

Optimising pharmaceutical care for dermatological presentations in community pharmacy practice

FIP Multinational Needs Assessment Programme (MNAP)

2026



International
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Federation

Colophon

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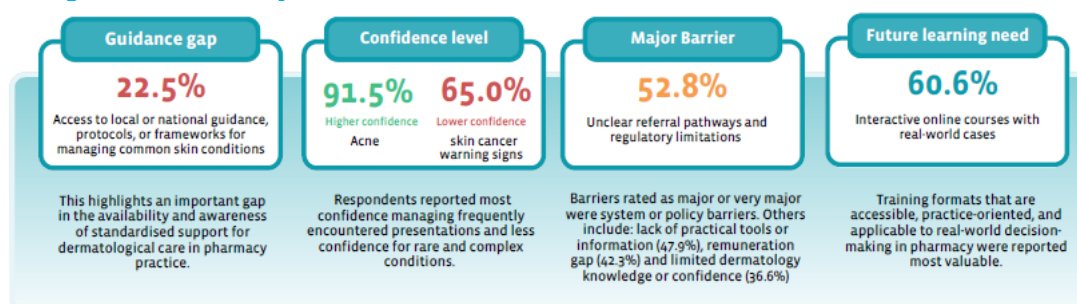


Executive summary

Dermatological presentations are commonly encountered in community pharmacy practice, where pharmacists are often among the most accessible health professionals for people seeking advice, self-care support and referral when needed.¹ This places pharmacists in a key position to support self-care, provide practical guidance, recognise warning signs, and refer when needed.

This report presents findings from the FIP Multinational Needs Assessment Programme (MNAP), based on a global survey and an accompanying insight board. It provides a high-level overview of dermatology-related practice in community pharmacy, identifies key gaps, and highlights priorities for future development. The survey received 409 responses, of which 142 eligible completed responses from 51 countries were included in the final analysis.

Key findings from the survey



The survey findings suggest that **dermatological care** is a routine part of pharmacy practice for many respondents. Overall, 85.9% of respondents reported dealing with dermatological queries daily or a few times a week. Within this respondent sample, the dermatological presentations most commonly encountered in routine practice were sensitive or reactive skin (n=99, 69.7%), acne (n=91, 64.1%), atopic dermatitis or eczema (n=90, 63.4%), skin infections or infestations (n=89, 62.7%), and scalp or hair concerns (n=86, 60.6%). These findings should be interpreted as reported practice experiences from respondents, not as estimates of population prevalence or disease frequency.

Respondents generally reported stronger confidence in supporting dermatological presentations commonly managed in pharmacy practice. Positive confidence, defined as being very confident or somewhat confident, was highest for **acne** (n=130, 91.5%), scalp and hair concerns (n=129, 91.5%), **atopic dermatitis** or **eczema** (n=128, 90.1%), baby or young child concerns (n=125, 89.9%), and sun-related concerns (n=123, 89.8%). By contrast, lower confidence was most evident for possible skin cancer warning signs (n=67, 65.0%), **cancer treatment skin side effects** (n=56, 49.1%), psoriasis (n=57, 41.3%), and rosacea (n=46, 34.1%). This suggests that respondents felt more assured when supporting familiar and frequently presented concerns, but less confident when supporting presentations that may be higher risk, more clinically complex, or require clearer referral pathways.

The condition-specific findings reinforce this picture. For acne, respondents reported high confidence across most tasks, especially assessing severity and deciding when to refer (92.9%), providing skincare support alongside acne treatment (89.4%), discussing antibiotic stewardship (88%), and supporting adherence (85.9%). The main reported weakness was differential diagnosis, with 37.3% not feeling confident. For eczema, respondents felt least challenged by supporting long-term self-management with emollients and addressing patient concerns about topical corticosteroids, but 59.2% found differentiating eczema from other **inflammatory skin conditions** challenging, and 48.6% found identifying red flags for referral more challenging.

For **sun protection and skin cancer prevention**, reported practice was mixed. For example, 43.1% mainly responded when patients asked, while 40.1% proactively initiated conversations with at-risk patients. Familiarity with suspicious **skin lesion** recognition tools was limited, with only 29.9% both knowing the tools and feeling confident using them, while 38.0% were aware of such tools but not confident and 32.1% were not

familiar with any. At the same time, willingness to take a more proactive role was high, with 81.0% clearly interested and 16.8% conditionally willing if training and support were available.

For oncology-related skin related side effects, willingness to support patients was strong, and the most common forms of support were recommending supportive skin products (58.5%), advising on dry skin, irritation, or rash (51.4%), and advising on sun protection and photosensitivity (50.7%). For medicine-related skin reactions, the most common actions were checking medicine and information sources for known reactions (72.5%), providing symptom relief and skin care advice (52.8%), and advising timely medical review (46.5%). Most respondents found pharmacovigilance reporting easy (n=86, 63.2%), but 28.7% found it difficult and 8.1% were unaware of how to report or did not know such a system existed. For wound care and skin barrier repair, confidence was generally high across key tasks. Respondents reported the greatest confidence in selecting appropriate over-the-counter products (92.9%) and advising on basic wound or skin barrier care (90.7%). Confidence was slightly lower for assessing severity and identifying red flags (82.1%) and counselling on follow-up and healing timelines (78.6%). The lowest confidence was reported for post-procedure supportive care (75.7%).

The survey also highlights structural constraints that may limit the full contribution of pharmacists to dermatological care. Only 22.5% of respondents (n=32) reported access to local or national guidance, protocols, or frameworks for managing common dermatological concerns in practice. Many respondents reported that pharmacists in their setting do not currently have authority to initiate or adapt treatment for common dermatological concerns (n=85, 59.9%), that no structured skin condition services are currently available in practice (n=74, 52.1%), and that pharmacists do not receive additional remuneration for dermatology-related care (n=126, 88.7%). Taken together, these findings suggest that respondents are supporting patients with dermatological concerns in routine practice, but often without the authority, service structures, decision support, or funding arrangements needed for more consistent and sustainable models of care.

Education and training emerged as a clear priority. Respondents most commonly reported receiving dermatology-related education or training through short workshops or webinars (n=81, 57.0%), undergraduate pharmacy education (n=78, 54.9%), and training delivered by manufacturers or industry (n=78, 54.9%). Preferred future formats were strongly practice-oriented, led by interactive online courses using real-world cases and decision scenarios (n=86, 60.6%) and short online modules or videos that can be completed in small blocks (n=76, 53.5%).

Referral findings also showed that most respondents felt clear about when to manage and when to refer, but referral pathways were often inconsistent; referral mechanisms were often informal; and post-referral feedback remained limited.

The strongest barriers reported by respondents were system or policy barriers, lack of remuneration, limited practical tools or information, and constraints related to time and private consultation space. The most valued supports were practical dermatology training using real-life cases, stronger collaboration with other health professionals, treatment selection guidance, guidance on medicine-related skin reactions, and decision-support tools such as algorithms and flowcharts.

Key findings from the insight board

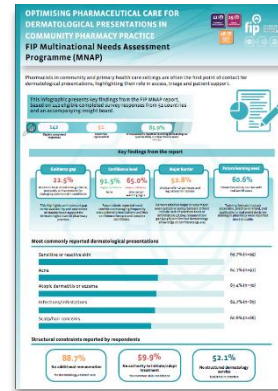
Findings from the insight board reinforced and deepened the survey results. Participants highlighted the need to strengthen practical competencies in dermatology, especially differential recognition, triage, referral decision-making, topical treatment literacy, patient counselling, and culturally responsive communication. They also emphasised the value of structured collaboration with dermatologists, general practitioners, and other health professionals, alongside clearer protocols, stronger training pathways, and more formal recognition of pharmacists' contribution to skin health. Across different regions, participants viewed dermatology not necessarily as a fully separate speciality, but as an increasingly important area of advanced competency within pharmacy practice.

Overall implications

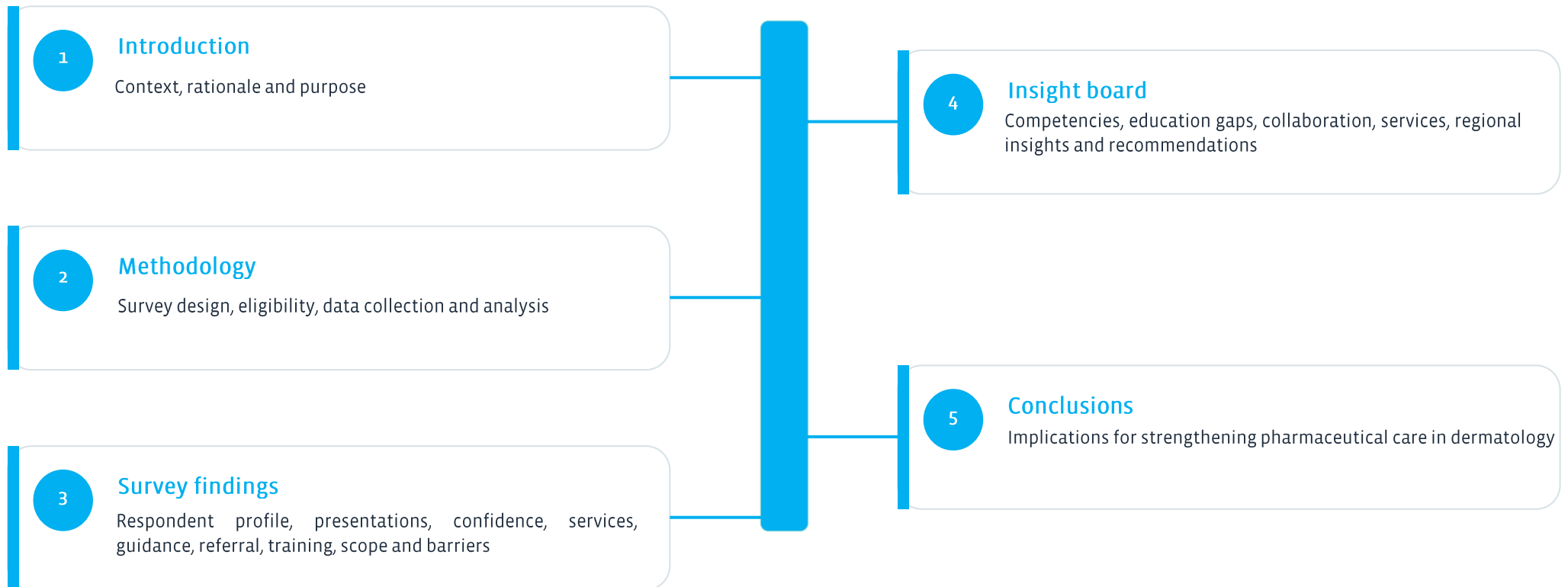
Overall, this report shows that respondents are already contributing to dermatological care in community pharmacy practice and primary healthcare settings, but that their role is shaped and often limited by education gaps, lack of structured guidance, uneven scope of practice, limited service infrastructure, and lack

of remuneration. Strengthening pharmaceutical care for dermatological presentations will therefore require action across multiple levels: more practical and case-based training, clearer tools and referral pathways, better integration within primary care and multidisciplinary systems, and enabling policy and funding frameworks.

This report is accompanied by an infographic summarising the key results, which can be accessed [here](#).



How the report is structured



1 Introduction

Beyond physical protection, the skin influences overall health, emotional well-being, and social interactions. Dermatological disorders are among the most prevalent health problems globally; a fact recognised by the World Health Organization (WHO) as a global health priority at the 78th World Health Assembly in May 2025.² They affect millions of people and carry significant economic weight alongside profound negative physical, psychological, and impaired quality of life for the patients; conditions such as atopic dermatitis, acne vulgaris, psoriasis, skin infections, and skin cancer impose a significant economic burden while negatively impacting patients' physical and psychological well-being.^{3, 4} Depression, anxiety, and stress are the most commonly associated mental health consequences.⁵ Despite being a health priority, dermatological care is scarce in certain regions.

Over the past two decades, community pharmacists have shifted their professional role from being focused on dispensing medicines to a more integrated role in disease management and delivery of patient-centred care.⁶ Within this context, skin conditions represent a significant proportion of consultations in community pharmacy settings.

Atopic dermatitis, also known as eczema, is one of the most commonly reported conditions in community pharmacies.³ This chronic inflammatory skin condition, characterised by itchy, erythematous lesions, affects 15–20% of people in developed countries, with onset frequently occurring in infants under six months, and persisting into adulthood in 10–30% of cases.⁷ Beyond physical symptoms, patients—particularly young adults—experience significant psychological and social consequences, including bullying, social isolation, stress, and anxiety, contributing to financial burden and reduced quality of life.

Acne vulgaris is a chronic inflammatory skin disease, particularly in areas of rich sebaceous gland distribution.³ The majority of patients are young, with 67.6% found in the age group of 18 to 29 years.⁸ At a global scale, adult acne alone affects hundreds of millions of people worldwide; the Global Burden of Disease Study 2019 estimated approximately 231 million prevalent cases and 117 million new cases each year.² The disease burden demonstrates significant heterogeneity across regions and genders, with greater severity in underdeveloped areas and among females.^{7, 9} Key aetiological factors include hormonal factors (82.7%), followed by bacteria (81.5%), stress (62.9%), and cosmetics (35.4%).¹⁰ In addition, dietary factors have also been implicated, with dairy consumption, sweets, chocolate, and oily food all being significantly associated with the presence of acne vulgaris. Beyond the physical dimension, most acne patients also suffer from low self-esteem, social withdrawal, and depression.¹¹

Psoriasis, also known as chronic plaque psoriasis, has been described as a relapsing chronic inflammatory skin disease and one of the most common reasons for dermatological hospital visits.¹² While affecting 0.5–11.4% of the population worldwide with two incidence peaks, one in early adulthood and another around 60 years of age,¹³ chronic stress experience and burnout syndrome have an appreciable influence on the health-related quality of life in patients and the therapeutic efficacy of treatments for it.¹² Furthermore, skin cancer, the most common cancer worldwide, and other skin reactions reduce patients' quality of life and may even require treatment changes where necessary.¹⁴

Treatment adherence remains a consistent challenge to effective management, influenced by limited disease understanding, forgetfulness, inconvenience, concerns about adverse effects, and the practical challenges of applying topical medications correctly.^{7, 9, 15–17} Self-treatment with topical antibiotics, use of complementary and alternative medicine (CAM), and self-searching for treatment on the internet are widespread.¹⁸ Misconceptions about sunscreen are common, and the rate of proper application is low, as seen in an Italian study.¹⁹ To address these, pharmacists hold a distinct and evidence-based advantage, positioned at the intersection of medication access, patient education, and ongoing monitoring.

As frontline healthcare providers, pharmacists are often consulted for dermatological concerns, to provide advice on over-the-counter treatments, offer guidance on skin care, and act as triage and referral points when necessary. They play a vital role in the management of skin diseases and contribute to improved patient outcomes through their expertise in medication management, independent prescribing, patient education and treatment monitoring, and connecting patients with relevant patient support organisations.^{3, 7, 15, 17, 20–24} Nevertheless, individual and systemic barriers continue to limit the extent to which pharmacists can operate effectively in this domain.

At the individual level, these barriers include the inability to provide a differential diagnosis, uncertainty about referrals, difficulties with the availability of over-the-counter treatment options, corticosteroid phobia, challenges in selecting the most appropriate treatment, and difficulties related to patient consultation, particularly time constraints and limited dermatological knowledge.^{3, 25} At the systemic level, barriers included weak communication and collaboration between pharmacists and other healthcare professionals, and different guidelines adopted across professions with no synchronised approach.⁷ The specialist pharmacist's role in dermatology remains nascent compared to established pharmacy specialities such as renal and oncology pharmacy.²² Consequently, there is a notable gap for pharmacists to establish specialised services, including a lack of specific board certifications and tailored training pathways.²⁶ Furthermore, supply chain issues such as shortages and discontinuations of topical medicines present additional operational challenges that constrain the pharmacist's capacity to deliver consistent, effective care.²²

Despite these challenges, community pharmacists are well-positioned to contribute to more accessible patient-centred dermatological care, particularly in underserved communities.⁹ This report provides a global overview of the current role of pharmacy in the management of common dermatological presentations, with a focus on community pharmacy and related primary health care settings. It brings together findings on consultation patterns, confidence, service provision, education and training, referral pathways, scope of practice, and barriers and support needs, in order to identify priorities for strengthening pharmacist-supported dermatological care.

The report is informed by a mixed-methods approach, combining a global survey of individuals working in eligible pharmacy settings with an insight board involving invited experts and representatives from multiple countries. Together, these data provide an initial high-level picture of current dermatology-related practice in pharmacy and help identify areas for future development, guidance, and policy attention.

2 Methodology

Figure 1 presents the MNAP process used to develop the report.

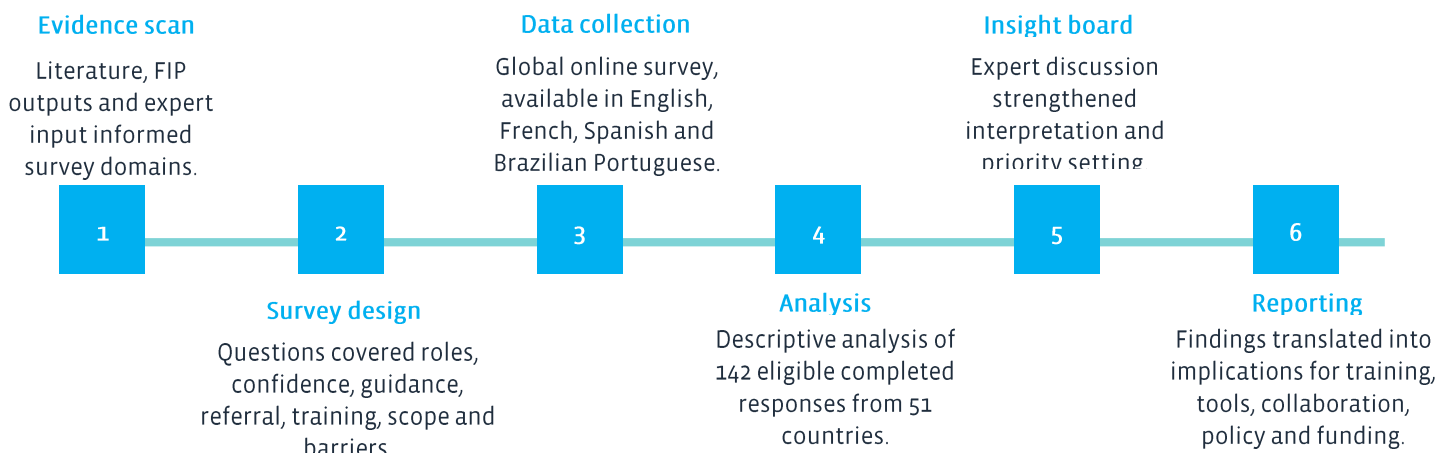


Figure 1: Data collection and reporting flow

2.1 Methods overview

This study employed a cross-sectional, global needs assessment survey design to explore the role of individuals working in community pharmacy and primary health care (PHC) pharmacy settings in managing common dermatological presentations.

The study aimed to generate practice-informed, descriptive evidence on:

1. Current roles and services in dermatological care
2. Pharmacists' confidence and clinical decision-making
3. Referral practices and system integration
4. Education, training, and scope of practice
5. Key barriers, enablers, and priority support needs.

The wider project also incorporated a global insight board, delivered on 25 March 2026, titled *Pharmacists in dermatology: Advancing skin health for all*. The session built on emerging evidence and initial survey findings, while gathering expert perspectives to support interpretation and identify priority areas for future analysis and reporting.

This combined approach supported the development of a broader intelligence base for future outputs in this area. The results of the insight board are highlighted alongside survey findings in this report.

2.2 Survey development

The survey instrument was developed through a structured, multi-step process, beginning with a gap analysis of the literature and existing evidence base.

A targeted desk review of published studies, relevant FIP outputs, and expert discussions was undertaken to identify common dermatological presentations in pharmacy practice, key gaps in training and practice support, and priority topics relevant to PHC delivery. These findings informed the selection of survey domains, which included consultation frequency and case mix, current pharmacy roles and services, use of guidance

and tools, condition-specific confidence and challenges, referral and decision-making pathways, education and training, scope of practice, remuneration, barriers, and support needs.

The draft survey was iteratively refined through internal review and expert input to ensure clarity, relevance to practice, and feasibility of completion. The final instrument was structured to reflect practical decision-making pathways within routine care.

2.3 Study population and eligibility

The target population comprised individuals working in community pharmacy and related PHC pharmacy settings, where pharmacists are involved in the management of common dermatological concerns as part of routine care.

Eligible participants included respondents working in:

- Community pharmacies (independent and chain/corporate settings)
- Primary care clinic or medical centre pharmacies
- Hospital outpatient pharmacy settings.

Eligibility was determined through a screening question at the start of the survey. Only respondents currently practising in community pharmacy or PHC environments were included in the analysis.

2.4 Data collection

Data was collected electronically using an online survey platform over a defined data collection period from 04 March to 10 April 2026.

A convenience sampling approach was used for global dissemination. The survey was distributed through:

- Direct dissemination to individual members of the FIP Community Pharmacy Section (CPS)
- Sharing through FIP Member Organisations (MOs) for onward distribution within national networks
- Broader circulation via FIP communication channels, including newsletters and social media.

To support global participation, the survey was available in English, French, Latin American Spanish, and Brazilian Portuguese.

The survey was designed to take approximately 15–20 minutes to complete. Participation was voluntary, and no incentives were provided. Responses were collected anonymously, stored securely in accordance with FIP data governance policies, and analysed in aggregate form.

In parallel, the project team convened the dermatology insight board on 25 March 2026, involving invited experts from multiple countries. The session was recorded to support analysis and the development of an outcomes report, and drew on a snapshot of preliminary survey findings while data collection was ongoing.

2.5 Data analysis

Data analysis was conducted at a high level in April 2026 following closure of the survey. Further detailed analyses will continue through June 2026 to support additional outputs and publications.

Survey responses were cleaned and validated prior to analysis. Data were analysed using descriptive statistical methods to summarise responses and identify global patterns.

Analysis focused on:

1. Dermatological consultation patterns and case-mix
2. Pharmacists' roles and services
3. Confidence and clinical challenges

4. Use of guidance and tools
5. Referral pathways and decision-making
6. Education, training, and scope of practice
7. Barriers, enablers, and priority support needs.

Insights generated through the 25 March 2026 insight board were also reviewed at a high level to support interpretation of findings and identify emerging priority themes.

2.6 Scope of reporting

This report presents high-level global findings intended to provide an initial overview of current practices, challenges, and needs. Findings from the insight board are also highlighted to complement survey results and provide additional expert perspectives.

Further in-depth analyses, including more detailed subgroup exploration and thematic synthesis, will be presented in subsequent publications and outputs.

All analyses were conducted at an aggregate level, and no individual respondents were identifiable.

3 Survey findings: A global snapshot of dermatology practice in pharmacy

This chapter presents a high-level overview of findings from the global survey, providing an initial snapshot of current practices, experiences and perspectives related to dermatological care in community pharmacy and primary health care (PHC) settings. The results are structured around the main thematic domains covered by the survey.

3.1 Respondent characteristics

A total of 409 responses were received. Following the initial screening question, 62 responses were excluded because respondents did not currently practise in a community pharmacy or primary health care setting. The findings presented in this report are based on 142 eligible completed responses.

Practice setting

As shown in Figure 2, most respondents practised in community pharmacy settings (n=126, 88.7%), including independent pharmacies (n=79, 55.6%), and chain or corporate pharmacies (n=47, 33.1%). Smaller proportions were based in primary care clinics or medical centre pharmacies (n=7, 4.9%), and hospital outpatient pharmacies (n=5, 3.5%). Four respondents selected “other”, including consultation services, pharmacy association roles, and training-related roles. Overall, the findings are therefore primarily reflective of frontline community pharmacy practice.

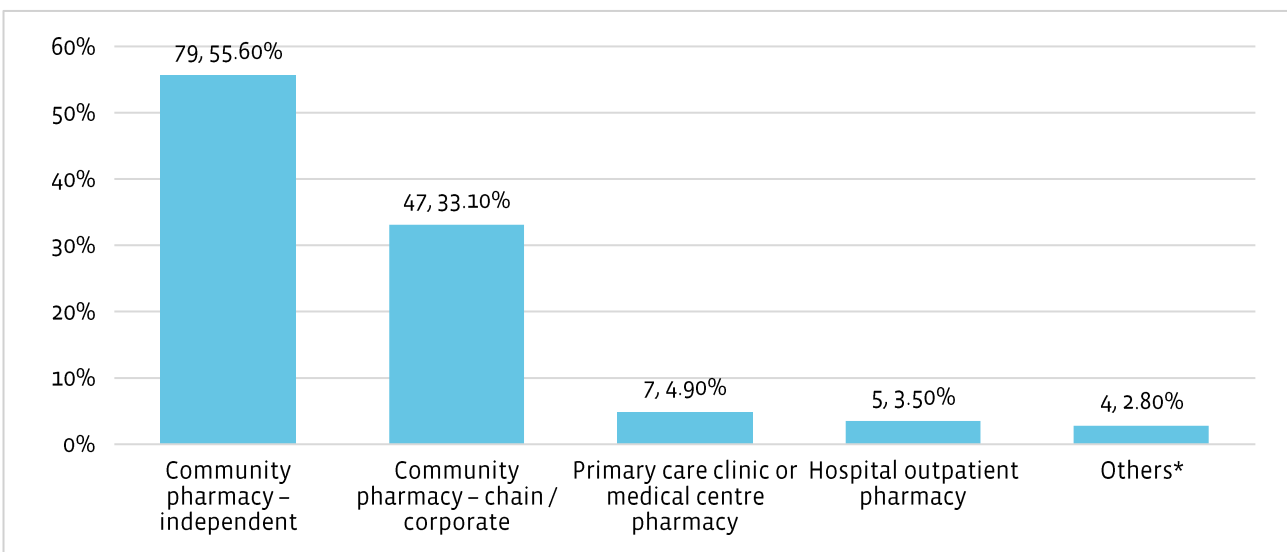


Figure 2: Distribution of respondents by practice setting (n=142)

Geographic distribution

Respondents represented 51 countries across multiple world regions, reflecting a broad distribution of perspectives and practice environments. The highest numbers of responses were reported from Argentina (n=14), followed by Chile and India (n=11 each), and Costa Rica and Croatia (n=9 each). Table 1 presents the distribution of respondents by country and region (n=142).

Table 1: Distribution of respondents by country and region (n=142)

Region	Countries	Response rate (n, %)
Africa	Botswana, Congo (DRC), Ghana, Madagascar, Malawi, Nigeria, South Africa, Tanzania, Zambia, Zimbabwe	25, 17.6%
Americas	Argentina, Brazil, Canada, Chile, Costa Rica, Ecuador, Guyana, Panama, Peru, Trinidad & Tobago, USA, Uruguay	48, 33.8%
Eastern Mediterranean	Jordan, Lebanon, Pakistan, Sudan, United Arab Emirates, Yemen	7, 4.9%
European	Andorra, Armenia, Azerbaijan, Bosnia & Herzegovina, Croatia, Denmark, France, Greece, Israel, Malta, Montenegro, Netherlands, Portugal, Serbia, Spain, Turkey, Ukraine	38, 28.2%
South-East Asia	India, Myanmar	12, 8.5%
Western pacific	Fiji, Korea (Rep.), Philippines, Singapore	10, 7.0%

Practice location

Respondents practised across a range of locations, including urban or metropolitan areas (n=81, 57.0%), semi-urban or town settings (n=50, 35.2%), and rural or remote areas (n=11, 7.7%). This distribution indicates that the survey captured perspectives from varied service delivery environments, with potential implications for access to dermatological care and referral support.

Professional roles

A range of professional roles was represented. Most respondents identified as pharmacy managers or owners (n=65, 45.8%), followed by community pharmacists working in staff or employed roles (n=60, 42.3%) and pharmacists working in primary care or clinical roles (n=9, 6.3%). Smaller proportions included trainees and pharmacy technicians.

Years of experience

Reported experience ranged from 0.5 to 50 years. The largest group had more than 11 years of professional experience (n=74, 52.1%), followed by those with 6 to 10 years (n=30, 21.1%), 0 to 2 years (n=20, 14.1%), and 3 to 5 years (n=18, 12.7%). The median respondents' years of professional experience was 12 years, with an interquartile range of 18 years (Q1: 5.0; Q3: 23.0), and the mean was 15.4 years. This suggests that the survey captured perspectives from both early-career and more experienced practitioners.

As shown in Figure 3, skin-related queries were a routine part of pharmacy practice. Overall, 44.4% of respondents (n=63) reported dealing with such queries very often (on a daily basis), while a further 41.5% (n=59) reported doing so often (a few times a week). Taken together, 85.9% of respondents (n=122) encountered skin-related consultations at least weekly, confirming that dermatological concerns form a regular part of frontline pharmacy practice. Only a small minority reported encountering such concerns less than once a week, and fewer than 1% indicated that they could not estimate the frequency.

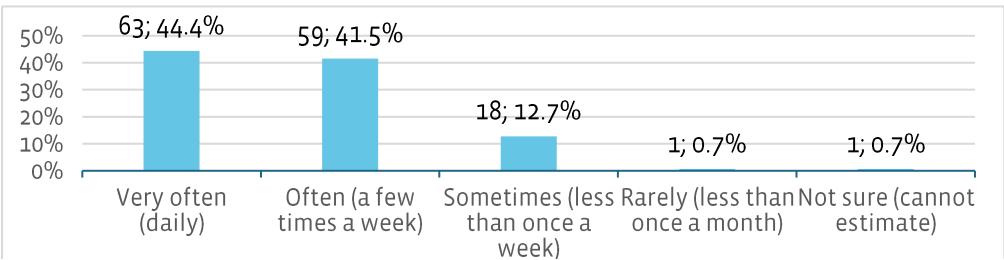


Figure 3: Frequency of skin-related queries encountered in pharmacy practice (n=142)

3.2 Consultations on practice

Respondents reported encountering a broad range of dermatological concerns and conditions in routine practice. As shown in Figure 4, when daily and weekly frequency are viewed together, the concerns most commonly encountered as part of routine practice were sensitive or reactive skin (n=99, 69.7%), acne (n=91, 64.1%), atopic dermatitis or eczema (n=90, 63.4%), skin infections or infestations (n=89, 62.7%), and scalp or hair concerns (n=86, 60.6%). Baby or young child dermatological concerns (n=82, 57.7%), minor wounds and skin barrier damage (n=79, 55.6%), ageing-related dermatological concerns (n=71, 50.0%), and sun-related concerns (n=71, 50.0%) were also commonly reported.

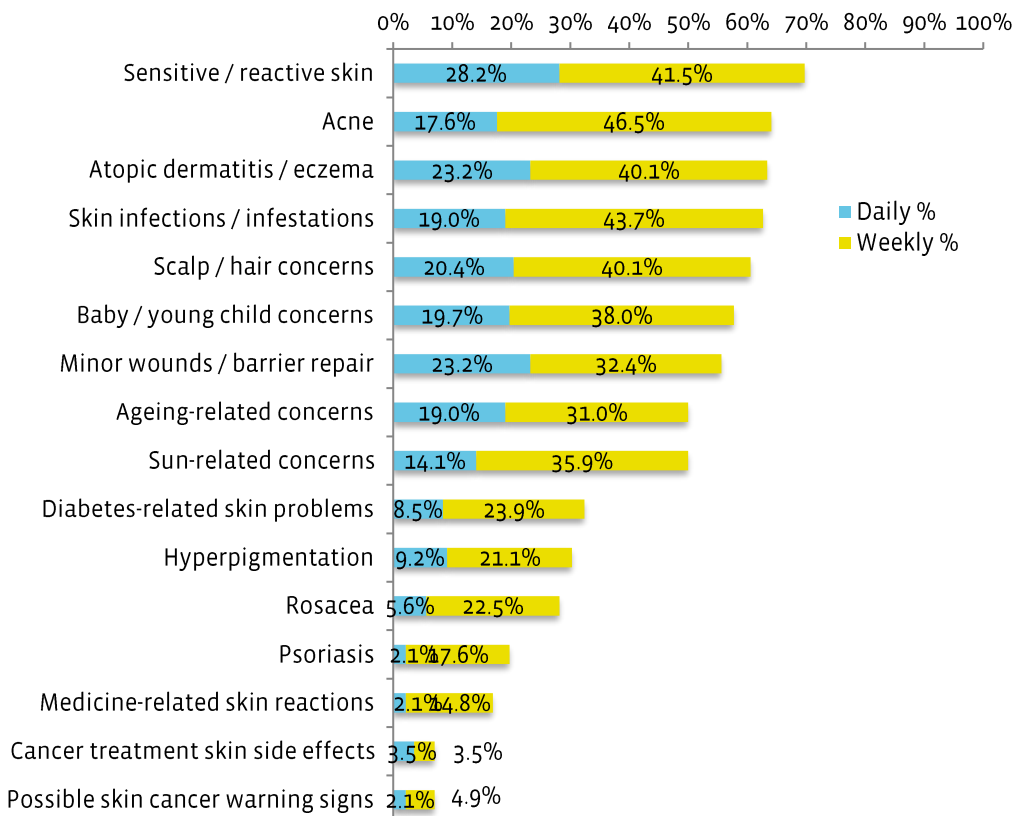


Figure 4: Skin concerns and conditions most encountered in practice, shown separately as very often (daily) and often (a few times a week) (n=142).

At the other end of the spectrum, some conditions were less commonly reported as part of frequent routine practice. These included psoriasis (n=28, 19.7%), suspected medicine-related skin reactions (n=24, 16.9%), skin side effects of cancer treatment (n=10, 7.0%), and possible skin cancer warning signs (n=10, 7.0%). Although encountered less often, these concerns remain important because they may require stronger assessment skills, clearer referral threshold and greater professional confidence.

Some conditions, including hyperpigmentation, rosacea, diabetes-related skin problems and psoriasis, were more often encountered sometimes or rarely rather than as part of the core weekly workload.

Overall, these findings highlight the dual nature of dermatological consultations in pharmacy. On one hand, pharmacists are routinely exposed to common and often manageable concerns such as acne, eczema, sensitive skin, and minor wounds. On the other hand, they are also expected to recognise and respond appropriately to less frequent but more complex or potentially serious presentations. This makes it important to understand not only what pharmacists encounter, but also how confident they feel in managing these concerns, which is explored in the following section.

3.3 Confidence in managing skin conditions

Confidence was assessed only for conditions that respondents had reported encountering in pharmacy practice in the preceding question, and therefore the valid n varied across items.

As shown in Figure 5, respondents reported high levels of confidence in managing several common dermatological presentations. Positive confidence, defined as respondents reporting that they were very confident or somewhat confident, was highest for acne (n=130, 91.5%), scalp and hair concerns (n=129, 91.5%), atopic dermatitis or eczema (n=128, 90.1%), baby or young child concerns (n=125, 89.9%), and sun-related concerns (n=123, 89.8%). Taken together, this pattern suggests that pharmacists felt most confident managing common, visible and frequently encountered presentations linked to self-care advice, symptom recognition and routine counselling.

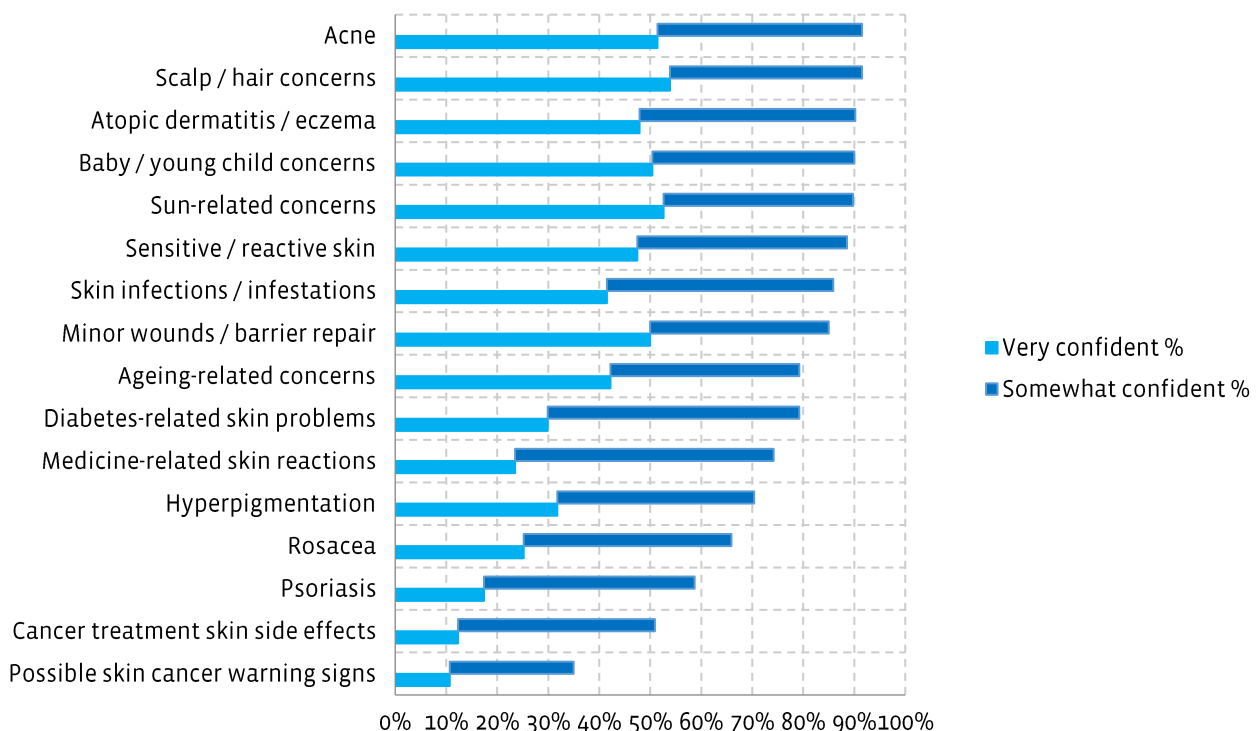


Figure 5: Confidence in managing common dermatological concerns and conditions, shown as very confident and somewhat confident (valid n ranged from 103 to 142 across items)

By contrast, as shown in Figure 6, confidence was lower for several less frequently encountered or potentially more complex conditions. Lower confidence, defined as respondents reporting that they were not very confident or not at all confident, was most evident for possible skin cancer warning signs (n=67, 65.0%), cancer treatment skin side effects (n=56, 49.1%), psoriasis (n=57, 41.3%), and rosacea (n=46, 34.1%).

Overall, these findings indicate that confidence was strongest for higher-frequency concerns that are more routinely managed in pharmacy practice, and lower for conditions that may require greater diagnostic caution, clearer referral judgement or more specialised knowledge. This pattern was particularly marked for possible skin cancer warning signs, where only 10.7% reported being very confident and 24.3% somewhat confident. A similar, though less marked, pattern was observed for cancer treatment skin side effects, psoriasis and rosacea.

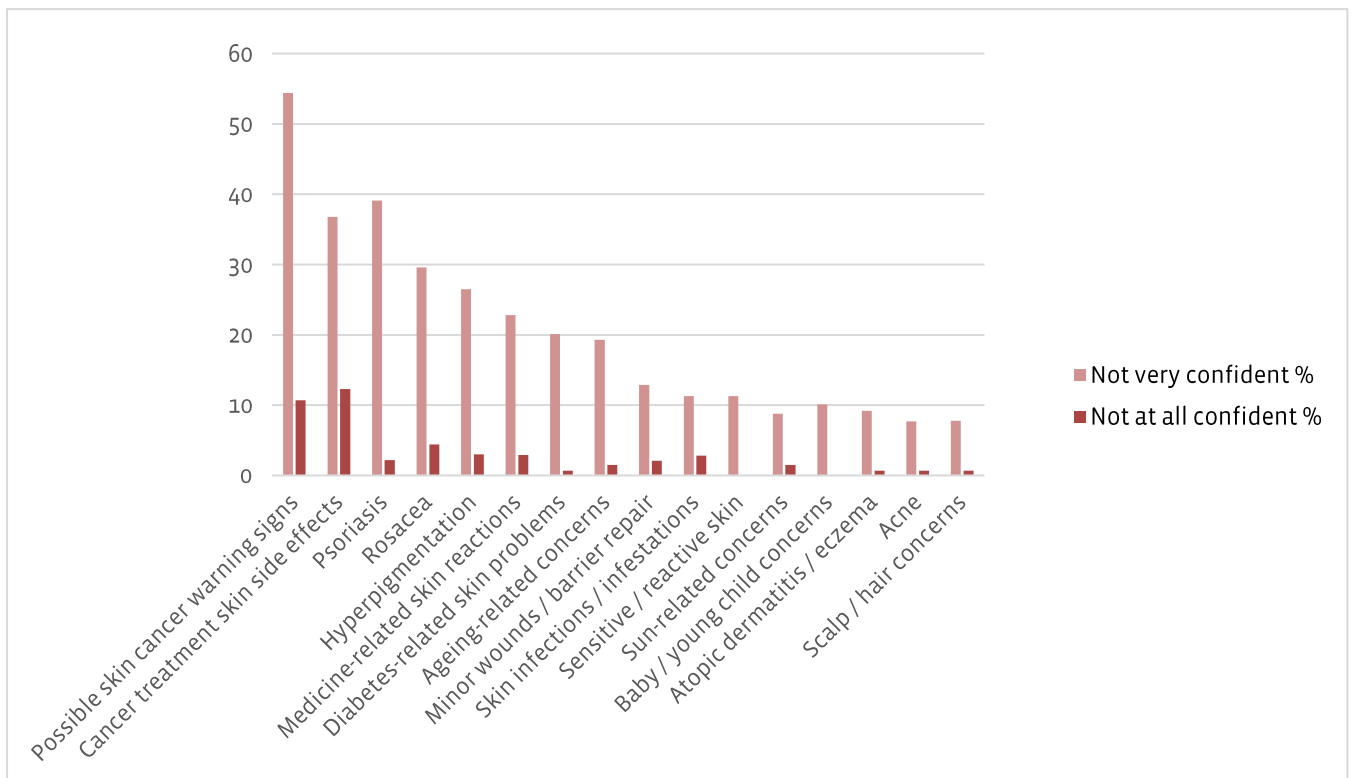


Figure 6: Confidence gaps in managing common dermatological concerns and conditions, shown as not very confident and not at all confident (valid n ranged from 103 to 142 across items).

3.4 Current roles and service provision in dermatology

As shown in Figure 7, respondents described a spectrum of roles in managing common dermatological presentations in practice. The largest group reported that they mainly provide advice when patients ask, without structured follow-up (n=52, 36.6%). A substantial proportion also reported being actively involved in ongoing management, with follow-up and referral where needed (n=47, 33.1%), while a further group reported providing advice and sometimes following up with patients (n=37, 26.1%). Only a small minority reported providing or leading a structured skin or dermatology service (n=5, 3.5%). Overall, these findings suggest that pharmacists' dermatology role is already extending beyond one-off advice in many settings, although more formalised service models remain limited.

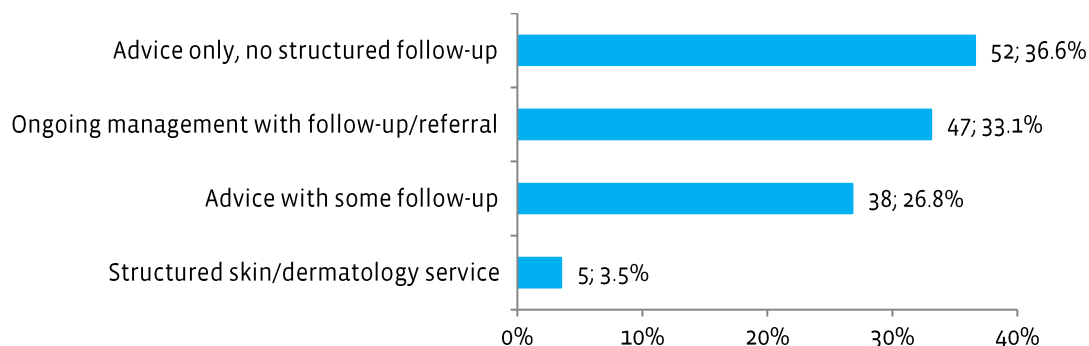


Figure 7: How respondents described their current role in managing dermatological concerns and conditions in pharmacy practice (n=142).

3.5 Use of guidance and decision-support tools

Only 22.5% of respondents (n=32) reported that local or national guidelines, protocols or frameworks were available to support the management of common dermatological presentations within their practice setting. By contrast, 49.3% (n=70) reported that no such guidance was available and 28.2% (n=40) were uncertain. This highlights an important gap in both the availability and awareness of standardised support for dermatological care in pharmacy practice.

Where pharmacist-specific guidance was absent, many respondents reported relying on guidance developed for other health professionals. Overall, 52.7% (n=58) reported using dermatology or primary care guidelines intended for other professionals, while 34.5% (n=38) indicated that they either did not use or were unaware of such guidance, and 12.7% (n=14) were uncertain.

As shown in Figure 8, respondents most commonly reported relying on general online resources, such as websites, forums or social media, for information on common dermatological presentations (n=77, 54.2%). This was followed by educational materials or tools developed by manufacturers or industry (n=66, 46.5%) and national clinical guidelines (n=59, 41.5%).

Other commonly used sources included guidance or toolkits produced by professional or public health bodies (n=51, 35.9%), local pharmacy protocols or standard operating procedures (n=44, 31.0%), common ailment service pathways (n=35, 24.6%), and electronic decision-support tools within pharmacy software (n=34, 23.9%). A smaller proportion indicated that they do not routinely use any specific guidance (n=15, 10.6%), while a small number selected other sources (n=7, 4.9%), including national pharmacy association resources, clinical dermatology references and training materials.

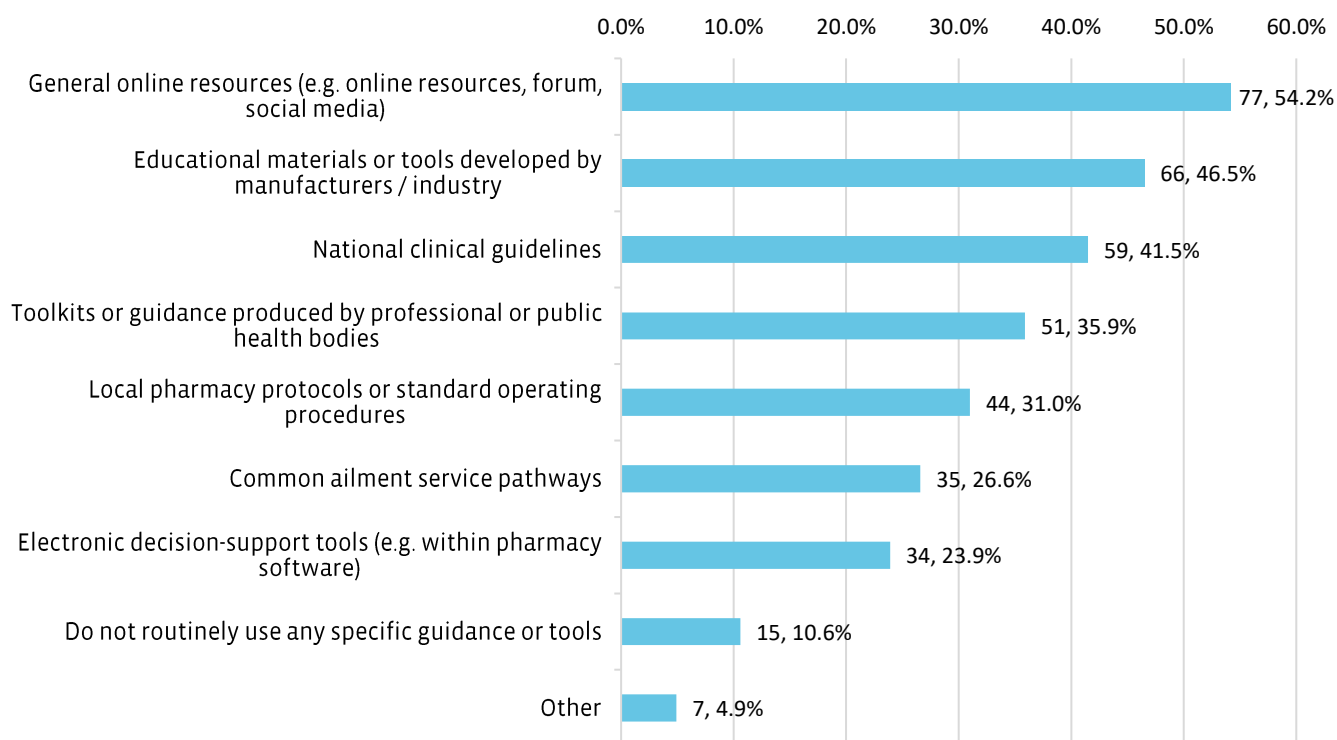


Figure 8: Types of guidance and tools used in practice (n=142)

Respondents also highlighted several areas where additional practical guidance would be valuable. The conditions most commonly identified as lacking practical guidance or tools were psoriasis (n=52, 36.6%), skin side effects of cancer treatment (n=50, 35.2%), possible skin cancer warning signs (n=50, 35.2%), suspected medicine-related skin reactions (n=49, 34.5%), and skin problems associated with diabetes (n=47, 33.1%).

Rosacea (n=44, 31.0%) was also frequently identified. These findings suggest that guidance needs are greatest where presentations are more complex, higher risk or less routinely managed.

The top conditions for which practical guidance was most often reported as lacking are shown in Figure 9.

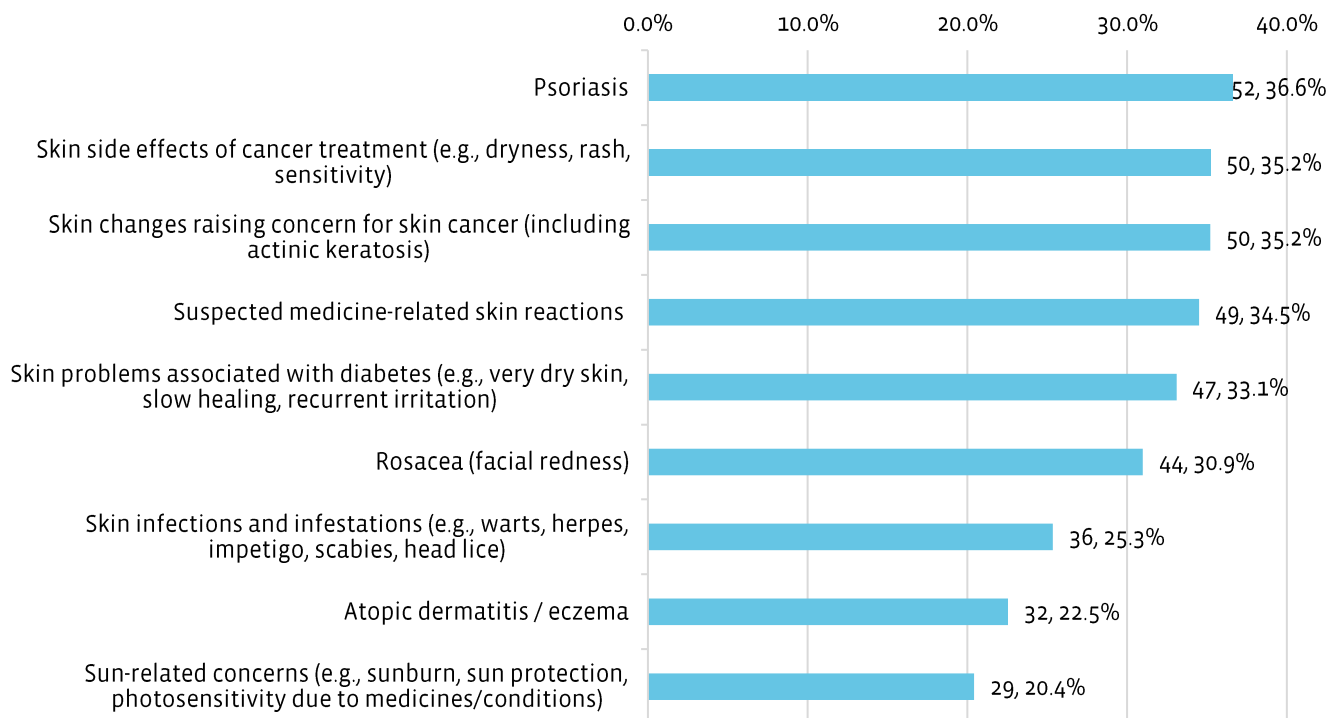


Figure 9: Top nine skin conditions where practical guidance is lacking (n=142)

3.6 Condition-specific practice insights

3.6.1 Acne management

As shown in Figure 10, overall confidence in acne management was high across most tasks. Respondents felt most confident in assessing severity and deciding when to refer (93.0%), and in providing skin care support alongside acne treatment (89.4%). Confidence was also high for discussing antibiotic use and stewardship (88.0%) and supporting adherence to longer-term treatment (85.9%). Managing expectations and timelines (81.7%) and dealing with treatment failure or recurrence (75.4%) were comparatively less strong areas, while differential diagnosis emerged as the most challenging task, with 37.3% reporting lower confidence. Overall, the findings suggest that pharmacists are comfortable with core acne support tasks but less assured in areas requiring diagnostic discrimination.

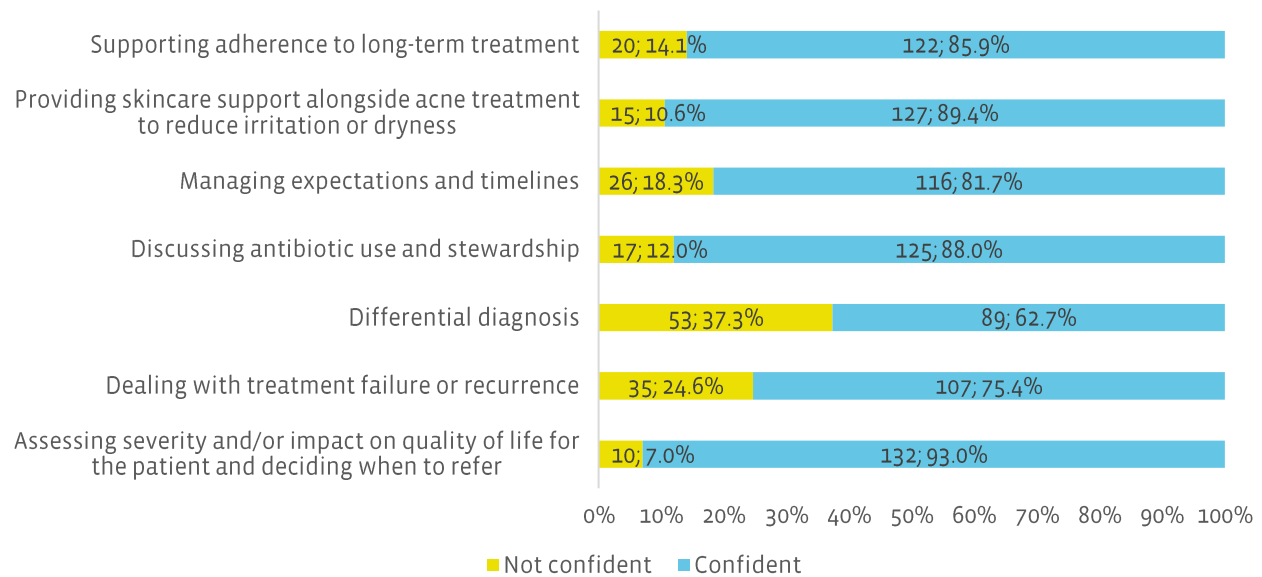


Figure 10: Pharmacist confidence across key acne management tasks (n = 142)

3.6.2 Atopic dermatitis/ eczema

As shown in Figure 11, pharmacists generally felt capable across several aspects of eczema management, but important challenges were also reported. Supporting long-term self-management with emollients and addressing patient concerns about topical corticosteroids were among the least challenging tasks. By contrast, differentiating eczema from other inflammatory skin conditions emerged as the most challenging area, with 59.2% reporting difficulty, followed by identifying red flags requiring referral (48.6%). These findings suggest that clinical assessment and differential recognition remain key gaps in eczema-related practice.

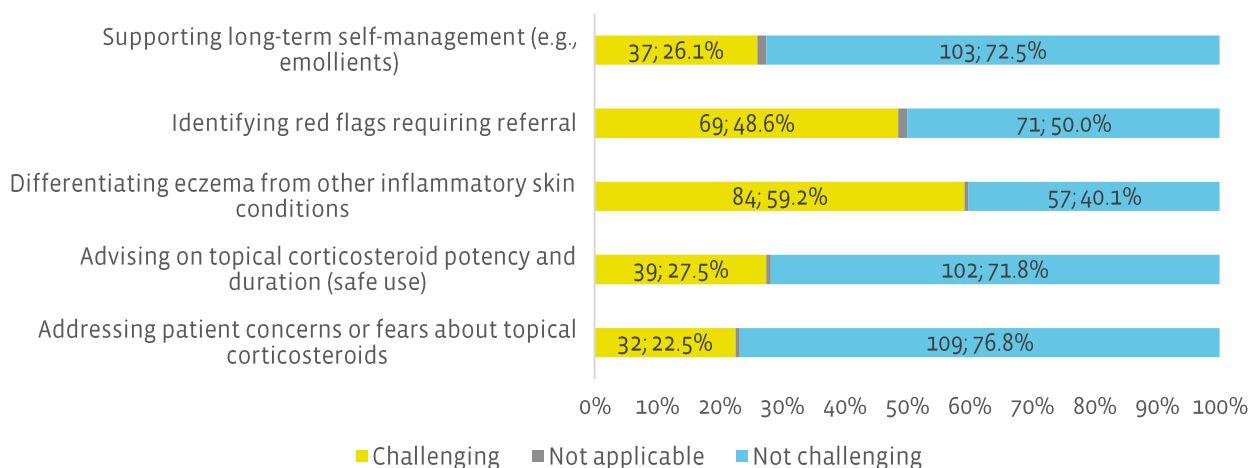


Figure 11: Key challenges in eczema management (n = 142)

3.6.3 Sun protection and skin cancer prevention

As shown in Figure 12, pharmacists were relatively engaged in sun protection conversations, although the nature of that engagement varied. The largest group mainly responded when patients asked about sun protection or sunscreen products (43.1%), while 40.1% reported proactively initiating conversations with at-risk patients. A smaller proportion provided advice as part of organised campaigns such as summer sun safety or skin cancer awareness (11.7%), and very few reported rarely providing sun protection advice at all (4.4%). Overall, the findings suggest broad engagement in sun protection counselling, with room to strengthen more proactive and targeted practice.

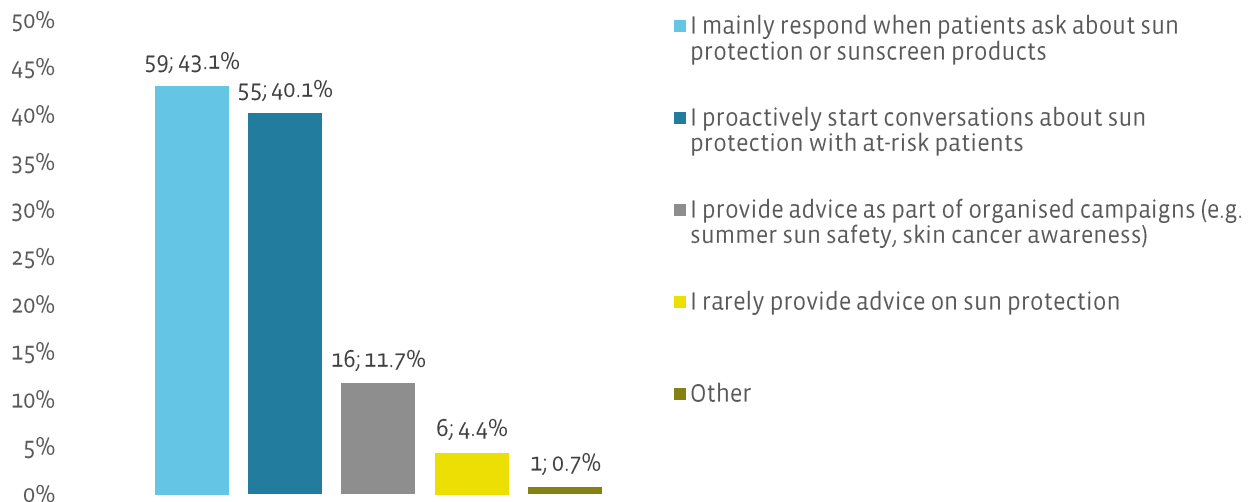


Figure 12: Pharmacists' role in sun protection (including photosensitivity and photoageing) (n = 137)

Familiarity and confidence in using suspicious skin lesion recognition tools remains limited across the respondent group, as shown in Figure 13. The largest proportion of respondents were aware of such tools but did not feel confident using them in practice (38.0%), while 32.1% were not familiar with any specific tools at all. Only 29.9% reported both knowing the tools and feeling confident applying them. This indicates an important gap between awareness and practical readiness in an area relevant to early recognition and referral.

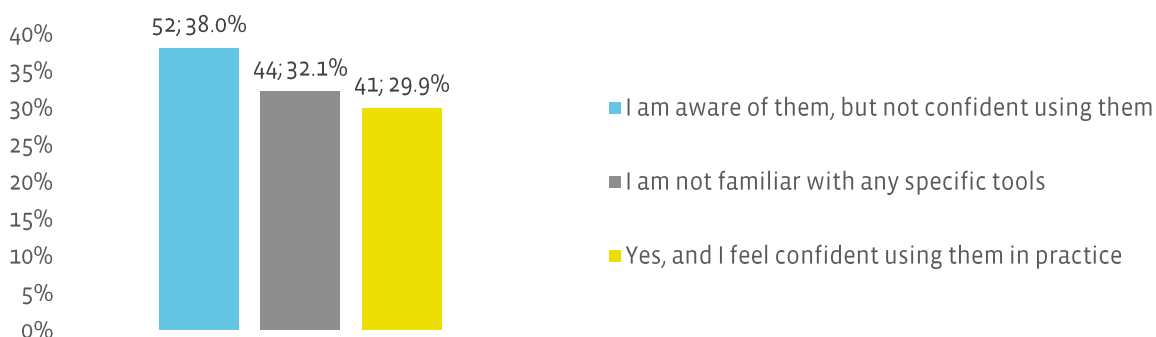


Figure 13: Familiarity with suspicious skin lesion recognition tools (n = 137)

3.6.4 Oncology-related skin effects

Respondents expressed strong willingness to adopt a more proactive role in supporting patients with cancer treatment-related skin problems. Overall, as shown in Figure 14, 81.0% (n=111) expressed clear interest and a

further 16.8% (n=23) indicated conditional willingness depending on access to appropriate training, tools or support. Only 2.2% reported no interest. Together, these findings suggest broad openness to expanded pharmacist involvement in this area.

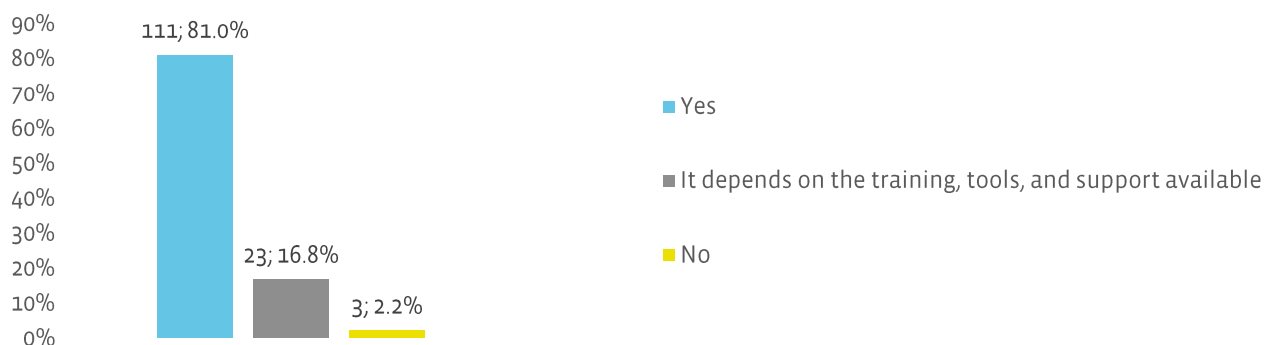


Figure 14: Willingness to support patients with skin problems related to cancer treatment (n = 137)

Among respondents supporting patients with cancer treatment-related skin problems, the most commonly reported activities were recommendations for supportive skin products such as moisturisers, emollients or barrier creams (58.5%), advice on managing dry skin, irritation or rash (51.4%), and advice on sun protection and photosensitivity (50.7%), as shown in Figure 15. Encouraging treatment adherence while managing skin effects (44.4%) and advising when to contact the oncology team or seek urgent care (37.3%) were less commonly reported. This pattern suggests that pharmacists are more comfortable with supportive care and product-related advice than with escalation and adherence-related functions.

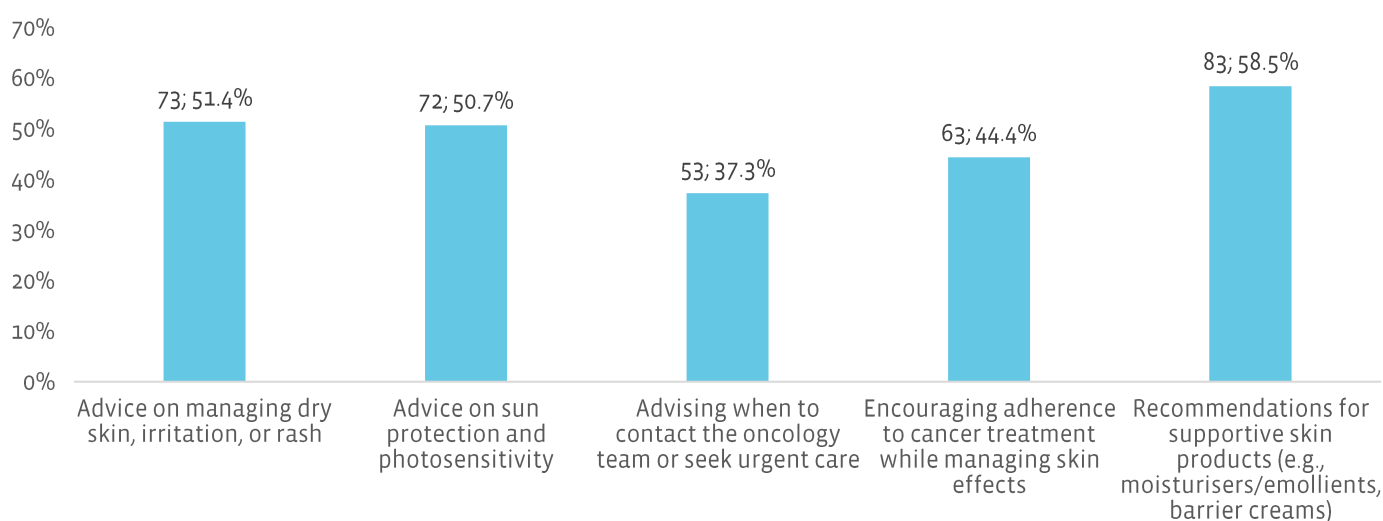


Figure 15: Types of support provided to patients with cancer treatment-related skin problems

3.6.5 Medicine-related skin reactions

As shown in Figure 16, the most commonly reported actions when a suspected medicine-related skin reaction was identified were checking medicines and information sources for known skin reactions (72.5%), providing advice on symptom relief and skin care (52.8%), and advising timely medical review (46.5%). Reporting to a pharmacovigilance or safety monitoring system (42.3%) and discussing the case with the prescriber (33.8%) were less commonly reported, while documentation in pharmacy records was least common (27.5%). These findings suggest that recognition and immediate advice are more embedded in practice than formal reporting and documentation

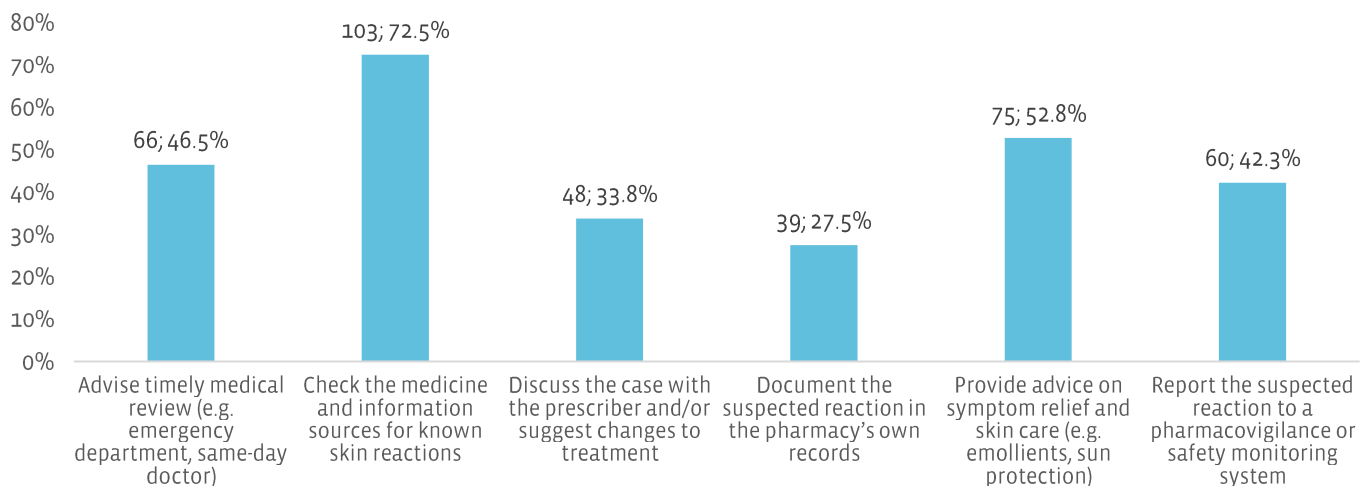


Figure 16: Action taken by pharmacists when a suspected medicine-related skin reaction is identified

As shown in Figure 17, most respondents who answered this item found reporting suspected skin reactions to a pharmacovigilance or safety monitoring system easy ($n=86$, 63.2%), while 39 respondents (28.7%) found it difficult. A small minority ($n=11$, 8.1%) were either unaware of how to report or did not know that such a system existed. Overall, the findings suggest that while most pharmacists are comfortable with the reporting process, a meaningful minority would benefit from clearer guidance and awareness support.

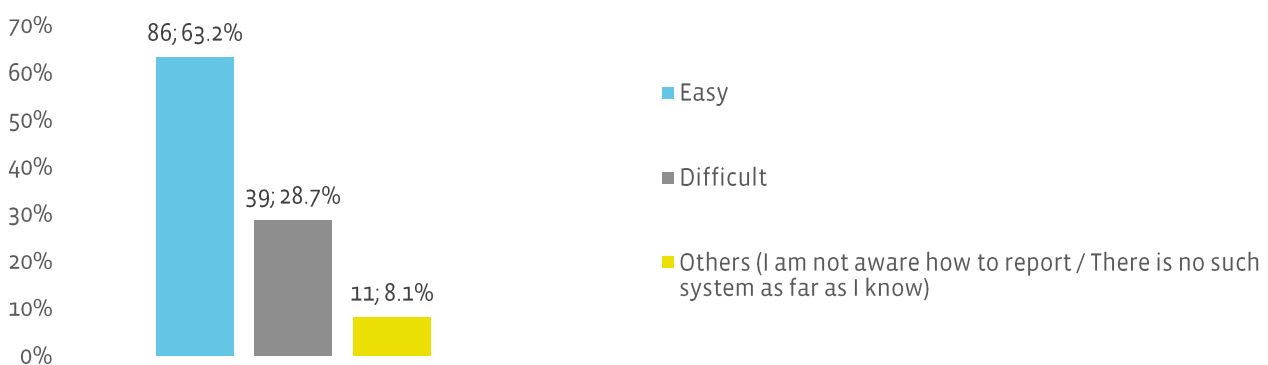


Figure 17: Perceived ease of reporting suspected skin reactions ($n = 136$)

3.6.6 Wound care and skin barrier repair

As shown in Figure 18, respondents demonstrated high confidence across all five wound and skin barrier care tasks. Confidence was highest for selecting appropriate over-the-counter products (92.9%) and advising on basic wound or skin barrier care (90.7%). Assessing severity and identifying red flags (82.1%) and counselling on follow-up and healing timelines (78.6%) also showed strong confidence. Confidence was lowest for

providing post-procedure supportive care advice (75.7%), which also recorded the highest proportion reporting lower confidence (23.6%). Overall, these findings suggest that wound care support is an area of relative strength, although post-procedure care may benefit from additional support.

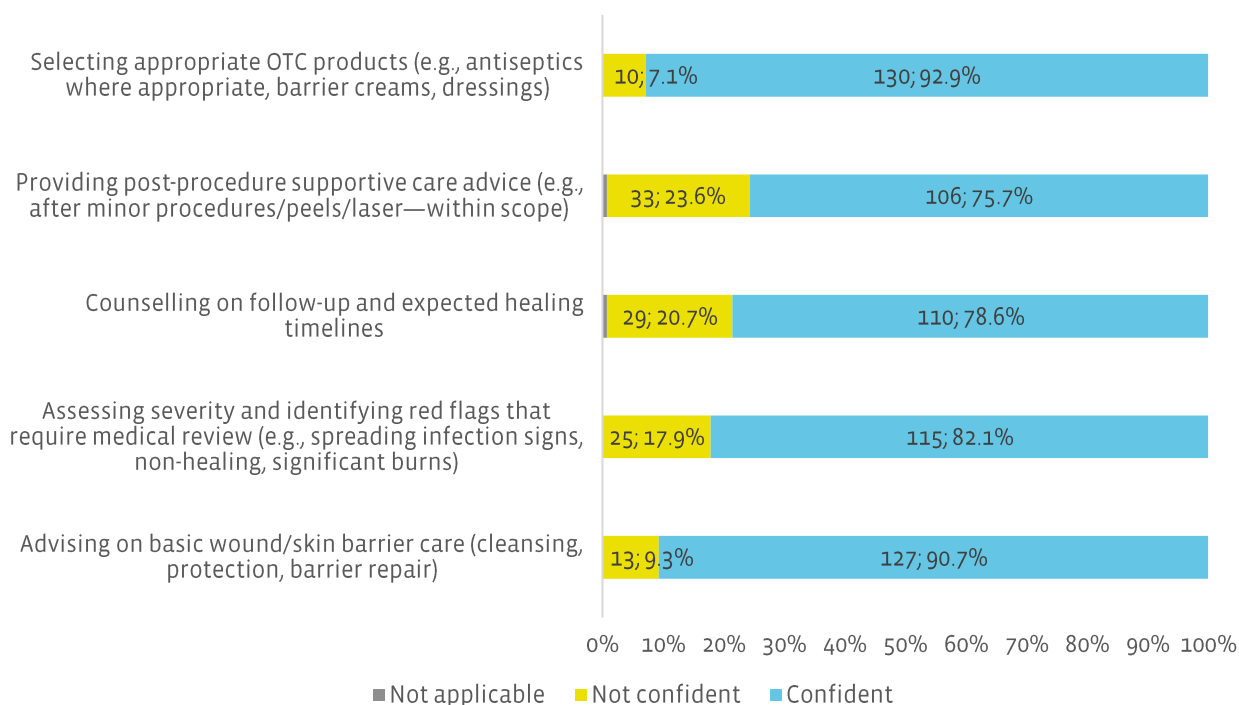


Figure 18: Pharmacist confidence in supporting patients with minor wounds/skin barrier damage or post-procedure skin care (n = 140)

3.7 Clinical decision-making and referral pathways

The majority of respondents, as illustrated in Figure 19, feel clear about when a skin concern falls within their professional role versus when referral is needed, with 57.0% reporting being "very clear" and a further 35.2% "somewhat clear," together accounting for over 92.2% of responses. Only a small minority indicated limited clarity, with 7.0% reported being "not very clear" and just 0.7% "not at all clear", suggesting that most pharmacists have a solid understanding of their scope of practice in relation to dermatological concerns, although a small group may still benefit from clearer professional guidance.

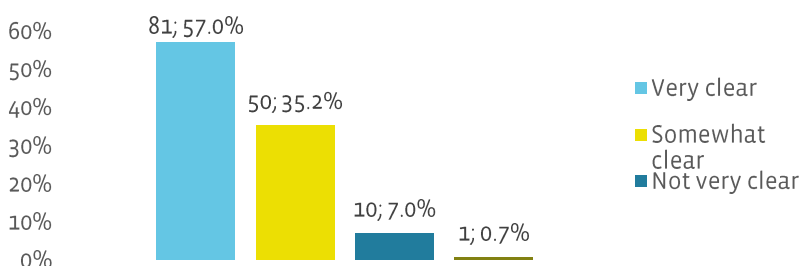


Figure 19: Pharmacists' clarity on scope of practice: when to manage dermatological concerns vs when to refer

Figure 20 demonstrates that responses were fairly divided on whether clear and practical referral pathways exist in respondents' pharmacy settings. While 45.8% of respondents indicated that such pathways do exist in their setting, a nearly comparable proportion (42.3%) reported that they do not, highlighting a gap in structured referral systems. Additionally, 12.0% were not sure, which may reflect inconsistency, lack of awareness, or variability in how referral processes are communicated or implemented.

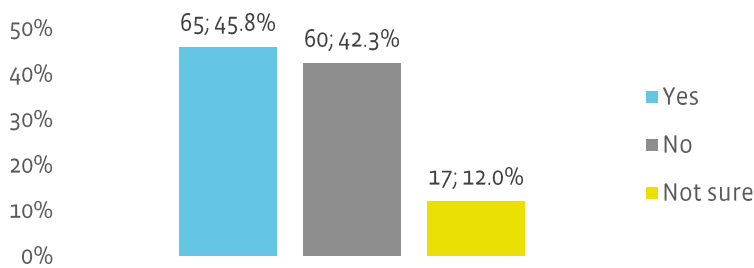


Figure 20: Availability of clear and practical referral pathways for dermatological concerns in pharmacies

Among those with referral pathways, as illustrated in Figure 21, agreed local pathways or minor ailment schemes were the least commonly used (only 4.9% used them), and electronic referral or shared digital systems were similarly rarely utilised (6.3%), suggesting that formal and technology-based systems are not yet widely adopted. In contrast, informal arrangements such as advising patients where to go were the most frequently used approach (33.8% used them), followed by direct communication with a prescriber via phone or email (21.8%) and formal referral forms or templates (10.6%), indicating that referral practice remains largely informal and relationship-dependent rather than systematised.

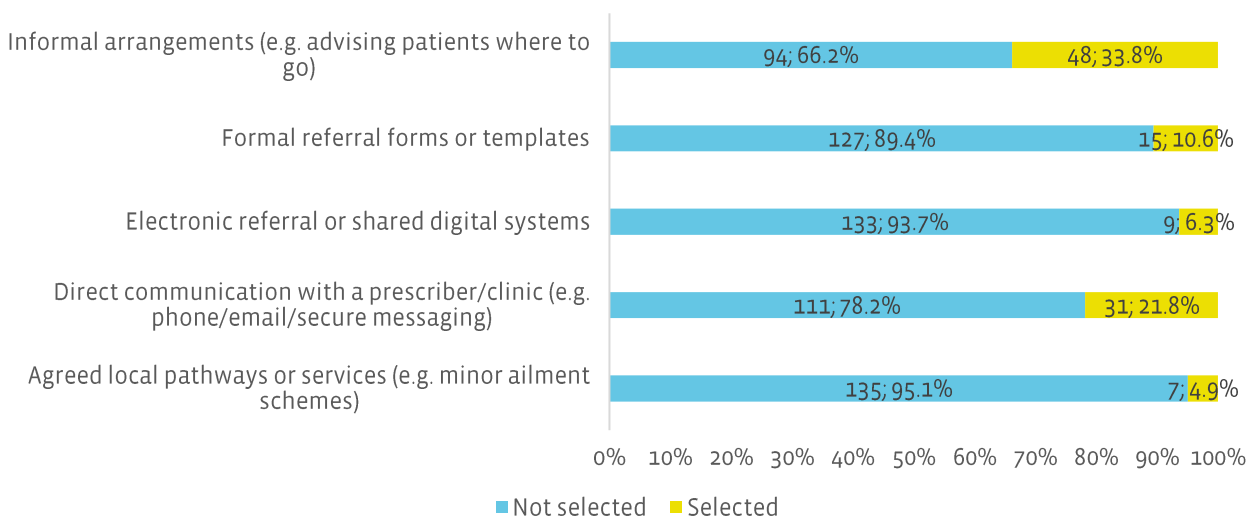


Figure 21: Referral mechanisms used in practice: How pharmacists direct patients with skin concerns to other health professionals

As illustrated in Figure 22, feedback following referral was inconsistent. The largest group reported receiving feedback only sometimes (40.1%), while 32.4% reported rarely receiving it. Only 14.1% reported often receiving feedback, 9.2% said they never did, and 4.2% indicated that the question was not applicable. This suggests that

closed-loop communication between pharmacists and other health professionals remains limited, with implications for continuity of care and learning from referral outcomes.

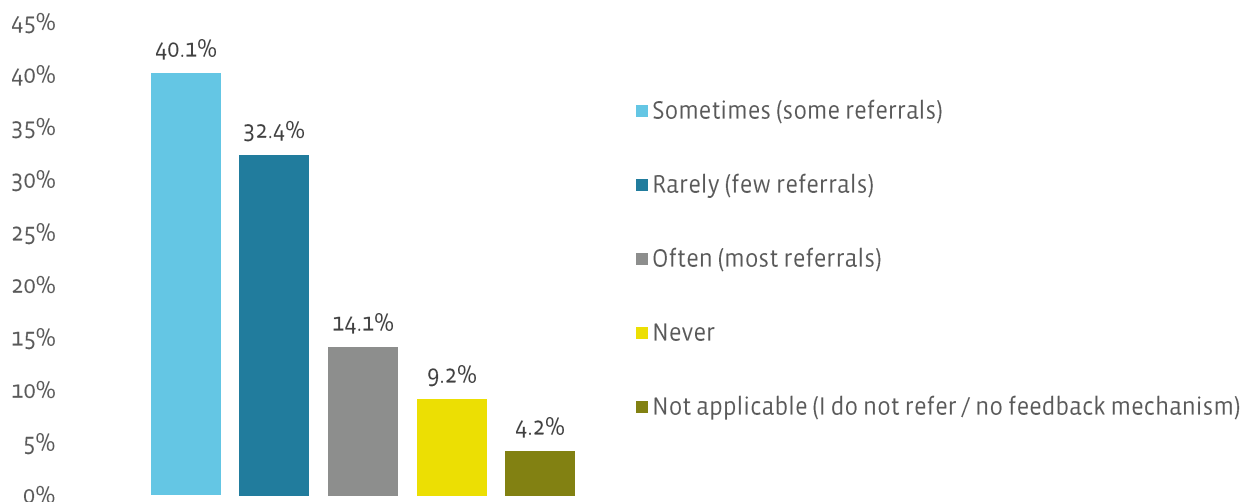


Figure 22: Frequency of post-referral feedback received by pharmacists following skin concern referrals

3.8 Education, training, and future learning needs

As shown in Figure 23, respondents most reported receiving dermatology-related education or training through short workshops or webinars (n=81, 57.0%), followed by content in undergraduate pharmacy training (n=78, 54.9%) and training provided by manufacturers or industry (n=78, 54.9%). Continuing professional development courses were also commonly reported (n=67, 47.2%), while on-the-job learning and experience only was selected by 60 respondents (42.3%). Content in postgraduate or specialist programmes was less commonly reported (n=35, 24.6%), and very few respondents selected none of the above (n=3, 2.1%).

Taken together, these findings suggest that dermatology-related learning has largely come from a mix of short-form education, undergraduate exposure, industry-supported training and practice-based learning, rather than from specialist postgraduate pathways. This suggests that dermatology is often approached as a practical and continuing area of learning within pharmacy rather than as a highly formalised area of professional training.

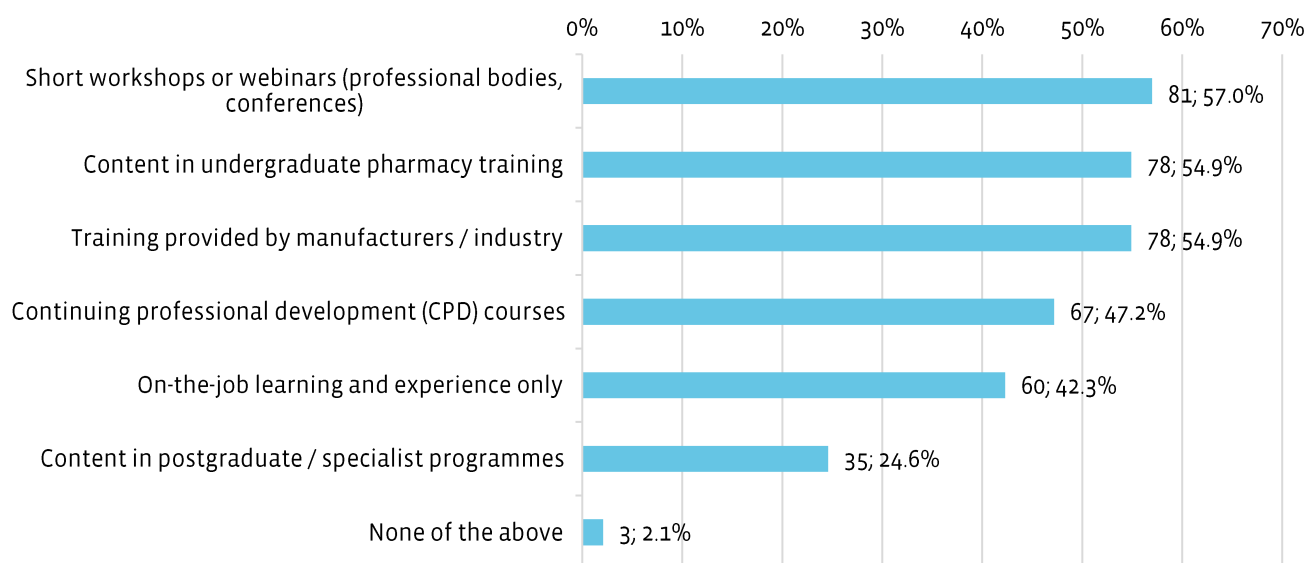


Figure 23: Dermatology-related education or training received at any stage in respondents' careers, shown as selected responses (n=142).

As shown in Figure 24, respondents showed a clear preference for practical and flexible learning formats for future dermatology education. The most selected option was interactive online courses with real-world cases and decision scenarios (n=86, 60.6%), followed by short online modules or videos that can be completed in small blocks (n=76, 53.5%). Other commonly preferred formats included written guidance or handbooks with practical algorithms (n=52, 36.6%), patient education tools to support counselling (n=48, 33.8%), and in-person workshops or seminars (n=47, 33.1%). Accredited CPD programmes were selected by 42 respondents (29.6%), while training or updates delivered or sponsored by industry were selected by 31 respondents (21.8%).

Overall, these findings suggest that respondents value training formats that are accessible, practice-oriented, and directly applicable to real-world decision-making in pharmacy. The strong preference for interactive online learning and short modular content may reflect the need for flexible education models that fit around professional workload.

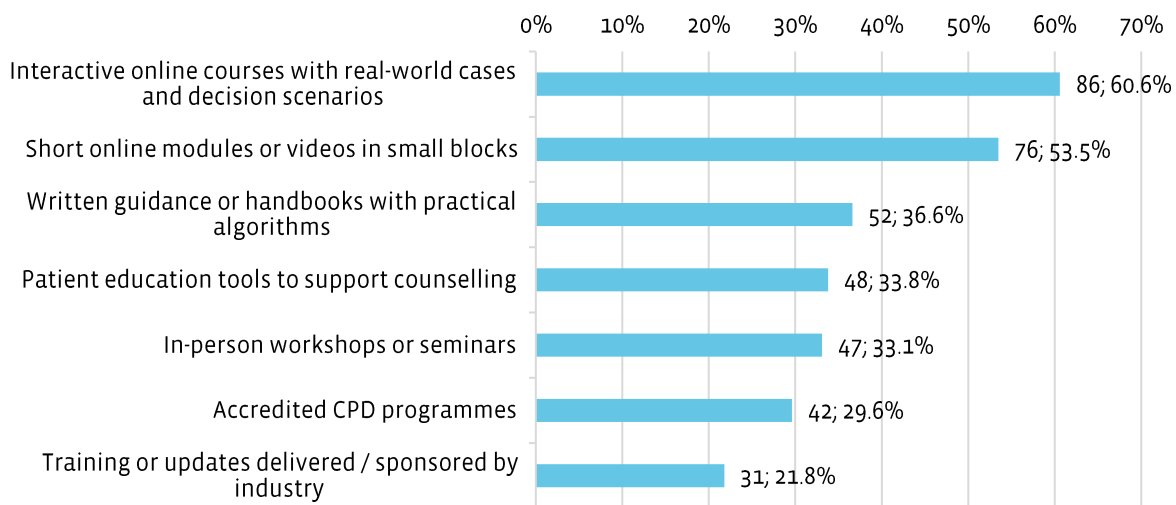


Figure 24: Preferred formats for future dermatology education or training, shown as selected responses (n=142; up to three responses allowed).

3.9 Scope of practice, service models and remuneration

Respondents reported considerable variation in the extent to which pharmacists are authorised to initiate or adjust treatment for common dermatological presentations in their current practice setting. Overall, the largest proportion indicated that pharmacists do not currently have prescribing or treatment-initiation authority for skin conditions (n=85, 59.9%), suggesting that in many settings pharmacists' contribution to dermatological care remains centred on assessment, counselling, product recommendation and referral rather than formal treatment initiation.

As shown in Figure 25, a substantial minority indicated that some degree of authority does exist in their setting, although this appears to vary according to local regulation, service model and practice environment. This points to an uneven landscape in which pharmacists' role in dermatological care may be expanding in some jurisdictions while remaining more limited in others.

Open-text responses provided additional detail on how this authority is understood in practice. Where respondents reported some level of authority, this most related to starting treatment for selected minor or common dermatological presentations, adjusting treatment that had already been initiated, or renewing or continuing existing prescriptions within defined limits. Taken together, these comments suggest that pharmacist involvement in dermatological treatment is often framed around low-risk, common, or protocol-supported care rather than unrestricted prescribing authority.

Overall, scope of practice appears to remain a key structural factor, shaping how far pharmacists can contribute to dermatological care. In settings where treatment authority is limited or absent, pharmacists

may still provide important front-line support, but their role may be constrained to advice, triage and referral. By contrast, where some authority exists, pharmacists may be better positioned to support timely access to care for common and manageable dermatological concerns.

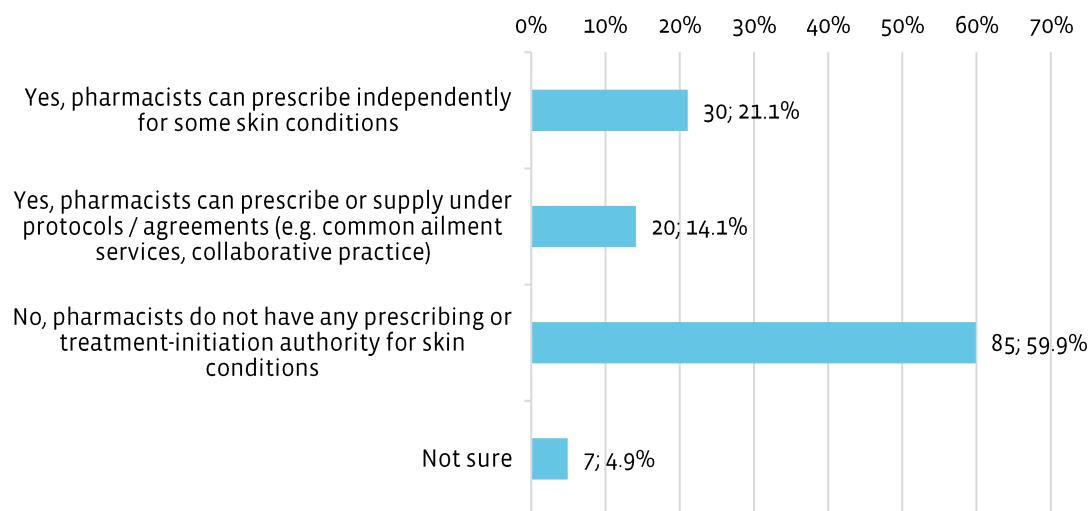


Figure 25: Pharmacists' authority to initiate or adapt treatment for common dermatological conditions in respondents' country or region (n=142).

Respondents also reported limited availability of structured pharmacy services specifically focused on skin conditions. Overall, just over half indicated that no structured skin-condition services were currently available in their practice (n=74, 52.1%). This suggests that while pharmacists may frequently support patients with skin-related concerns in routine consultations, these activities are often delivered informally rather than through designated service models.

As shown in Figure 26, where services did exist, they were more likely to take the form of selected or targeted offers rather than fully embedded dermatology pathways across practice settings. This pattern suggests that formal service development in this area remains limited relative to the routine burden of dermatological consultations reported elsewhere in the survey.

This gap is notable when considered alongside the frequency with which pharmacists reported encountering skin-related concerns in practice. Taken together, the findings suggest that dermatological support is already occurring in pharmacy, but often without the benefit of structured service models, defined workflows or formally recognised practice pathways.

Overall, these findings point to an important disconnect between the high frequency of dermatological consultations in pharmacy and the more limited development of formal service models to support them.

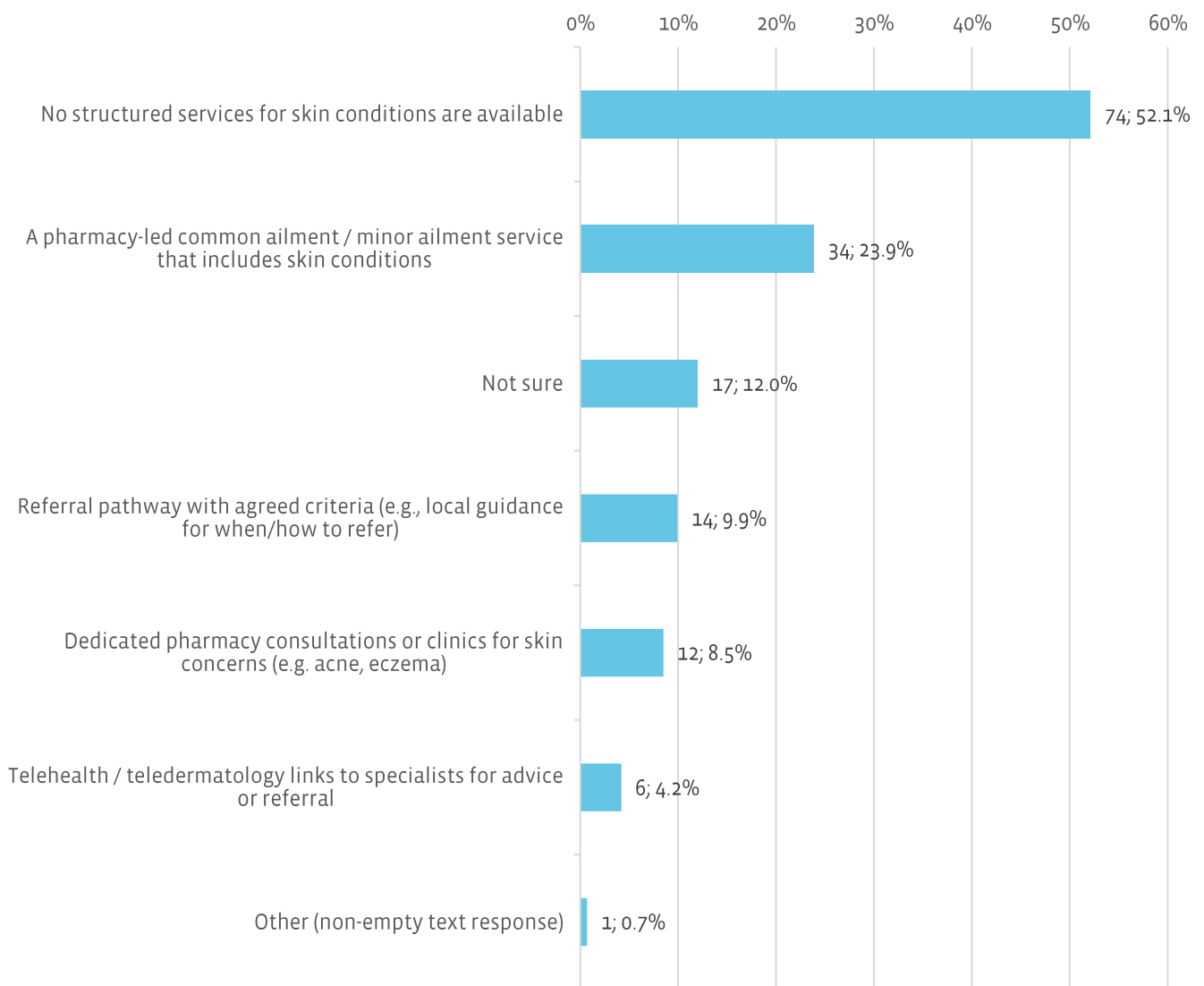


Figure 26: Structured services for skin conditions currently available in practice, shown as selected responses (n=142).

A clear finding from the survey was the limited remuneration associated with dermatology-related care in pharmacy. Most respondents reported that pharmacists do not receive additional remuneration for providing dermatology-related care (n=126, 88.7%). This suggests that in most settings, support for skin-related concerns is absorbed within routine pharmacy practice rather than recognised as a separately funded clinical activity.

As shown in Figure 27, only a small minority reported the existence of payment or additional recognition for such care. This indicates that although pharmacists may already be providing advice, follow-up and practical support for common dermatological presentations, these contributions are rarely backed by explicit funding arrangements.

Open-text responses to the follow-up question were limited, but where payment models were described, they most often referred to per-consultation or fee-for-service arrangements. These comments suggest that where remuneration does exist, it is more likely to be linked to defined consultations or service-based activity than to broad recognition of dermatology-related care as part of routine pharmacy practice.

Taken together, these findings suggest that remuneration remains a major structural barrier to the wider development and sustainability of pharmacist-led dermatology support. Even where pharmacists are involved

in ongoing management, product advice or follow-up, the absence of additional payment may restrict the time, consistency and service development needed to strengthen this area further.

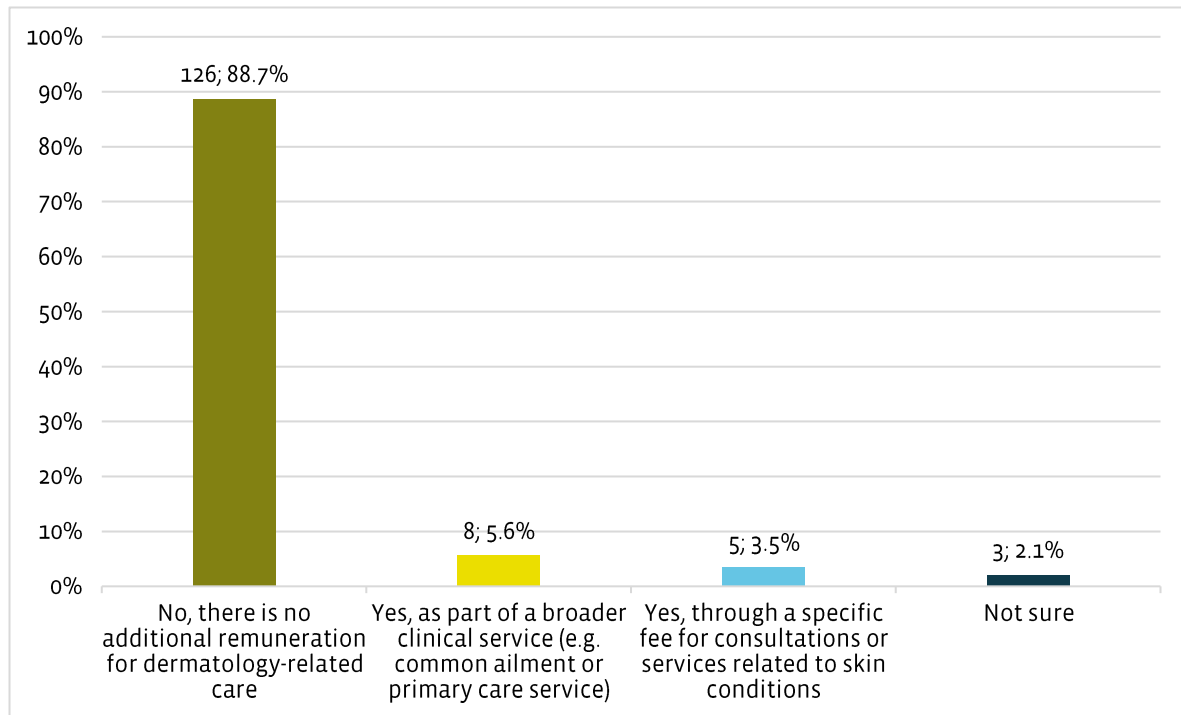


Figure 27: Additional remuneration for dermatology-related care in current pharmacy practice (n=142).

3.10 Barriers to dermatological care and priority support needs

Respondents reported a range of barriers affecting the provision of dermatology-related services in pharmacy practice. As shown in Figure 28, the barriers most often rated as major or very major were system or policy barriers, including unclear referral pathways and regulatory limitations (n=75, 52.8%), lack of practical tools or information such as clear protocols or access to patient records (n=68, 47.9%), and lack of remuneration or financial incentives for dermatology-related services (n=60, 42.3%). Practical constraints, including limited consultation time and lack of private space, were also important (n=51, 35.9%), while limited dermatology knowledge or confidence was rated as a major or very major barrier by 36.6% (n=52).

Patient expectations and perceptions were more often rated as a moderate barrier than as a major one, while limited dermatology knowledge or confidence showed a more even spread across categories. Limited access to suitable treatment options or products was less frequently perceived as a critical barrier than the structural and system-related issues described above.

Overall, the findings suggest that the greatest constraints on dermatology-related care in pharmacy are system-level rather than product-level.

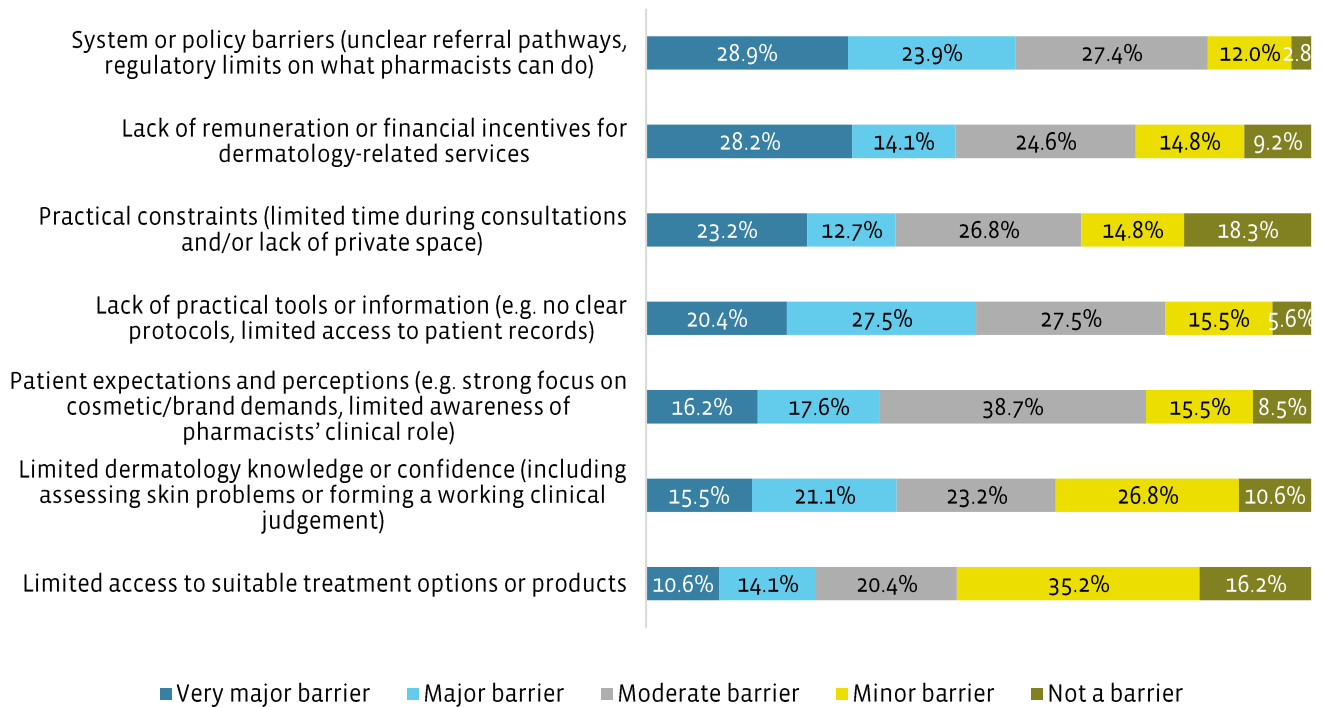


Figure 28: Barriers that limit effective dermatology care

Figure 29 shows that respondents regarded a wide range of support strategies as helpful, but several stood out clearly. The supports most often rated as very or extremely helpful were targeted dermatology training using real-life cases ($n=122$, 85.9%), stronger collaboration with other health professionals ($n=119$, 83.8%), guidance on treatment selection, including OTC and adjunctive therapies ($n=118$, 83.1%), and guidance for medicine-related skin reactions ($n=116$, 81.7%).

Practical algorithms or flowcharts for common presentations ($n=111$, 78.2%) and clear triage and referral criteria ($n=108$, 76.1%) were also highly valued. Guidance for diverse skin types and skin of colour was strongly rated ($n=105$, 73.9%), highlighting the importance of inclusive and clinically relevant support.

Overall, the findings suggest that respondents see the greatest value in practical, case-based training, clearer tools and guidance, and stronger system integration.

A smaller set of open-text responses reinforced these quantitative findings ($n=20$, 20.4%). Additional needs most commonly related to clearer policy and regulatory support, ongoing training, practical tools and guidance, stronger collaboration with other health professionals, adequate infrastructure such as private consultation space, and better recognition of pharmacists' role in dermatological care.

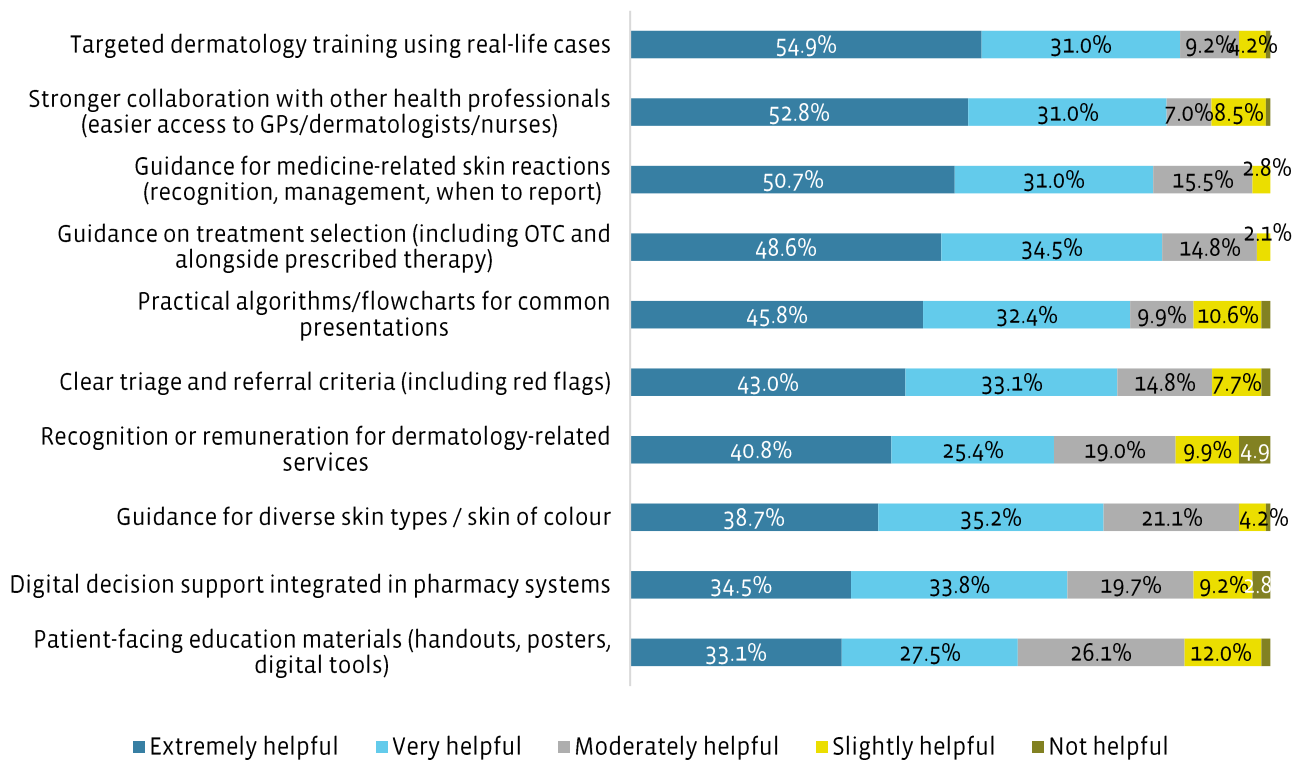


Figure 29: Supports perceived as most helpful

4 Key insights from the insight board

The insight board aimed to:

1. Define and frame the evolving role of pharmacists in managing skin diseases;
2. Identify and prioritise key dermatological indications;
3. Discuss indications according to country, zone, or cluster of countries;
4. Assess educational gaps in pharmacy curricula and professional development regarding dermatology, including: skin pathophysiology and care, dermocosmetics, and formulation and galenics; and, identify effective educational formats to bridge dermatology knowledge gaps;
5. Explore patient service models that support pharmacists' engagement in skin health;
6. Maximise collaboration throughout the patient journey, identifying opportunities to develop pharmacist-led services that enhance patient outcomes and professional knowledge;
7. Evaluate how education is structured for pharmacists across countries and determine whether to keep, change, or discontinue existing approaches.

Across five indications—photoprotection, acne, repair, atopic dermatitis, and oncology/skin toxicities—the experts addressed the following key questions:

Table 2: Question categories

Category	Question
Identifying the pharmacist's role in dermatology	What are the key competencies (knowledge and skills) pharmacists require to manage common skin conditions effectively? What services or interventions do pharmacists provide to manage these dermatological conditions? What barriers limit pharmacists' involvement in skin health? How can pharmacists collaborate more effectively with dermatologists, general practitioners, and other healthcare professionals? How do environmental and lifestyle factors influence these priorities? Are there specific underserved populations or emerging skin conditions that pharmacists should focus on?
Educational gaps and opportunities	What is the current dermatology education within undergraduate and continuing professional pharmacy curricula? Where are the key knowledge gaps related to differential diagnosis, patient counselling, product selection, or referral practices? To what extent are dermocosmetics, formulation, and galenics incorporated into pharmacy education? Can you share examples of where established best practices are working well?
Effective education and learning models	Which learning formats are most effective for pharmacists? What collaborations are needed to co-develop practical and accessible educational resources? Should dermatology be considered a specialist competency area within professional pharmacy frameworks?
Patient services	What pharmacist-led skin health services could be implemented or expanded? How can dermocosmetic counselling be integrated ethically and effectively into daily pharmacy practice?

	Can you share examples of effective patient services from your setting or others?
Regional insights and best practices	How is dermatology taught, practised, and prioritised in different regions? What policy or regulatory enablers currently support pharmacist-led dermatology services? How can FIP tailor its recommendations to reflect cultural, regulatory, and market differences across regions?

4.1 Defining the pharmacist’s role in dermatology

4.1.1 Key competencies for effective management of dermatological conditions

Effective management of common dermatological conditions in community pharmacy requires confidence in recommending products tailored to individual patient needs. To practise at this level, pharmacists need solid clinical knowledge of skin physiology and pathophysiology and dermatological conditions combined with structured triage and differential diagnosis skills.

“Pharmacists must distinguish between conditions that can be managed in the pharmacy and those requiring referral, especially in settings where they are the first point of care. Those red flags should be timely identified.”

“There is a growing recognition of skin integrity over lifetime, especially with older patients who have thinning skin, reduction of natural oils and subsequent skin tears. It is important to understand the importance of skin changes over lifetime, rather than always being responsive.”

Another key competency is an evidence-based knowledge of dermatological treatments, active ingredients and formulation. In-depth knowledge on available dermatological treatments, such as prescription-only, over-the-counter (OTC), dermocosmetic products used as adjunctive treatments for a wide range of dermatological conditions, condition-specific therapeutics (topical corticosteroid literacy and antibiotic stewardship for acne) and the clinical effectiveness of these interventions builds pharmacist confidence in providing appropriate recommendations for the patient. A participant from Nigeria identified knowledge and skill in formulation as an enabler for better navigating the growing range of skincare products with functional and quasi-therapeutic benefits. This includes the ability to design appropriate dosage forms (e.g., creams, gels, emulsions, serums) for optimal skin delivery, ensure ingredient compatibility and stability, maintain appropriate pH to support skin barrier integrity, and evaluate safety profiles to minimise irritation or adverse reactions.

Furthermore, public health education is crucial. The consensus showed that strong communication skills and patient counselling are essential for managing patient expectations in dermatological care. This includes the ability to ask the right questions, understand patient concerns, and select the appropriate approach. Counselling encompasses education on therapeutic information, correct use of treatments, practical tips, and support for adherence. As such, pharmacists would be able to address common patient misconceptions about rapid results, ‘miracle treatments’, and the limits of self-care and better improve treatment adherence, skin care recommendations, and patient follow-up.

“Pharmacists have an important role in supporting patients who are already on prescribed dermatological therapy. They help ensure proper understanding and adherence to treatment, which is particularly important in conditions like acne, where patients may discontinue therapy due to side effects if they are not adequately informed.”

In addition, providing culturally sensitive care and showing empathy are also important. Beyond clinical expertise, a deep understanding of the cultural realities that shape patients’ behaviours and decisions and being cognisant that dermatological conditions have a huge negative impact on psychology and quality of life is required.

“Patients may be using traditional remedies like ayurvedic medicine, traditional Chinese medicine. They may follow cosmetic practices such as skin lightening, or be facing stigma related to visible skin condition. If we fail to acknowledge these realities, we might misdiagnose, patient adherence may be affected, or we might lose the patient’s trust.”

Lastly, pharmacists need to be familiar with appropriate, evidence-based recommendations and clinical guidelines. This enables documented clinical reasoning that supports appropriate, evidence-based decision-making.

“Pharmacists need to develop familiarity with practical tools and clinical guidelines, enabling decisions that are appropriate and aligned with evidence-based practice.”

4.1.2 Pharmacists’ contribution to dermatological care across community and clinical settings

In community settings, pharmacists assess symptoms, advise on OTC medicines and dermocosmetic products, provide guidance on appropriate skincare measures and patient health education, particularly to promote photoprotection and support adherence to prescribed treatments. The following table shows expanded roles in some countries.

Table 3: Expanded roles of community pharmacists in dermatological care

Country	Expanded roles of community pharmacists
Italy	Teledermatology, allowing pharmacists to facilitate access to specialists
Switzerland	Initiate treatment for certain dermatological conditions (patient must be present in person) and documentation of the dispensing Compounding individualised formulations either in-house or through an external laboratory
UK	Pharmacist-led consultations with structured follow-up (pilot study with psoriasis)

In clinical and hospital settings, pharmacists contribute to the management of more complex dermatological conditions, particularly through the optimisation of pharmacotherapy, monitoring of treatment safety, and prevention of drug interactions. Their expertise is especially relevant in the use of systemic therapies, including immunomodulators and biological treatments.

In dermocosmetic contexts, pharmacists provide added value through professional counselling, supporting patients in selecting products appropriate for their skin type or condition, and ensuring their safe and effective use. This role is particularly important given the wide availability of dermocosmetic products across non-medical channels. Pharmacists also play a key role in identifying situations requiring medical referral, thereby reinforcing their function as a link between self-care and specialised care.

4.1.3 Barriers limiting pharmacists’ involvement in skin health

Key barriers that participants highlighted include educational gaps in dermatology training, regulatory limitations, financial constraints, and partial recognition of the pharmacist's clinical role by patients and physicians.

Educational gaps

The limited inclusion of dermatology-related content in undergraduate pharmacy degree curricula means many pharmacists subsequently acquire specialised training in this field through master’s degrees, courses, or continuing professional development programmes. As shared by the participant from Canada, a national curriculum survey conducted across all ten Canadian pharmacy schools highlighted that, even where the required competencies are clearly defined, the training infrastructure to build them systematically does not yet exist.

Knowledge gained at university tends to be general and limited. In US pharmacy schools, dermatological conditions are often given lower priority than other chronic conditions, such as hypertension or diabetes. Whereas on looking at dermatology as a whole, there are tiers that are assigned to the various conditions, but still, it is taught with information at a very high level, but poorly in assessment competencies.²⁷

Participants also highlighted the theoretical aspect of dermatology courses, having little exposure to real-life cases. Students may be able to recognise conditions but are not adequately equipped to conduct assessments or differential diagnoses. A participant from the UK noted that undergraduate courses do not give students the ability to examine skin properly, leading to a lack of confidence in future practice.

“... nowhere do they teach them about how to palpate and examine skin.”

There is also a competency gap in formulation, particularly in some African contexts, where basic pharmaceuticals are taught but not sufficiently developed. Furthermore, topics such as oncology-related skin toxicities, sun-induced skin damage, and foundational principles of UV risk stratification are not covered in most Canadian schools.

“What we're really missing is the real-life cases and practical training, especially in recognising different conditions and distinguishing between similar cases. So, it seems that pharmacists are only as well educated as they continue to engage after university, because what we gain during our studies is mostly theoretical”

Regulatory and financial barriers

Participants also noted a lack of locally adapted professional guidelines and regulatory limitations that constrain standardised and confident decision-making. In Switzerland, the medicines and services that pharmacists are authorised to provide as part of dermatological care, including telemedicine consultations, are not reimbursed by compulsory health insurance. Financial barriers for patients are therefore highly present and prevent low-threshold, equitable access to medical advice.

“Cost is a barrier in New Zealand for low-income patients to access treatments via the pharmacy. Many OTC products are funded if they are on a prescription.”

Workload, time constraints and professional perception

Pharmacists face daily organisational barriers, including time management pressures, intense daily workload, and the absence of suitable spaces to provide professional services in greater depth, compounded by limited patient and physician awareness of their clinical role.

“Further challenges are represented by time management constraints and the intensity of daily workload, combined with a still partial awareness among patients of the pharmacist's role; together, these factors reduce the potential to deliver more structured and comprehensive care.”

“In the Spanish healthcare system, a limited perception of the community pharmacist's care role persists in certain areas, which may hinder greater integration of pharmacists into collaborative care models with other healthcare professionals.”

4.1.4 Collaborations between pharmacists, other healthcare professionals and the public

Interprofessional collaboration is key to improving outcomes in dermatological health. The following approaches and models were proposed to enable the realisation of the full value of pharmacists in dermatological care:

1. Greater integration of pharmacists into multidisciplinary teams, with clearly defined roles;
2. Development of effective models of interprofessional exchange and collaboration;
3. Adoption of shared, validated clinical protocols with primary care and dermatology;
4. Establishment of structured communication channels between healthcare professionals, which facilitate the joint monitoring of certain dermatological conditions and improve continuity of care for the patient;

5. Use of digital tools to enable dermatological consultations in pharmacies, supported by online physicians through telemedicine;
6. Promote interprofessional training programmes and education, which foster mutual understanding of competencies and contribute to improving coordination between pharmacists, primary care doctors and dermatologists;
7. Raise patient awareness of the dermatological services available at the pharmacy;
8. Monitoring of dermatological treatments, reinforcing treatment adherence, monitoring potential adverse effects and providing health education to patients.

Pharmacists are uniquely positioned to bridge the gap between cosmetic innovation and healthcare standards. They help to improve access to dermatological care, optimise the use of healthcare resources and improve clinical outcomes for patients.

“Integrating pharmacists more intentionally into the skincare and personal care value chain will elevate industry standards and align product development with global best practices.”

To better illustrate this, a participant from Switzerland highlighted the success of a 2025 pilot project of a skin cancer screening campaign in pharmacies and the launch of a nationwide awareness campaign of pharmacy services.

“It is important to promote interprofessional exchange and collaboration. It is also important to raise awareness among customers about the services available at the pharmacy. PharmaSuisse is currently launching a nationwide campaign called ‘Green Light’ to draw attention to the services available at the pharmacy. The aim of the campaign is also to ensure that customers know when to visit the pharmacy and when to go straight to the doctor.”

4.1.5 Key dermatological indications representing priority areas for pharmacist involvement globally and regionally

Photoprotection emerged as the primary area of need and the greatest opportunity for pharmacist involvement. Beyond supporting safe sun exposure, it plays a critical role in the prevention of skin cancer, positioning pharmacists as key providers of evidence-based guidance.

In daily community pharmacy practice, several dermatological indications further highlight the importance of pharmacist involvement. There is a rising prevalence of sensitive and reactive skin, requiring careful product selection and patient education. Acne remains one of the most common conditions encountered, where pharmacists play a key role in supporting appropriate treatment choices and improving adherence. In addition, allergic skin reactions, particularly during summer, are becoming more frequent, reinforcing the pharmacist’s role as a first point of contact for initial assessment and management. Participants also emphasised the importance of pharmacist involvement in the management of atopic dermatitis, fungal infections, minor skin infections and wound care. In these areas, pharmacists contribute through early recognition, initial management, and timely referral when necessary. Their role is further strengthened by the time they spend with patients, particularly in explaining the correct use of treatments such as emollients, topical corticosteroids and other prescription therapies.

4.1.6 Environmental and lifestyle factors influencing skin care conditions

Environmental factors such as dry air, pollution, and sun exposure play a major role in skin health. For instance, reduced ozone coverage in New Zealand has contributed to high rates of melanoma. Similarly, in Spain, prolonged exposure to solar radiation is a key driver of skin cancer, photodermatoses, photoaging, and hyperpigmentation. In addition, everyday exposures, including excessive heating, air conditioning, and cold wind, can aggravate dermatological conditions. High levels of air pollution, particularly in large urban areas such as Madrid, further contribute to the deterioration of skin barrier function, especially when combined with ultraviolet radiation.

“The reduced ozone coverage causes high rates of melanomas, etc. The public is encouraged to get moles checked for changes, etc., and patients will ask the pharmacist for their opinion. I don’t think that pharmacists always know which ones to refer.”

Lifestyle factors also have a substantial impact on skin health. Habits such as frequent washing, using hot water, and harsh cleansers can lead to skin dryness and impair the skin barrier. More broadly, diet and overall lifestyle behaviours play an important role in maintaining skin integrity and resilience. Through accessible, daily interactions, pharmacists can educate patients and provide a holistic approach to skin health management.

“In this context, moisturisation should be promoted as a daily routine, with products selected according to season and skin type. Pharmacists therefore play a key role in educating patients and encouraging simple yet effective behavioural changes, often through brief but impactful interactions.”

4.1.7 Adapting communication strategies to populations

Participants highlighted the importance of adapting approaches and communications according to age group and specific patient populations:

- 1. Infants: Infant skin requires particular caution and knowledge to enable confident differential diagnosis and successful triage.
- 2. Adolescents: With younger populations, education on the correct and appropriate use of products is essential, particularly for teenagers managing acne.
- 3. Older patients: The emphasis should be on supporting and simplifying skincare routines. Skin fragility related to ageing must be considered carefully, with particular attention to educating patients about appropriate product choices.
- 4. High-risk groups: For sensitive populations such as oncology patients and pregnant women, a higher level of awareness is needed, especially in recognising red flags and adapting recommendations accordingly.
- 5. Low-income patients: Financial barriers prevent access to pharmacy-based treatment for some patients, even though pharmacies represent one of the most accessible touchpoints for at-risk groups.

4.2 Educational and knowledge gaps in dermatological conditions

4.2.1 Current situation regarding training in dermatology within pharmacy degree curricula and continuing professional development

Table 4 provides a country-specific comparison, highlighting a strong global consensus on existing educational gaps, particularly the imbalance between theoretical knowledge and practical competencies. While continuing professional development partially addresses these gaps, variability in access and structure remains a key challenge. In addition, participants emphasised that dermatology requires significant hands-on experience, making it difficult to fully address these needs within traditional undergraduate curricula alone.

Table 4: Undergraduate and continuing professional education in dermatology

Country	Undergraduate curriculum	Continuing professional development (CPD)
Asia (general)	Limited and fragmented; predominantly theoretical; low clinical exposure; weak patient assessment skills; formulation briefly covered; limited dermatology-focused internships	Gaps in structured CPD; variable access and insufficient depth
Bosnia and Herzegovina	General coverage with basic knowledge; limited depth in product knowledge and practical application; dermocosmetics are more prominently represented, reflecting efforts to align with evolving market trends, but gaps remain in translating this knowledge into effective patient counselling	Strong need for more structured, practice-oriented CPD to support real-life decision-making

Canada	Highly variable self-care education (13–91 hours); inconsistent coverage of key conditions (e.g., acne, atopic dermatitis); major gaps in oncology skin toxicities and sun-related damage; limited skin of colour training	Use of tools such as DermNet; CPD exists, but gaps remain in key competency areas
Germany	Comparable to other countries; dermatology is not strongly emphasised; compounding remains an important component of practice	Comparable need for CPD; strong role of compounding and collaboration with dermatologists
Italy	Limited and insufficiently structured dermatology training; dermocosmetics, formulation, and galenics are minimally integrated; gap between education and practice needs	Mainly addressed through postgraduate education and CPD; still insufficiently structured
Malaysia	Strong emphasis on experiential learning; hospital exposure integrated (e.g., 8-week placements) and also community pharmacy exposure to bridge the theory–practice gap	Not clearly specified
New Zealand	Focus on common conditions (acne, dermatitis, photoprotection); limited coverage of complex conditions (e.g., drug-induced reactions); reduced emphasis on compounding; use of tools such as DermNet	CPD varies; some pharmacists pursue additional training (often industry-supported); small group of specialised pharmacists
Nigeria	Foundation in pharmaceuticals and formulation, but not enough; limited clinical dermatology training and diagnostic skills	Needs strengthening in dermatology-specific CPD
Spain	Limited dermatology content; dermopharmacy taught as an optional short module (~4 months)	Well-developed: postgraduate courses, master's degrees, CPD programmes, and strong support from professional bodies (workshops, guidelines, tools, conferences, digital resources)
Switzerland	Strong theoretical foundation but limited practical application; formulation and galenics are taught through practical laboratory work, with focus remaining largely on manufacturing processes rather than on their role in supporting clinical decision-making and individualised patient advice	Highly developed and valued; multiple providers offering courses and specialisations (e.g., “skin pharmacy”), largely voluntary
United Kingdom	Basic knowledge provided but limited development of differential diagnosis skills; emerging improvements (e.g., skin of colour training and more practical approach)	CPD available; examples include pharmacist-led services and pilot programmes (e.g., psoriasis management)
United States	Limited and decreasing emphasis; short modules (~2 weeks) or dispersed content; focus on OTC/basic triage (non-prescription courses, APHA resources)	Available but variable; gaps remain in clinical decision-making (e.g. Rx vs OTC)

Participants noted that the progressive reduction of compounding training in certain curricula limits pharmacists' understanding of key formulation principles, such as vehicle selection, stability, and drug delivery, which are essential for optimising therapeutic outcomes in dermatology. The growing presence of inadequately trained individuals in product formulation raises concerns regarding product safety, efficacy, and regulatory compliance. Through training in pharmaceuticals, stability, microbiology, quality assurance, and patient safety, pharmacists can offer significant added value in formulation science.

4.2.2 Existing key gaps in dermatological knowledge

Differential diagnosis and clinical assessment

Gaps in differential diagnosis were consistently identified as a major limitation in dermatological practice. In Spain, diagnosis remains the exclusive responsibility of physicians, positioning pharmacists primarily in a

detection role rather than clinical decision-making. However, even within this scope, pharmacists reported limited confidence in recognising and differentiating dermatological conditions. In addition, insufficient training in recognising conditions across different skin types, particularly skin of colour, further increases the risk of misinterpretation or delayed identification of dermatological conditions.

“The biggest gap lies in diagnosis, as dermatology requires practical experience. If a consultation has taken place, it is the pharmacist’s responsibility to offer the patient a follow-up so that he/she can learn from the consultation.”

Patient counselling and therapeutic guidance

Patient counselling represents another critical gap, particularly in translating knowledge into clear, practical advice. Participants highlighted challenges in areas such as corticosteroid literacy, including appropriate potency selection, duration of use, and application techniques. Notably, “corticophobia” was reported not only among patients but also among pharmacists, reflecting underlying uncertainty in clinical use.

“In terms of steroid potency, we have dermatologists who explain to the patients how to use them, which does not always align with our instructions, i.e., ‘use sparingly’.”

More broadly, there is a need for stronger competencies in providing individualised guidance, including UV risk assessment, skin type evaluation, and appropriate product or treatment selection based on patient-specific characteristics. These elements were identified as essential foundations for effective dermatological care, but are not consistently embedded in current training frameworks.

Product selection and dermocosmetic expertise

This area represents both a gap and an opportunity. In some settings, such as Switzerland, advanced competencies in formulation and compounding, particularly the preparation of individualised topical treatments, are highly valued by both dermatologists and patients. However, this competency is not consistently developed across countries, and its practical application remains uneven.

Referral practices

Uncertainty around referral practices emerged as another key challenge. Difficulties in identifying clear referral thresholds, particularly in distinguishing between conditions that can be managed in the pharmacy and those requiring medical intervention, exist. Importantly, participants emphasised that this gap is not solely related to knowledge of individual conditions, but rather to the absence of structured decision-making frameworks. The lack of clear protocols and operational pathways limits pharmacists’ ability to act confidently and consistently in dermatological care.

“The main gaps are not related to knowledge of individual skin conditions, but more importantly, to the lack of clear and practical operational protocols. The absence of structured decision-making pathways represents a key limitation in strengthening the pharmacist’s role in dermatological care.”

“Structured decision-making processes, such as algorithms, can be a useful starting point, but they are not always sufficient. Skin conditions are not always straightforward.”

4.3 Effective education and learning models

4.3.1 Effective learning formats for pharmacists

Flexible, interactive, and case-based learning formats were consistently identified as the most effective for pharmacists, outperforming traditional on-site or live training sessions. Participants highlighted several preferred learning models, including online continuing education, interactive workshops, peer discussions with dermatologists, case-based studies supported by real-life images, and on-demand webinars.

Online training allows pharmacists to access up-to-date content and undertake training at times that best suit their professional activities, facilitating wider participation across their country. These formats offer several

advantages: compatibility with pharmacists' work schedules, more engaging and particularly appealing to younger pharmacists, and enable the direct application of knowledge to real-life scenarios. However, in some areas, professional bodies still promote face-to-face conferences and meetings, which allow pharmacists to interact directly with industry experts, learn about the latest scientific developments, and foster professional exchange and networking. As such, the most effective training models tend to be blended formats that combine a theoretical component with a practical component based on real-life situations encountered in community pharmacy practice.

“When it comes to dermatology, it is also extremely important to provide adequate training for the entire pharmacy team, as the pharmacist is usually not the first point of contact. This is why flexible formats are also easier to organise within a pharmacy. It is appreciated when learning can take place using case studies, including real-life images. Interaction with and learning from a dermatologist is also appreciated.”

“Flexible learning formats are essential to ensure effective training for pharmacists, particularly in the context of demanding daily practice.”

“Interactive workshops and case-based learning are probably the most engaging and especially appealing to younger pharmacists.”

In specific contexts such as Spain, the General Pharmaceutical Council of Spain and the Official Pharmacists' Chambers are actively committed to developing training programmes accredited by the Continuing Education Commission of the National Health System. This accreditation ensures scientific rigour and allows courses to award official continuing education credits, which can be considered in professional processes such as competitive examinations or tenders for the allocation of new pharmacy premises. On the other hand, as no specific certification is required to practise dermopharmacy in community pharmacies in Spain, formal certification programmes are currently of less interest to many pharmacists compared to other models of continuing professional development.

4.3.2 Collaboration needed to co-develop practical and accessible educational resources

Partnerships between professional organisations and industry were identified as essential to support the development of structured educational pathways. The dermatological industry plays a key role in supporting education grounded in clinical and scientific evidence, practical experience, patient trends across different markets, and real-life patient scenarios.

Participants mentioned that FIP could analyse the various pharmaceutical intervention strategies for dermatological conditions in different countries and promote the development of pharmaceutical intervention protocols or guidelines. For example, participants suggested developing workshops based on complex, real-life cases, including detailed guidance on product selection and the rationale behind combining specific active ingredients. Another important insight was the need to strengthen collaboration between academia and practice to ensure continuity from undergraduate education to ongoing professional development.

Overall, these collaborations should aim to build strong synergy between dermatologists and pharmacists and to create interdisciplinary, evidence-based, and practice-oriented learning resources that reflect real-life patient care.

4.3.3 Potential consideration of dermatology as a specialist competency within professional frameworks

When discussing whether dermatology should be considered a separate speciality, participants generally emphasised that the priority should be about strengthening competencies within existing pharmacy practice frameworks, rather than creating a fully distinct speciality. In particular, reinforcing foundational knowledge for all pharmacists was seen as essential to provide appropriate health advice to the public.

“The high demand for advice from the public means that pharmacists must be prepared to identify possible skin conditions, guide patients in the initial management of minor symptoms, recommend adjunctive dermocosmetic treatments, promote skin care measures, and refer patients to a doctor when necessary for diagnosis and pharmacological treatment.”

“Dermatology should be considered a focused area of advanced competency within pharmacy practice, rather than a fully separate speciality.”

At the same time, given the breadth of dermatology and the current shortage of qualified specialists, participants highlighted the importance of expanding opportunities for advanced education and specialisation for those who want to explore it. This would enable pharmacists to develop their expertise further in this area while continuing to support their role in primary care.

Overall, this reflects a balanced perspective in which dermatology is integrated within pharmacy practice, while offering structured pathways for advanced competency development. As such, dermatology is increasingly recognised as a highly relevant area of expertise, given its frequent occurrence in everyday patient interactions and its growing importance in primary care.

“All pharmacists should have a solid understanding of the basics, with opportunities for those who want to explore this area more deeply.”

4.4 Patient services

4.4.1 Pharmacist-led skin health services could be implemented or expanded

Participants suggested pharmacist-led skin health services that would consequently improve the quality and consistency of counselling provided in pharmacies. These include:

1. Structured skin screening activities supported by dedicated questionnaires, which identify patient needs, guide appropriate recommendations and facilitate early detection of dermatological conditions.
2. Chronic skin disease management that can optimise treatment use and support patient self-management.
3. Pharmacist-initiated therapy to contribute to symptom resolution and enable timely treatment and referral.
4. Pharmacist-led dermatology clinics to provide “in-between” care between consultations and strengthen collaboration with specialists and primary care.

Participants also have shared examples of effective pharmacist-led services from their countries:

Table 5: Examples of effective pharmacist-led skin health services

Country	Examples
Bosnia and Herzegovina	Dedicated consultation areas for acne management, addressing psychological and social impact
Canada	Large-scale implementation of pharmacist-led minor ailment services ²⁸ ~97% symptom resolution or improvement <0.2% adverse events Protocol-based prescribing (e.g., corticosteroids with mandatory adjunct skincare) (outcomes data accessible through FLOWsights : app.mapflow.ca/flowsights)
Spain	Dermopharmaceutical service, including reviewing the patient’s pharmacotherapy, assessing environmental and personal factors that may influence the skin, reviewing the patient’s skincare routine and, where appropriate, providing advice on food supplements related to skin health
Switzerland	Interprofessional collaboration with dermatologists Joint campaigns Telemedicine consultations
UK	Pilot studies in psoriasis and eczema showing improved disease outcomes and quality of life

Gathering evidence from different countries and studies helps identify best practices and build a reference model. This can support the development of a framework adaptable to different healthcare and regulatory contexts. In parallel, such evidence can be used for advocacy to drive policy change, secure funding, and strengthen pharmacists' credibility in expanding their role in dermatology care.

4.4.2 Ethical and effective integration of dermocosmetic counselling

A key challenge identified is the potential conflict between pharmacists' clinical role and the commercial environment of community pharmacy. To address this, dermocosmetic counselling must remain firmly anchored in patient benefit and clinical relevance. Participants emphasised that pharmacists should feel confident providing recommendations without concern for commercial bias, supported by structured and evidence-based approaches.

Recommended tools and approaches include:

1. Structured consultation frameworks with checklists
2. Patient-centred communication strategies
3. Use of evidence-based guidelines
4. Standardised documentation and follow-up protocols
5. Clear criteria for referral to a doctor.

4.5 Regional insights and practices

The way dermatology is taught, practiced and prioritised, as well as enablers supporting the delivery of pharmacy-led dermatology services across various countries, is summarised in Table 6.

Table 6: Countries' practices and enablers that support pharmacist-led dermatology services

Country	Examples
Bosnia and Herzegovina	Dermatology education for pharmacists is similar in Italy. Pharmacists are actively involved in counselling, prevention, and supporting the implementation of therapy. However, they are not authorised to prescribe or extend prescriptions issued by physicians, as the current regulations do not allow it. This restricts the scope of practice and limits potential contribution to dermatological care.
Canada	There are several common ailment prescribing workflow tools available in pharmacy locations that support clinical decision-making and documentation, e.g., MAPflow, MedSask, etc. These tools provide confidence and competence to assess and prescribe or refer when needed and to prescribe if necessary, and capture valuable outcomes data. Regulation and a combination of broad stakeholder engagement, implementation science, and a prospective evaluations framework were instrumental in building Ontario's minor ailment prescribing service.²⁹ The regulation was the starting point, not the finish line. What made it work was everything built around it.
Italy	Dermatology education is not strongly emphasised during undergraduate training and is mainly developed through postgraduate education and continuing professional development. This highlights the importance of lifelong learning to address existing gaps in dermatological competencies. In practice, pharmacists are actively involved in counselling, prevention, and the management of dermatological conditions. However, their role in more advanced clinical or diagnostic activities remains limited by the regulatory framework.
New Zealand	Dermatology is included within undergraduate curricula through dedicated modules, and community pharmacy is widely recognised as a first point of contact for dermatological

	advice and treatment. Pharmacists have access to “pharmacist-only medicines”, some of which would be considered prescription-only in other settings, reflecting a level of regulatory trust and expanded scope of practice. However, despite this enabling regulatory framework, remuneration for pharmacists’ services is lacking. Patients often bear the full cost of both advice and recommended products, which can limit access and reduce the impact of pharmacist-led care.
Spain	Undergraduate pharmacy training is approached from a care-based perspective within community pharmacy, which includes content related to skin physiology, pharmacology applied to dermatological conditions, and dermopharmacy. However, specialisation in this field is generally developed later through continuing professional development programmes, master’s degrees, and specialised courses. In practice, dermopharmacy is strongly embedded within community pharmacy due to the high frequency of skin-related consultations. Pharmacists often act as the first point of contact for patients and play a key role in providing health advice, managing dermatological conditions, educating patients, and referring to physicians when necessary. This role is supported by several enabling factors, including legislation that recognises community pharmacists as healthcare professionals, allowing them to deliver pharmaceutical care and health education in dermatology. In addition, professional bodies such as The General Pharmaceutical Council of Spain and the Official Pharmacists Chambers are actively present and develop protocols, training programmes, and tools that facilitate service implementation. The extensive network of over 22,000 community pharmacies further ensures high accessibility of these services to the population.
Switzerland	Pharmacists benefit from an expanded scope of practice, including the ability to prescribe medicines for certain dermatological conditions and compounding, which acts as a strong enabler for their role in patient care. However, these services are not consistently covered by insurance, creating a financial barrier that may limit patient access and reduce the uptake of pharmacist-led interventions.
UK	Access to secondary care is very difficult with long waiting lists. The rationale for these pharmacy-led services is to ensure that patients get adequate care and know how to use their treatments properly to improve possible outcomes. This pharmacy-level service reduces pressure on GPs or the demand to be referred to secondary care.

4.6 Recommendations for FIP

Building on the findings from the insight board, there is a clear opportunity for FIP to play a central role in promoting and advancing dermatological care within pharmacy practice globally. This requires a coordinated approach that combines the development of practical guidance, flexible education models, advocacy efforts, and system-level support. Importantly, recommendations should remain adaptable to different regulatory, cultural, and healthcare contexts, ensuring relevance and feasibility across countries. The recommendations highlighted by participants are summarised below:

1. Develop interactive and practical dermatology guidance on photoprotection, acne, skin repair, atopic dermatitis, and oncology related skin toxicities to inform pharmacists’ knowledge and skills and support.
2. Strengthen education through flexible and continuous learning models to ensure continuity between undergraduate education and continuous professional development.

3. Enable pharmacist-led dermatology services by providing practical tools and implementation frameworks to facilitate integration into existing practice.
4. Develop a strong advocacy and evidence structure to demonstrate economic and systemic impact, and communicate value to policymakers, funders, the public and pharmacists.
5. Promote global collaboration and knowledge sharing through shared best practices, case studies, and dermatology-focused events and symposia.
6. In line with FIP policy to work across disciplines and areas of expertise, where appropriate, to engage the support and expertise of dermatologists in guidance and training as well as drawing upon their expertise and experience in digital events, symposia and congresses, ensuring that such expertise is readily available.

5 Conclusions

Pharmacists are already contributing meaningfully to the management of common skin conditions across different care pathway, from advice on self-care and over-the-counter treatments to follow-up, referral, and support for the safe and appropriate use of medicines and dermocosmetic products, to responding to skin related side effects of medicines. The findings in this report show that skin-related enquiries are a routine part of pharmacy practice and that pharmacists often represent an accessible first point of contact for patients seeking support. At the same time, the report makes clear that the full potential of pharmacy in dermatological care is not yet being realised. Across countries and settings, pharmacists' contribution remains shaped by education gaps, limited access to structured guidance, uneven scope of practice, insufficient service infrastructure, and lack of remuneration.

The survey and insight board together point to a consistent message that, as expected, pharmacists report being most confident in managing common and frequently encountered dermatological concerns, but less confident in relation to higher risk, less familiar, or more complex presentations, particularly where stronger assessment skills, clearer referral thresholds, and more structured clinical support are needed. This reinforces the importance of practical competency development, case-based education, locally relevant guidance, and stronger integration with wider health systems. It also highlights the need to move beyond viewing dermatology support in pharmacy as informal or incidental, and instead to recognise it as an increasingly important area of practice that can contribute to timely care, continuity, and health system efficiency.

Looking ahead, strengthening pharmacy's role in skin health will require coordinated action across education, practice, policy, and advocacy. This includes improving access to practical training and decision support tools, developing clearer referral and service pathways, strengthening collaboration with other health professionals, and creating enabling regulatory and funding environments.

FIP is well placed to support this agenda through guidance development, workforce support, evidence generation, advocacy, and global knowledge sharing. By building on the findings and recommendations presented in this report, there is a clear opportunity to strengthen pharmacist-supported dermatological care and improve access to safe, person-centred skin health services worldwide and a series of supported interventions to build capacity and capability in our pharmacy workforce globally.

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Annex 1 Insight board participants

Chair		
Catherine Duggan	CEO, FIP	UK

FIP Team	
Nisa Masyitah	Data and Intelligence Manager
Stephanie Rakotomalala	Disease Prevention and Self-Care Programme Intern
Mfonobong Timothy	Disease Prevention and Self-Care Programme Manager

Participants		
Rhiannon Braund	Head of the School of Pharmacy and Biomedical Sciences, University of Waikato; Chair of the Dermatology Advisory Committee for PHARMAC	New Zealand
Chizaram Amarauche Chukwu	Consultant Pharmacist at Federal Medical Centre, Abuja; Chief Product Officer at Speckles Beauty	Nigeria
Mohamed Elsbakhawi	Pharmacist/Owner, Shoppers Drug Mart, Mississauga	Canada
Nina Griesse-Mammen	Head, Division Scientific Evaluation, Department of Medicine, ABDA - Federal Union of German Associations of Pharmacists	Germany
Allan Mathews	Dean, Faculty of Pharmacy, Quest International University	Malaysia
Nardine Nakhla	Associate Professor, School of Pharmacy, University of Waterloo	Canada
Katherine O'Neal	Member, American Pharmacists Association	USA
Rajani Shakya	Professor, Department of Pharmacy, Kathmandu University	Nepal
Rod Tucker	Practising community pharmacist and independent researcher; Specialist guest lecturer, University of Bradford (part-time)	UK
Regina von Burg	Member, Pharmasuisse	Switzerland
Ana Zovko	Executive Member, Community Pharmacy Section, FIP	Bosnia and Herzegovina
Participants who submitted written responses		
Carolina Martinez-Berganza	Director of International Affairs, General Pharmaceutical Council of Spain	Spain
Paolo Levantino	Clinical Pharmacist, Journalist and Scientific Consultant, Secretary of Fenagifar (National Federation of Young Pharmacists Associations)	Italy

Observers from LRP	
Caroline Bissières	Director of Medical Development – Active Cosmetics
Sirine Oueida	Global Medical Relations Assistant
Charles Ribeyre	Education & Pharmacy Communication Director

Annex 2 Survey questions

The survey questions below are presented in a simplified format for reference. Internal survey programming instructions, display logic, comments and implementation notes have been removed. Some questions were shown only where relevant based on respondents' previous answers.

Screening question

Do you currently practise or work in a community pharmacy or primary care setting?

- ☐ Yes
- ☐ No

Section A. Practice profile

A1. What best describes your main practice setting?

- ☐ Community pharmacy, independent
- ☐ Community pharmacy, chain/corporate
- ☐ Primary care clinic or medical centre pharmacy
- ☐ Hospital outpatient pharmacy
- ☐ Other, please specify

A2. In which country do you primarily practise?

Drop-down list

A3. Where is your primary practice located?

- ☐ Urban/metropolitan area
- ☐ Semi-urban/town
- ☐ Rural or remote area

A4. What is your current role?

- ☐ Community pharmacist, staff/employed
- ☐ Community pharmacist, manager/owner
- ☐ Pharmacist in primary care or clinic-based setting
- ☐ Trainee pharmacist/intern/pre-registration pharmacist
- ☐ Pharmacy technician
- ☐ Other, please specify

A5. How many years have you been practising in your current professional role?

Numeric entry: ____ years

Section B. Routine frequency of dermatological consultations

B1. Overall, approximately how often do you deal with skin-related queries?

- ☐ Very often, daily
- ☐ Often, a few times a week
- ☐ Sometimes, less than once a week
- ☐ Rarely, less than once a month
- ☐ Never
- ☐ Not sure/cannot estimate

B2. In your day-to-day practice, how often are you consulted about the following skin concerns or conditions?

Response options:

- ☐ Very often, daily
- ☐ Often, a few times a week
- ☐ Sometimes, less than once a week
- ☐ Rarely, less than once a month
- ☐ Never
- ☐ Not sure/cannot estimate

Items:

Inflammatory and chronic conditions

Acne

Atopic dermatitis/eczema

Sensitive or reactive skin, including allergic reactions

Psoriasis

Rosacea/facial redness

Baby/young child skin concerns, such as diaper rash, drool rash or lip-licking irritation

Scalp, infection and infestation-related presentations

Scalp and hair concerns, such as dandruff, seborrhoeic dermatitis or hair loss

Skin infections and infestations, such as warts, herpes, impetigo, scabies or head lice

Sun, wound and treatment-related presentations

Sun-related concerns, such as sunburn, sun protection or photosensitivity due to medicines or conditions

Minor wounds, skin barrier damage and post-procedure care, such as cracks/fissures, chapped lips, superficial burns, and care after laser, chemical peel, cryotherapy or stitch removal

Suspected medicine-related skin reactions, such as rash after starting a medicine

Skin problems associated with diabetes, such as very dry skin, slow healing or recurrent irritation

Skin side effects of cancer treatment, such as dryness, rash or sensitivity

Skin changes raising concern for skin cancer, including actinic keratosis

Skin conditioning and ageing-related presentations

Hyperpigmentation, such as melasma or post-inflammatory marks after acne

Ageing-related skin concerns, such as wrinkles, loss of firmness or anti-ageing products

B2x. Are there any common skin concerns you are consulted about that were not listed above?

☐ No

☐ Yes, please specify

B3. How confident do you feel managing the following skin concerns or conditions?

Response options:

☐ Very confident

☐ Somewhat confident

☐ Not very confident

☐ Not at all confident

Items were based on the skin concerns or conditions listed in B2, where applicable.

Section C. Current role in dermatology and services provided

C1. Overall, how would you best describe your role in managing common skin conditions in your current practice?

☐ Mainly provide advice when patients ask, without structured follow-up

☐ Provide advice and sometimes follow up with patients

☐ Actively involved in ongoing management, with follow-up and referral when needed

☐ Provide or lead a structured skin/dermatology service, such as a common ailment service or dedicated clinic

☐ Other, please specify

Section D. Guidance and tools

D1. In your setting, are there any local or national guidelines, protocols or frameworks that support pharmacists in managing common skin conditions?

☐ Yes

☐ No

☐ Not sure

D1a. If pharmacist-specific guidance is not available, are you aware of, or do you use, dermatology or primary care guidelines intended for other health professionals to support your practice?

☐ Yes

☐ No

☐ Not sure

D2. Which of the following types of guidance or tools do you use when supporting people with skin conditions? Select all that apply.

- ☐ National clinical guidelines
- ☐ Local pharmacy protocols or standard operating procedures
- ☐ Common ailment service pathways
- ☐ Electronic decision-support tools, such as within pharmacy software
- ☐ Toolkits or guidance produced by professional or public health bodies
- ☐ Educational materials or tools developed by manufacturers/industry
- ☐ General online resources, such as websites, forums or social media
- ☐ I do not routinely use any specific guidance or tools
- ☐ Other, please specify

D3. Among the skin concerns you encounter in practice, for which do you feel practical guidance or tools are most lacking? Select up to five.

Items were based on the skin concerns or conditions listed in B2, where applicable.

Section E. Condition-specific modules

E1. Acne management

E1.1. How confident do you feel about the following aspects of acne management in your practice?

Response options:

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ Not at all confident

Items:

Assessing severity and/or impact on quality of life for the patient and deciding when to refer
 Managing expectations and timelines
 Supporting adherence to long-term treatment
 Discussing antibiotic use and stewardship
 Dealing with treatment failure or recurrence
 Differential diagnosis

E2. Atopic dermatitis/eczema

E2.1. How challenging do you find the following aspects of eczema management in your practice?

Response options:

- ☐ Not challenging
- ☐ Slightly challenging
- ☐ Moderately challenging
- ☐ Very challenging
- ☐ Extremely challenging
- ☐ Not applicable

Items:

Differentiating eczema from other inflammatory skin conditions
 Identifying red flags requiring referral
 Advising on topical corticosteroid potency and duration
 Addressing patient concerns or fears about topical corticosteroids
 Supporting long-term self-management, such as emollients and trigger management

E3. Sun protection and skin cancer prevention

E3.1. In your current practice, how would you describe your role in relation to sun protection, including photosensitivity and photoageing? Select one.

- ☐ I mainly respond when patients ask about sun protection or sunscreen products

- ☐ I proactively start conversations about sun protection with at-risk patients
- ☐ I provide advice as part of organised campaigns, such as summer sun safety or skin cancer awareness
- ☐ I rarely provide advice on sun protection
- ☐ Other, please specify

E3.2. Are you familiar with any tools or approaches for recognising suspicious skin lesions that may require further assessment, for example, the ABCDE rule for moles?

- ☐ Yes, and I feel confident using them in practice
- ☐ I am aware of them but not confident using them
- ☐ I am not familiar with any specific tools

E3.3. Would you be interested in a more proactive role in skin cancer prevention and awareness?

- ☐ Yes
- ☐ No
- ☐ It depends on the training, tools and support available

E4. Oncology-related skin effects

E4.1. When supporting patients with skin problems related to cancer treatments, what kind of support do you usually provide? Select all that apply.

- ☐ Advice on managing dry skin, irritation or rash
- ☐ Advice on sun protection and photosensitivity
- ☐ Recommendations for supportive skin products, such as moisturisers, emollients or barrier creams
- ☐ Encouraging adherence to cancer treatment while managing skin effects
- ☐ Advising when to contact the oncology team or seek urgent care
- ☐ Other, please specify

E5. Medicine-related skin reactions

E5.1. When you see a possible medicine-related skin reaction, what do you usually do? Select all that apply.

- ☐ Check the medicine and information sources for known skin reactions
- ☐ Provide advice on symptom relief and skin care, such as emollients or sun protection
- ☐ Discuss the case with the prescriber and/or suggest changes to treatment
- ☐ Advise timely medical review, such as emergency department or same-day doctor
- ☐ Report the suspected reaction to a pharmacovigilance or safety monitoring system
- ☐ Document the suspected reaction in the pharmacy's own records
- ☐ Other, please specify

E5.2. In your country or region, how easy is it for you to report suspected medicine-related skin reactions to the national or regional pharmacovigilance system?

- ☐ Very easy
- ☐ Somewhat easy
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ I am not aware of how to report
- ☐ There is no such system, as far as I know

E6. Wound care and skin barrier repair

E6.1. How confident do you feel in the following aspects of supporting patients with minor wounds/skin barrier damage or post-procedure skin care?

Response options:

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ Not at all confident
- ☐ Not applicable

Items:

Assessing severity and identifying red flags that require medical review, such as spreading infection signs, non-healing or significant burns

Advising on basic wound/skin barrier care, such as cleansing, protection and barrier repair

Selecting appropriate over-the-counter products, such as antiseptics where appropriate, barrier creams or dressings
 Providing post-procedure supportive care advice, such as after minor procedures, peels or laser, within scope
 Counselling on follow-up and expected healing timelines

Section F. Professional judgement and decision-making

F1. How clear are you, in your professional role, about when a skin concern can be managed within your role versus when referral to another health professional is needed?

- ☐ Very clear
- ☐ Somewhat clear
- ☐ Not very clear
- ☐ Not at all clear

F2. In your setting, are there clear and practical pathways for referring patients with skin concerns to other health professionals, such as GPs, dermatologists or nurses?

- ☐ Yes
- ☐ No
- ☐ Not sure

F3. If referral pathways exist, how do they usually work in practice? Select all that apply.

- ☐ Formal referral forms or templates
- ☐ Electronic referral or shared digital systems
- ☐ Agreed local pathways or services, such as minor ailment schemes
- ☐ Direct communication with a prescriber or clinic, such as phone, email or secure messaging
- ☐ Informal arrangements, such as advising patients where to go
- ☐ Other, please specify

F4. After you refer or direct a patient with a skin concern, how often do you receive any feedback about the outcome, from the patient or another health professional?

- ☐ Often, most referrals
- ☐ Sometimes, some referrals
- ☐ Rarely, few referrals
- ☐ Never
- ☐ Not applicable

Section G. Education, training and system context

G1. Dermatology education and training

G1.1. At any stage in your career, what dermatology-related education or training have you received? Select all that apply.

- ☐ Content in undergraduate pharmacy training
- ☐ Content in postgraduate training or specialist programmes
- ☐ Continuing professional development courses on skin conditions
- ☐ Short workshops or webinars, such as from professional bodies or conferences
- ☐ Training provided by manufacturers/industry, such as dermocosmetics or products
- ☐ On-the-job learning and experience only
- ☐ None of the above

G1.5. Which types of education or training formats would you prefer for dermatology topics in the future? Select up to three.

- ☐ Short online modules or videos that can be completed in small blocks
- ☐ Interactive online courses with real-world cases and decision scenarios
- ☐ In-person workshops or seminars
- ☐ Written guidance or handbooks with practical algorithms
- ☐ Patient education tools, such as leaflets, posters or apps, to support counselling
- ☐ Accredited CPD programmes
- ☐ Training or updates delivered or sponsored by industry
- ☐ Other, please specify

G2. Scope of practice and prescribing context

G2.1. In your country or region, do pharmacists have any authority to initiate or adapt treatment for common skin conditions, for example through prescribing rights or structured common ailment services?

- ☐ Yes, pharmacists can prescribe independently for some skin conditions
- ☐ Yes, pharmacists can prescribe or supply under protocols or agreements, such as common ailment services or collaborative practice
- ☐ No, pharmacists do not have any prescribing or treatment-initiation authority for skin conditions
- ☐ Not sure

G2.1a. If yes, please briefly describe what pharmacists are allowed to do for skin conditions, for example renew prescriptions, start certain medicines or adjust treatment.

Open text

G2.2. In your current practice, are any of the following structured services for skin conditions available? Select all that apply.

- ☐ A pharmacy-led common ailment/minor ailment service that includes skin conditions
- ☐ Dedicated pharmacy consultations or clinics for skin concerns, such as acne or eczema
- ☐ Telehealth/teledermatology links to specialists for advice or referral
- ☐ Referral pathway with agreed criteria, such as local guidance for when/how to refer
- ☐ No structured services for skin conditions are available
- ☐ Not sure
- ☐ Other, please specify

G3. Remuneration and recognition

G3.1. Are pharmacists in your setting reimbursed or remunerated in any specific way for providing dermatology-related care, beyond the margin on products?

- ☐ Yes, through a specific fee for consultations or services related to skin conditions
- ☐ Yes, as part of a broader clinical service, such as common ailment or primary care service
- ☐ No, there is no additional remuneration for dermatology-related care
- ☐ Not sure

G3.1a. If yes, please briefly describe how this remuneration works, for example per consultation, per service, capitation or other.

Open text

Section H. Barriers and priority needs

H1. To what extent do the following factors limit your ability to provide effective care for people with skin conditions in your practice?

Response options:

- ☐ Not a barrier
- ☐ Minor barrier
- ☐ Moderate barrier
- ☐ Major barrier
- ☐ Very major barrier
- ☐ Not applicable

Items:

Practical constraints, such as limited time during consultations and/or lack of private space

Limited dermatology knowledge or confidence, including assessing skin problems or forming a working clinical judgement

Lack of practical tools or information, such as no clear protocols or limited access to patient records

Limited access to suitable treatment options or products

System or policy barriers, such as unclear referral pathways or regulatory limits on what pharmacists can do

Lack of remuneration or financial incentives for dermatology-related services

Patient expectations and perceptions, such as strong focus on cosmetic or brand demands, or limited awareness of pharmacists' clinical role

H2. How helpful would each of the following supports be in improving dermatology care in your practice?

Response options:

- ☐ Not helpful
- ☐ Slightly helpful
- ☐ Moderately helpful
- ☐ Very helpful
- ☐ Extremely helpful

Items:

Clear triage and referral criteria, including red flags

Practical algorithms/flowcharts for common presentations

Guidance on treatment selection, including over-the-counter and alongside prescribed therapy

Guidance for medicine-related skin reactions, including recognition, management and when to report

Guidance for diverse skin types/skin of colour

Patient-facing education materials, such as handouts, posters or digital tools

Digital decision support integrated in pharmacy systems

Targeted dermatology training using real-life cases

Stronger collaboration with other health professionals, such as easier access to GPs, dermatologists or nurses

Recognition or remuneration for dermatology-related services

H2a. Are there any other supports that would help improve dermatology care in your practice?

- ☐ No
- ☐ Yes, please specify

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