately; use shared decision-making and referral for psychosocial care.	Observed counselling or role play and patient/caregiver feedback where feasible.
M11. Referral, counter-referral, teledermatology and clinical image governance	Select emergency, urgent, priority or routine referral; provide interim care; complete and track referral; use counter-referral; obtain consent and capture clinically useful images; formulate specialist requests; document and act on advice.	Referral and documentation audit plus image-capture or teleconsultation simulation.
M12. Recording, standardized terminology and coding, surveillance, outbreak response, data use and quality improvement	Record standardized clinical information; use national terminology and coding, including ICD-11 where implemented; notify reportable diseases; detect unusual clusters; protect data; use routine and referral data to improve care.	Record review, reporting exercise and a small quality-improvement task.

F.3 Instructional methods

Method	Required function
Guided image interpretation	Builds systematic observation, lesion description, pattern recognition and recognition across skin tones.
Case-based discussion	Develops differential diagnosis, uncertainty management, treatment choice, referral and ethical reasoning.
Simulation and skills stations	Practises focused examination, counselling, wound care, specimen handling, clinical photography, documentation and emergency response.
Supervised clinical encounters	Demonstrates transfer to real practice and allows direct feedback on performance and patient safety.
Job aids and decision-support tools	Reinforces correct action at the point of care and supports standardized management and referral.
Digital microlearning and refreshers	Supports spaced reinforcement, updates and access in low-bandwidth settings without replacing observed competency assessment.

F.4 Training package quality standards

Quality standard	Minimum verification
Technical accuracy	Content is consistent with current national and WHO guidance and has documented clinical review.
Competency alignment	Every module and assessment item maps to an approved competency and scope-of-practice decision.
Patient safety	Danger signs, contraindications, referral thresholds and limits of practice are explicit and assessed.
Equity and representation	Images, cases and language represent diverse skin tones, ages, sexes, disabilities and underserved settings without stigmatizing portrayals.
Educational quality	Materials use active learning, clear learning outcomes, realistic cases, feedback and valid assessment methods.
Usability and accessibility	Materials are understandable to the target cadre and available in appropriate languages, formats and low-bandwidth or offline options.

Quality standard	Minimum verification
Ethics, consent and privacy	Clinical images and cases have appropriate consent, governance, attribution and privacy protection.
Implementation support	Training is linked to medicines, diagnostics, job aids, supervision, referral and specialist support.
Version control and updating	Materials identify the responsible authority, approval status, version, review date and process for urgent updates.

F.5 Development, validation and rollout pathway

Phase	Core activities	Key output
1. Curriculum specification	Select target cadres; map competencies and scopes; classify conditions as manage, recognize/refer or urgent referral; define measurable outcomes.	Approved curriculum and assessment blueprint.
2. Content and tool development	Adapt existing materials; develop missing PHC content, cases, images, algorithms, facilitator guidance and assessments.	Draft integrated training package.
3. Technical and educational validation	Review with dermatology, PHC, nursing, NTD, pharmacy, rehabilitation, mental health, education and affected-person representatives.	Validated package ready for piloting.
4. Pilot and implementation research	Test in contrasting PHC settings; assess feasibility, learner performance, safety, referral quality, acceptability and equity.	Pilot report and revised package.
5. Accreditation and scale-up	Approve or accredit; prepare trainers and supervisors; integrate into pre-service, in-service and CPD systems; monitor competence and service results.	National implementation with continuous quality improvement.

Implementation rule
A training event should count toward GAP-SKIN competency implementation only when it uses an approved competency-based curriculum, includes appropriate assessment, records results, and is linked to supervision, mentorship or workplace verification. Attendance alone is insufficient.

Annex G. National dermatology specialist-development pathway and planning template

This annex supports countries with no dermatologist, or no sustainably accessible dermatologist, to move from interim specialist support to a regulated national specialist workforce. It should be completed jointly by the Ministry of Health, education and finance authorities, the professional regulator, training institutions, referral services and regional/international partners.

G.1 Country decision pathway

8. 1. Confirm whether the country has a nationally recognized dermatologist who is available for clinical governance, referral and training, not merely listed in a register.
9. 2. If no, activate an interim regional referral and teledermatology network and designate a national skin-health clinical lead.
10. 3. Approve a national workforce needs assessment, specialist scope and title, accreditation route, financing and retention plan.
11. 4. Confirm national recognition of the selected qualification, then sponsor an initial cohort of at least two trainees, or another justified size for a small state or pooled regional model, through an accredited regional, twinned or sandwich postgraduate programme.
12. 5. Establish a national specialist service and faculty base when the first cohort returns.
13. 6. Open a domestic or joint accredited programme only when the minimum conditions in Section 8.5.1 are met; otherwise maintain a durable regional training route.
14. 7. Monitor service access, referral outcomes, workforce retention, geographic distribution, training quality and succession.

G.2 National planning template

Planning field	Country specification
Current specialist availability and distribution	
Annual referral burden, priority conditions and service gaps	
Interim external referral and teledermatology partner(s)	
National clinical lead and accountable institution	
Protected specialist title, scope and regulator	
Recognized training route, regulator confirmation and partner institution(s)	
Justified first-cohort size and trainee profiles	
Financing, salary, tuition and return posts	
Retention, rural access and succession package	
National service site, diagnostics and multidisciplinary support	
Domestic programme readiness gaps and target date	
Monitoring milestones and review schedule	

G.3 Suggested milestone indicators

Milestone	Verification
M0: Interim access established	Signed referral/teledermatology agreement, response standards, named accountability and patient-transfer pathway.
M1: National plan approved	Costed plan, regulatory decision, candidate selection criteria, financing and retention package.

Milestone	Verification
M2: First cohort in training	At least two funded trainees, or another nationally justified cohort size, in recognized postgraduate programmes with documented supervision, regulatory recognition and return posts.
M3: National service functioning	Returning specialists appointed; referral service, multidisciplinary links, outreach and data system operational.
M4: Programme readiness confirmed	Independent review confirms governance, curriculum, faculty, case volume, resources, assessment and quality systems.
M5: Sustainable pipeline	Accredited domestic/joint programme or durable regional route, regular intake, CPD, retention and succession monitoring.

References

1. World Health Organization. WHA78.15. Skin diseases as a global public health priority. Seventy-eighth World Health Assembly, 27 May 2025. Geneva: WHO; 2025.

2. World Health Organization. Global Action Plan on Skin Diseases 2026–2035: Skin Health for All. Draft for review/public consultation. Geneva: WHO; 2026.

3. World Health Organization. Global Competency and Outcomes Framework for Universal Health Coverage. Geneva: WHO; 2022. ISBN 978-92-4-003466-2.

4. World Health Organization. Global Competency Framework for Universal Health Coverage. Geneva: WHO; 2022. ISBN 978-92-4-003468-6.

5. World Health Organization. Rehabilitation Competency Framework. Geneva: WHO; 2021. ISBN 978-92-4-000828-1.

6. World Health Organization. Adapting the WHO Rehabilitation Competency Framework to a specific context. Geneva: WHO; 2021. ISBN 978-92-4-001533-3.

7. World Health Organization. Using a contextualized competency framework to develop rehabilitation programmes and their curricula. Geneva: WHO; 2021. ISBN 978-92-4-001657-6.

8. World Health Organization. Ending the neglect to attain the Sustainable Development Goals: a strategic framework for integrated control and management of skin-related neglected tropical diseases. Geneva: WHO; 2022. ISBN 978-92-4-005142-3.

9. World Health Organization. Recognizing neglected tropical diseases through changes on the skin: a training guide for front-line health workers. Geneva: WHO; 2018. ISBN 978-92-4-151353-1.

10. World Health Organization. Self-care competency framework, volume 1: global competency standards for health and care workers to support people's self-care. Geneva: WHO; 2023. ISBN 978-92-4-007742-3.

11. World Health Organization. Global curriculum guide for community health workers. Geneva: WHO; 2025. ISBN 978-924-0-11806-5.

12. International League of Dermatological Societies. ILDS Skin Health Training Hub. Accessed 20 July 2026.

13. British Dermatological Nursing Group. Dermatology Nursing Competencies: Developing dermatology nurses from novice to expert. London: BDNG; 2012.

14. Royal College of General Practitioners, British Association of Dermatologists and Primary Care Dermatology Society. Guidance and Competences for GPwERs: Dermatology and Skin Surgery. Version 1.1. London: RCGP; 2024.

15. Mahé A, Faye O, N'Diaye HT, Konaré HD, Coulibaly I, Kéita S, Traoré AK, Hay RJ. Integration of basic dermatological care into primary health care services in Mali. Bull World Health Organ. 2005;83(12):935–941.

16. Faye O, Bagayoko CO, Dicko A, Cissé L, Berthé S, Traoré B, et al. A teledermatology pilot programme for the management of skin diseases in primary health care centres: experiences from a resource-limited country (Mali, West Africa). Trop Med Infect Dis. 2018;3(3):88. doi:10.3390/tropicalmed3030088.

17. Global Action Plan on Skin Diseases (GAP-SKIN) 2026–2035. Compendium of Indicators for Monitoring and Evaluating Progress. Pre-publication draft for technical consultation. Version 0.4; 10 July 2026. Internal working document; not official WHO guidance.

18. Classification of Common Skin Diseases for Management or Referral at Primary Health Care Level. WHO-aligned guidance with ICD-11 MMS codes, release 2026-01. Version 1.0; 2026. Technical review draft.

19. World Health Organization. Transforming and scaling up health professionals' education and training: World Health Organization guidelines 2013. Geneva: WHO; 2013. ISBN 978-92-4-150650-2.

20. World Health Organization. Global strategy on human resources for health: Workforce 2030. Geneva: WHO; 2016. ISBN 978-92-4-151113-1.

21. World Health Organization. Report of the first WHO global meeting on skin-related neglected tropical diseases, Geneva, Switzerland, 27-31 March 2023. Geneva: WHO; 2024. ISBN 978-92-4-009133-7.

22. International League of Dermatological Societies. Regional Dermatology Training Centre, Moshi, Tanzania: supra-regional training, research and clinical centre. Accessed 20 July 2026.

23. World Health Organization. Global patient safety action plan 2021-2030: towards eliminating avoidable harm in health care. Geneva: WHO; 2021. ISBN 978-92-4-003270-5.

24. World Health Organization. Ethics and governance of artificial intelligence for health: WHO guidance. Geneva: WHO; 2021. ISBN 978-92-4-002920-0.

25. World Health Organization. WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas. Geneva: WHO; 2021. ISBN 978-92-4-002422-9.

26. World Federation for Medical Education. WFME Global Standards for Quality Improvement: Postgraduate Medical Education. 2023 edition. Copenhagen: WFME; 2023.

27. World Health Organization. WHO Academy. Geneva: World Health Organization. Available from: https://www.whoacademy.org/. Accessed 21 July 2026.

Interpretation note
This framework is a policy and competency system model. National clinical guidance must determine condition-specific diagnosis, treatment, medicines, procedures and referral thresholds. All consultation-draft GAP-SKIN content should be updated when the final global action plan and implementation guidance are adopted.