Disaster Medicine and Public Health Preparedness

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Research Letters

Cite this article: Fernández Camporro Á and Arcos González P (2026). Skin Diseases: The Forgotten Problem in Complex Humanitarian Emergencies. *Disaster Medicine and Public Health Preparedness*, **20**, e37, 1–2
https://doi.org/10.1017/dmp.2025.10282

Received: 19 November 2022
Revised: 23 November 2024
Accepted: 15 October 2025

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Skin Diseases: The Forgotten Problem in Complex Humanitarian Emergencies

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Introduction

One of the most relevant types of human-made disasters, due to its intense and long-lasting effects on health, is the so-called Complex Emergency (CE) or Complex Humanitarian Emergency, defined since the early 1990s as "a relatively acute situation affecting a large civilian population, usually involving a combination of a situation of war or massive civil disturbance, food insecurity or shortage, and population displacement, resulting in a significant increase in mortality."[1]

Skin diseases are the fourth most common cause of all human disease, affecting almost one-third of the world's population, and thanks to extensive epidemiological research on the subject, their morbidity, mortality, and impact are well known in the general population.[2]

However, the interest in the research of skin diseases among populations facing CE or disasters is scarce, and there are a limited number of studies on the prevalence and characterization of those diseases in specific contexts.[3–5]

Methods

We conducted a narrative synthesis of peer-reviewed studies addressing skin diseases in displaced or crisis-affected populations within CEs or disaster contexts. Sources included epidemiologic studies, outbreak reports, and field assessments focusing on refugee camps, internally displaced persons (IDPs), or populations affected by natural disasters.

Results

Research on skin diseases in CE and disasters shows a notable heterogeneity, both in their epidemiological designs, the sizes of the population samples used, as well as in the classification of skin diseases used. Many of these studies focus only on one type of disease that occurred in a particular disaster (often floods), and, in general, the epidemiological information provided is fragmented and very limited. All these circumstances make it difficult to compare results between different studies and to approach the real incidence, prevalence, and impact of skin diseases in populations affected by disasters and CE.

Discussion

Not only from the research point of view, but also from the perspective of health care for populations in CE, it can be said that skin diseases have traditionally been overlooked when establishing health care priorities in these crisis situations. This assignment of a priority only secondary is probably because the main priorities for health intervention in a complex humanitarian emergency are given to those disease processes that cause high mortality among the population and that must be controlled as quickly as possible, particularly during the acute phase of a CE when crude mortality rate is above 2 per 10,000 affected per day.[6]

In a reasonable manner, in CE, the main interest is focused on diseases or problems that can cause short-term mortality, for example, acute waterborne or airborne diseases, particularly certain types of communicable diseases that have the capacity to cause outbreaks that are difficult to control, for example, measles. But CE are crises that tend to become chronic, and in this second phase, the health situation is different.

The lack of interest can be easily verified by examining the few references to the approach to these skin diseases in the various intervention manuals of humanitarian agencies[7] as well as in the published literature. However, these diseases are especially present in CE with population displacement and settlement in refugee camps with precarious hygienic-sanitary conditions or water shortages, and in the cases of specific disasters like floods.[8,9]

Skin diseases were relevant in CE with population displacement and settlement in refugee camps[10] such as the cases of Dadaab Refugee Camp (Kenya), established in 1991 and housed more than 500,000 refugees, the Cox's Bazar Refugee Camp (Bangladesh), also from 1991, with

more than 1 million refugees, mainly from the Rohingya community, and the Zaatari Refugee Camp (Jordan) from 2012 came to house more than 150,000 people.

There is a clear need to conduct higher-quality studies in complex emergency contexts in order to obtain a good estimate of the prevalence and real impact of these diseases. For a better characterization of the problem as well as for a better comparability of the data, we highlight the importance of homogenizing the epidemiological designs in studies with similar characteristics. The joint work between dermatologists and epidemiologists will be essential for a better understanding of the role of skin diseases in disasters and CEs.

Author contribution. A.F.C.—Conceptualized the work, reviewed the evidence, and drafted the manuscript.

P.A.G.—Contributed to the design, interpretation of findings, and critical manuscript revision.

Both authors approved the final version.

Competing interests. None.

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https://doi.org/10.1017/dmp.2025.10282 Published online by Cambridge University Press