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Africa: Pathways to Health and Pharmaceutical Sovereignty

Health Resilience in Africa: Three Pathways from Practice — Trust, Institutions, and Economic Readiness

Internet Shutdowns During Elections and Their Impact on Public Health: Lessons from Uganda

Turning commitment into motion: Kenya's path to cervical cancer elimination

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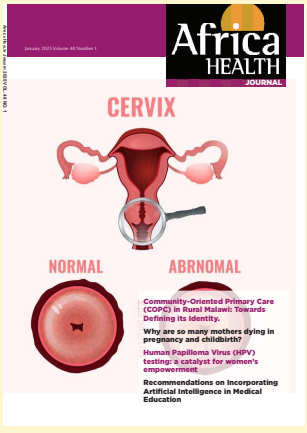
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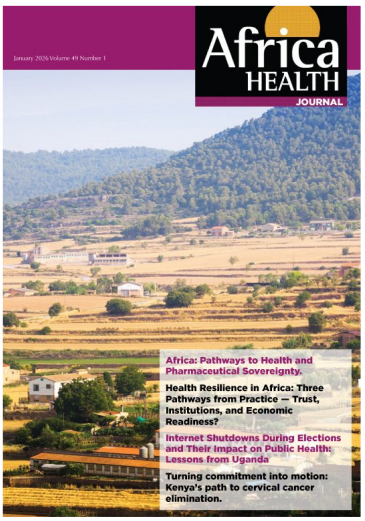


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Contents

Vol 49 No.1 January 2026



Editorial

03 Keeping People Healthy

Elsie Kiguli-Malwadde

Opinion

06 Beyond Treating Disease: Why Africa Must Start Measuring Good Health

David Ojut Okello

Features

07 Africa: Pathways to Health and Pharmaceutical Sovereignty

09 Health Resilience in Africa: Three Pathways from Practice — Trust, Institutions, and Economic Readiness

12 Internet Shutdowns During Elections and Their Impact on Public Health: Lessons from Uganda

David Ojut Okello examines how the internet and public health are intertwined, documents the harmful health effects of internet shutdowns, and offers practical recommendations on how to protect essential health connectivity.

15 A simple guide to toddlers and screen time

Jolandi Becker elaborates the dangers of technology on the social development and sleep pattern of toddlers .Giving advice on how it could be handled in a better way.

16 Turning commitment into motion: Kenya's path to cervical cancer elimination

Taofik Oloruko-Oba gives us a synopsis into the journey Kenya is undertaking in the fight against cancer of the cervix.

18 Building Resilient Youth: Sport-Based Mental Health and Addiction Prevention Systems – The MIK Health & Wellness Experience

Shummu-Ê-L Mulenga Bukata Chanda gives us an insight into the problem of addiction among the youth in Zambia and how an organisation he founded is tacking it.

22 €1M Awarded to Norwegian–Dutch Healthtech Team Developing Innovative Jaundice Solution for Newborns in Africa

Picterus AS (Norway) and GOAL 3 (Netherlands) together won the Eurostars grant of 1M EUR to bring new jaundice screening technology to healthcare settings where it is needed most, with the potential to impact millions of newborns and help prevent the severe health complications caused by untreated jaundice in low-resource settings.

24 Lancet Global Health publishes a study demonstrating Medicines for Malaria Venture's unmatched global health impact and value

29 The Future of Global Health Governance: Implications for Africa and a Continental Strategy Toward Agenda 2063

Patrick Kadama examines the recent geopolitical shifts, what it means for global health and the implications for Africa.

31 Education for peace, wellbeing and sustainability in Africa: Marking the Parameters

Obijiofor Aginam takes us on a journey of the linkage between education peace and wellbeing and elaborates on the proposal from UNESCO on how this can be done.

34 Yes! We Can End Tuberculosis If Communities Lead the Way

Medicine Digest

37 Abstracts from Renowned Journals

CPD Challenge

42 Test Yourself

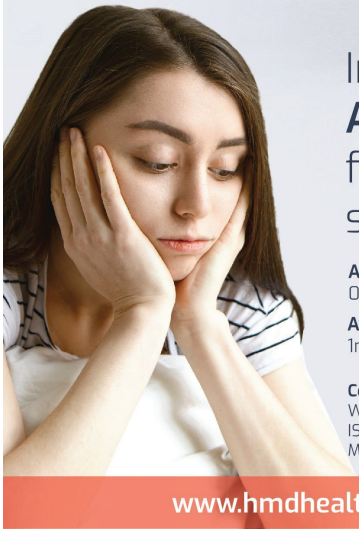
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Keeping People Healthy



January brings a cluster of global and national health observances that remind us prevention and wellbeing must lead our efforts if we are to build resilient health systems.

This issue opens with an opinion by Dr. David Okello, drawn from the recent East, Central and Southern Africa Health Community (ECSA-HC) ministerial meeting in Eswatini. He argues that African health strategies remain skewed toward emergency response and disease control. Dr. Okello calls for a reframing: count health, celebrate health and plan for health. His recommendations, shifting resources to preventive services, strengthening primary care, and embedding health promotion across sectors are practical guideposts for policymakers.

David O. Odhiambo's piece on pharmaceutical sovereignty complements that view by tracing pathways to a more self-reliant African pharmaceutical sector. Leading the African Pharmaceutical Network, Odhiambo makes the case for structured, context-sensitive interventions that shore up regulatory systems, local manufacturing, supply chains and human capital. His analysis underscores that access to medicines is as much about robust systems as it is about production.

Resilience is another recurring theme. Our article on health resilience distils lessons from Ebola, HIV and COVID-19 into three interlinked pathways: social and behavioral resilience, institutional and systems resilience, and economic/industrial resilience. Each pathway carries specific policy implications ranging from community engagement and risk communication to supply chain diversification and fiscal preparedness culminating in consolidated recommendations for governments and development partners.

Digital infrastructure and health connectivity also feature. David Ojut Okello examines the public-health consequences of internet shutdowns, showing how disrupted connectivity undermines emergency response, continuity of care and access to health information. His practical recommendations aim to safeguard essential health services and ensure digital networks remain available in crises.

We also tackle everyday health choices. An evidence-based article on screen time outlines how excessive exposure affects toddlers' brain development, social skills and sleep, and offers balanced guidance for caregivers seeking to use technology without compromising healthy development.

Cervical cancer remains a pressing challenge across Africa. Taofik Oloruko-Oba reviews Kenya's National Cervical Cancer Elimination Action Plan 2026–2030, aligned with WHO's 90-70-90 targets. He highlights the need for sustained political commitment, innovative financing, and community engagement to overcome cultural barriers and low participation. With the right investments, cervical cancer can move from a leading cause of death to a largely preventable condition.

Youth mental health and substance abuse receive focused attention in Shummu-Ê-L Mulenga Bukata Chanda's report from Zambia. Describing the Sport for Mental Resilience model developed by MIK Health & Wellness, he argues for upstream, community-based prevention that keeps young people on healthy life trajectories rather than relying predominantly on treatment and crisis response. The model leverages routine sport engagement, simple psychosocial content and accountable referral systems—an evidence-aligned approach that produces measurable development returns and can be scaled with government, academic and donor partnerships.

Innovation and partnerships also bring tangible wins. We report on the Eurostars award to Picterus AS (Norway) and GOAL 3 (Netherlands)—a €1M grant to deploy new newborn jaundice screening technology where it is most needed. If scaled, this innovation could prevent severe jaundice complications in millions of newborns in low-resource settings.

An economic analysis published in Lancet Global Health shows the value of targeted investments: MMV's work on antimalarials delivered health benefits estimated at 13 times the investment between 2000 and 2023. This kind of return on investment should encourage funders to prioritize product development partnerships and long-term financing for health innovation.

Patrick Kadama explores how geopolitical shifts create both vulnerability and opportunity for Africa. He argues that the continent's place in the changing global health order will depend on institutional consolidation, fiscal credibility and coherent continental governance aligned with Agenda 2063.

Obijiofor Aginamgives us a narrative on global polycrisis, conflict, climate disasters, pandemics, inequality, digital dividesannd how all this undermines SDGs in Africa. He describes how UNESCO urges reimagined education promoting peace, health, sustainability, global citizenship, empathy, digital ethics and lifelong learning. Integrating education and health as social determinants can build resilient, inclusive societies and advance Agenda 2030 through policy, community, and international cooperation.

As always, this issue includes our Medicine Digest, quiz, news updates and advertisements. Africa Health Journal remains an open-access, web-based resource (www.africa-health.com) updated daily and engaging readers on social media. We invite readers and partners to support both print and digital editions as we work together toward stronger, prevention-oriented health systems for Africa.

Elsie Kiguli-Malwadde, Editor: Africa Health Journal,
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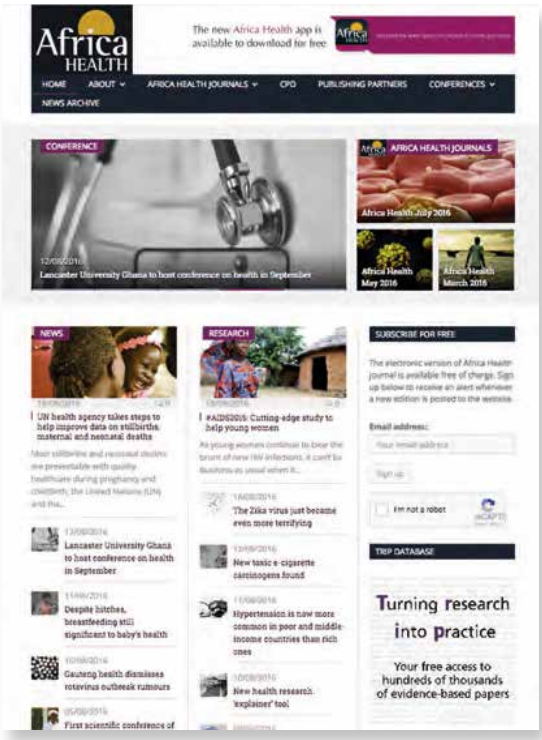
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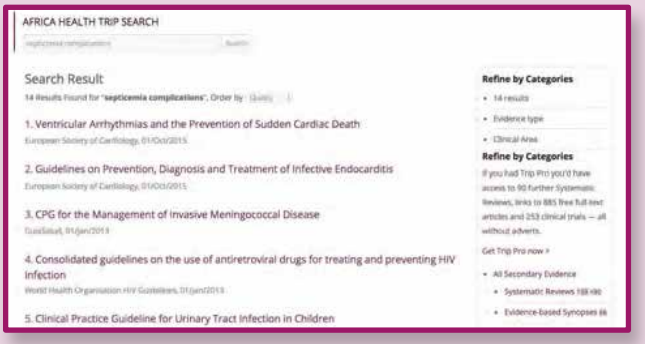
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Beyond Treating Disease: Why Africa Must Start Measuring Good Health



I recently returned from the East, Central and Southern Africa Health Community (ECSA-HC) Ministerial Meeting in Eswatini, where ministers and senior health leaders from across East, Central and Southern Africa confronted an uncomfortable reality: our health systems face shrinking donor funding, rising demand, and widening service-delivery gaps. Discussions focused on domestic resource mobilisation, governance, and sustaining essential services in an increasingly constrained fiscal environment.

Yet one observation stood out. Our health systems devote far more energy to responding to disease than to keeping people healthy.

We count infections, admissions, deaths, and stock-outs. We track outbreaks with urgency. We compile dashboards filled with disease-specific indicators. But where, in routine national reporting, do we systematically count people who are thriving? Where do we measure sustained well-being, resilience, productivity, or social participation?

Consider a familiar example. After becoming pregnant, a woman is closely monitored by the health system through antenatal visits and childbirth. But once delivery and immediate postnatal care are completed, she largely disappears from structured follow-up—unless illness brings her back. Her physical recovery, mental health, and social well-being in the years between pregnancies rarely attract systematic attention. In practice, the system waits for pathology before it responds.

This pattern reflects a deeper structural design flaw. National budgets, information systems, and performance frameworks are organised primarily around diagnosing and treating disease. Success is measured by reductions in mortality and morbidity—important achievements, but incomplete ones. Even where policy documents speak of well-being, prevention, and resilience, monitoring systems remain overwhelmingly disease-centric.

This orientation has been shaped by decades of vertical programmes and emergency responses. Disease indicators are concrete, measurable, and politically compelling. But their dominance has created a distorted picture of performance. We know in detail how people fall ill; we know far less about how they remain well.

Universal Health Coverage is often framed as access to services without financial hardship. That is essential—but insufficient. If UHC becomes synonymous with expanding treatment, we risk building increasingly expensive systems that chase illness rather than prevent it. True coverage should enable people to live healthy, productive, and dignified lives throughout their lifespan.

The Sustainable Development Goals call not only for reduced mortality but for the promotion of well-being. Yet in practice, our reporting frameworks emphasise deficits rather than assets. We measure what goes wrong more consistently than what goes right.

What would it mean to correct this imbalance?

First, we need a simple framework of indicators that reflect positive health. These need not be complex. Self-reported physical and mental well-being; the ability to work, learn, and perform daily activities without limitation; prolonged periods without need for curative care; maternal mental health beyond childbirth; independence and social participation among older persons—these are measurable realities. They tell us whether people are functioning well, not merely surviving.

Second, we should invest in understanding protective factors. In remote communities in Uganda and elsewhere, some individuals go an entire year—or longer—without visiting a health facility because of illness. Such experiences rarely appear in official statistics. Yet they may hold valuable lessons about social cohesion, environmental conditions, behaviours, and informal support systems that sustain health. By failing to document these realities, we overlook opportunities to strengthen prevention.

Third, measuring good health would strengthen the case for domestic investment. Ministries of finance rightly ask what returns health spending generates. A system that can demonstrate improved functionality, productivity, and resilience is better positioned to show that health is not merely a cost centre, but a foundation for economic and social development.

Some may argue that adding new indicators risks overburdening already stretched systems. But the greater risk lies in continuing to steer by an incomplete compass. When we measure only disease, we incentivise reactive and often costly care. When we also measure well-being, we encourage prevention, community engagement, and cross-sector collaboration.

Africa's health leaders have already endorsed the principles of people-centred care, prevention, and resilience. The policy language exists. What is missing is alignment between our rhetoric and our metrics.

As fiscal space tightens and expectations rise, the strategic question is not whether we can afford to measure good health. It is whether we can afford not to.

If we continue to define success solely by how effectively we treat illness, we will remain locked in a cycle of reaction. But if we begin to count health—systematically and visibly—we can reorient our systems toward sustaining well-being, not just managing disease.

It is time for African health systems to count health, celebrate health, and plan for health. Only then will universal coverage reflect the full meaning of what health was always meant to be.

Dr David Ojut Okello, Executive Director African Centre for Global Health and Social Transformation (ACHEST), Kampala, Uganda, dokello@achest.org

Africa: Pathways to Health and Pharmaceutical Sovereignty

David O. Odhiambo gives us an insight into pathways to health and pharmaceutical sovereignty in Africa.



Different types of drugs

From 15th to 16th December 2025, I had the privilege and opportunity to participate in a policy convening hosted by the Mahatma Gandhi Institute of Education for Peace and Sustainable Development (MGIEP) , a UNESCO category 1 Research Institute based in Delhi, India. The convening was hosted in Kampala, Uganda under the theme: **"Peace as the Foundation for Well-being and Sustainability in Africa."** This was an opportunity for the organization to convene stakeholders in the healthcare sector to assess the continental healthcare landscape, the intersection with peace and the need for structured interventions to deliver positive healthcare outcomes as a prerequisite for peaceful coexistence, wellbeing and sustainability in Africa.

Drawing on my work leading the African Pharmaceutical Network (APN) – a pan-African platform that works to strengthen Africa's pharmaceutical ecosystem through workforce development, business ecosystem support services and policy advocacy, I presented on the pathways to health and pharmaceutical sovereignty in Africa. This came at an opportune moment considering the developments that were taking shape in the industry from operationalization of the African Medicines Agency (AMA) to establishment of the African Pooled Procurement Mechanism (APPM) by the Africa CDC with commitment to strengthen local manufacturing.

Dr. David O. Odhiambo, Executive Director – African Pharmaceutical Network (APN), david.odhiambo@africanpharmanetwork.net

Health Sovereignty is the ability of nations to finance, produce, and govern their own health systems and countermeasures. Pharmaceutical sovereignty is the ability of nations to control their own health technologies ensuring reliable access to essential medicines, vaccines and diagnostics by building domestic research and development (R&D) and manufacturing, reducing reliance on foreign supply chains, and asserting control over health policies. Pharmaceutical sovereignty is especially vital during global health crises to counter supply chain fragilities as were witnessed during the COVID-19 pandemic.

It is critical that when we discuss health and pharmaceutical sovereignty, we put to context the human lives and livelihoods behind the numbers. With a population of approx. 1.3 billion, the continent imports between 70 – 90% of its pharmaceutical needs. For vaccines the continent produces less that 1%. These statistics point to an over-levered pharmaceutical system where external dependence exposes our people to risks which must be contended with. With growing risk of outbreaks in the continent, unless pragmatic solutions are designed to safeguard the pharmaceutical supply chain systems in the continent, the level of exposure in the event of an outbreak of public health interest arises will be catastrophic.

In my presentation I painted a picture of the landscape with focus on appreciating the reality of our circumstances and aiming to transform the narrative. The below table outlines some of the data on the current healthcare and pharmaceutical landscape in Africa.

Focus Area	Current Status
Disease Burden	• Africa has the highest burden of disease globally – 25% of global disease burden. • Infectious/communicable diseases account for approx. 60% of disease burden. • Growing burden of non-communicable diseases – approx. 40%. • Growing threat of disease outbreaks.
Healthcare Financing	• Poverty is a critical challenge with affordability of healthcare compromised. • Government budgets below 15% - Abuja Declaration. • Out of pocket financing predominant with insurance averaging 20%.
Health Workforce	• Africa currently has approx. 3% of global health workforce. • Africa is a net exporter of healthcare workers. • Underemployment or unemployment of healthcare workers a key challenge. • There are skills gaps in different segments of the healthcare impeding service delivery.
Data & Information	• Weak health information management systems (HIMS). • Data gaps in actual healthcare landscape to inform interventions. • Parallel health programmes which compromise continuity of care.
Medical Products, Vaccines & Technologies	• Africa imports more than 70% of medical products and technologies. Limited local manufacturing capacity. • Out of stock situation is a perennial problem in public health facilities with most patients purchasing products in the private market. • Quality of health products and technologies is compromised with substantial burden of substandard, counterfeit and falsified medicines. • Disjointed and weak regulatory systems for oversight of distribution and supply chain systems in the continent.
Multi-sectoral Approach	• There is a growing appreciation of multi-sectoral approach and public-private partnerships as an enabler for health & pharmaceutical sovereignty in Africa. • Mechanisms and frameworks for multisectoral collaborations and PPPs are nascent. • Limited number of bankable projects for effective PPPs in the continent. • Limited economic/financial muscle in the continent affects viability of private ventures serving as a deterrent for private investments.

Cognizant of these dynamics, there's need for structured and contextually sound interventions anchored on strengthening pharmaceutical systems in the continent. There is need for work to address key ecosystem hurdles and challenges in the continent with focus on:

- Workforce development - the growth of the industry is predicated on competent, skill and meaningfully engaged talent in the ecosystem. It's therefore imperative to invest in the right skills aligned with developmental priorities and industry needs. The African Pharmaceutical Network (APN) through the African Pharmaceutical and Biomedical Sciences Training Institute works to close this gap in collaboration with international organizations and pharmaceutical industries to deliver relevant training for the right skill needed by the industry.
- Economic incentives and ecosystem support services to attract investments into the industry. These range from technical support in maneuvering the regulatory landscape, understanding the market dynamics, optimizing reimbursement channels for products introduced in the market and enabling partnerships with ecosystem parts across the ecosystem. Through Ryculture Health and Social Innovation, the APN works to deliver bespoke advisory support services for players working in or venturing into the African pharmaceutical markets.



Female pharmacist working drugstore

[1]UNESCO MGIEP: https://mgiep.unesco.org/
[2]African Pharmaceutical Network (APN): https://africanpharmanetwork.net/
[3]African Medicines Agency (AMA): https://au-ama.africa/
[4]African Pooled Procurement Mechanism (APPM): https://africacdc.org/appm/

Health Resilience in Africa: Three Pathways from Practice — Trust, Institutions, and Economic Readiness

Robert Agyarko describes how Africa's outbreaks resilience depends on robust routine services, public trust, and institutions that can coordinate and act, embodied in three pathways: social/behavioural, institutional/system, and economic/industrial.

Abstract

Africa's repeated experience with HIV, Ebola, and COVID-19 shows that health resilience is not primarily built through written preparedness plans or imported technologies. Systems fail most severely where routine services are fragile, public trust is low, and institutions cannot coordinate at speed. This review synthesises practice-based lessons into three pathways for building resilience: (1) **social and behavioural resilience**, grounded in trust, leadership, risk literacy and faithful implementation; (2) **institutional and system resilience**, anchored in sustained capacity, coordination platforms and institutional memory; and (3) **economic, financial and industrial resilience**, including financial protection, logistics as core infrastructure, and domestic productive capacity for essential commodities during shocks. Across all three pathways, the critical operational test is implementation fidelity—whether designed interventions are delivered consistently, appropriately and at scale. The paper proposes a concise set of policy and delivery actions: institutionalise community trust and risk communication as a capability; fund coordination and surveillance as routine functions; strengthen financial protection and provider payment systems; elevate logistics performance and supply continuity; and treat industrial readiness as a health security asset. These actions offer a disciplined agenda for moving from crisis response to durable system strength in African contexts.

Keywords: resilience; health systems; trust; preparedness; financing; logistics; Africa; implementation fidelity

Introduction: why resilience fails in practice

In Africa, discussions of "health resilience" often begin with preparedness plans, emergency protocols and new technologies. Yet the recurring pattern across major shocks suggests a harder truth: health systems do not collapse because plans are missing; they collapse because everyday systems are already overloaded and brittle. When crisis arrives, it does not create weakness—it exposes it.

Over three decades, successive crises have functioned as stress tests. HIV demonstrated early that leadership, trust and collective behaviour could shift trajectories even before advanced treatment was widely available. Ebola exposed the speed with which fear and mistrust can outpace clinical response and amplify transmission. COVID-19 revealed how quickly supply chains, financing arrangements, workforce systems and public confidence can fracture under prolonged pressure.

A central lesson is that many countries often "know what to do". The constraint is execution: implementation with fidelity—whether what is designed is what is actually delivered, consistently, appropriately, and at scale in real environments. This review therefore focuses on operational pathways: what resilience looks like when it is practical, measurable and repeatable, not rhetorical.

To make the argument usable for frontline health workers, policy actors and academicians, this paper groups lessons into three pathways that are repeatedly observed in the African experience:

1. **Social and behavioural resilience**
2. **Institutional and system resilience**
3. **Economic, financial and industrial resilience**

Each pathway ends with specific policy implications, followed by a consolidated set of recommendations.

Pathway One: social and behavioural resilience

Resilience begins with people—trust, leadership, collective behaviour and risk literacy. Uganda's HIV experience in the 1990s is a widely cited illustration. Evidence suggests that behaviour change, credible public messaging and social mobilisation contributed to substantial reductions in HIV prevalence in the early 1990s, before treatment scale-up transformed outcomes.[1] [2] The point is not to simplify a complex epidemic into one factor. It is to highlight that the early turning of the curve depended heavily on societal response, not sophisticated technology.

Ebola in West Africa reinforced the same lesson. Beyond the tragic deaths, the outbreak showed that fear and mistrust can spread faster than pathogens where institutions are not trusted, where communities feel excluded, or where response is perceived as imposed rather than owned.[3] Communities that trust messages and messengers adopt protective behaviours earlier, disclose contacts more readily, and seek care sooner. Where trust is absent, resistance, concealment, and delayed care-seeking can accelerate transmission.

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This pathway has two practical implications that are often undervalued:

- **Trust is not a communication product; it is a governance outcome**. It is earned through respectful engagement, fairness in access, and consistent service delivery.
- **Behaviour change is not automatic once information is provided**. It requires credible leadership, culturally competent approaches, and aligned incentives.

Education is a quiet but decisive lever here—not only as curriculum, but as risk literacy, social learning and confidence in credible sources. In fragile settings, misinformation and polarisation can fracture the collective behaviours on which public health depends. Social resilience, therefore, includes the capability to withstand misinformation, sustain cooperation, and preserve legitimacy under stress.

Policy and delivery implications

1. **Institutionalise risk communication and community engagement (RCCE)** as a year-round capability, not a crisis add-on.
2. Build **trusted messenger networks** (community leaders, faith leaders, health workers, teachers) with two-way feedback loops.
3. Embed **risk literacy** in schools and community platforms, including digital literacy, to reduce misinformation vulnerability.

Pathway Two: institutional and system resilience

Crises are unforgiving to weak institutions—but kind to strong ones. Preparedness is often framed in terms of documents and plans. In practice, resilience is built through **coordination platforms, trained professionals, institutional memory, surveillance, and legitimacy**.

Senegal's Institut Pasteur de Dakar is a helpful illustration of sustained capacity. It has produced the yellow fever vaccine for decades, reflecting long-term scientific and manufacturing competence.[4] During COVID-19, it supported diagnostics and surveillance activities and has been positioned for expanded manufacturing capacity through further investment, including the MADIBA facility.[5] The central point is the timeline: institutions that perform in crisis are built patiently over years, not assembled during emergencies.

Nigeria's Centre for Disease Control provides a second illustration. The practical value of such institutions is that they serve as credible national anchors—able to coordinate surveillance, issue guidance, and communicate to the public. Evidence on NCDC's risk communication during the COVID-19 response underscores the importance of institutional authority and tailored communication approaches, including in low-literacy settings.[6]

Institutional resilience is also visible in the presence (or absence) of reliable coordination mechanisms. Emergency Operations Centres (EOCs), incident management systems, and functional coordination across ministries determine whether countries can mobilise quickly and sustain response operations. When these mechanisms are in place and routinely exercised, the response is faster, more precise, and more coherent. When they are improvised, gaps multiply.

Finally, institutional weakness has costs far beyond the health sector. Outbreaks disrupt trade, investment, tourism, workforce productivity and fiscal stability. This is why resilience should not be treated as a narrow health agenda—it is a national security and economic stability agenda.

Education contributes here through professional formation, leadership continuity and systems thinking—creating a workforce capable of operating across silos and sustaining competence across political.

Policy and delivery implications

1. Fund and professionalise **surveillance, EOCs and incident management** as routine functions, not donor projects.
2. Maintain **workforce surge capacity** (rosters, rapid training, deployment protocols).
3. Protect institutional continuity through **stable mandates, leadership succession planning and ring-fenced operating budgets**.

Pathway Three: economic, financial and industrial resilience

The third pathway is often discussed late but experienced early in every crisis: **money, logistics and productive capacity.**

Financial protection and system stability

Financial protection stabilises both household behaviour and service continuity. Ghana's National Health Insurance Scheme (NHIS) is an instructive example. While challenges are recognised—coverage gaps, benefit design constraints, reimbursement delays and sustainability pressures—review evidence indicates the scheme has influenced utilisation and reduced direct payment barriers in many settings.[7] The resilience logic is simple: when people have financial protection, they seek care earlier; facilities maintain more predictable revenue; and trust is less easily destroyed during shocks.

This yields a blunt conclusion: health resilience cannot be built on out-of-pocket payments and emergency donor appeals. Populations cannot finance their way through shocks; systems that rely on episodic external mobilisation remain brittle.

Logistics as infrastructure

Logistics is not a back-office function; it is resilience infrastructure. Rwanda's drone-enabled medical deliveries demonstrate the principle that technology works when embedded in a real operational need and integrated into national logistics. Gavi's documentation of Rwanda's national drone delivery service highlights the use case of urgent deliveries (such as blood), addressing geography and access constraints.[8]

However, similar technologies can fail when applied without fidelity—when used for non-urgent deliveries to already accessible facilities, without integration into supply systems, and without community confidence. The lesson is not "drones work" or "drones fail"; the lesson is

that technology does not create resilience—appropriate use does.

Industrial readiness as health security

COVID-19 demonstrated how dependence on global supply chains can create vulnerability. Morocco's rapid scaling of mask production has been described as an example of repurposing domestic capacity during crisis—reflecting state coordination, private-sector responsiveness and industrial readiness.[9] Whether for PPE, diagnostics, oxygen ecosystems, or essential medicines, the ability to pivot domestic production reduces dependency, shortens lead times and sustains essential services.

Education matters here through skills formation, innovation capacity and public–private coordination competence—enabling the technical and managerial ecosystem required for local production and quality assurance.

Policy and delivery implications

1. Strengthen financial protection while fixing the practical bottlenecks that undermine credibility—especially provider payment delays and benefit clarity.
2. Treat logistics performance as a strategic KPI (lead time, stockout rates, last-mile reliability), and integrate innovations into system design.
3. Build industrial readiness for selected essential commodities as a health security capability, not a prestige project.
4. The cross-cutting test: implementation fidelity

Across all three pathways, the operational determinant is fidelity: **does the intervention that was designed get delivered as intended—consistently and at scale?** Many African settings are not short of strategies; they are short of disciplined implementation.

Implementation fidelity fails for predictable reasons:

- Interventions are over-designed and under-supported
- Incentives do not match expected behaviours.
- frontline constraints are ignored (staffing, supplies, supervision, transport)
- Leadership changes disrupt continuity.
- communities are engaged late, as an afterthought

Resilience programmes should therefore be evaluated not only by "plans produced" but by capabilities exercised: response time, supply continuity, service utilisation under stress, trust indicators, and the stability of routine services during shocks.

Policy recommendations (10-point agenda)

A. Build trust and behavioural resilience

1. Institutionalise RCCE as a permanent capability with budgets, trained staff, and feedback loops.
2. Develop trusted messenger networks linked to primary care and schools, with rapid rumour management.
3. Embed risk and digital literacy in education systems and community platforms to reduce misinformation vulnerability.

B. Institutionalise preparedness and system capability

1. Ring-fence funding for surveillance, EOCs/incident management and public communication as routine national functions.
2. Maintain workforce surge arrangements (rosters, rapid training, deployment and protection protocols).
3. trengthen inter-ministerial coordination with clear authority lines and regular simulation/exercise cycles.

C. Secure financing, logistics and industrial readiness

1. Expand and improve **financial protection** while repairing credibility gaps (especially provider payment delays and transparency).
2. Elevate **logistics as infrastructure** with measurable performance targets (stockouts, lead times, cold chain, last-mile).
3. Identify a short list of **strategic health commodities** for regional/local production and emergency repurposing.
4. Align partners behind **country-owned execution**—supporting operating capability, not parallel projects.

Conclusion

Africa's experience across HIV, Ebola and COVID-19 shows that resilience is neither a document nor a gadget. It is a set of capabilities built into everyday systems long before a crisis arrives. Social trust and collective behaviour are the first line of defence. Institutional capacity and coordination determine whether the response can be executed at speed. Economic protection, logistics strength, and industrial readiness determine whether systems can withstand prolonged shocks without collapse.

The practical agenda is clear: invest in trust as a capability, institutionalise preparedness, strengthen financial protection and logistics, and treat industrial readiness as part of health security. Above all, make implementation fidelity the benchmark. What matters is not what is planned—but what is repeatedly delivered.

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Internet Shutdowns During Elections and Their Impact on Public Health: Lessons from Uganda

David Ojut Okello examines how the internet and public health are intertwined, documents the harmful health effects of internet shutdowns, and offers practical recommendations on how to protect essential health connectivity.

Introduction

In recent years, governments across the world have increasingly resorted to temporary internet and social media restrictions during politically sensitive periods, particularly elections. These measures are often justified on grounds of national security, prevention of violence, and control of misinformation. During Uganda's recent presidential and parliamentary general elections, nationwide restrictions on internet access and social media platforms were implemented with similar objectives.

While the security rationale for such actions has been widely articulated, far less attention has been paid to their unintended consequences—particularly on public health and social well-being. In a country where mobile connectivity increasingly underpins access to healthcare, information, and social support, the interruption of digital services carries significant implications. This article examines the health and social impacts of internet shutdowns and offers constructive, forward-looking recommendations for balancing security needs with the protection of population health.[1,2]

The Growing Role of Digital Connectivity in Health Care

Over the past decade, Uganda and many low-and middle-income countries have expanded the use of digital health technologies. Mobile phones and internet-enabled platforms are now used for telemedicine consultations, appointment scheduling, referrals, chronic disease management, mental health counselling, and public health communication.[3,4]

For many patients—particularly those in rural or underserved areas—digital connectivity bridges long-standing gaps in physical access to healthcare facilities. For others, such as people living with chronic illness, disabilities, or mental health conditions, telemedicine and online support are essential components of care rather than optional services.[5]

Impact of Internet Shutdowns on Health Services

Disruption of Telemedicine and Continuity of Care

Internet shutdowns directly interrupt telemedicine services, preventing patients from consulting healthcare providers, sharing test results, or receiving timely medical advice. Evidence from multiple settings shows that disruptions in digital connectivity undermine continuity of care and delay diagnosis and treatment, particularly for chronic and non-communicable diseases.[6,7]

Healthcare providers also face challenges in coordinating referrals, accessing electronic health records, and communicating across facilities. Even short-term disruptions can have cascading effects on patient outcomes, especially in emergency and referral-dependent cases.[8]

Reduced Access to Health Information

Access to reliable health information is a recognized social determinant of health. Internet shutdowns limit access to trusted guidance on medication use, maternal and child health, infectious disease prevention, and emergency alerts.[9]

Studies examining communication disruptions have shown that shutdowns can create information vacuums that increase anxiety, reduce adherence to treatment, and make it harder for public authorities to disseminate accurate health messaging during crises.[10]

Mental Health and Psychosocial Effects

Political uncertainty and social disruption are often associated with increased psychological stress. Internet shutdowns can amplify these effects by isolating individuals from social networks, counselling services, and online peer support communities.[11]

For patients receiving telepsychology or mental health support, abrupt loss of connectivity may interrupt care and exacerbate symptoms of anxiety, depression, and distress, particularly among young people and those with pre-existing mental health conditions.[12]

Broader Social and Economic Determinants of Health

Beyond direct health services, internet shutdowns have indirect effects on health through economic and social pathways. Disruptions to digital commerce, mobile money services, and informal economic activity reduce household income and financial resilience. Evidence from low-income settings shows that economic shocks are closely linked to poorer nutrition, reduced healthcare utilization, and delayed treatment seeking.[13,14]

These effects tend to disproportionately affect already vulnerable populations, widening existing health and social inequities.

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Balancing Security Concerns with Public Health Protection

It is important to recognize that governments have a legitimate responsibility to maintain public order and national security, particularly during elections. However, growing global evidence suggests that blanket internet shutdowns carry significant social and health costs and may undermine essential services without proportionate public safety benefits.[1,15]

A more balanced approach—one that protects essential health functions while addressing security risks—can safeguard both public well-being and national stability.

Policy Considerations and Constructive Recommendations

Protect Essential Health Connectivity

Governments may consider formally designating health services—such as telemedicine platforms, emergency communications, hospital information systems, and public health messaging—as protected services that remain operational during periods of restriction.[5,16]

Use Targeted and Proportionate Measures

Targeted, time-limited restrictions, rather than nationwide shutdowns, can reduce harm while addressing specific security threats. Advances in network management allow for more proportionate interventions.[1,17]

Strengthen Alternative Health Communication Channels

Investment in SMS-based alerts, radio health programming, and community health worker networks can provide redundancy and ensure continuity of health information when internet access is limited.[9]

Engage Health Sector Stakeholders

Early consultation with health professionals, patient groups, and telecommunications providers can help identify critical services and establish practical exemption mechanisms ahead of elections or emergencies.[16]

Promote Transparency and Public Communication

Clear communication regarding the scope, duration, and rationale for restrictions can reduce uncertainty, maintain public trust, and support compliance with both security and health objectives.[1]

Conclusion

Uganda's experience illustrates the deep interdependence between digital connectivity and public health. While security considerations are legitimate, evidence indicates that widespread internet shutdowns can significantly disrupt healthcare delivery, worsen mental health outcomes, and exacerbate social inequities.

Integrating public health considerations into digital governance—through proportionate measures, protected health connectivity, and transparent decision-making—offers a constructive path toward safeguarding both national security and population well-being.



A doctor working on the internet courtesy of FREEPIK

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A simple guide to toddlers and screen time

Jolandi Becker elaborates the dangers of technology on the social development and sleep pattern of toddlers .Giving advice on how it could be handled in a better way.

"We've all seen it, your 2-year-old sees a photograph and instinctively tries to "swipe" it. It's adorable, but it also shows just how naturally toddlers are drawn to screens. This makes it important for parents to be mindful of screen exposure and its potential impact on early development", says Jolandi Becker, spokesperson for Baby Womb World.

Here's a closer look at what to keep in mind when it comes to screen time for toddlers.

The Dopamine Response

It's easy to rely on screens to keep toddlers occupied, after all, nothing grabs their attention quite like a tablet or television. Every swipe and tap triggers instant responses: colors, sounds, and movement. This rapid stimulation prompts the brain to release dopamine, a chemical that plays a key role in our reward system and feelings of pleasure.

Dopamine can be addictive. When the screen is removed, toddlers may initially struggle to re-engage with slower-paced real-life experiences. This is because their brains have become accustomed to instant responses, making ordinary activities seem less exciting in comparison.

The takeaway? Controlled and limited screen time is important to prevent toddlers from becoming overly reliant on fast, digital rewards for entertainment.

Screen Time and Social Development

The first three years of life are critical for social development. During this time, the brain is laying the foundation for communication, emotional understanding, and relationships.

Excessive screen time can limit opportunities for toddlers to engage in "real-world" social interactions, playing, talking, observing facial expressions, and responding to tone of voice. These experiences help develop the frontal lobe, which is essential for interpreting social cues and building meaningful connections.

While occasional screen use is unlikely to cause permanent harm, regular or extended exposure may reduce opportunities for these foundational experiences. Encouraging play with real people and engaging activities is key for healthy social growth.

Screen Time and Sleep

Screens can also affect sleep. The blue light emitted by tablets, phones, and televisions can suppress melatonin production – the hormone that signals the body it's time to sleep. For toddlers, melatonin typically starts rising in the early evening, helping them wind down and get restful sleep.

Exposing toddlers to screens in the critical pre-bedtime hours (around 5–7 PM) can delay melatonin production, making it harder for them to fall asleep. Poor sleep can contribute to irritability, behavioral challenges, and even a weakened immune system.

To protect your toddler's sleep, consider limiting screen use in the evening and introducing calming, screen-free routines instead, such as reading, quiet play, or music.

Finding the Balance

Screens aren't inherently "bad," and technology can have a role in early learning and family connection. The key is moderation:

- Under 2 years: Avoid sedentary screen time, except for brief video calls with loved ones.
- 2–3 years: Limit to no more than 1 hour per day, and less is better.
- 3–4 years: Keep sedentary screen time to 1 hour or less, focusing on high-quality content.
- Instead of relying on screens to occupy your toddler, try interactive, hands-on alternatives:
- Read a book together.
- Make up a family dance or song.
- Draw or play with toys that encourage creativity and movement.
- Keep meals screen-free to support family connection and better sleep.

Every family is different, and finding the right balance will depend on your routines, lifestyle, and your child's temperament. The goal is to introduce technology thoughtfully while prioritizing real-world experiences that support healthy brain development, social skills, and sleep.

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Jolandi Becker (Managing director at Good Night) spokesperson for Baby Womb World Rosa-Mari Le Roux, rosa@reklame.co.za

Turning commitment into motion: Kenya's path to cervical cancer elimination.

Taofik Oloruko-Oba gives us a synopsis into the journey Kenya is undertaking in the fight against cancer of the cervix.

Introduction

The world has come a long way in the fight against cancer. However, not all cancers are equal. I would like to highlight one cancer in particular here: cervical cancer, which is caused by the common Human Papillomavirus (HPV). In Kenya, even though cost-effective interventions that could reduce the cervical cancer burden are available, it remains the leading cause of cancer-related death among women in the country. We can change that.[1]

The story of humanity and cervical cancer is multifaceted. It is marked by many human victories and also some disappointments. But we have an opportunity to beat this disease once and for all. We have all the tools we need. Preventative HPV vaccinations are available. Screening technology has become highly accurate, and with a high-precision test, both precancer and invasive cancer can be treated.[1]

Our policymakers acknowledge that to enable Kenya to protect its women of all ages, Kenya launched its National Cervical Cancer Elimination Action Plan 2026–2030, aligned to the World Health Organization targets to eliminate cervical cancer as a public health threat.

Roche Diagnostics has partnered with the government to support the strategy, working with national stakeholders to strengthen screening through high-performance HPV testing, self-sampling approaches, and digital health solutions by leveraging existing testing infrastructure. Our next primary challenge is to address limited participation by Kenyan women.[1]

The interventions and infrastructure we have are well established, and through public-private partnerships, they are becoming increasingly accessible. Ultimately, though, our success will be measured by how effectively the interventions are integrated into real health systems and financed in a way that supports long-term delivery.

In 2022 alone, an estimated 5,845 women in Kenya were newly diagnosed and 3,591 lost their lives to the disease, accounting for 12.2% of all cancer deaths among women[1]. The age-standardised incidence rate stands at 32.8 per 100,000 women.[1]

A clearer national direction

The Ministry of Health has reaffirmed cervical cancer as a public health priority, aligning national efforts with the World Health Organization's (WHO) global elimination strategy built around the 90–70–90 targets for vaccination, screening and treatment by 2030. 2

As per the WHO guidelines, that means:

Taofik Oloruko-Oba, Country Manager, Kenya, at Roche diagnostics



Taofik Oloruko Oba

"To eliminate cervical cancer, all countries must reach and maintain an incidence rate of below 4 per 100,000 women. Achieving that goal rests on three key pillars and their corresponding targets.

- **Vaccination:** 90% of girls fully vaccinated with the HPV vaccine by the age of 15;
- **Screening:** 70% of women screened using a high-performance test by the age of 35, and again by the age of 45;
- **Treatment:** 90% of women with pre-cancer treated and 90% of women with invasive cancer managed.

Each country should meet the 90–70–90 targets by 2030 to get on the path to eliminate cervical cancer within the next century." (Source: WHO)

Testing is voluntary. And we need more women to test willingly. If cervical cancer is diagnosed at an early stage, there is hope. To truly illustrate that, let's consider that this is hope for the women who power our workforce, protect and care for our families, and form the backbone of our society.

The other side of the coin is that, if the cancer is only diagnosed in an advanced stage, treatment is more complex, more costly and outcomes are less likely to be positive. This reality underlines why prevention and early detection are so important for women across the country.[2]



Woman getting HPV vaccine

Prevention works when systems work

Kenya's HPV vaccination programme provides a strong foundation. Expanding and sustaining coverage among adolescent girls is essential to breaking the cycle of transmission over time. At the same time, screening remains critical for women of any age who are already at risk.[2]

Integrating cervical cancer screening into existing service platforms, including HIV and reproductive health programmes, offers an efficient way to reach more women without building parallel systems.[2] This integrated approach strengthens continuity of care and supports broader universal health coverage goals.[2]

Laboratory infrastructure already exists across the country. Leveraging this capacity through coordinated planning and appropriate financing can accelerate access while improving system efficiency. This approach to integration may be our greatest hope as a sustainability strategy.

Financing for durability

Reaching the 90–70–90 targets will require investment models that move beyond short-term projects. Public funding remains essential, but it cannot act alone. Kenya's elimination landscape is more likely to respond to blended financing models that align public priorities with private sector expertise and innovation.[3]

Public-private partnerships have a proven role to play in areas such as diagnostics, logistics, training and data systems. When designed collaboratively, these partnerships can help scale proven interventions, reduce fragmentation and support national ownership.[3]

Reaching women where they are

Awareness and acceptability are our next secret weapons. Cultural barriers, fear and misinformation still prevent many women from accessing screening services. Kenya has intensified community engagement and public awareness efforts to address these barriers and encourage informed participation. Private sector partners must work with the public sector to maintain momentum in this area.[2]

Additionally, innovations such as self-collection for HPV testing can further reduce access challenges, particularly in rural and underserved areas.

Maintaining momentum

Kenya has laid the necessary groundwork. Political commitment, clearer policy alignment and growing system capacity provide a platform for progress. In May 2025, the Kenyan Ministry of Health, through the Social Health Authority (SHA) and Roche East Africa, signed a Memorandum of Understanding (MoU) to significantly reduce the cost of cancer testing and treatment, with a focus on breast and cervical cancer. The next phase is about execution at scale.

Sustaining momentum will require continued leadership, reliable financing and strong collaboration across sectors. Integrated testing, efficient use of existing infrastructure and co-created partnership models offer practical pathways to accelerate impact.

Elimination will not happen overnight. But with sustained focus and coordinated action, cervical cancer can increasingly be prevented, detected early and managed effectively within a resilient Kenyan health system.

Each girl vaccinated, each woman screened and each patient treated brings Kenya closer to a future where cervical cancer no longer defines outcomes for women, families and communities.

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Building Resilient Youth: Sport-Based Mental Health and Addiction Prevention Systems – The MIK Health & Wellness Experience

Shummu-Ê-L Mulenga Bukata Chanda gives us an insight into the problem of addiction among the youth in Zambia and how an organisation he founded is tackling it.



Shummu Ê-L Mulenga Bukata Chanda giving a mental health talk at the University of Lusaka in Lusaka Zambia

Introduction

Across sub-Saharan Africa the health community is increasingly aware that adolescent and young-adult mental health problems and substance use are not isolated clinical concerns: they undermine education, reduce employability and productivity, strain families, and contribute to social unrest. In Zambia the stakes are high: youth form a large proportion of the population and early prevention of addiction and psychosocial distress would deliver outsized returns for national development. This article argues for a systems-first approach, building low-cost, community-owned preventive platforms that reach children and adolescents before problems become clinical crises. It describes MIK Health & Wellness's Sport for Mental Resilience (SMR) pilot in Kanchibiya as a practical example of how sport, combined with deliberate psychosocial content and referral pathways, can become a scalable public-health intervention. The article closes with concrete recommendations for health services, education authorities and development partners.

The problem: youth mental health, substance use and development risk

Shummu-Ê-L Mulenga Bukata Chanda, Founder & President, MIK Health & Wellness (Made in Kanchibiya), Zambia. smbchanda@gmail.com

Zambia's demographic structure concentrates risk and opportunity: a large youth cohort can power rapid development if healthy and engaged, or magnify social and economic fragility if psychosocial needs go unmet.[1] Across Southern Africa, studies have documented alarmingly high rates of depressive symptoms among adolescents: many surveys report prevalences in the 25–30% range for school-aged youth, and several syntheses point to an even higher pooled burden for depression across the continent. These mental-health burdens are tightly associated with risky behaviours, including early initiation of alcohol and tobacco use, and increased vulnerability to sexual health risks.

Tobacco and alcohol remain important entry points to longer-term addiction. Country profiles and policy analyses estimate adult current smoking prevalence in Zambia at roughly 10% (with wide gender disparities), and the economic cost of tobacco has been estimated in policy briefs at ZMW 2.8 billion annually (about 1.2% of GDP), including health expenditures and productivity losses.[2,3] Meanwhile, regional reviews find current alcohol use among adolescents ranges widely but is significant (reported pooled estimates often in the low double digits), underlining the need for preventive measures during school and pre-school years.

Taken together, these facts make clear that mental-health and addiction risks among youth are not only



The young boys of MIK–CYS football team!

clinical but developmental problems: they degrade school performance, erode human capital, and, when unaddressed, feed social instability. Treating illness is necessary, but insufficient. Prevention delivered at scale through community and education systems must become the strategic priority.

Why prevention must be systems-driven

Health systems and education systems in many low- and middle-income countries (LMICs) are structured around episodic care and crisis management. For adolescent mental health and addiction, the evidence points to three realities:

1. Most harmful trajectories begin early; by the time young people present to clinical services, problems are often entrenched.
2. Social and behavioural drivers (poverty, idleness, weak school linkages, peer influence) are central; clinical services alone cannot change those determinants.
3. Low-cost, structured, frequent contact, delivered through trusted community platforms, is the most feasible prevention strategy at scale.

Therefore, the logical public-health answer is to build systems that (a) create routine, protective contact for children and adolescents, (b) embed brief psychosocial curricula and gatekeeper training into those contacts, and (c) ensure simple referral and data loops that connect community practice to district health and education authorities.

MIK's operational thesis: sport, research and ultimately policy reform as preventive infrastructure

MIK Health & Wellness is a Zambian-born, youth-led organization formed to convert lived experience and community credibility into scalable prevention platforms. Our core thesis is that sport — particularly organised football in many communities — is not merely recreation. It is existing, culturally resonant infrastructure for routine engagement with boys and young men. If training sessions are intentionally redesigned to include brief psychosocial components, mentorship, attendance discipline and referral pathways, they can function as a low-cost, repeatable prevention system.

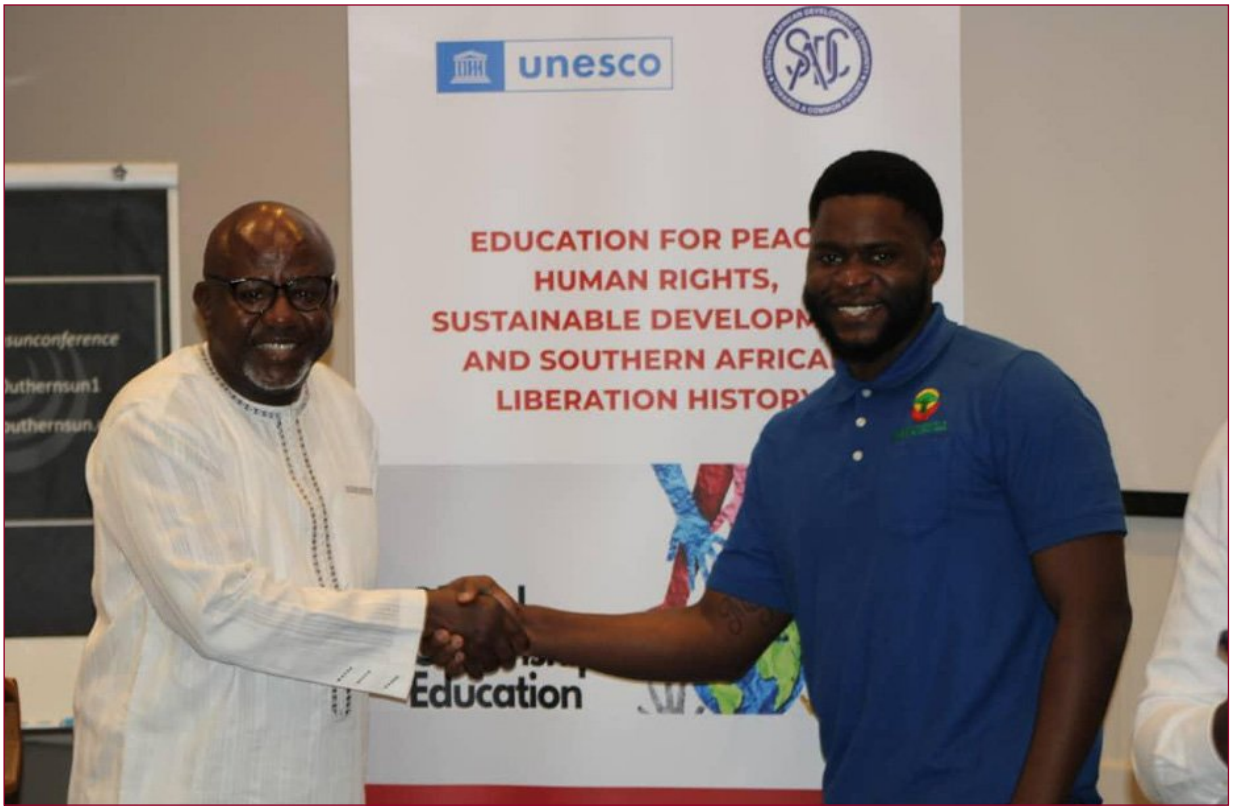
Key design features of the Sport for Mental Resilience (SMR) model are:

- **Routine and predictability**. 4 times-weekly practices establish habit and reduce idle time; a key risk factor for substance initiation.
- **Mental-resilience moments**. Each session begins and ends with a 5–10 minute facilitator-led discussion on discipline, anger management, stress, and refusal skills.
- **Earned incentives**. Equipment and recognition are tied to attendance, behaviour and school performance (rewarding responsibility rather than creating dependency).
- **Data and referrals**. Simple attendance registers, 3-question wellbeing checklists, and escalation SOPs link coaches to district health or MIK referral partners when risk is detected.

This systems design recognises that behaviour change is incremental and context-bound: sport provides the cadence; psychosocial briefings provide the content; and referral pathways ensure safety nets for higher levels of need.

Kanchibiya pilot: from idea to practice

In Kanchibiya District (MIK's legacy site), we launched MIK Chalabesa Youth Football Club (MIK-CYFC) for boys aged approximately 8–17. The programme started with minimal equipment but clear rules: consistent attendance, respectful behaviour, and an agreement to stay alcohol and tobacco-free. Coach Jerry Simfukwe (a respected community coach) leads sessions that integrate short resilience modules and weekly reflections. The headmaster of the local school has offered institutional support, and MIK maintains attendance and basic self-reported wellbeing metrics.



Dr Abdul Rahman Lamin head of social and health sciences UNESCO ROSA and self during our annual meeting in Johannesburg South Africa.

Early operational lessons are instructive. First, community leadership matters more than equipment: local ownership by school and coach creates stability. Second, repetition matters: consistent sessions established routine and gradually shifted norms around alcohol use and idleness. Third, evidence matters to scale: keeping simple, verifiable records (attendance, school performance, basic wellbeing items) allowed MIK to produce rapid "impact snapshots" used to attract in-kind donors and local government interest.

Kanchibiya's model intentionally treats sport as entry point, not end: the goal is to produce a cohort of young people with greater school retention, fewer early initiations into substance use, and improved psychosocial coping.

Partnerships, research and policy alignment

MIK has pursued partnerships to anchor practice in evidence and policy. We are engaged with UNESCO's Regional Office for Southern Africa (ROSA) under the Youth As Researchers (YAR) Initiative and are aligning pilot learning with UNESCO-MGIEP (Mahatma Gandhi Institute of Education for Peace) research frameworks; a step that strengthens the model's legitimacy for education sectors and donors. These partnerships allow us to embed youth-led research methodologies, co-design wellbeing modules for schools (GCED aligned), and plan regional dissemination. Close links with district education and health offices ensure referral and sustainability pathways.

Why this model is cost-sensible and scalable

Prevention through sport is cost-sensible for several reasons. First, the incremental cost of adding short psychosocial content, coach training (psychological first aid basics), and basic monitoring tools is low compared with recurrent clinical costs for established substance use disorders and severe mental illness. Second, sport facilities and gatherings already exist informally in most districts; formalising them requires modest in-kind support (balls, bibs, cones) rather than large capital investments. Third, the model's built-in metrics (attendance, school linkage, self-reported wellbeing) provide donors and ministries with rapid, policy-relevant indicators that can justify modest investment and scale.

A recent national tobacco investment case (Zambia) suggested that investing in FCTC-aligned interventions yields large returns in saved lives and averted economic losses, an economic logic that equally supports upstream addiction prevention through community platforms.

Implementation considerations and safeguards

A community-based sport model must prioritise safeguarding, ethics and measurement:

- **Safeguarding & child protection**. All adults in contact with children must be vetted; coaches must receive child-protection training and clear referral SOPs must be established with district health and social services.
- **Trauma-informed practice**. Resilience conversations

must avoid re-traumatisation; coaches should be trained to identify distress and use simple, safe supportive language.

- **Monitoring & evaluation**. Indicators must be simple and feasible: attendance, school attendance linkage, a 3-item wellbeing screener, and incident/referral logs. Rigorous randomized evaluation is desirable but not required for early scale; pragmatic implementation research can produce the needed policy evidence.
- **Gender and inclusion**. Football can engage boys effectively, but parallel, culturally appropriate platforms are needed for girls and out-of-school adolescents. Inclusion plans should be explicit at the outset.

Policy recommendations for health and education leaders

For Ministries of Health, Education and Youth, and development partners, the following actions would accelerate prevention at scale:

1. Recognize prevention platforms (sport, schools, faith settings) as part of the national mental-health strategy; allocate modest seed funding for coach training and monitoring tools.
2. Adopt simple, harmonized indicators for youth wellbeing and school engagement that community programmes can report into district dashboards.
3. Invest in coach/teacher mental-health literacy (brief trainings on PFA, referral pathways and psychosocial support).
4. Prioritize child protection protocols within all community youth interventions, including background checks and clear complaint mechanisms.
5. Fund implementation research and operational learning to adapt models to urban, peri-urban and girls' programmes.

Conclusion: from prevention to national resilience

Zambia and the region face a pivotal choice: continue to invest disproportionately in treatment and crisis response, or rebalance resources toward upstream, community-based prevention that keeps young people on healthy life trajectories. The Sport for Mental Resilience model is not a panacea; it is a strategic, evidence-aligned way to use existing community infrastructure to protect youth mental wellbeing, reduce early substance use, and deliver measurable development returns. By combining routine engagement, simple psychosocial content, and accountable referral systems, we can make the healthier and more productive choice the easiest choice for our children. MIK Health & Wellness stands ready to partner with government, universities and development agencies to test, learn and scale this approach; because prevention is not only public health good practice; it is nation building.

Acknowledgements

I thank the MIK team, Coach Jerry Simfukwe, our youth builders, and our partners at UNESCO ROSA and MGIEP for their support and partnership in pilot implementation and learning.



A young man vaping courtesy of FREEPIK

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€1M Awarded to Norwegian–Dutch Healthtech Team Developing Innovative Jaundice Solution for Newborns in Africa

Picterus AS (Norway) and GOAL 3 (Netherlands) together won the Eurostars grant of 1M EUR to bring new jaundice screening technology to healthcare settings where it is needed most, with the potential to impact millions of newborns and help prevent the severe health complications caused by untreated jaundice in low-resource settings.

Joint innovation for better newborn care

Picterus AS and GOAL 3 announce today the official launch of JaundiceCARE, a joint Eurostars-funded project to develop and clinically validate a neonatal jaundice management system tailored to low-resource settings. Eurostars is a European funding program that supports innovative R&D projects led by SMEs.

The project addresses a major global health challenge: neonatal jaundice, which affects 60-80% of newborns worldwide, with 10% developing severe cases, causing over 100,000 deaths and 75,000 brain injuries annually. Early, accurate screening is critical but current methods can be inaccurate, costly, and invasive. Vital signs and other clinical data are rarely integrated, leading to improper treatment.

"Jaundice is a common condition that is fairly easy to manage and treat given the right knowledge and tools," says Tormod Thomsen, CEO of Picterus. "Unfortunately, too many newborns and their families are suffering the devastating consequences of severe jaundice, and this is what we aim to change with JaundiceCARE."

The Power of Collaboration

To help solve this issue, Picterus AS and GOAL 3 have joined together to create JaundiceCARE. JaundiceCARE will integrate Picterus® Jaundice Pro, an app-based medical device that allows for non-invasive jaundice screening of newborns, with GOAL 3's IMPALA, a patient management and monitoring platform developed for hospitals with limited resources. Together, they will create a unified, AI-powered clinical decision support system that combines early jaundice screening, with vital-signs monitoring and risk assessment.

"JaundiceCARE will give healthcare workers in low-resource settings an affordable, accurate, and accessible solution for non-invasive management of jaundice in newborns" says Niek Versteegde, CEO of GOAL 3. "It will help to prevent thousands of brain injuries and deaths that result from improper diagnosis of jaundice. We are very excited about the impact this product will make."

Validation in Tanzania

The development of JaundiceCARE will take place over 2 years. After the initial design, the technology will first be clinically validated (in preparation for CE Class 2a certification) in Tanzanian hospitals in collaboration with the Paediatric Association of Tanzania.

"Tanzania is excited to welcome this breakthrough!" says Dr Theopista Masenge, President of the Paediatric Association of Tanzania. "With Picterus' gentle, non-invasive technology and IMPALA monitoring working together, our newborns get safer care, our health workers get simpler tools, and our families get peace of mind. This is the future we've been waiting for."

Upon completion of the two-year project, it is expected that JaundiceCARE will be ready for use in hospitals settings across the world, both as a standalone software product and integrated into GOAL 3's IMPALAs patient management platform.

The project contributes to UN Sustainable Development Goal 3 by aiming to reduce preventable neonatal deaths and improve health equity globally

About Eurostars

Eurostars is a joint program between the European Union's Horizon Europe initiative and national funding bodies which supports innovative companies in international R&D projects with strong market potential. You can find out more about the Eurostars program here.

Picterus AS is a Norwegian medical technology company developing innovative solutions to improve newborn healthcare globally. Its flagship product, Picterus Jaundice® Pro, is an app-based medical device for easy, accurate, affordable, and non-invasive jaundice screening. By expanding access to accurate and timely jaundice screening, it supports better health outcomes for newborns worldwide.

Boilerplate GOAL 3

GOAL 3 is a purpose driven medtech company from the Netherlands. Our mission is to enable and empower health workers where it is needed the most, aiming to improve access to quality care for 100 million people by 2030. Our core innovation, the IMPALA system, is a comprehensive patient monitoring platform designed for resource-limited settings. It unburdens health workers and tackles preventable deaths in neonatal, pediatric, and maternal care by enabling a shift from reactive to proactive care. It has been shown to reduce pediatric mortality by 40-51% and neonatal mortality by 27%. You can find out more about GOAL 3 via their website.

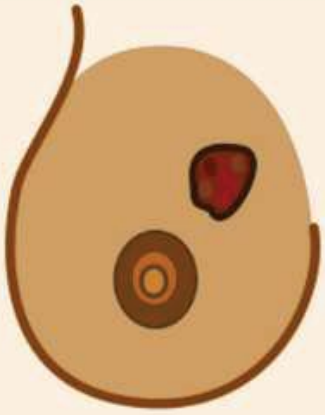
Aaron Boyle, aaron.boyle@goal3.org, Picterus Bieke Boden, social@picterus.com

Breast Changes and Breast Cancer Warning Signs that need Medical Attention!

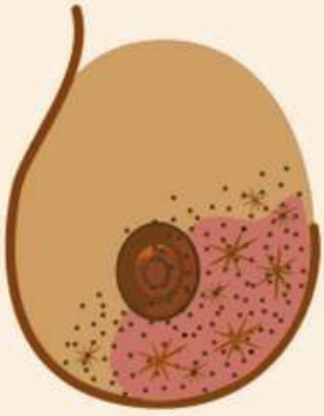
***Do not ignore* these symptoms or delay seeing a medical professional.**
A needle biopsy and mammogram can help rule out possible cancer.



Hard or Soft Lump in breast, armpit, chest



Breast sores that don't heal



Redness, puckered, scaly, thickened skin

Early Detection = Early Treatment



Inverted, sunkened nipple



Breast shape, size changes, bulges, dimples, flattens, shrinks or swells

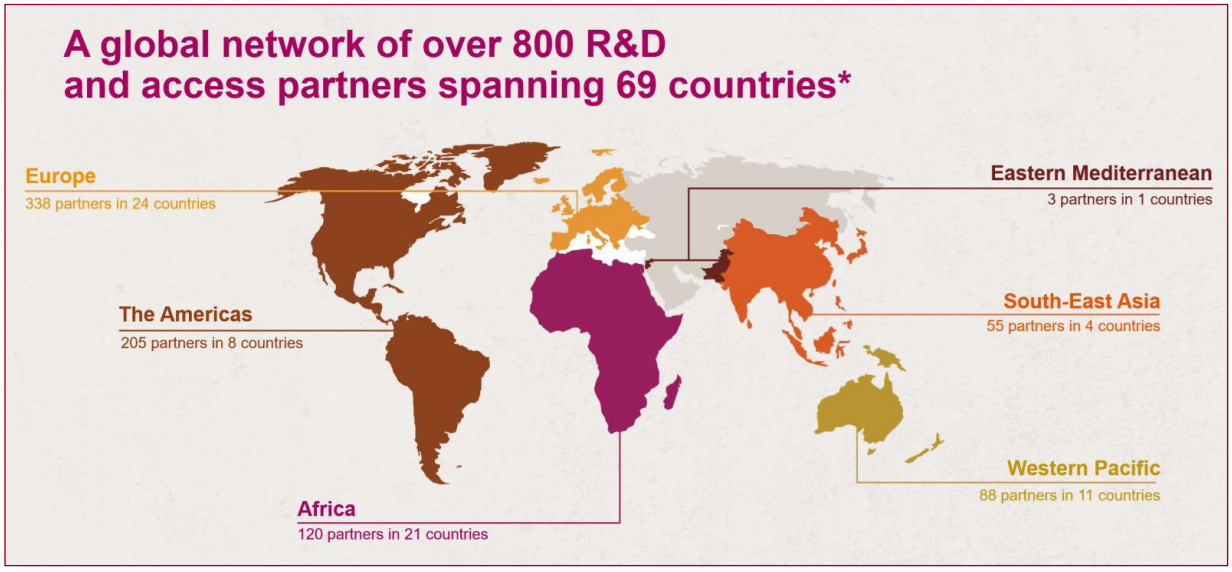


Bloody, cloudy, smelly fluid, nipple leaking

African American Breast Cancer Alliance
AABCA

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Lancet Global Health publishes a study demonstrating Medicines for Malaria Venture's unmatched global health impact and value



Over 800 partners in 69 countries 2026

A new economic analysis in the Lancet Global Health describes how investments in MMV delivered 13 times their value in health benefits between 2000 and 2023.

Each dollar invested yielded a 52% return per year, every year, demonstrating the long-term impact of MMV's work.

MMV's product development partnership model is an effective and efficient way for donors to fund global health innovation, delivering measurable results.

Geneva, Switzerland, 17 February 2026. A landmark study published in The Lancet Global Health confirms that Medicines for Malaria Venture (MMV), a product development partnership (PDP) that unites the funds and expertise of the public and private sectors, delivers exceptional global health impact and value for money.

The study, measuring the impact of global research and development investment in product development partnerships: a case study on return on investment in antimalarial drug development, was published following rigorous analysis and peer review. It found that for every $1 invested in MMV between 2000 and 2023, society gained $13 in monetized health benefits. This reflects healthier lives and fewer deaths.

The study was conducted by experts from leading academic institutions Imperial College London and the London School of Economics and Political Science (LSE) in collaboration with consulting firm Cambridge Economic Policy Associates, MMV, and the UK Foreign, Commonwealth and Development Office (FCDO), one of MMV's funders. Dr Lesong Conteh, Associate Professorial Research Fellow at LSE Health and the study's corresponding author, said: "This analysis demonstrates that funds invested in MMV are working extraordinarily hard. Every dollar produces outsized and sustained benefits for malaria-affected regions. In a constrained funding environment, identifying investments that consistently deliver is critical." This evidence also underscores the vital role that investing in the PDP model plays in generating global health returns beyond any single organization.

Exceptional return on investment and life-saving impact

This first-of-its-kind study evaluates the return on investment in research and development (R&D) delivered by MMV. Using a robust data-driven approach and building on real-world evidence, it estimates the reach and health impact of MMV-supported malaria medicines across 36 countries. The analysis uses a conservative approach by factoring in the costs of both successful and failed drug development and applying cautious assumptions when estimating deaths averted and healthy years of life saved.

Commenting on the findings, Dr Martin Fitchet, Chief Executive Officer of MMV, said: "The study highlights the powerful impact that innovation, partnerships and sustained investment can achieve. This kind of rigorous analysis is vital in helping us hold ourselves to account for delivering transformative impact for the communities most at risk of malaria. We are deeply grateful to our donors and partners, without whom MMV's achievements would not be possible."

The study also shows that each dollar spent on MMV's R&D results in a return of 52% per year, every year. The PDP approach is supported by the United Kingdom government, the Gates Foundation and other donors because it lowers risk, improves success rates and delivers benefits for investors, partners and communities.

Supporting health outcomes and unlocking sustainable investment

MMV improves health outcomes in malaria-endemic countries by tackling critical gaps such as drug-resistant strains, and developing and delivering treatments for at-risk populations as well as transmission-blocking therapies. These innovations reduce disease burden and free resources for other priorities.

At the same time, MMV's pooled funding model de-risks investment and accelerates innovation by bringing partners together to collaborate and share their expertise.

Mr Gareth Jenkins, Managing Director of Malaria No More UK, said: "This publication provides timely new evidence of the huge value Medicines for Malaria Venture brings, as a leading product development partnership, by fostering innovations to fight malaria. With efforts to end malaria facing a perfect storm of challenges, continued investment in R&D is as important as ever. "I hope decision makers will draw on these findings and prioritize PDPs, such as MMV, in their plans to overcome these mounting threats to progress against a disease that can and must be ended in our lifetimes."

Join MMV in eradicating malaria

Despite major progress, malaria remains a deadly disease with 282 million cases and 610,000 deaths in 2024. The situation is compounded by the spectre of antimalarial drug resistance advancing in Africa, as identified in the recent WHO World malaria report 2025. "We are proud of the lives saved and progress we've contributed to," said Dr Fitchet. "But we cannot be complacent. In this changing world, now more than ever we need to hold ourselves to the highest of standards to deliver for the communities that need us."

MMV calls on governments, industry leaders, and philanthropists to invest in R&D to save more lives and eliminate malaria

PDPs are non-profit organizations that bridge the gap between public health needs and market-driven incentives by coordinating and financing the research, development and delivery of new health products for diseases of poverty.

As of 2026, MMV is funded by Action for Women's Health, the Australian Department of Foreign Affairs and Trade (DFAT); Global Health EDCTP3 Joint Undertaking (GH EDCTP3 JU) co-funded by the European Union .; the Federal Ministry of Research, Technology and Space through KfW; the Gates Foundation; the Global Health Innovation Technology Fund (GHIT); the Korea International Cooperation Agency (KOICA); Open Philanthropy; the RIGHT Foundation; the Swiss Agency for Development and Cooperation (SDC); the State Secretariat for Education, Research and Innovation (SERI); UK Foreign, Development & Commonwealth Office (FCDO) and Unitaid.

The study assessed MMV's performance using two key financial metrics

About the two key financial metrics used

Benefit-cost ratio (BCR)

BCR is commonly used in public sector and social projects to compare benefits (often non-monetary). BCR helps assess whether large capital investments are worth undertaking.

The BCR was calculated by dividing the monetized disability-adjusted life years (DALYs) generated by PDP-supported drugs by the cost of delivery plus the investments received by MMV. This shows the overall efficiency and impact of MMV's investments; i.e. BCR = (value of DALYs from MMV-supported drugs) ÷ (cost of delivery + MMV investments).

Internal rate of return (IRR)

This is typically used in business and private sector projects, accounting for the timing of cash flows.

IRR was based on total 2000–2023 investments and health gains derived from PDP[1]supported drugs, measured as DALYs minus the delivery cost of the products.

Key findings for the period 2000-2023

- MMV was involved in the clinical development of over 45 products, with 16 products commercially available and 12 generating sales by 2023
- Benefit-cost ratio: US$ 12.99 (12.92–13.06)
- Internal rate of return: 52.13% (95% uncertainty interval 52.11 – 52.16)
- Total MMV-supported products: 12 Total number of deaths averted (i.e. lives saved): 1,591,470
- Total DALYs averted (i.e. number of healthy life years restored): 86,929,036
- Total monetized DALYs: US$ 10,219,690,725
- Total cost of delivery: US$ 784,968,890
- Total number of high-burden countries assessed: 36

About MMV

No one should die from malaria. Yet in 2024, more than a quarter of a billion people fell sick and over 600,000 lives were lost, most of them young children. We believe this is unacceptable.

Founded in 1999, MMV is a not-for-profit product development partnership (PDP). We work "end-to-end" to discover, develop and deliver accessible and affordable medicines to treat, prevent and eliminate malaria. Starting where the need is greatest with children and pregnant women, we collaborate equitably with partners across sectors and geographies, ensuring innovation reflects local realities and reaches those most at risk.

It's working. As of 2026, we have brought forward 19 medicines that have treated or protected more than 1.3 billion people worldwide.

We cannot stop now. MMV is part of an ecosystem of partners determined to eliminate malaria. As a PDP, we bring the public and private sectors together to promote the equitable development of breakthrough solutions to help end malaria and advance health for all.

For more information, visit www.mmv.org.

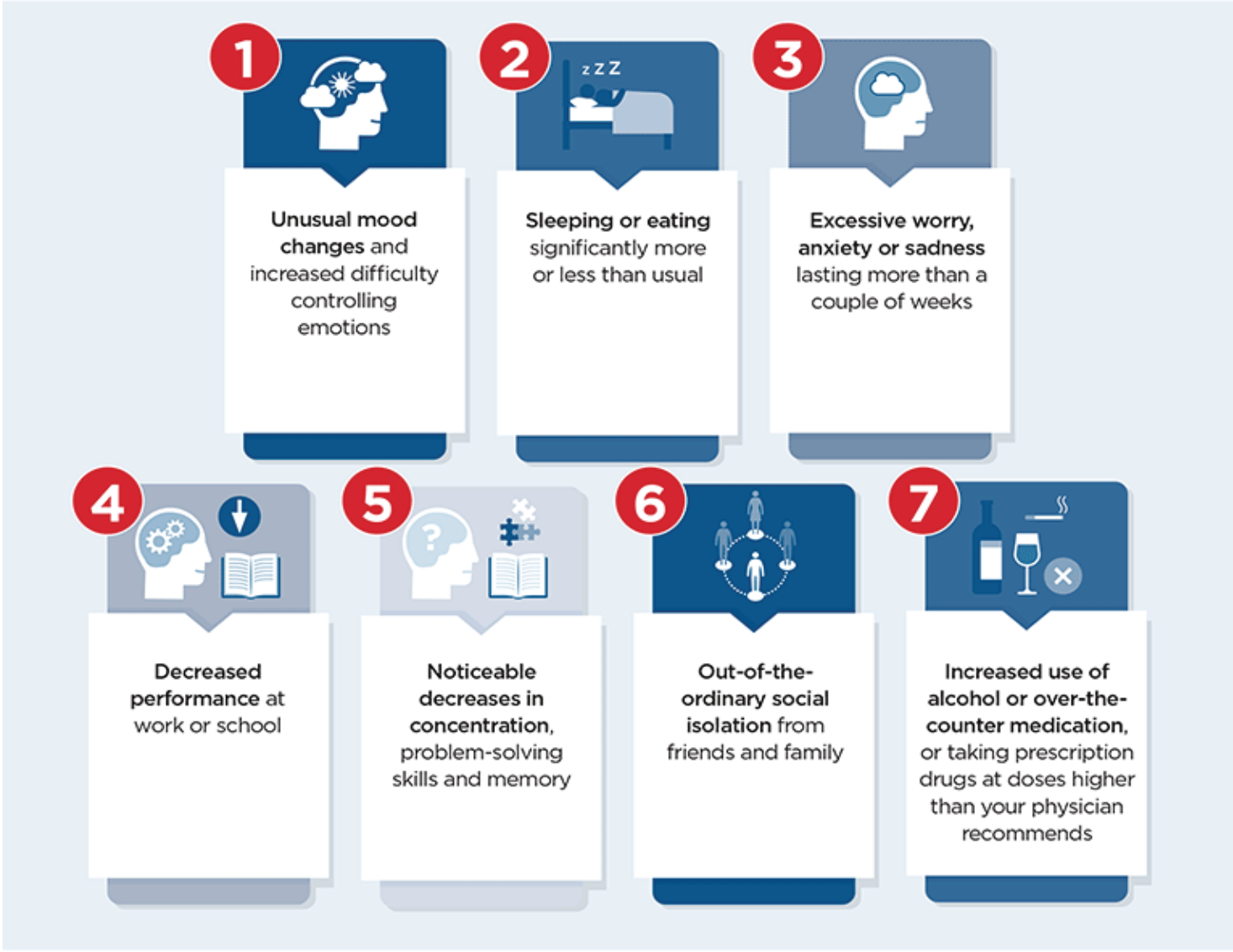
Follow MMV on social media: X | LinkedIn | YouTube | Facebook

For press enquiries, please contact: Doreen Yomoah, Communications Manager Medicines for Malaria Venture, Mobile: +41 79 238 60 74 Email: yomoahd@mmv.or

Behavioral Health:
7 Warning Signs

Mental Health Awareness begins with recognizing symptoms like these.

May is Mental Health Awareness Month—designated to highlight the importance of behavioral health in people's lives and celebrate recovery from mental illness. The first step toward better mental health can be to recognize that there's an issue, says **Frank Ghinassi, PhD**, Senior Vice President of Behavioral Health and Addictions services at RWJBarnabas Health, and President and Chief Executive Officer of Rutgers University Behavioral Health Care. Signs that you or a loved one may want to consider seeking care from a behavioral health professional include:



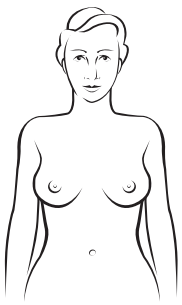
Call **1-800-300-0628** or visit **rwjbh.org/behavioralhealth** for information about our behavioral health services or a referral to a mental health specialist near you.

RWJBarnabas HEALTH

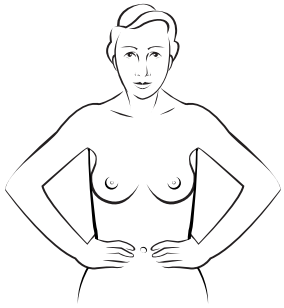
RUTGERS University Behavioral Health Care

Breast Self-Awareness (BSA)

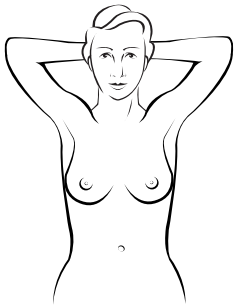
Choose a day each month that will be easy to remember and make breast self-awareness a regular part of your good health routine. Breast self-awareness is also important in women with breast implants.



A. Stand before a mirror and look at both breasts. Check for anything unusual, such as nipple retraction, redness, puckering, dimpling or scaling of the skin. Look for nipple discharge. All discharge should be reported to your doctor. Note the color, whether it came from both breasts and whether it came from one or more openings.



B. Next, press your hands firmly on your hips and lean slightly toward your mirror as you pull your shoulders and elbows forward with a squeezing or hugging motion. Look for any change in the normal shape of your breasts.



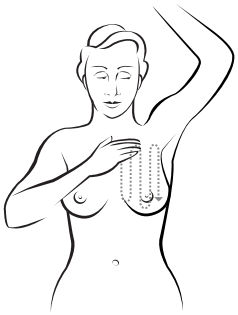
C. Looking in the mirror, raise your arms and rest your hands behind your head. This allows you to see the underside of your breasts.



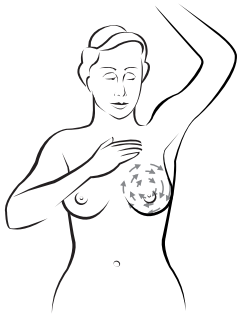
D. Place your left hand on your waist, roll your shoulder forward and reach into your underarm area and check for enlarged lymph nodes (small glands that fill with fluid when you have an infection). An enlarged node would feel like a corn kernel or a bean. Also check the area above and below the collar bone. Repeat on the right side.



E. Raise your left arm. Use the pads of three or four fingers of your right hand to examine your left breast. Use three levels of pressure (light, medium and firm) while moving in a circular motion. Check your breast area using a set pattern. You can choose (1) lines, (2) circles or (3) wedges.



1. Lines
Beginning at the outer edge of your breast, move your fingers downward using a circular motion until they are below the breast. Then move your fingers slightly toward the middle and slowly move back up.



2. Circles
Beginning at the outer edge of your breast, use the flat part of your fingers, moving in circles slowly around the breast. Gradually make smaller and smaller circles toward the nipple. Be sure to check behind the nipple.



3. Wedges
Starting at the outer edge of the breast, move your fingers toward the nipple and back to the edge.

You should not lift your fingers while feeling the breast. Whatever method you choose, make sure to cover the entire area, including the breastbone, collarbone, upper chest area and bra line. Pay special attention to the area between the breast and the underarm itself. Feel for any unusual lump, mass or thickening under the skin.



F. Lie flat on your back with your left arm over your head and a pillow or folded towel under your left shoulder. This position flattens the breast and makes it easier to examine. Use the same motion described in step E. Some women like to use body lotion in this step.

Many women prefer to do steps D through F in the bath or shower.

Woman's

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- **Peter Sands**, Executive Director, Global Fund to Fight HIV, TB, and Malaria,**Switzerland**
- **Fola Adeleke**, Executive Director, Global Center on AI Governance, **Canada**
- **John Wong**, Senior Vice President , Health Innovation & Translation, **National University of Singapore**
- **Solange Baptiste**, Executive Director, **ITPC Global, South Africa**
- **Abebe Bekele**, Dean, **School of Medicine, UGHE Rwanda**
- **Richard Damania**, Chief Economist, **The World Bank**
- **Kashmira Date**, Senior Director, **Medical and Scientific Affairs, Pfizer, USA**
- **Wafaie Fawzi**, Professor of Global Health, **Harvard University, USA**
- **Emilie Filmer-Wilson**, **United Nations Population Fund (UNFPA)**
- **Linda Fried**, Dean Emerita, **Mailman School of Public Health, Columbia University, USA**
- **Sofia Gruskin**, Director, **Institute on Inequalities in Global Health, USC, USA**
- **Adil Haider**, Fmr. Dean of Medicine, **Aga Khan University, Pakistan**
- **Chris Hanley**, Director, **Grand Challenge on Climate and Health, National Academy of Medicine, USA**

See other confirmed speakers

The Future of Global Health Governance: Implications for Africa and a Continental Strategy Toward Agenda 2063

Patrick Kadama examines the recent geopolitical shifts, what it means for global health and the implications for Africa.

Abstract

Background:

Recent geopolitical shifts, including the withdrawal of a major power from the World Health Organization (WHO) and escalating armed conflict in the Middle East, have altered the institutional and political economy foundations of global health governance. The changes raise concerns regarding financing stability, supply chain resilience, and normative coherence, (i.e., the alignment, consistency, and harmonious integration of norms, rules, and values within a system to avoid contradictions and ensure effectiveness). These shifts have significant implications for African health systems.

Analysis:

Drawing on global health governance theory and contemporary policy developments, this paper examines the risks of fragmentation, conditional bilateralism, and data sovereignty tensions. It assesses how geopolitical conflict may amplify systemic vulnerabilities in multilateral cooperation.

Policy Implications:

A coordinated continental response anchored in African Union (AU) leadership, pooled financing mechanisms, regulatory harmonization, and strengthened primary health care infrastructure is necessary to mitigate risk and enhance "negotiating leverage".

Conclusion:

Geopolitical disruption creates both vulnerability and opportunity. Africa's strategic positioning within the evolving global health order will depend on institutional consolidation, fiscal credibility, and coherent continental governance frameworks aligned with Agenda 2063.

Introduction

The Canadian Prime Minister Mark Carney explicitly argued at the held 56th World Economic Forum in Davos, Switzerland, That the global geopolitical landscape is undergoing "a rupture, not a transition" which is manifesting as a massive shift from a rules-based world order, towards a fragmented, multipolar system defined by competition, bilateralism, and regional power blocks. This is a serious contradiction and challenge to the conventional core strength of Global Health Governance, which has "historically depended on inclusive" cross national (joint) multilateral coordination through the World Health Organization (WHO), supplemented by "major power" financing and "rules-based normative" leadership. Therefore, recent geopolitical developments have challenged this configuration and hence the conceived "rupture" now underway. Developments such as the withdrawal of a "major power" principal contributor to WHO alters funding predictability and symbolic legitimacy of that institution, while escalating conflict in the Middle East intensifies supply chain volatility and humanitarian financing pressures. For African states (many of which rely on external assistance for disease control, immunization, and surveillance), these dynamics warrant systematic evaluation to guide mitigating actions rather than scholarly concerns by the regional and country-based elite.

Global Health Governance (GHG) as Political Economy

Global health governance operates within a political economy shaped by sovereignty, power asymmetries, and institutional interdependence to ensure normative coherence, (i.e., the alignment, consistency, and harmonious integration of norms, rules, and values within systems to avoid contradictions and ensure effectiveness). In general, then, Health diplomacy as a subset of GHG is the use of foreign affairs for negotiations, and international cooperation to improve health outcomes, bridge political divides, and enhance global security.

The discourse however appears to be that while, on the one-hand, the trans-national nature of global health diplomacy inclusively aims to diffuses the authority of countries across state and non-state actors in global settings to produce global public goods for health and to ensure a rules-based and reliably financed global public health domain, it has also on the other hand, been argued that health diplomacy may reflects fragmenting strategic national interests which encourages the development of "Bilateral Health Agreement" as arrangements to foster innovation and efficiency yet, with the knowledge that it often increases transaction costs and weaken accountability, particularly for lower-income states "negotiating individually".

Patrick Kadama, Director, Policy and Strategy African Centre for Global Health and Social Transformation (ACHEST), Kampala, Uganda

Fragmentation and Conditional Bilateralism

The shift toward bilateral health arrangements can generate flexibility but risks normative inconsistency. Without harmonized standards however, surveillance systems may diverge, reducing interoperability and global comparability apart from increased transaction costs. Furthermore, conditional agreements concerning pathogen and genomic data sharing may reproduce sovereignty tensions and sustain structural inequities unless accompanied by "mutually enforceable benefit-sharing" mechanisms. These concerns are particularly salient for African states seeking equitable access to countermeasures developed from shared resources.

Geopolitical Conflict and Systemic Vulnerability

Escalating hostilities and armed conflict in strategically significant regions such as the Middle East have the potential to divert global political attention away from health governance reform; to affect global energy markets, shipping transport routes, and insurance costs. Health systems dependent on imported medical commodities, pharmaceuticals and cold-chain logistics are sensitive to such volatility. Humanitarian financing diversion to conflict areas may further constrain resources available for health system strengthening in sub-Saharan Africa. Such instability threatens the stability of supply chains for medical commodities and pharmaceuticals which may increase costs for African health systems. These dynamics illustrate the interconnectedness of geopolitical stability and health security.

A Continental Strategy Aligned with Agenda 2063

To enhance resilience, Africa requires coordinated continental mechanisms rather than isolated national responses. Strategic priorities include: (1) AU-facilitated negotiation platforms to reduce asymmetrical bargaining; (2) continental governance standards for data and pathogen sharing; (3) pooled financing instruments for emergency preparedness; (4) regulatory harmonization to support regional manufacturing; and (5) strengthened primary health care systems supported by interoperable digital infrastructure. These measures align with Agenda 2063's aspiration for healthy and prosperous societies.

Discussion

The evolving global health landscape underscores the need for empirical monitoring of financing flows, supply chain dependencies, and governance reforms. Future research should quantify the fiscal exposure of African health systems to funding shifts away from multilateral arrangements and assess the cost implications of geopolitical supply disruptions of these shifts. Policy reform must be evidence-informed and institutionally grounded.

Conclusion

Geopolitical realignment does not inevitably weaken global health cooperation, but it exposes structural vulnerabilities. Africa's response should prioritise institutional coordination, financing reform, and strategic autonomy within multilateral engagement. A disciplined, continent-wide strategy will determine whether Africa remains reactive or emerges as a credible actor in shaping global health governance reform.



Global Health Worker protesting against poor pay, courtesy of FREEPIK

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Education for peace, wellbeing and sustainability in Africa: Marking the Parameters

Obijiofor Aginam takes us on a journey of the linkage between education peace and wellbeing and elaborates on the proposal from UNESCO on how this can be done.



Leadership Education and Advancement Program (LEAP) at a school in Kenya

The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States – Constitution of the World Health Organization

Prologue:

The world is facing a plethora of interlinked crises: full-blown civil wars between countries with far-reaching global social and economic repercussions; internecine conflicts and social tensions among groups and communities within countries; rising polarization and socio-economic inequalities in and between countries; climate-induced extreme weather events (floods, tsunamis, cyclones, tornadoes); hunger and food insecurity; emerging and re-emerging infectious diseases; energy crisis, and increasing digital divide between the global North and South, and within countries. Often described as a polycrisis because of their simultaneous occurrence across time and space in different regions of the world, these multiple emergencies coalesce into a massive disruptive force impacting peace, wellbeing, and sustainability disproportionately across the world. These rapid and interconnected emergencies have placed populations in Africa, and other developing regions of the world in a state of accelerated and heightened mental, social, and physical uncertainties and anxieties, requiring renewed cooperation, inclusive policy frameworks, community-driven and holistic approaches to promote peace and nurture a sustainable future for all. Given the integrated and interdependent nature of the 17 Sustainable Development Goals (SDGs) in Agenda 2030, what role might education, broadly defined, play in nurturing peace, wellbeing and sustainability in African societies?

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Issue-linkages for peace, wellbeing and sustainability

COVID-19, the most recent global pandemic since the 2009 H1N1 influenza, as of 22 February 2026, was estimated by the World Health Organization to have killed over 7 million people globally.[1] COVID rolled back the gains made by countries towards achieving the 169 targets of the 17 Sustainable Development Goals (SDGs) in Agenda 2030 including SDG 4.7 that aims to ensure,

among others, that all learners acquire knowledge and skills to promote sustainable development, global citizenship, and a culture of peace and non-violence by 2030. As argued by Beaumont, "two decades of progress in the reduction of extreme poverty, the elimination of which is one of the sustainable development goals, have been pushed into a sharp reverse by a combination of the impact of the Covid-19 pandemic, the growing climate emergency and increasing debt"[2]. COVID disrupted education and learning systems and exposed the fault lines between the rich and poor countries on vaccine equity and access to life saving medical countermeasures during emergency.[3]

Climate change, one of the most serious existential threats of our time, has unleashed extreme weather events and natural disasters in different regions: floods, hurricanes, heatwaves, forest fires, tsunamis, tornadoes and cyclones. In the latest Synthesis Report, the Intergovernmental Panel on Climate Change (IPCC), stated that "human-caused climate change is already affecting many weather and climate extremes in every region across the globe", leading to "widespread adverse impacts and related losses and damages to nature and people".[4] Inspired by the pioneering work of the IPCC on the categories of extreme events and disasters, some scholars argue that "the number of recorded natural disasters has more than doubled in number, from around 200 a year to over 400" over the past three decades.

Emerging digital technologies driven by Artificial Intelligence (AI) are transforming multiple sectors of human endeavor, offering gains but also paradoxically sparking ethical and regulatory dilemmas around digital divide, data privacy, digital saturation, mental and emotional wellbeing, and job displacement.[6]

Can education for peace drive wellbeing and sustainability?

In Reimagining Our Futures Together: A new social contract for education, UNESCO proposed redefining the purposes of education to steer education systems away from emphasizing values of individual success and national competition towards "solidarity, understanding of our interdependencies, and caring for each other and the planet".[7] In recent decades, an influential school of thought (scholars, educationists, and practitioners) has argued that education is not just literacy and numeracy but a lifelong endeavor that offers a foundation for peace and harmonious coexistence. Education policies must ensure good quality education "integrated with skill acquisition, and along with that promise, comprehensive growth and personality development for every individual".[8] To address the multi-faceted and holistic development that an individual deserves in all five domains of human personality: physical, intellectual, emotional, psychological, and spiritual,[9] UNESCO has elaborated norms to promote education for peace, human rights, and sustainable development in the 21st century.

UNESCO's Recommendation on Education for Peace, Human Rights and Sustainable Development (unanimously adopted UNESCO 193-member states in 2023) focuses on how education should evolve in the 21st century to bring about lasting peace, reaffirm human rights and promote sustainable development in the face of contemporary threats and challenges facing communities in different regions. The Recommendation outlines **14 guiding principles, concrete learning outcomes and priority action areas** for holistically reshaping all aspects of education systems. Beyond critical literacy and numeracy skills, learners should acquire competencies like empathy, critical thinking, intercultural understanding and environmental stewardship. The highlights of the Recommendation include: (i) a new understanding of peace (not just the absence of war and conflict but a dynamic process that nurtures the values of human dignity, and taking care of ourselves, and the planet we share), (ii) Education for sustainable development (fostering knowledge about the root causes of climate change, its impact, and ways to adapt and mitigate), (iii) Global citizenship education (preparing learners that value human dignity, cooperation, and dialogue that nurtures empathy and respect for the diversity of cultures and opinions), (iv) Gender equality and education (promoting gender equality and acknowledging its importance for realizing the right to education), and (v) Education in the digital era (the opportunities of new technologies for teaching and learning highlighting the importance of critical thinking, empathy, and understanding of key principles of digital security, privacy, and ethical online interactions).

Because peace has always been construed as not just the absence of war, "education for peace" goes beyond the narrow confines of "peace education" by looking at the formal and informal education systems including lifelong learning opportunities for all. In doing so, education for peace encompasses a holistic approach that addresses the competencies and variables for positive and negative peace towards promoting peaceful, sustainable, and inclusive societies. Given these complex challenges, formal and informal education systems must be reimagined to build peace, wellbeing, and sustainability.

Epilogue: locating education and health at the centre of sustainability

The quest to promote just, inclusive, and sustainable societies through education for peace is consistent with the foundational pillars and principles of inclusivity and solidarity codified in the Constitution of the World Health organization:

1. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
2. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.
3. The achievement of any State in the promotion and protection of health is of value to all.
4. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

5. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
6. The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health.
7. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people
8. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Adopted in 1946, these foundational principles of inclusivity and solidarity were recognized as "basic to the happiness, harmonious relations and security of all peoples". The synergy between education for peace, wellbeing and sustainability is a reinforcing relationship where health is a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'; peace is not just the absence of war'; and education goes beyond literacy, numeracy, and the cognitive mastery of academic knowledge. In this endeavor, education emerges as a key social determinant of health. UNESCO has, for decades, promoted a range of programmes under the broad umbrella of education for peace, including Social and Emotional Learning (SEL), education for sustainable development, and education for health and wellbeing. These programmes reflect a holistic, and human-centered approach to wellbeing and sustainability. In the realm of peace, wellbeing and sustainability, the synergy of education and health in Africa can lead to positive and measurable outcomes scaling back the morbidity and mortality burdens of newly emerging and reemerging infectious diseases; the prevalent non-communicable diseases and unhealthy lifestyles; the health-related impact of climate change, and a cluster of social determinants of health. The integrated nature of the 17 SDGs in the 2030 Agenda for sustainable development underscores the importance of a holistic conception of health beyond disease, peace beyond war, and education beyond tests and examinations. This holistic paradigm offers a pragmatic anchorage for the "right of everyone" to the enjoyment of the highest attainable standard of health, and the 'promotion of just, peaceful, and inclusive societies' in Africa and elsewhere.

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Yes! We Can End Tuberculosis If Communities Lead the Way



A young boy getting a checkup by doctor courtesy of FREEPIK

This 24 March, World Tuberculosis (TB) Day, we are reminded that TB is both preventable and curable, yet it continues to devastate the most vulnerable. People living with HIV, those suffering from malnutrition, and families struggling under the impacts of climate change are still dying from a disease that should no longer claim lives.

Recent floods in Mozambique have been unprecedented in parts of the country, destroying entire harvests, washing away homes, and making travel to health clinics nearly impossible. Imagine a subsistence farmer whose entire crop is gone. He has little to eat and cannot reach the clinic to collect his TB medication. TB continues to take lives precisely because these struggles are invisible unless communities can speak up and be heard.

TB is more than a disease of the lungs. It isolates, stigmatises, and threatens the survival of entire families. In the Marracuene and Matola districts, drug-resistant TB and stock-outs of essential medicines have been persistent challenges. Families struggle to support loved ones through long, complex treatment regimens while facing fear, stigma, and daily hardships intensified by climate shocks.

Nina Helen Hallstrom, Senior Partnership Officer, ADPP Mozambique.

Over the past two years, 15,900 people used OneImpact, a community-led monitoring tool implemented in partnership with the Stop TB Partnership, to report barriers to TB care in Mozambique. Most users lived in rural areas, and the platform improved communication, access to services, and treatment adherence. OneImpact demonstrated that technology alone cannot end TB. It works only when combined with human connection, local leadership, and community advocacy.

Between October 2025 and January 2026, the Challenge Facility for Civil Society project was built on this foundation in the Marracuene and Matola districts. People affected by TB could share their experiences in real time through OneImpact. During these four months, 239 people reported 272 barriers to care, including 97 drug stock-outs that affected patients with drug-resistant TB. Over 6,000 people participated in TB literacy sessions, learning about prevention, treatment adherence, and stigma reduction. At the same time, 420 individuals with DR-TB joined Survivor Clubs, peer networks that offered psychosocial support and guidance to navigate long and complex treatment regimens.

Human stories bring these numbers to life, such as someone, who almost abandoned his treatment after being rejected by his family. With support from trained community activists and his peers in the Survivor Club,



A nurser getting ready work courtesy of FREEPIK

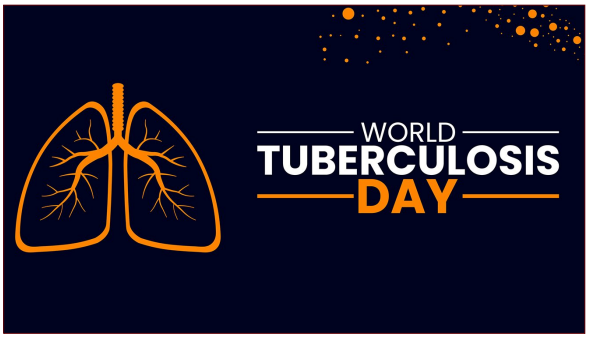
he received counselling, re-engaged his family, and completed his therapy. His journey shows that stigma is not just a social issue; it is a clinical barrier and directly affects treatment outcomes. Listening to and supporting communities can save lives.

The project also achieved lasting systemic change. The National Tuberculosis Program formally endorsed community-led monitoring indicators, including those specific to drug-resistant TB. Community-generated, geo-referenced data allowed health authorities to respond quickly. Every patient affected by drug stock-outs received medication within seven days. This demonstrates the power of documenting barriers, acting on data, and trusting communities to lead the response.

Ending TB requires more than medicines. It requires partnership, sustained investment, and respect for the knowledge of those most affected. Global donors can help accelerate impact by funding locally led initiatives, supporting community health workers, and expanding digital and peer-based interventions that empower patients. When communities lead, technology is meant to support human connection, and when employed in the way we have with OneImpact, treatment adherence improves, and health systems become more accountable.

This World Tuberculosis Day, we must remember that yes, we can end TB, but only if we document barriers, listen to the affected, and act together. By combining human insight, innovation, and cross-sector collaboration, we can turn fear into adherence, isolation into support, and commitments into life-saving outcomes.

Helen Hallstrom is the Country Director of ADPP Mozambique, an organization working to improve education, health, and community development across Mozambique. With extensive experience in international development and program leadership, she has supported large-scale initiatives that strengthen local communities through teacher training, youth empowerment, and sustainable development programs. Under her leadership, ADPP Mozambique continues to expand partnerships and implement community-based solutions that contribute to national development priorities and the achievement of the Sustainable Development Goals.



***World Tuberculosis Day 20** courtesy of Era Hospital*

Ending Tuberculosis: A Global Responsibility We Cannot Ignore

What if tuberculosis (TB) were no longer a global health threat, because we finally treated it as a shared responsibility? As we look ahead to the World Conference on Lung Health (WCLH), I believe it's time to turn a shared risk into a shared investment, and in doing so, affirm the value of every life.

Every second, someone dies from TB. More than 1.3 million lives are lost each year, yet the world barely notices. Over 10 million people fall ill annually, facing not only disease but stigma, mental distress, and economic hardship. TB does not just attack lungs; it fractures families, futures, and communities.

One in four people globally carries latent TB, which can reactivate - fueling future outbreaks, including drug-resistant strains. Its persistence is driven by poverty, overcrowding, malnutrition, HIV, and even climate change.

The disease spreads silently, weakening economies, deepening inequality, and threatening health security everywhere.

While most cases occur in 30 low- and middle-income countries, TB is resurging in regions once thought safe. For example, TB cases in England increased by 13.6% in 2024 compared with the previous year, according to the UK Health Security Agency, the second consecutive year of significant growth, following an 11% rise in 2023. A lack of control of TB in one region of the world is a threat to all.

This is a global problem, but I believe there is an African solution. Mozambique is among the 15 countries with the highest TB burden. Yet it also demonstrates how progress is possible through partnership. The government, through its National TB Programme, has worked hand-in-hand with our teams at ADPP Mozambique and the Humana People to People Federation. Together, we have built a model of community-driven TB control that combines early detection, treatment support, and education. Over the past five years, ADPP's community health teams have screened more than 6.4 million people, diagnosed over 108,000 TB cases, and raised treatment success rates for drug-resistant TB from 71% to 82%, while cutting deaths from 14% to 9% across four provinces. Through the OneImpact community-led monitoring system, problems are identified and solved in real time, further improving detection and treatment outcomes.

Through this work, we know the human face of TB. We urge all those attending the WHLC to consider the people we reach every day in our communities. Cases I've personally been involved with include Maria from Mozambique, who was cast out of her home when her sister believed her TB was caused by a spirit. Left on the street with her two children, she faced the disease alone, until a community health worker found her, helped her access treatment, and supported her recovery.

Then there is Jorge, a father of five, who fell ill with multidrug-resistant TB and could no longer work. His family lost their income and could not afford enough food to sustain him through treatment. Weakened and desperate, he abandoned therapy, putting himself and others at risk.

Community-based approaches that understand these realities and meet people where they are, are not only saving lives; they are cost-effective. The cost of community TB prevention, active case finding, and home-based treatment support is far lower than the economic and human cost of uncontrolled TB.

Without adequate investment, TB will continue to kill over 4,000 people each day, infect more than 43 million others, and drain an estimated US$1 trillion in lost productivity.

Yet the cost of ending TB worldwide would be only an estimated US$250 billion between 2023 and 2030. Every dollar invested could generate up to US$40 in economic value, and even more in low and middle-income countries. There is huge potential upside to our economies and more importantly our humanity, from eradicating TB worldwide.

Encouragingly, we already have the tools to fight TB; what is missing is scale, coordination, and sustained investment. COVID-19 showed what can be achieved when urgency, funding, and political will converge. Trillions were mobilized to protect economies and lives. Ending TB would cost less than 10% of global military spending, a small fraction to end humanity's oldest pandemic.

While governments work to strengthen domestic health financing, there is an urgent need for philanthropic foundations, private companies, and impact investors - both international and domestic - to step up.

We must come together and fund community-led TB programs, proven to be cost-effective in finding and supporting people with TB. We must expand access to rapid diagnostics to detect TB early and stop transmission. We must invest in new TB vaccines and ensure equitable rollout to protect future generations. And we must support domestic and regional investment mechanisms that help African countries sustain TB control into the future.

If the world could mobilise unprecedented resources for COVID-19, we can do the same for TB. When we invest in people, dignity, and resilient communities, we not only save lives but strengthen economies and unlock our collective human potential. Those meeting at WCLH and beyond must prove that global solidarity is more than just words.

Nina Helen Hallstrom, Senior Partnership Officer, ADPP Mozambique.

General Medicine

Uncontrolled Hypertension Among Adult Hypertensive Patients in Addis Ababa Public Hospitals — Cross-Sectional Study

Abstract: Uncontrolled hypertension can cause stroke, myocardial infarction, heart failure, renal failure, dementia, blindness, and death. This study aimed to assess the prevalence and associated factors of uncontrolled hypertension among adult hypertensive patients at public hospitals in Addis Ababa, Ethiopia, using the updated JNC-8 classification. A hospital-based cross-sectional study was conducted from April 12 to May 12, 2024, involving 408 hypertensive patients selected via systematic random sampling across three public hospitals. Data were collected using a structured interview questionnaire, chart review, and physical measurements. Among the 15,508 hypertensive patients followed at the study hospitals, the three sites were selected by simple random sampling. This study incorporated patients' knowledge as a variable, distinguishing it from earlier studies that predominantly applied the older JNC-7 classification. Findings highlighted significant gaps in blood pressure control and identified modifiable determinants that could inform targeted interventions.

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Socio-Demographic and Lifestyle Factors Associated with Hypertension in Nigeria: Results from a Country-Wide Survey

Abstract: With the rising prevalence of hypertension in Africa, understanding the dynamics of socio-demographic and lifestyle factors is key to its management. This study used a cross-sectional survey design with a modified WHO STEPS questionnaire administered to 3,782 adult Nigerians selected from both urban and rural communities across all six Nigerian geopolitical regions. Among participants, 56.3% were women, 65.8% were married, and 52.5% resided in rural areas. Mean ages were 53.1 ± 13.6 years among hypertensive individuals versus 39.2 ± 15.0 years among normotensive counterparts. Regarding lifestyle, 30.7% reported low physical activity, 4.1% were current tobacco users, and 35.4% consumed alcohol. Being married (OR = 1.88, 95% CI: 1.41–2.50) or widowed (OR = 1.57, 95% CI: 1.05–2.36), compared with being unmarried, was significantly associated with hypertension. The study addresses important gaps in country-wide evidence on hypertension risk factors in Nigeria.

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Hypertension in Sub-Saharan Africa: Cross-Sectional Surveys in Four Rural and Urban Communities

Abstract: Cardiovascular disease is the leading cause of adult mortality in low-income countries, yet data on hypertension prevalence in sub-Saharan Africa (SSA) remain scarce. This study aimed to assess the prevalence and determinants of hypertension across four SSA populations — rural Nigeria and Kenya, and urban Namibia and Tanzania — through cross-sectional household surveys conducted between 2009 and 2011. Among 7,568 included adult respondents, age-standardised hypertension prevalence was 19.3% (95% CI: 17.3–21.3) in rural Nigeria, 21.4% (19.8–23.0) in rural Kenya, 23.7% (21.3–26.2) in urban Tanzania, and 38.0% (35.9–40.1) in urban Namibia. In hypertensive individuals, grade 2 or 3 hypertension (≥160/100 mmHg) ranged from 29.2% to 43.3% across sites. Control of hypertension ranged from just 2.6% in Kenya to 17.8% in Namibia. Obesity prevalence ranged from 6.1% to 17.4%, and together with age and sex, BMI independently predicted blood pressure in all study populations. Diabetes prevalence ranged from 2.1% to 3.7%.

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Factors Associated with Glycaemic Control Among Patients with Type 2 Diabetes Mellitus in Ho, Ghana — A Cross-Sectional Study

Abstract: Effective glycaemic control remains a major challenge in the management of type 2 diabetes mellitus (T2DM) in low-resource settings. This cross-sectional study investigated factors associated with glycaemic control among T2DM patients attending a health facility in Ho, Ghana. Adult patients with a confirmed diagnosis of T2DM were enrolled, and data on demographic characteristics, medication adherence, self-management practices, and glycated haemoglobin (HbA1c) levels were collected. Binary and multivariate logistic regression analyses were used to identify independent predictors of poor glycaemic control (HbA1c ≥7%). Findings revealed that medication non-adherence, low health literacy, and inadequate dietary management were significantly associated with suboptimal glycaemic control. The study underscores the need for patient-centred diabetes education programmes and enhanced support for medication adherence in Ghanaian primary healthcare settings.

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Incident Type 2 Diabetes and Its Risk Factors in Men and Women Aged 40–60 Years from Four Sub-Saharan African Countries: Results from the AWI-Gen Study

Abstract: Data on the incidence of type 2 diabetes (T2D) in sub-Saharan Africa (SSA) remain sparse and highly heterogeneous. The AWI-Gen (Africa Wits-INDEPTH Partnership for Genomic Research) longitudinal study examined incident T2D and associated risk factors in a multi-country cohort of men and women aged 40–60 years in Ghana, Kenya, South Africa, and Burkina Faso. A systematic PubMed search identified 17 prior studies from 12 SSA countries, which showed wide variability in incidence from 4 to 63 cases per 1,000 person-years, and only four studies specifically targeted the middle-aged population. Using standardised methods across all sites, this study assessed risk factors including adiposity, physical inactivity, and metabolic markers. Waist circumference and triglyceride levels emerged as independent predictors of incident dysglycaemia and T2D. The study provides important evidence to guide targeted prevention strategies for diabetes in middle-aged African populations.

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Maternal Health

Institutional Delivery Dropout After Antenatal Care Booking in LMICs — A Multilevel Analysis of 29 DHS Datasets

Abstract: Institutional delivery dropout (IDD) — where women who attend antenatal care (ANC) subsequently deliver outside health facilities — is a major problem disproportionately affecting low- and middle-income countries (LMICs) and is associated with increased risks of adverse birth outcomes. This study assessed the pooled prevalence and determinants of IDD among women in LMICs using Demographic and Health Survey (DHS) data from 29 countries collected between 2016 and 2021. Data analysis was performed using STATA version 14, with a forest plot used to estimate the pooled prevalence of IDD. Multilevel binary logistic regression was applied to identify independent determinants, reported as adjusted odds ratios (AOR) with 95% confidence intervals. The pooled prevalence of IDD after ANC booking was 22.25% (95% CI: 18.25–26.25). Significant predictors of IDD included rural residence, lower educational attainment, absence of a decision-making role, and lower household wealth. The findings highlight that accessing antenatal care does not guarantee facility-based delivery, and point to structural and socioeconomic barriers that must be addressed to improve safe delivery rates in LMICs.

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Incidence and Predictors of Severe Postpartum Haemorrhage After Caesarean Delivery in South-Central Ethiopia — A Retrospective Cohort Study

Abstract: Postpartum haemorrhage (PPH) following caesarean delivery (CD) is a life-threatening obstetric emergency with significant implications for maternal survival in low-resource settings. This retrospective cohort study was conducted at a referral hospital in South-Central Ethiopia and included 728 women who underwent caesarean section. Data were extracted from medical records including baseline, obstetric, and perioperative characteristics. Multivariate logistic regression analyses with adjusted odds ratios (AOR) and 95% confidence intervals were used to identify independent predictors. The incidence of severe PPH was 3.6% (n = 26). Independently associated factors included: previous caesarean scar of ≥2 (AOR 4.08, 95% CI: 1.20–13.86), antepartum haemorrhage (AOR 2.89, 95% CI: 1.01–8.16), severe preeclampsia (AOR 4.52, 95% CI: 1.24–16.46), maternal age ≥35 years (AOR 2.77, 95% CI: 1.02–7.52), general anaesthesia (AOR 4.05, 95% CI: 1.37–11.95), and classical uterine incision (AOR 6.01, 95% CI: 1.51–23.98). These findings underscore the importance of identifying high-risk obstetric patients pre-operatively to guide targeted prevention strategies.

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Maternal Outcomes of Severe Preeclampsia and Eclampsia and Associated Factors Among Women Admitted at Referral Hospitals in Amhara Region, North-West Ethiopia — An Institutional Cross-Sectional Study

Abstract: Preeclampsia and eclampsia remain leading causes of maternal morbidity and mortality in Ethiopia, where indirect obstetric complications are prevalent. This institution-based cross-sectional study examined maternal outcomes and associated factors among 456 women admitted with severe preeclampsia or eclampsia at referral hospitals in the Amhara Regional State, North-West Ethiopia. Structured data collection tools were used to extract obstetric and clinical data from medical records. Binary and multivariable logistic regression analyses were performed to identify predictors of adverse maternal outcomes. Nearly two-thirds (63.2%) of cases occurred during the antepartum period, while 28.9% and 7.9% were intrapartum and postpartum, respectively. Of the 456 women, 37.7% experienced adverse maternal outcomes. Among those, 56.9% experienced PPH and 0.5% died from eclampsia-related complications. Educational status, rural residence, monthly family income, parity, history of abortion, booking status,

and timing of drug administration were identified as significant predictors. Strengthening emergency obstetric care and early ANC uptake is essential to reducing adverse outcomes.

Reference

Bayou G, Tesfaye K, Gebre B, Getachew M, Haile K. Maternal outcomes of severe preeclampsia and eclampsia and associated factors among women admitted at referral hospitals of Amhara Regional State: institutional-based cross-sectional study, North-West Ethiopia. Front Glob Womens Health. 2025;6:1555778. doi:10.3389/fgwh.2025.1555778.

Preeclampsia and Eclampsia-Specific Maternal Mortality in Bangladesh: Levels, Trends, Timing, and Care-Seeking Practices

Abstract: Despite a steady global decline in maternal mortality, preeclampsia and eclampsia remain among the most common causes of maternal death, accounting for approximately 14% of all global maternal fatalities. This population-based analysis used data from three rounds of the Bangladesh Maternal Mortality Survey (BMMS) conducted in 2001, 2010, and 2016 to assess trends in preeclampsia/eclampsia-specific maternal mortality ratios (MMR), timing of death, and care-seeking practices. Verbal autopsy data were reviewed and causes of death classified using standard criteria. The preeclampsia/eclampsia-specific MMR changed from 77 (uncertainty range [UR] 44–111) per 100,000 live births in 2001 to 40 (UR 19–60) in 2010, with a reversal to 46 (UR 29–65) in the 2016 BMMS. Nearly three-quarters (76%) of deaths occurred in rural areas, and over 59% were in households with lower socioeconomic status. These findings indicate stalling progress and reinforce the need for targeted, cause-specific programmatic action to reduce preeclampsia-related mortality in Bangladesh.

Reference

Jabeen S, Siddique AB, Hossain AT, Khan S, Haider MM, Tahsina T. Preeclampsia and eclampsia-specific maternal mortality in Bangladesh: Levels, trends, timing, and care-seeking practices. J Glob Health. 2023;13:07003. doi:10.7189/jogh.13.07003. PMID: 37022714.

Caesarean Section Training Practices in LMICs vs High-Income Countries — A Convergent Mixed-Methods Cross-Sectional Study

Abstract: Caesarean section (CS) is one of the most commonly performed obstetric procedures worldwide, yet training practices vary substantially between settings. This convergent parallel mixed-methods cross-sectional study identified and compared CS training practices globally, focusing on differences between high-income countries (HICs) and low- and middle-income countries (LMICs). An online survey was conducted between October 2023 and January 2024 using REDCap software and distributed via professional obstetrics and gynaecology networks, including the South African Society of Obstetrics and Gynaecology (SASOG). A total of 411 participants from 42 countries were included — 42% (n = 172) from HICs and 58% (n = 239) from LMICs. Participants from LMICs performed significantly more CS procedures annually (mean 138 ± 221 cases) compared to HIC counterparts (mean 44 ± 64 cases; $p < 0.001$). However, LMIC trainees reported significantly fewer formal structured teaching opportunities, less simulation-based training, and lower satisfaction with supervision quality. Qualitative data highlighted contextual challenges including staff shortages and resource constraints. The study underscores the urgent need for standardised, context-appropriate CS training programmes in LMICs.

Reference

de Waard J, Rall K, Hannan J, Pattinson R, Theron G, Nunes I. Current practices in caesarean section training: A cross-sectional study comparing high- and low-middle-income countries. Int J Gynaecol Obstet. 2025. doi:10.1002/ijgo.70696. Epub ahead of print. PMID: 39863947.

Surgery

Perioperative Patient Outcomes in the African Surgical Outcomes Study (ASOS): A 7-Day Prospective Observational Cohort Study

Abstract: There is a need to increase access to surgical treatments in African countries, but perioperative complications represent a major global healthcare burden, and there are few studies describing surgical outcomes in Africa. This 7-day, international, prospective, observational cohort study enrolled patients aged 18 years and older undergoing any inpatient surgery across 25 African countries. Hospitals were recruited using convenience sampling, with data required from at least 10 hospitals per country and for at least 90% of eligible patients. Each country selected one recruitment week between February and May 2016. The primary outcome was in-hospital postoperative complications, graded as mild, moderate, or severe. One in five surgical patients in Africa developed a perioperative complication, following which one in ten patients died. Despite being younger with a lower-risk profile and lower complication rates than the global average, African patients were twice as likely to die after surgery compared with the global benchmarks. African surgical hospitals were markedly under-resourced, with a median combined total of specialist surgeons, obstetricians, and anaesthesiologists of 0.7 (IQR 0.2–1.9) per 100,000 population — far below the Lancet Commission on Global Surgery's recommended threshold. The volume of surgical procedures in Africa was also very low at 212 (65–578) per 100,000 population annually. The study concludes that surgical outcomes will remain poor in Africa unless perioperative care for patients with deteriorating physiological function is urgently addressed.al health strategies, and more rigorous monitoring and evaluation.

Reference

Biccard BM, Madiba TE, Kluyts HL, Munlemvo DM, Madzimbamuto FD, Basenero A, et al.; African Surgical Outcomes Study (ASOS) investigators. Perioperative patient outcomes in the African Surgical Outcomes Study: a 7-day prospective observational cohort study. Lancet. 2018 Apr 21;391(10130):1589–1598. doi:10.1016/S0140-6736(18)30001-1. PMID: 29306587.

Mortality of Emergency Abdominal Surgery in High-, Middle-, and Low-Income Countries — GlobalSurg 1

Abstract: Surgical mortality data are collected routinely in high-income countries, yet virtually no low- or middle-income countries have perioperative outcome surveillance in place. This prospective, multicentre, cohort study prospectively collected worldwide mortality data following emergency abdominal surgery and compared findings across countries stratified by the UN's Human Development Index (HDI). Self-selected hospitals performing emergency surgery submitted prespecified data for consecutive patients during at least one 2-week interval between July and December 2014. Data were obtained for 10,745 patients from 357 centres in 58 countries — 6,538 from high-HDI, 2,889 from middle-HDI, and 1,318 from low-HDI settings. The overall 24-hour mortality rate was 1.6% (high 1.1%, middle 1.9%, low 3.4%; $p < 0.001$), rising to 5.4% by 30 days (high 4.5%, middle 6.0%, low 8.6%; $p < 0.001$). Of the 578 patients who died, 404 (69.9%) did so between 24 hours and 30 days. The study demonstrated a steep gradient in mortality risk by national income level, underscoring the urgent need for improved surgical outcome surveillance and postoperative care systems in LMICs.

Reference

GlobalSurg Collaborative. Mortality of emergency abdominal surgery in high-, middle- and low-income countries. Br J Surg. 2016 Jul;103(8):971–988. doi:10.1002/bjs.10151. Epub 2016 May 4. PMID: 27145169.

Surgical Site Infection After Gastrointestinal Surgery in High-, Middle-, and Low-Income Countries — GlobalSurg 2

Abstract: Surgical site infection (SSI) is one of the most common healthcare-associated infections, but its importance as a global health priority is not fully understood. This international, prospective, multicentre cohort study quantified the burden of SSI after gastrointestinal surgery across countries worldwide. Consecutive patients undergoing elective or emergency gastrointestinal resection during 2-week periods at any healthcare facility globally were enrolled between January and July 2016. Countries were stratified by the UN's Human Development Index (HDI). Data were entered from 12,539 patients across 343 hospitals in 66 countries. The 30-day SSI incidence more than doubled from high-HDI (9.4%), to middle-HDI (14.0%), to low-HDI (23.2%) settings. Following risk factor adjustment, patients in low-HDI countries remained at greatest risk of SSI (adjusted odds ratio 1.60, 95% credible interval 1.05–2.37; $p = 0.030$). Antibiotic resistance in SSI pathogens was detected in 16.6% of patients from high-HDI, 19.8% from middle-HDI, and 35.9% from low-HDI countries ($p < 0.001$). The findings confirm that patients in LMICs carry a disproportionate burden of SSI and antibiotic resistance, and that pragmatic randomised trials based in LMICs are urgently needed.

Reference

GlobalSurg Collaborative. Surgical site infection after gastrointestinal surgery in high-income, middle-income, and low-income countries: a prospective, international, multicentre cohort study. Lancet Infect Dis. 2018 May;18(5):516–525. doi:10.1016/S1473-3099(18)30101-4. Epub 2018 Feb 13. PMID: 29452941.

Outcomes After Surgery for Children in Africa (ASOS-Paeds): A 14-Day Prospective Observational Cohort Study

Abstract: Safe anaesthesia and surgery are a public health imperative, yet there are few data describing outcomes for children undergoing surgery in Africa. This study aimed to generate robust epidemiological data on patient care and outcomes for children undergoing anaesthesia and surgery in African hospitals. A 14-day, international, prospective, observational cohort study enrolled children aged under 18 years undergoing surgery at hospitals across all levels of care in Africa. Each hospital recruited all eligible children over a 14-day period within the study window from January 15 to December 23, 2022. Outcomes following anaesthesia and surgery for children in Africa were poor, with complication rates up to four-fold higher (18% vs 4.4–14%) and crude, unadjusted in-hospital mortality rates 11-fold higher compared with high-income countries (23.15 deaths vs 2.18 deaths per 1,000 children). The study identified a high rate of failure to rescue following postoperative complications as a key driver of mortality. The authors conclude that to improve surgical outcomes for children in Africa, health system strengthening, provision of safe environments for anaesthesia and surgery, and failure-to-rescue strategies are urgently required.

Reference

ASOS-Paeds Investigators. Outcomes after surgery for children in Africa (ASOS-Paeds): a 14-day prospective observational cohort study. Lancet. 2024 Apr 13;403(10435):1482–1492. doi:10.1016/S0140-6736(24)00103-X. Epub 2024 Mar 22. PMID: 38527482.

Determinants of Morbidity and Mortality Following Emergency Abdominal Surgery in Children in Low- and Middle-Income Countries — GlobalSurg Collaborative

Abstract: Child health is a key priority on the global health agenda, yet the provision of essential and emergency surgery in children is patchy in resource-poor regions. This multicentre, international, prospective cohort study aimed to determine the mortality risk for emergency abdominal paediatric surgery in low-income countries globally. Self-selected surgical units performing emergency abdominal surgery submitted prespecified data for consecutive children aged under 16 years during a 2-week period between July and December 2014. The UN's Human Development Index (HDI) was used to stratify countries, and 30-day postoperative mortality was the primary outcome, analysed by multilevel logistic regression. Neonates (≤1 month) had the highest mortality risk (OR 8.36, 95% CI: 4.06–17.22; $p < 0.001$) compared to older children, while infants (>1 month to <2 years) also had significantly elevated risk (OR 4.40, 95% CI: 1.83–9.95; $p = 0.001$). Low HDI was independently associated with greater morbidity and mortality compared to high-HDI settings, even after adjusting for patient and operative factors. The findings highlight the critical gap in safe paediatric emergency surgical care in LMICs and point to anaesthetic, intensive care, and delayed treat-

ment access as key modifiable contributors.

Reference

GlobalSurg Collaborative. Determinants of morbidity and mortality following emergency abdominal surgery in children in low-income and middle-income countries. BMJ Glob Health. 2016 Dec 12;1(4):e000091. doi:10.1136/bmjgh-2016-000091. eCollection 2016. PMID: 28588977; PMCID: PMC5321375.

Child Health

Childhood Mortality During and After Acute Illness in Africa and South Asia: A Prospective Cohort Study (CHAIN Network)

Abstract: Despite remarkable reductions in child mortality globally, more than 5 million children died in 2019, predominantly in low- and middle-income countries (LMICs). This prospective multisite cohort study aimed to characterise inpatient and post-discharge mortality among acutely ill children across sub-Saharan Africa and South Asia. A cohort of 3,101 children aged 2–24 months were recruited at admission to hospital for any acute illness at nine hospitals in Bangladesh, Pakistan, Kenya, Uganda, Malawi, and Burkina Faso between November 2016 and January 2019. Children were stratified by nutritional status into no wasting, moderate wasting, and severe wasting/kwashiorkor groups. Common admitting diagnoses included diarrhoea (55%), severe pneumonia (21%), malaria (14%), and severe anaemia (14%). Inpatient mortality was 3.5% for children with no wasting, 8.1% among those with moderate wasting, and 20.4% for those with severe wasting or kwashiorkor. Post-discharge mortality mirrored inpatient mortality patterns, underscoring that discharge does not signal recovery. Low mid-upper arm circumference (MUAC), representing a high-risk nutritional state, was the strongest predictor of both inpatient and post-discharge mortality. The study concludes that risk stratification strategies integrating nutritional status are critical to targeting high-risk children for enhanced monitoring and intervention in LMIC hospital settings.

Reference

Childhood Acute Illness and Nutrition (CHAIN) Network. Childhood mortality during and after acute illness in Africa and south Asia: a prospective cohort study. Lancet Glob Health. 2022 May;10(5):e673–e684. doi:10.1016/S2214-109X(22)00118-8. PMID: 35427524.

Contribution of Malnutrition to Infant and Child Deaths in Sub-Saharan Africa and South Asia — CHAMPS Network

Abstract: Malnutrition is estimated to contribute to 45% of all childhood deaths globally, yet these modelled estimates lack direct measurement in high-burden countries. This multisite observational study analysed CHAMPS (Child Health and Mortality Prevention Surveillance) data collected at seven sites — Bangladesh, Ethiopia, Kenya, Mali, Mozambique, Sierra Leone, and South Africa — between December 2016 and December 2023. An expert Determination of Cause of Death (DeCoDe) panel adjudicated each case using clinical chart review, verbal autopsy, postmortem physical examination, minimally invasive tissue sampling, quantitative PCR, and histopathology. Among 1,601 deaths in children under five years, malnutrition was identified as a causal or significant factor in 39.5% of cases. Most malnutrition-related deaths had an infectious cause (89.1%), and the adjusted odds of having malnutrition as a causal or significant condition were 2.4 times higher for deaths involving infectious diseases. Common pathogens in the causal pathway included Klebsiella pneumoniae (30.4%), Streptococcus pneumoniae (21.5%), Plasmodium falciparum (18.7%), and Escherichia coli/Shigella (17.2%). The findings emphasise the urgent need for integrated interventions addressing both malnutrition and infectious diseases to reduce under-5 mortality in LMICs.

Reference

Madewell ZJ, Blau DM, Barengo N, Acácio S, Agócs M, Alam M, et al. Contribution of malnutrition to infant and child deaths in Sub-Saharan Africa and South Asia. BMJ Glob Health. 2024 Dec 5;9(12):e017262. doi:10.1136/bmjgh-2024-017262. PMID: 39638608; PMCID: PMC11624724.

Neonatal Sepsis and Mortality in Low- and Middle-Income Countries from a Facility-Based Birth Cohort: An International Multisite Prospective Observational Study (BARNARDS)

Abstract: Neonatal sepsis is a primary cause of neonatal mortality and an urgent global health concern, with 99% of global neonatal deaths occurring in LMICs. The Burden of Antibiotic Resistance in Neonates from Developing Societies (BARNARDS) study recruited mothers and neonates into a prospective observational cohort study across 12 clinical sites in Bangladesh, Ethiopia, India, Pakistan, Nigeria, Rwanda, and South Africa. Primary outcomes were clinically suspected sepsis, laboratory-confirmed sepsis, and all-cause neonatal mortality during the first 60 days of life. The incidence of clinically suspected sepsis was 166.0 per 1,000 livebirths, laboratory-confirmed sepsis was 46.9 per 1,000 livebirths, and all-cause mortality was 0.83 per 1,000 neonate-days. The majority (72.5%) of laboratory-confirmed sepsis cases occurred within the first 3 days of life. Maternal hypertension, previous maternal hospitalisation, preterm birth, perinatal asphyxia, and multiple births were independently associated with increased risk of both suspected and confirmed sepsis. These findings highlight the disproportionate burden of neonatal sepsis and mortality in LMICs and call for targeted strategies to address antibiotic resistance and infection prevention in newborn care settings.

Reference

Seale AC, Blencowe H, Manu AA, Nair H, Bahl R, Qazi SA, et al. Estimates of possible severe bacterial infection in neonates in sub-Saharan Africa, south Asia, and Latin America for 2012: a systematic review and meta-analysis. Corrected and republished: Neonatal sepsis and mortality in low-income and middle-income countries from a facility-based birth cohort: an international multisite prospective observational study. Lancet Infect Dis. 2022 Jun;22(6):e168–e180. doi:10.1016/S1473-3099(21)00707-X. PMID: 35427523.

CPD Challenge

Questions

Q1 Indicate whether each of the following statements is TRUE (T) or FALSE (F) regarding lifestyle factors associated with hypertension in Africa.

a. Low physical activity is associated with an increased risk of hypertension.
b. Many African cross-sectional studies consistently show sustained hypertension prevalence to be higher among current smokers after adjusting for confounders such as BMI and age.
c. While light-to-moderate alcohol consumption has sometimes been described as cardioprotective, this protective effect is inconsistent and does not negate its hypertensive impact at higher intake levels.
d. Multiple population-based studies in sub-Saharan Africa demonstrate higher hypertension prevalence among married or widowed individuals, compared with unmarried individuals.
e. Abdominal (central) obesity appears more strongly associated with hypertension than BMI alone in many African cohorts.

Q2 Please indicate as TRUE or FALSE, factors Associated with glycemic control among patients with Type 2 Diabetes Mellitus in Africa:

a. Across multiple African settings, medication non-adherence remains one of the strongest predictors of poor glycaemic control.
b. In many sub-Saharan African settings, limited formal education and language barriers complicate diabetes self-management.
c. Evidence across African primary healthcare systems shows that structured, culturally adapted, patient-centred education improves self-monitoring behaviours, medication adherence and glycaemic outcomes.
d. There is a need for patient-centered diabetes education programs and enhanced support for medication adherence in primary healthcare settings.
e. Increased waist circumference and elevated triglycerides are not recognized components of metabolic syndrome and are not consistently associated with insulin resistance and glycaemic control.

Q3 Indicate whether each of the following statements is TRUE (T) or FALSE (F) regarding predictors of severe postpartum haemorrhage (PPH) after caesarean delivery in Africa.

a. A previous caesarean section does not increase the risk of abnormal placentation, including placenta previa and placenta accreta spectrum disorders.
b. Antepartum haemorrhage (APH), particularly due to placenta previa or placental abruption, significantly increases the likelihood of severe bleeding at delivery.
c. Severe preeclampsia which is frequently associated with thrombocytopenia and coagulation abnormalities, is consistently identified as an independent predictor of severe PPH after adjusting for confounders.
d. Maternal age ≥35 years is associated with an increased risk of severe postpartum haemorrhage.
e. The use of general anaesthesia and a classical uterine incision are associated with an increased risk of severe postpartum haemorrhage.

Q4 Indicate whether each of the following statements is TRUE (T) or FALSE (F) regarding determinants of Morbidity and Mortality Following Emergency Abdominal Surgery in Children in LMICs

a. Neonates (≤1 month of age) generally have the highest mortality risk compared to older children.
b. A low Human Development Index (HDI) is independently associated with greater morbidity and mortality compared to high-HDI settings, even after adjusting for patient and operative factors.
c. There is a critical gap in safe paediatric emergency surgical care in LMICs, with anaesthetic capacity, limited intensive care services, and delayed access to treatment identified as key modifiable contributors.
d. Although child health is a priority on the global health agenda, the provision of essential and emergency surgical care for children remains inconsistent in many resource-limited settings.
e. All of the above statements are correct.

Q5 Indicate whether each of the following statements is TRUE (T) or FALSE (F) regarding neonatal sepsis and mortality in low- and middle-income countries.

a. Neonatal sepsis is a major cause of neonatal mortality and an urgent global health concern, with approximately 99% of global neonatal deaths occurring in low- and middle-income countries.
b. The majority of laboratory-confirmed neonatal sepsis cases occur within the first 72 hours of life (early-onset sepsis).
c. Maternal hypertension, previous maternal hospitalization, preterm birth, perinatal asphyxia, and multiple gestation are frequently NOT associated with an increased risk of both suspected and laboratory-confirmed neonatal sepsis.
d. Preterm birth, birth asphyxia, and neonatal infections are among the leading causes of neonatal mortality, and preterm neonates carry a disproportionately high risk of death in LMICs.
e. Key risk factors for neonatal mortality include the need for resuscitation at birth, intrapartum infection, congenital anomalies, household smoke exposure, maternal betel nut chewing, a prior history of neonatal death, and failure to seek care for labour complications.

Answers

1.a). T; b). F; c). T; d). T; e). T
2.a). T; b). T; c). T; d). T; e). F
3.a). F; b). T; c). F; d). T; e). T
4.a). T; b). T; c). T; d). T; e). T
5.a). T; b). T; c). F; d). T; e). T

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