Africa Health October 2026 Vol. 49 No. 4

Africa HEALTH JOURNAL



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From Innovation to Impact: Reflections from the 9th AFREhealth Annual Conference

Africa Centres for Disease Control and Prevention (Africa CDC) and World Health Organization (WHO) call for urgent, community-led action to contain Ebola in the Democratic Republic of the Congo (DRC)

The silent epidemic in maternal health: why more pregnant

Africa Health is a journal of continuing medical education information for health professionals, health managers and political leaders in Africa and globally

Published four times a year by the

African Centre for Global Health and Social Transformation

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www.africa-health.com

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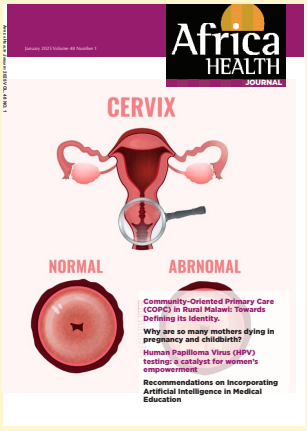
Layout
Elvis Muyanja

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Printed by **Elysian Printers** in Kampala and **Multinational Concepts Ltd.** in Lagos

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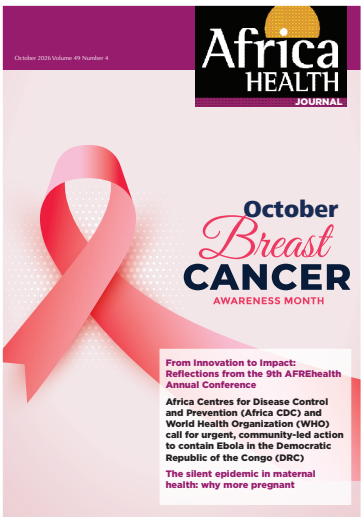


Africa Centre for Global Health and Social Transformation
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ISSN 0141-9536 (print)
ISSN 2053-4760 (online)

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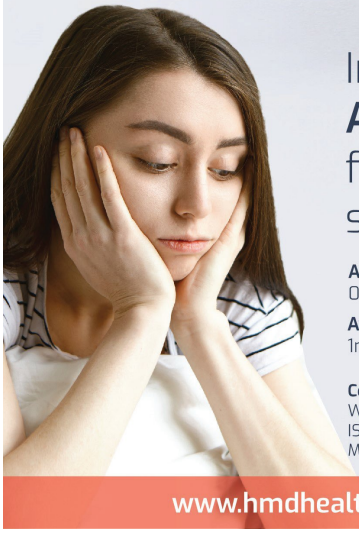
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From Conferences to Action: Strengthening Africa's Health Systems



This issue of Africa Health Journal comes at a time when health systems across Africa face complex, interconnected challenges. Five conferences reported in this edition highlight a shared priority: developing a competent, responsive and resilient health workforce. Discussions on education, recruitment, deployment, retention, migration, research, technology and community engagement show that strengthening health systems requires more than training professionals; it demands coordinated leadership, effective policies, investment and collaboration.

An opinion marking Uganda's 64 years of independence acknowledges health gains and unfinished business across Africa. It considers lessons from other nations that gained independence from Western powers and calls on African health professionals and other technocrats to use their knowledge and influence to accelerate health transformation.

The second annual Consortium of Medical Schools–Africa (COMS-A) conference, MedEdAfrica 2026, held in Ethiopia from 6–8 July, moved the conversation from establishing a continental network towards implementing a shared agenda for medical education and workforce transformation. Discussions covered preparing the workforce for uncertainty, using technology and artificial intelligence (AI) in health professions education, harmonising standards, improving quality and strengthening partnerships. The challenge is to translate these priorities into practical changes in curricula, teaching, assessment and workforce preparation.

The Network: Towards Unity for Health (TUFH) 2026 Conference, held in Manila, Philippines, from 4–7 August, reinforced collective action and community co-creation as essential to health equity. The Bayanihan Declaration and Call to Action offers a framework for moving from dialogue to action. Its message resonates in Africa, where communities must help shape services that meet local needs. Sustainable improvement depends on listening to people and involving them in decisions affecting their health.

The 16th East, Central and Southern Africa Health Community (ECSA-HC) Best Practices Forum and 32nd Directors Joint Consultative Committee Meeting, held in Manzini, Eswatini, from 5–7 August, enabled participants to exchange experience and showcase health systems innovations. Discussions emphasised collaboration across institutions and sectors. Regional partnerships and sharing effective practices strengthen preparedness and responses to emerging threats, allowing countries to learn from one another instead of tackling similar challenges in isolation.

Elsie Kiguli-Malwadde, Editor: Africa Health Journal, kigulimalwadde@achest.org

Uganda hosted the ninth annual conference of the African Forum for Research and Education in Health (AFREhealth) at Speke Resort Munyonyo, Kampala, from 24–26 August 2026. Under the theme "From Innovation to Impact: Strengthening Health Education, Research, and Service Delivery for a Resilient Africa," discussions addressed people-centred systems, translating research into practice, workforce development beyond curricula and programmes, digital transformation, AI and collective leadership. The conference marked a transition in leadership. The next annual conference will be held in Botswana from 3–5 August 2027. African-led networks must ensure innovation and research produce measurable improvements in services and outcomes.

The Fourth Annual Maseno University and Northwestern University Health Professions Education Conference, held in Kisumu, Kenya, in April 2026, focused on building educators' capacity. Participants explored generative AI in clinical care and education, ethical implementation, educational scholarship and faculty development. As AI's influence grows, institutions must ensure it improves learning and practice while protecting privacy, promoting fairness and maintaining professional accountability.

Beyond conference reports, this issue addresses urgent public health and professional concerns. An article on Ebola examines challenges in the Democratic Republic of the Congo and Uganda's response, underscoring preparedness, coordination and timely action. "Networking and Collaboration in Health Sciences: Connecting Locally, Leading Globally" explores the skills and relationships needed to build meaningful professional networks, particularly for early-career professionals.

Three clinical articles address hepatitis B in maternal health, immune profiling and the global shortage of dermatologists. The hepatitis B article calls for routine antenatal screening, accessible testing, effective linkage to care and timely newborn protection, reinforcing prevention, early diagnosis and continuity of care. Gilbert Elvis Oloo's personal essay explores anxiety, loneliness and unemployment, presenting physical education as a community lifeline. Together, these contributions remind us that health encompasses physical, psychological and social well-being.

As always, this issue includes our Medicine Digest, quizzes, news updates and advertisements. Africa Health Journal remains an open-access, web-based resource (www.africa-health.com) updated daily and engages 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.

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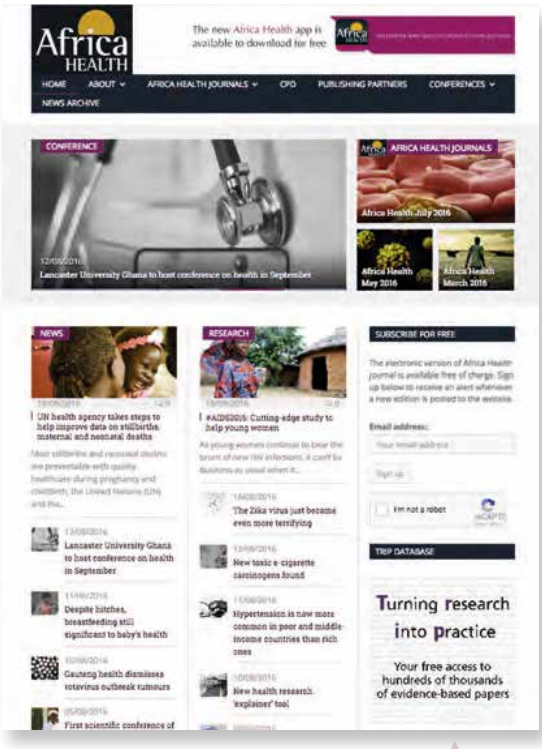
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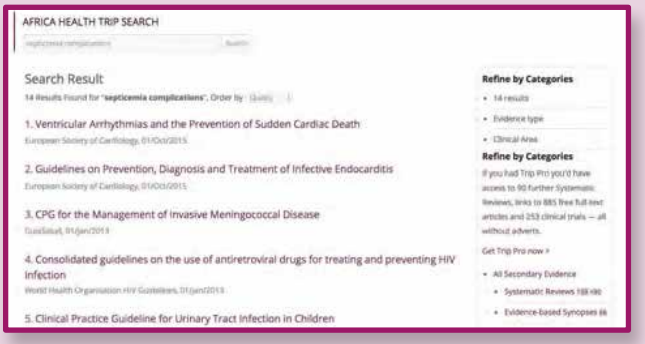
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Independence and the Health of a Nation: Africa's Unfinished Journey



The late Dr. Ebrahim Malick Samba, former WHO Regional Director for Africa, with whom I was privileged to work closely, often observed that politics is medicine at another level. Political decisions profoundly influence health, and health professionals must engage with politics—not necessarily as politicians, but as advocates for policies that improve lives.

As African nations reflect on more than six decades of independence, questions persist about how far its promises of freedom, development and human dignity have been realised. Uganda's 64th Independence anniversary on 9 October 2026 offered an opportunity to revisit this debate. The subdued celebrations raised a wider question: has independence benefited ordinary citizens or disproportionately favoured political elites?

The true test of independence is not simply who governs, but whether people live longer, healthier and more dignified lives.

The gains—and the unfinished business

At independence, many African countries lacked adequate schools, health facilities and trained professionals. Since then, life expectancy has increased, immunization expanded, maternal and child health improved, and universities and research institutions have grown. Progress against HIV/AIDS, malaria and tuberculosis demonstrates what investment, science, community engagement and international cooperation can achieve.

Uganda illustrates this progress. World Bank data show that life expectancy at birth rose from approximately 45.6 years in 1960 to 68.5 years in 2024. These gains reflect advances in health services, disease prevention, living conditions and medical science, supported by Ugandan health workers, communities and international partners.

During my service as WHO Representative in Kenya, an elderly British settler remarked that I might never have become a doctor, let alone a WHO expert, had Uganda and other African countries not gained independence. His observation stayed with me. Political freedom opened educational and professional opportunities previously beyond the reach of many Africans, enabling them to realize their potential and contribute to society.

Yet sovereignty has not automatically delivered health, prosperity or social justice. Millions still face barriers to essential services, including shortages of health workers and medicines, long distances to facilities and unaffordable care. Avoidable maternal and child deaths persist, while diabetes, hypertension and cancer add to the burden of infectious diseases. Inequalities in access to quality care remain stark.

The health workforce presents another contradiction: countries train professionals while facilities remain understaffed and qualified people struggle to find employment. Inadequate financing, restrictive recruitment budgets, poor working conditions and weak workforce planning prevent countries from translating training into better services. Training health workers without enabling them to serve their communities wastes public investment and human potential.

What can Africa learn?

International comparisons offer food for thought. In 1960, life expectancy at birth was approximately 54 years in South Korea and 66 years in Singapore. By 2024, both countries had reached about 83–84 years, compared with 68.5 years in Uganda. Sri Lanka and Bangladesh recorded approximately 78 and 75 years, respectively. These differences raise an important question: what enables some nations to translate development into longer, healthier lives?

Resources and social conditions matter, but so do political and technical leadership, long-term planning, accountable institutions and effective use of public resources. Corruption and poor implementation squander scarce resources and undermine sound policies. Independence must deliver not merely political authority, but competent governance and tangible improvements in people's lives.

Health professionals must bring evidence, integrity and citizens' interests into public debate. This means advocating adequate domestic health financing, equitable access to quality care, reliable supplies of essential medicines, and workforce policies linking training to employment and retention. It also means challenging corruption and waste, strengthening accountability and promoting prevention through families, schools, workplaces and communities.

Advocacy alone is insufficient. African professionals must help shape policy, strengthen institutions, mentor future leaders and hold decision-makers accountable. When policies fail or public resources are misused, silence and inaction are not acceptable. Our expertise must serve society beyond our immediate professional duties.

A call to action

Fulfilling the promise of independence requires accountable political leadership, competent technical leadership, sustained investment and active citizen participation.

African health professionals and other technocrats possess the knowledge and influence to accelerate this transformation. We cannot leave the continent's future to political leaders alone while watching things go wrong. We must engage constructively, speak courageously and act collectively to secure better health and greater human dignity for all. **If not now, then when?, if not by us then by whom?**

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

From Continental Vision to Collective Action: Reflections from the Second Consortium of Medical Schools–Africa Conference in Addis Ababa

The second annual conference of the Consortium of Medical Schools–Africa (COMS-A), known as MedEdAfrica 2026, was held from 6–8 July 2026 at the Ethiopian Skylight Hotel in Addis Ababa, Ethiopia. Hosted by the Ministry of Health of Ethiopia in partnership with COMS-A and the University of Global Health Equity (UGHE), the conference brought together medical educators, academic leaders, policymakers, regulators, students, researchers, health professionals and development partners from across Africa and beyond.

The conference marked an important milestone for COMS-A. Established in Kigali, Rwanda, in March 2025, COMS-A emerged from a shared recognition among African medical education leaders that the continent requires a stronger, coordinated and African-led platform to transform medical education and, ultimately, health systems. Its mission is to promote excellence in medical education, research and innovation while strengthening social accountability, partnerships and equitable access to quality education.

The Addis Ababa meeting therefore represented more than another scientific conference. It provided an opportunity to move from the formation of a continental network towards implementation of a shared agenda for medical education and health workforce transformation.

A continent coming together

The scale and diversity of participation demonstrated the growing relevance of COMS-A. More than 750 participants from 46 countries and 117 institutions attended, including approximately 195 student delegates. The scientific programme featured 22 sessions, six plenary sessions, 86 oral presentations and 117 abstracts.

This diversity was particularly important because Africa's medical education systems operate in highly varied linguistic, socioeconomic, regulatory and health-system contexts. COMS-A seeks to provide a common platform while respecting these differences. Its membership model includes full membership for accredited medical schools, as well as affiliate, associate and honorary membership categories, thereby creating opportunities for medical councils, professional associations, allied health institutions and distinguished educators to participate.

The conference also demonstrated the importance of students as partners rather than simply recipients of medical education. Their participation reinforced the need for education systems that are responsive to learners, communities and the changing demands of health systems.

Preparing the health workforce for uncertainty

The theme of the conference, "Preparing Africa's Health Workforce for an Uncertain Future: Harnessing Partnerships, Technology, Innovation, and Leadership," captured the central challenge confronting medical schools. Africa's health systems are experiencing rapid demographic, epidemiological, technological and environmental changes. Medical schools must therefore prepare graduates not only to provide clinical care, but also to lead change, work across disciplines, use emerging technologies responsibly and respond to complex population health needs.

Four broad areas dominated the conference: leadership, governance, African ownership and partnerships; transformative technologies, artificial intelligence and simulation; alignment of medical education with maternal, newborn and child health and broader health-system priorities; and learner-centred education, assessment and accreditation.

The emphasis on African ownership was particularly significant. For decades, medical education reform on the continent has sometimes been shaped by externally developed models, standards and financing priorities. The COMS-A approach provides an opportunity for African institutions to define their own priorities while engaging global partners as collaborators rather than substitutes for African leadership.



Countries that have medical schools that are belong to COMS-A

Elsie Kiguli Malwadde is the Deputy Executive Director and Director, Health Workforce Education and Development, African Center for Global Health and Social Transformation, Kampala Uganda.



Some of the attendees of COMS-A

Technology and artificial intelligence: opportunity with responsibility

Artificial intelligence, digital health, simulation and other educational technologies featured prominently. These technologies have enormous potential to expand access to learning resources, support clinical reasoning, strengthen simulation-based education and facilitate collaboration between geographically dispersed institutions.

However, the conference discussions also highlighted an important principle: technology should serve educational and health-system objectives rather than become an objective in itself. African medical schools need appropriate infrastructure, faculty capacity, ethical frameworks, digital literacy and context-sensitive approaches to ensure that technological innovations reduce rather than deepen inequities.

From harmonisation to quality improvement

Another important issue was the need to strengthen the quality and relevance of medical education across Africa. COMS-A is already collaborating with WHO AFRO on curriculum harmonisation, with the aim of supporting competency-based education and greater alignment of training with African health needs.

Harmonisation, however, should not mean uniformity. African medical schools differ considerably in their resources, populations, health systems and institutional missions. The challenge is to establish appropriate continental standards while allowing institutions sufficient flexibility to respond to local needs.

Similarly, accreditation and assessment must increasingly focus on whether graduates possess the competencies required by their communities and health systems, rather than simply whether institutions comply with prescribed processes.

Building partnerships that produce results

A recurring message from Addis Ababa was that collaboration must move beyond meetings and memoranda of understanding towards measurable results. COMS-A's strategic priorities include expanding membership, supporting curriculum harmonisation, developing faculty and higher education leadership academies, establishing regional training centres and centres of excellence, creating digital platforms for sharing educational resources and data, and developing student and faculty exchange mechanisms.

These initiatives have the potential to create a genuinely connected African medical education ecosystem. Medical schools can share faculty expertise, curricula, simulation resources, research capacity and digital learning materials. Such collaboration is particularly valuable for institutions with limited resources.

Looking forward

The Addis Ababa conference demonstrated that COMS-A has rapidly evolved from an idea into an increasingly influential continental platform. Its greatest strength is its African ownership and collective institutional voice. Its greatest challenge will be translating this collective enthusiasm into sustained programmes, financing, research, policy influence and measurable improvements in medical education and health outcomes.

The second COMS-A conference therefore should be understood not simply as a successful gathering of medical educators, but as part of a broader movement to redefine how Africa educates its health workforce. The next phase must focus on implementation: strengthening institutions, investing in educators and learners, embracing appropriate technology, improving accreditation and assessment, promoting research and ensuring that medical education remains socially accountable.

If COMS-A can sustain the partnerships and momentum generated in Addis Ababa, it can become a powerful mechanism for ensuring that African medical schools are not merely preparing graduates for today's health challenges, but are shaping the health systems Africa will need tomorrow.

The Network: Towards Unity for Health (TUFH) 2026 Conference

The Network: Towards Unity for Health (TUFH) 2026 Conference was held from 4–7 August 2026 in Manila, Philippines, hosted by the University of the Philippines Manila in collaboration with Mapúa University, Ocugen, and TDR/SIHI Woods System of Care. The conference brought together 377 participants from 37 countries, including health professionals, educators, students, researchers, policymakers and other health-sector stakeholders.

TUFH is a global, interprofessional and intergenerational organization committed to advancing health equity and social accountability. It brings together health leaders, educators, students and policymakers to challenge conventional approaches to health education and health service delivery and to promote systems that respond to community health priorities. TUFH is a WHO Affiliate and operates as an official non-state actor in official relations with the World Health Organization. Its activities include an annual global conference, fellowships and academies, and Centers of Excellence that recognize institutions demonstrating leadership in socially accountable health professions education and practice.

The theme of the 2026 conference was "Bayanihan for Health Equity: Co-creating Social Innovations for Responsive and Resilient Health Systems." Bayanihan is a Filipino concept emphasizing communal unity, collective action and mutual support. The theme highlighted the importance of working together across communities, professions, institutions and generations to address health inequities and develop sustainable health solutions.

The conference focused on four major subthemes: community-driven health systems; equity by design through technology, data and innovation; strengthening the global health workforce; and translating policy into practice through local partnerships. These themes reflected the need to ensure that health systems are responsive to local needs, that innovation reduces rather than increases inequity, and that health workers are appropriately trained, supported and equitably distributed, particularly in underserved communities.

The conference was officially opened by the Chancellor of the University of the Philippines Manila, who emphasized the value of face-to-face engagement and partnerships in advancing scientific progress. The Chancellor described conferences such as TUFH as a form of Bayanihan, bringing people from diverse backgrounds together to develop partnerships that transcend borders. The participation of students alongside global health leaders was particularly emphasized as an important feature of the meeting.

The programme included keynote presentations, plenary sessions, workshops, oral and poster presentations, networking activities and visits to communities and health programmes across Manila. The site visits provided participants with opportunities to move beyond academic discussions, interact with local health workers and communities, understand local experiences and appreciate the practical realities of delivering responsive health services. Participants also had the opportunity to experience Filipino culture and community life.

Six thematic summits generated considerable interest, addressing specific areas of health equity, including intellectual and developmental disabilities and autism, integrated behavioural health, women's health, rural and remote health, and ageing and health. These sessions highlighted the need for health systems to respond to the different needs of population groups and to address geographical, social and demographic barriers to accessing care.

A key outcome of the conference was the Bayanihan Declaration, which reaffirmed that health equity is a shared responsibility requiring collaboration across communities, professions, institutions and countries. The Declaration emphasized meaningful community participation, social accountability, equitable health professions education, strengthening the health workforce, responsible use of technology and data, and the development of responsive and resilient health systems. It also recognized the importance of local knowledge and community-driven innovations in developing sustainable health solutions.

The accompanying Call to Action emphasized the need to translate these commitments into practical measures. Stakeholders were encouraged to place communities at the centre of health-system planning, strengthen socially accountable health professions education, improve recruitment and retention of health workers in underserved areas, use technology and data to advance equity, strengthen partnerships, translate evidence and policy into practice, and support the scaling of successful community-driven innovations. The Call to Action also encouraged interprofessional and intergenerational collaboration and emphasized the importance of measurable commitments and sustained implementation.

The conference was highly relevant to global health, particularly in relation to equitable access to health services, rural and remote service delivery, health workforce distribution, infrastructure, technology and community participation. The discussions reinforced the importance of strengthening partnerships between communities, government, academic institutions, health facilities and other stakeholders.

Overall, TUFH 2026 provided an important platform for global learning, networking and collaboration. Its central message was that health equity requires collective action and co-creation with communities. The Bayanihan Declaration and Call to Action provide a framework for moving from dialogue to practical action and offer valuable lessons for strengthening community-responsive, equitable and resilient health systems.

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From Best Practices to Action: Reflections from the 16th ECSA-HC Best Practices Forum

The 16th ECSA-HC Best Practices Forum and 32nd Directors Joint Consultative Committee Meeting took place in Manzini, Kingdom of Eswatini, from 5–7 August 2026, following three days of pre-conference activities from 2–4 August. Held under the theme, "***Shaping the Future of Health in the ECSA Region: Advancing Health Security, Innovation and Sustainability***," the Forum brought together policymakers, researchers, health professionals, innovators and development partners from across East, Central and Southern Africa.

The Forum provided an important platform for countries and institutions to exchange knowledge, showcase innovations and share practical experiences in strengthening health systems. A recurring message was the importance of working beyond institutional and sectoral silos. Participants explored how regional collaboration, cross-border partnerships, innovation and sharing of best practices can strengthen health systems and improve preparedness for emerging health threats.

The discussions covered a broad range of issues, including health security, health-system resilience, innovation, sustainability, human resources for health, knowledge and evidence sharing, and regional collaboration. Importantly, the emphasis was not simply on identifying promising practices, but on understanding how they can be adapted, scaled and translated into sustainable improvements in health services.

Representing the African Centre for Global Health and Social Transformation (ACHEST), Executive Director Dr. David Okello participated as a keynote speaker in a plenary session on Human Resources for Health (HRH). His presentation highlighted a persistent contradiction facing African health systems: countries continue to experience serious shortages of health workers, while many trained professionals remain unemployed or underemployed.

For many years, the African health workforce debate has focused predominantly on brain drain—the migration of doctors, nurses, midwives and other health professionals in search of better employment opportunities and working conditions. While this remains an important concern, Dr. Okello challenged participants to consider a related phenomenon: brain waste.

The paradox is striking. Africa needs more health workers, yet in some countries trained professionals cannot find employment. Governments face limited fiscal space, constrained public-sector wage bills and recruitment restrictions, while the rapid expansion of health-professional training, particularly in the private sector, is not always sufficiently linked to national workforce requirements or employment opportunities.

This raises a fundamental question: Is Africa facing only a shortage of health workers, or also a failure to adequately plan, finance and absorb the workforce it is producing?

Dr. Okello argued for a more integrated approach linking health-workforce planning, training, financing, employment and retention. His central message was captured in four words: Plan. Train. Employ. Retain.

The message was particularly timely in the context of the emerging Africa Health Workforce Agenda 2026–2035, which places stronger emphasis on planning, educating, employing and retaining the health workforce needed to meet Africa's health needs. The challenge now is to ensure that such continental commitments translate into action at country and institutional levels.

This also reflects one of the broader lessons of the ECSA-HC Forum: best practices have value only when translated into implementation and results. Africa has no shortage of policies, strategies, resolutions and innovative ideas. The more difficult task is creating the financing, institutional arrangements, accountability mechanisms and partnerships required to put them into practice.

For the health workforce, this means ensuring that training institutions produce the right numbers and mix of professionals, with competencies aligned to health-system needs; governments and partners create and finance employment opportunities; health workers are equitably deployed; and working environments support professional growth and retention.

It also requires health, education, finance, labour and public-service sectors to work together rather than addressing workforce challenges independently. Training institutions, governments and the private sector all have a role in ensuring that investments in health-professional education translate into a workforce available where and when populations need it.

The discussions at the 16th ECSA-HC Best Practices Forum therefore reinforced an important principle: the future of African health systems will depend not only on the innovations we generate, but on our ability to take what works, adapt it to local realities, finance it and implement it at scale.

For the health workforce, this means moving from commitments to implementation, from boardrooms to workplaces, and from best practices to measurable health outcomes.

Plan. Train. Employ. Retain. This is more than a workforce slogan. It is a practical framework for turning Africa's investments in health education and human capital into stronger health systems, greater health security and better access to quality health care.

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The 9th AFREhealth Conference

The African Forum for Research and Education in Health (AFREhealth) held its 9th Annual Conference from 24–26 August 2026 at Speke Resort Munyonyo in Kampala, Uganda. Hosted by Mbarara University of Science and Technology (MUST), the conference brought together 348 participants from 22 countries and 74 institutions across Africa and beyond. Participants included health professionals, researchers, health professions educators, policymakers, students, development partners and health-care leaders.

The conference theme, "From Innovation to Impact: Strengthening Health Education, Research, and Service Delivery for a Resilient Africa," captured a critical challenge facing African health systems: how to move beyond generating knowledge and developing innovations to ensuring that these translate into tangible improvements in health, education and service delivery.

The conference was structured around four interconnected sub-themes: digital transformation and artificial intelligence in health education, research and service delivery; strengthening health workforce education and retention; integrated approaches to communicable and non-communicable diseases; and building climate-resilient health systems through community engagement and sustainable One Health partnerships. The largest number of abstracts focused on communicable and non-communicable diseases, followed by health workforce education and retention, digital transformation and artificial intelligence, and climate resilience and One Health.

From research to solutions

A major message emerging from the conference was that African research must increasingly be translated into practical solutions. The keynote speaker, **Dr. Cosmas Mwikirize** from Uganda's Ministry of Science, Technology and Innovation, Office of the President, emphasised the importance of connecting research with government policy, programmes and investment.

The keynote challenged the traditional separation between knowledge generation and implementation. African institutions produce considerable research, but the value of that research ultimately depends on whether it informs decisions, improves services and responds to the needs of communities.

The example of the **Engozi mountain stretcher system** from southwestern Uganda illustrated the potential of indigenous knowledge and home-grown innovation to address practical health-system challenges. Such examples demonstrate that innovation does not necessarily require sophisticated or expensive technology. In many circumstances, locally developed solutions can provide appropriate responses to problems experienced by communities.

The challenge, therefore, is to create systems that identify, evaluate, support and scale promising African innovations. This requires closer relationships among universities, governments, communities, innovators and health-care providers.

Building health systems around people

The Guest of Honour, **Rt. Hon. Robinah Nabbanja, Prime Minister of Uganda**, challenged delegates to focus research and clinical training on reducing the preventable disease burden across African countries. This call placed the patient and community at the centre of discussions about research, education and service delivery.

One of the striking features of the opening ceremony was the presentation of locally developed innovations. Among these was the Breast Cancer Cradle, a low-cost medical design developed by Mr. Osbert Tumuhimbise to alleviate severe physical suffering and strengthen palliative care for women with advanced breast cancer. The innovation attracted the attention of the Prime Minister, who pledged to seek funding for its development.

The Breast Cancer Cradle provided a practical illustration of the conference theme. Innovation becomes meaningful when it addresses an identified health problem and has the potential to improve the experience of patients and families.

Health workforce: beyond curricula and programmes

Another important reflection was that strengthening the African health workforce requires more than developing training programmes and curricula. Effective health workforce development also depends on leadership, supportive working environments, retention strategies, interprofessional collaboration and meaningful engagement with decision-makers.

Africa continues to face complex and interconnected health challenges. Health professionals must be prepared not only to manage communicable diseases but also the growing burden of non-communicable diseases, climate-related health threats and emerging emergencies. Education and training institutions therefore need to prepare graduates who can work across professional and disciplinary boundaries and adapt to changing health needs.

The conference discussions reinforced the importance of connecting health professions education with the realities of health service delivery. Training institutions, Ministries of Health and communities need to work together to ensure that health workers are equipped with competencies that are relevant to the populations they serve.

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Digital transformation and artificial intelligence

Digital transformation and artificial intelligence were another important area of discussion. Their growing application in education, research and health-care delivery presents significant opportunities for African countries.

However, technology should not become an end in itself. Its value should be assessed according to whether it improves access, quality, efficiency and equity in health services and education. African institutions will also need to consider the skills, infrastructure, governance and ethical frameworks required to use emerging technologies responsibly.

The discussion on digital transformation therefore needs to move beyond adoption of technology towards determining how digital tools can solve specific African health-system problems.

Responding to multiple health challenges

The prominence of the communicable and non-communicable disease theme, which attracted the largest number of abstracts, reflects the changing nature of Africa's health burden. African health systems must increasingly respond simultaneously to infectious diseases and chronic conditions.

This calls for integrated approaches to education, research and service delivery. It also reinforces the importance of interprofessional collaboration and stronger links between clinical services, public health, research institutions and communities.

At the same time, climate change is increasingly relevant to health-system resilience. Building climate-resilient systems requires attention to environmental determinants of health, community participation and sustainable One Health partnerships. These issues cannot be addressed effectively by any single profession or institution.

From innovation to impact

Perhaps the strongest message from the 9th AFREhealth Conference was that **innovation must be connected to impact**. Generating research, publishing papers and developing new technologies are important, but they represent only part of the journey.

The next step is translation: translating research findings into policies, policies into programmes, innovations into sustainable services, and knowledge into improved health outcomes. This requires mechanisms through which evidence can reach decision-makers and through which communities can participate in identifying and shaping solutions.

The conference also highlighted the importance of investing in African universities and research institutions so that they can become stronger producers of knowledge, technologies, vaccines and therapeutics. Building this capacity is essential if African countries are to develop solutions that respond to their own priorities and reduce dependence on externally developed interventions.

A call for collective leadership

The conference demonstrated that strengthening African health systems cannot be achieved through isolated interventions. It requires collective leadership and sustained collaboration among academia, government, health professionals, communities, innovators and development partners.

For AFREhealth, this is particularly important because its work brings together health professions education, research and service delivery. The conference provided an opportunity for participants to reflect on how these three areas can be more deliberately connected to produce resilient and equitable health systems.

Ultimately, the 9th AFREhealth Conference was a call to move from knowledge generation to **knowledge translation, from innovation to implementation, and from individual initiatives to collective action**. Africa has considerable intellectual, professional and innovative capacity. The challenge is to create the partnerships, policies, financing and institutional systems necessary to convert this capacity into sustained improvements in health.

Absolutely. I would make this a more meaningful leadership-transition and institutional-continuity paragraph, rather than simply describing the ceremony. It can fit naturally near the end of the article, just before the concluding section.

A new chapter in AFREhealth leadership

The closing ceremony marked an important moment in the continuing evolution of AFREhealth. **Ms. Judy N. Khanyola** was formally installed as the new President of AFREhealth, succeeding **Prof. Nelson Sewankambo**. In a symbolic transfer of leadership and responsibility, Prof. Sewankambo handed the AFREhealth presidential necklace to Ms. Khanyola, signifying the formal transfer of authority and the beginning of a new chapter for the organisation.

The ceremony provided an opportunity to recognise the contribution of the outgoing Governing Council members and to acknowledge their service to the network. Members who had completed their terms were presented with citations and honoured for their leadership, commitment and contribution to advancing AFREhealth's mission. The new Governing council members were sworn in at this time.

The transition demonstrated an important strength of AFREhealth: leadership renewal within a framework of institutional continuity. As the new leadership takes forward the work of the network, the experience and institutional memory of previous leaders remain an important resource. The change in leadership therefore represents not an end to one phase, but a continuation of the collective effort to strengthen health professions education, research and service delivery across Africa.

The installation of the new President was particularly fitting at a conference centred on moving "**From Innovation to Impact**." Sustaining impact requires not only innovative ideas and evidence but also effective leadership, strong institutions and a commitment to collective action. The leadership transition at the closing ceremony symbolised AFREhealth's continuing commitment to building African-led institutions capable of responding to the continent's evolving health challenges.

The message is clear: **African innovation must not simply demonstrate what is possible; it must reach the people and communities who need it most**.

From Innovation to Impact: Reflections from the 9th AFREhealth Annual Conference

The 9th AFREhealth Conference concluded in Kampala at Munyonyo on Wednesday, 26 August 2026. I was honoured to receive a plaque of appreciation on behalf of African Centre for Global Health and Social Transformation (ACHEST), recognising the organisation as one of the conference sponsors.

For ACHEST, this was more than an opportunity to support another important African health meeting. It was also a moment to reflect on an initiative to which the organisation has contributed from its formative years.

ACHEST played an important role in the creation and early development of AFREhealth. One of its past presidents, Dr. Elsie Kiguli-Malwadde, of ACHEST, helped mobilise support from partners and provided leadership that helped steer AFREhealth through its early years. Her contribution, together with that of many colleagues and institutions across Africa, helped establish a platform that has grown into an important continental network for advancing health professions education, research and service delivery.

AFREhealth now brings together universities and health training institutions across Africa committed to strengthening these areas. The theme of this year's conference, "From Innovation to Impact: Strengthening Health Education, Research, and Service Delivery for a Resilient Africa," was therefore both timely and thought-provoking.

After three days of stimulating presentations, discussions and exchanges, I came away with two reflections that stayed with me.

First, Africa has no shortage of innovative research. Our universities and research institutions are generating impressive knowledge. African researchers are addressing some of the continent's most important health challenges, and much of this work is finding its way into reputable peer-reviewed journals.

But we must ask a more difficult question: *How much of this knowledge is actually changing the lives of ordinary people?* Too often, the journey appears to end with publication. Evidence may be generated and disseminated, but does not always find its way into policy, clinical practice, community programmes or health-system decisions. The result is a persistent gap between what we know and what we do.

The challenge, therefore, is not simply to produce more research. We must become much better at translating evidence into action and action into measurable health outcomes. Universities need stronger links with governments, health facilities, communities and policymakers so that research responds to real-world problems and its findings are deliberately taken to scale.

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Second, we are training increasing numbers of health professionals, yet many are not finding their way quickly enough to the communities and health facilities where they are most needed.

This raises another important question: *Are we training the right number and mix of health workers for the needs of our populations?*

The expansion of health professional training, particularly in the private sector, can be driven by legitimate demand but also by institutional incentives to expand enrolment. Training, however, cannot be an end in itself. A qualified health professional who cannot find employment, or whose skills are not deployed where they are needed, represents a loss not only to the individual but also to society.

Africa therefore needs stronger alignment between health workforce planning, training, financing and employment. We should not simply ask how many health workers our institutions can train. We should ask how many are needed, what skills are required, where they are needed, how they will be financed and how they can be retained.

The principle should be simple: ***Plan. Train. Employ. Retain***.

These challenges are not the responsibility of universities alone. They require governments, health professional councils, training institutions, employers, development partners, researchers and communities to work together. AFREhealth provides an important platform for precisely this kind of collaboration.

For me, this is where the conference theme becomes particularly powerful. "From Innovation to Impact" should challenge us to move beyond celebrating what we have created to demonstrating what difference it makes. Africa has demonstrated that it can generate knowledge, develop innovative solutions and train health professionals. The next step is to ensure that these investments translate into stronger health systems and healthier communities.

This is also why organisations such as ACHEST value platforms like AFREhealth. Our contribution to its early development reflected a belief that Africa needs institutions and networks capable of connecting knowledge, people and action across the continent.

The future of African health will depend not only on how much knowledge we generate or how many professionals we train, but on how effectively we translate knowledge into practice and training into service. The ultimate measure of innovation is not the novelty of the idea, the number of graduates produced, or the number of papers published. It is whether lives are improved.

That, for me, is what "***From Innovation to Impact***" should ultimately mean

Building capacity among health professions educators in Kenya: Proceedings of the Fourth Annual Maseno University and Northwestern University Health Professions Education Conference

Summary

Investment in health professions education (HPE) and efforts to advance health workforce competency have increasingly been prioritized as strategies to meet evolving population health needs globally. Consequently, establishing forums that foster knowledge exchange, faculty development, and innovation in HPE is important, particularly in low and middle-income settings. The Annual Maseno University and Northwestern University Health Professions Education Conference is representative of this effort in Kenya. The Fourth Annual conference was held in Kisumu, Kenya in April 2026 and brought together health professionals and institutional leaders from across the country to discuss the transformative role of artificial intelligence (AI) in healthcare and health professions education in the region. Sessions explored practical applications of generative AI in clinical care and education, ethical and responsible AI implementation, and educational scholarship and faculty development in HPE. The meeting also recognized the graduates of the inaugural class of the Maseno University Northwestern University Educators (MUNUEd) Certificate Program, an online HPE certificate course adapted for Kenyan learners. Overall, the conference strengthened regional collaboration in HPE, promoted responsible integration of AI into healthcare and education, and provided a platform for dissemination of locally generated best practice recommendations.

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Introduction

Health professions education is increasingly recognized as a critical avenue for responding to systemic health inequities—extending beyond efforts to address health workforce shortages to improving the quality of care provided and promoting a more equitable distribution of skilled health professionals.[1,2] Many institutions are striving to reform existing health professions education infrastructure to alleviate workforce deficiencies. Providing health professionals with a foundation in evidence-based educational theory and practice—in concepts such as curriculum design, program assessment, feedback delivery, and scholarship—fosters the development of educational leaders and promotes cultures of innovation, mentorship, and quality improvement that strengthens institutional, and ultimately health systems', capacity.[2,3]

As Kenya strives to achieve universal health coverage and address shortages and low retention rates among healthcare workers, the development of a proficient health workforce via various educational reforms, including the shift toward competency-based education, has become a national priority.[4,5]

Collaboration between international academic partners has emerged as an effective approach in advancing the field of health professions education while remaining responsive to local priorities. By combining educational expertise with local leadership and institutional knowledge, these partnerships support sustainable capacity building.[2] The partnership between Maseno University and Northwestern University's Institute for Global Health is an example of such an initiative, giving rise to the Maseno University and Northwestern University Health Professions Education Conference. Since the inaugural event in 2023, the conference has been established as a regular opportunity for health professionals across Kenya to collaborate, network, and engage in scholarship in HPE. The following is a summary of the proceedings of the Fourth Annual Maseno University and Northwestern University HPE Conference.

Conference Outline

The Fourth Annual Maseno University and Northwestern University HPE Conference was hosted in Kisumu, Kenya, from 23-24 April 2026, and pre-conference proceedings were held on 22 April 2026. The theme of the conference was *Reimagining Health Professions Education in the Age of Emerging Artificial Intelligence*.

Conference objectives:

- To provide opportunity for Kenyan health professionals to discuss integration and implications of AI in healthcare education
- To recognize and foster HPE-related scholarship
- To provide opportunity for networking, interprofessional



Conference Participants at one of the sessions

collaboration, and community-building among educators and institutional leaders
- To recognize graduates of the MUNUEd Certificate Program

The conference was attended by 79 delegates from 15 institutions across Kenya [Table 1]. Invitations were sent from Maseno University through peer networks. All graduates of the MUNUEd Certificate Program were in attendance. Individuals represented the spectrum of health professions, including clinical medicine and surgery, laboratory medicine, pharmacy, and library and information sciences.

Pre-Conference

Pre-conference proceedings included an interactive session on simulation by Dr. Colleen Fant of Northwestern University and poster presentations by participants of the MUNUEd Certificate Program. A total of 25 posters were presented on a variety of scholarly activities, including needs assessments and scoping reviews, curriculum development initiatives, and novel learning and evaluation tools. Participants presented their posters in small group sessions. A graduation ceremony was held during which graduates received certificates of completion and recognition by program leadership and the Dean of the School of Medicine at Maseno University.

Table 1
Conference Delegates by Institution/Organization

Institution/Organization	Number of Delegates
Maseno University *[Hosting University]*	45
Uzima University	10
Kenya Medical Training College (KMTC)	9
Northwestern University *[Co-Hosting University]*	4
Public Service Board (Kisumu County)	1
Jaramogi Oginga Odinga Teaching Hospital (JOOTRH)	1
Kibabii University	1
Kapsabet High School	1
Masinde Muliro University of Science and Technology (MMUST)	1
Moi University	1
National Spinal Injury Reference Hospital	1
Quantum Kisumu Health Service Ltd	1
Synergy Clinic	1
University of Nairobi	1
Institution not specified	1
Total	**79**



Conference participants

Three posters received Outstanding Poster Recognition Awards:

- "Implementation of Learning Theories in Two Universities of the Western Region of Kenya" by Dr. Stephen Okeyo, Uzima University
- "Strengthening Intrapartum Clinical Decision-Making Among Bachelor of Science in Nursing Students Through Labor Care Guide-based Educational Intervention" by Catherine Simiyu, Kibabii University
- "Mental Health Resilience and Social Accountability in Kenya's Medical Curriculum: A Scoping Review" by Dr. Bernard Awuonda, Maseno University

Conference Topics

Opening remarks were presented by Dr. Ashti Doobay-Persaud of the Northwestern University Institute for Global Health and Dr. David Ongarora, the Acting Deputy Vice Chancellor of Maseno University.

Dr. George Omondi Oyoo of the University of Nairobi presented the opening keynote address titled, "Reimagining Rheumatology Education in the Age of AI." He described the evolving role of AI in the field of rheumatology and reviewed the results of the Emerging European Alliance of Associations for Rheumatology Network (EMEUNET) Survey assessing global adoption and perceptions of AI in the field. Survey results showed wide uptake and application of AI technology, primarily large language models for research, literature reviews, and writing support. He noted that utilization has been concentrated in low-risk and efficiency tasks rather than higher stakes uses such as diagnosis or decision-support. Barriers include limited AI literacy among health professionals; inadequate governance of these technologies; concerns related to ethics, data privacy, and transparency; and low trust that algorithms are relevant to local settings. He emphasized the significant potential of AI to strengthen workforce capacity, particularly in low and middle-income countries, if institutions can prioritize safe and structured integration means.

The keynote address was followed by a series of engaging talks and plenary discussions.

Examples included:

Background noise and reverberation times in university teaching areas at two campuses of Maseno University, Kisumu, Kenya *by Dr. Stephen Ogendo, Maseno University*

Dr. Stephen Ogendo reported findings of his study evaluating differences in noise level and reverberation time across Maseno University campus learning centers and the possible impact upon learning. He and his research team conducted a prospective cross-sectional study comparing background noise and reverberation times between buildings of two different Maseno city campuses. Findings demonstrated that background noise level and reverberation times did not meet acoustic guidelines as advised by the American National Standards Institution. Variation between buildings were identified as were variations among locations within the same rooms and at different times throughout the day. He discussed the potential impact of these environmental factors in hindering learning. The study concluded that institutions must take into consideration reverberation times in designing educational spaces to reduce noise level, promote speech intelligibility, and optimize learning.

Effect of digitalization on students' clerkship within the hospital *by Dr. Allan Yienya, Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH)*

Dr. Allan Yienya discussed his experience and reviewed literature regarding the impact of digitization upon medical student clerkships. He posed important questions, including whether digital learning platforms impair the role modeling aspect of education and whether the lack of body language cues affects learning. He raised concerns regarding challenges in equity as all students may not have equal access to technology or afford data usage costs. He considered the potential loss of social and collaborative learning. He also reviewed the difficulty in providing feedback with an online system and provided strategies for adaptation. He drew attention to the change in culture and professionalism expectations that digitalization has introduced, such as the use of devices on rounds. He highlighted important benefits, such as earlier recognition of certain aspects of learner performance and the ability to continue online learning despite disruptions in classroom teaching. He emphasized the need to develop clear institutional guidelines on use of devices and digital learning platforms.

AI use cases in HPE and Ethical use of AI in HPE *by Dr. Wagaki Gicheru, Kenya Medical Training College*

Dr. Wagaki Gicheru reviewed strategies for incorporating AI in education. She discussed examples of useful video-generating tools, such as Google Vids and Veo 3.1; presentation platforms, such as Napkin AI; and research sources, such as Consensus AI. She explained the predicted evolution of incorporation and impact of AI in HPE utilizing the Gartner's Hype Cycle model. She recognized the need to balance AI in training, but the importance of providing educators with appropriate training in AI to enact balance.

Integration of AI in healthcare: a focus in radiology and imaging *by Dr. Joseph Abuya, Moi University*

Dr. Joseph Abuya spoke of the growing role of AI in the field of radiology and imaging. He discussed benefits particularly with image acquisition—decreased motion artifact, automated patient positioning, and reduced need for sedation as a result. He discussed Kenya emerging as a lead adopter of AI in the region given the shortage of radiologists and AI's role in bridging this gap. He reviewed the regulatory and technical landscape of AI in radiology. He urged practitioners to remain aware of the limited transparency and algorithmic bias embedded in data sets. He reviewed the importance of abiding by medical-legal obligations related to data privacy and informed consent.

Transforming teaching practices with AI *by Dr. Richard Ongowo, Maseno University*

Dr. Richard Ongowo spoke of his experiences utilizing AI in teaching practices. He presented various AI uses, including generation of clinical cases, simulation of clinical decision-making, summarization of complex topics, and exposure to various learning resources. He discussed examples of incorporation in active adult-learning experiences, including problem-based, case-based, and flipped classroom settings.

Reflections of a student teacher *by Dr. Stephen Okeyo, Uzima University*

Dr. Stephen Okeyo reflected on his experience completing the MUNUEd Certificate Program, emphasizing the shift in perspective that comes with taking on the role of a learner as a health professional. He reviewed the opportunity to gain empathy for one's own trainees, to adopt a growth mindset, to practice humility and self-reflection, and to connect with new mentors.

AI in medical education and practice—the promise and the place: a clinical informatician's perspective *by Dr. Dedan Opondo, Synergy Clinics Hospital*

Dr. Dedan Opondo emphasized the importance of supporting trainees to become trusted members of the academic society and fostering their professional identity as healthcare practitioners. He discussed ensuring trainees are not handicapped during their transition from theory to practice and knowledge to skills. He spoke of the potential application of AI in performance capture and evaluation. He argued that to embed and optimize AI in medical education, institutions first need to bolster digital and physical medical informatics infrastructure.

Conclusion

The conference concluded with a "Way Forward Panel" during which Kenyan leaders in HPE offered their thoughts on the direction of the field. Panelists underscored the significance of establishing HPE as a focus in healthcare training institutions across the East Africa region and of continuing to promote opportunities for educator development, interprofessional collaboration, scholarship, and community-building in HPE. The panel also discussed ongoing collaborative efforts of the Maseno University and Northwestern University partnership. This included the announcement of the second cohort of the MUNUEd Certificate Program, which commenced in August 2026, and plans for the Fifth Annual Maseno University and Northwestern University HPE conference planned for April 2027. The conference reflects a continued institutional and bidirectional commitment to the advancement of health professions education in improving health outcomes.

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10TH AFREhealth CONFERENCE

DATE: 3 - 5 AUG, 2027

VENUE: GABORONE, BOTSWANA

HOST: UNIVERSITY OF BOTSWANA

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THEME: A DECADE OF AFRICAN EXCELLENCE: RE-IMAGINING SELF-RELIANT HEALTH SYSTEMS FOR AFRICA





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Africa Centres for Disease Control and Prevention (Africa CDC) and World Health Organization (WHO) call for urgent, community-led action to contain Ebola in the Democratic Republic of the Congo (DRC)



Ebola outbreak DRC

Community, religious, women and youth leaders have a critical role in building trust, addressing concerns and ensuring that response measures reflect local realities

The Africa Centres for Disease Control and Prevention (Africa CDC) (https://AfricaCDC.org/) and the World Health Organization (WHO) have called for an urgent scale-up of the community-led Ebola response in the Democratic Republic of the Congo (DRC), with stronger early detection, contact follow up, access to care, support for frontline health workers and faster delivery of resources to affected communities.

The call followed a joint high-level mission to Uganda and DRC on 4 and 5 August, which drew lessons from Uganda's successful containment of local transmission, assessed operational challenges in Bunia and brought the priorities of communities and frontline responders into high-level discussions with national leaderships in Kinshasa. The mission was led by Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, H.E. Dr. Jean Kaseya, Director-General of Africa CDC, and Dr. Mohamed Janabi, WHO Regional Director for Africa.

With visits in Kampala, Bunia and Kinshasa, members of the delegation met national and provincial authorities, response coordinators, health workers, community representatives and partners. The mission assessed progress, identified critical operational gaps and brought the concerns of affected communities and frontline teams directly to national leadership.

Uganda shows that containment is possible

In Kampala, the delegation engaged with national authorities and response teams following Uganda's declaration of the end of its outbreak on 28 July 2026. Uganda recorded 20 confirmed cases and two deaths. All previously listed contacts completed follow-up.

Africa CDC and WHO commended Uganda's leadership and the work of health workers, communities and partners. The country's experience demonstrated the importance of early detection, rapid contact tracing, coordinated national action, trusted community

Distributed by APO Group on behalf of Africa Centres for Disease Control and Prevention (Africa CDC). Media contacts: Africa CDC Directorate of Communications and Public Information communications@africacdc.org World Health Organization: Email: media@who.int

engagement and strong cross-border surveillance.

The organizations stressed that preparedness must be maintained. Continued transmission in the DRC means neighbouring countries remain at risk and must sustain surveillance, laboratory readiness and cross-border coordination.

Communities at the centre in Bunia

The delegation then travelled to Bunia, in Ituri Province, the epicentre of the outbreak. It met provincial authorities, national and provincial response teams, frontline health workers, community representatives and partners supporting the response. The delegation also visited the Rwangole Ebola Treatment Centre and assessed its readiness to expand access to timely, quality care. The field visit reinforced a central conclusion of the mission: containing and stopping the outbreak will depend on communities.

People must receive clear information from voices they know and trust. They must be able to recognize symptoms, report alerts early and seek care without fear. Communities must be directly involved in surveillance, referrals, treatment, safe and dignified burials and decisions affecting their families.

Community, religious, women and youth leaders have a critical role in building trust, addressing concerns and ensuring that response measures reflect local realities.

The delegation recognized the courage of communities and health workers operating under extremely difficult conditions, including insecurity, population movement, poor road access, misinformation and severe pressure on health services.

It also heard directly about the barriers slowing the response, including delayed detection, limited access to care, resistance to some response activities, shortages of essential supplies and insufficient support for frontline teams.

Ituri accounts for nearly 90% of confirmed cases in the DRC, with Bunia, Rwampara and Mongbwalu health zones among the most affected. Response operations must match the pace of transmission

As of 4 August 2026, the DRC had reported 3973 confirmed cases, 1801 deaths and 776 recoveries across 51 health zones in five provinces.

In the latest 24-hour reporting period, the country recorded 99 new confirmed cases and 52 deaths.

Contact follow-up stood at 75%, below the operational target of at least 95% required to identify transmission chains rapidly and ensure that new cases are detected among known contacts.

A total of 674 people were under care. Treatment-centre occupancy in North Kivu had reached 139%, placing severe pressure on available beds, health workers and response operations.

Africa CDC and WHO called for immediate action to:

- identify cases earlier and raise daily contact follow-up to at least 95%;
- bring testing, referral, isolation and treatment services closer to affected communities;
- urgently expand treatment, laboratory, ambulance and safe and dignified burial capacity;
- protect, equip, support and pay frontline health workers on time;
- strengthen infection prevention and control in health facilities;
- maintain essential health services for affected communities;
- improve secure access to areas affected by insecurity and poor infrastructure;
- work through trusted community leaders at every stage of the response;
- sustain cross-border surveillance and regional preparedness; and
- ensure that committed financing reaches frontline operations without delay.

Field findings brought to national leadership in Kinshasa

The mission concluded in Kinshasa with meetings with the President of the Republic and members of Government. Dr. Tedros, Dr. Kaseya and Dr. Janabi, discussed the findings from Kampala and Bunia with national authorities and partners. The discussions focused on government leadership, stronger operational coordination, community engagement, support for health workers, access to affected areas, continuity of essential health services and the rapid deployment of additional capacity and financing. The principals reaffirmed their support for a government-led and nationally-coordinated response bringing together national and provincial authorities, Africa CDC, WHO, humanitarian and development partners, health workers and communities.

"In some areas of eastern DRC, the Ebola outbreak is outpacing our response, making it imperative that we rapidly scale up every aspect of our efforts to contain it," said Dr. Tedros. "We stand in solidarity with the Government, affected communities, and the courageous health workers serving under exceptionally difficult circumstances. But this must be backed by sustained commitment, greater resources, and stronger international support. Together, we must guarantee safe access for responders, protect civilians and health workers, and mobilize the support needed to end this outbreak and save lives."

"Containing and ultimately stopping this outbreak will come from communities," said Dr. Jean Kaseya, Director-General of Africa CDC. "When people have information they trust, can report symptoms early and seek care without fear, we can break every chain of transmission. Our responsibility is to bring the response closer to communities and give frontline teams the support they need."

Africa CDC and WHO reaffirmed their commitment to supporting the Government of the DRC and affected communities through one coordinated response.

Both organizations will continue to deploy technical expertise, strengthen regional preparedness and mobilize the resources required to interrupt transmission and protect lives.

Africa CDC and WHO continue to advise against unnecessary restrictions on travel or trade. Countries should instead strengthen surveillance, laboratory capacity, preparedness and cross-border coordination.

Networking and Collaboration in Health Sciences: Connecting Locally, Leading Globally



Networking opportunities *courtesy of magnific.*

Introduction

Healthcare is increasingly interconnected. The challenges facing health systems from shortages of health workers and limited resources to emerging diseases, technological change and the need for stronger research capacity cannot be addressed by individuals or institutions working in isolation. Effective networking and collaboration have therefore become essential competencies for health sciences students, early-career professionals, researchers, educators and leaders.

Networking is more than collecting business cards or building a long list of contacts. It is the intentional development of professional relationships that create opportunities for learning, mentorship, research, service, leadership and career growth. At its heart, networking is built on relationships, trust and value. It is about mutual support, shared learning, collaboration and professional growth rather than simply using people to advance one's career.

The future of healthcare depends not only on what health professionals know, but also on who they learn from and work with.

Why Networking Matters in the Health Sciences

The complexity of modern healthcare makes collaboration indispensable. Medical education, for example, has benefited significantly from international and regional partnerships that have strengthened curricula, faculty development and research capacity across Africa. Through networks, institutions can share expertise, resources, innovations and experiences that would otherwise remain isolated.

A powerful lesson is that great healthcare professionals do not work alone, they work through networks.

For students and early-career professionals, networks can open doors to internships, research opportunities, mentorship, employment, scholarships and leadership experiences. More importantly, relationships developed early in one's career can become long-term professional partnerships.

Networking should therefore begin before graduation. A student's classmates, lecturers, supervisors and professional contacts may eventually become researchers, hospital directors, policymakers, deans, professional leaders or collaborators. Today's classmate may be tomorrow's professional partner.

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Networking at Different Levels

Networking and collaboration can take place at national, regional and global levels. Each level provides different opportunities and benefits.

National Networking: Starting Locally

The first network for many health professionals is their own country. Students and early-career professionals can build relationships with other universities, teaching hospitals, professional councils, medical associations, non-governmental organisations and the Ministry of Health.

These relationships can provide access to internships, research projects, mentorship and employment opportunities. They also help young professionals understand the national health system and identify areas where their skills can contribute.

Starting locally is important because meaningful professional relationships often grow from shared experiences and common challenges.

Regional Networking: Learning Across Africa

The next level is regional networking, building connections across African countries. Opportunities include African student associations, regional research collaborations, conferences and professional networks.

Regional networking is particularly important because African countries often face similar health challenges while developing innovative solutions in different contexts. Sharing these experiences can accelerate learning and reduce duplication.

There is a powerful principle behind South-South collaboration: Africa has solutions that Africa can share with Africa.

Regional networks can support joint research, leadership development and a deeper understanding of African health challenges. They also create opportunities for young professionals to develop a sense of collective responsibility for the continent's health systems.

Organisations and networks such as the African Forum for Research and Education in Health (AFREhealth), the Network Towards Unity for Health (TUFH), the Consortium of Universities for Global Health and other regional and international partnerships demonstrate how collaboration can connect individuals and institutions across geographical boundaries.

Global Networking: Connecting Beyond Africa

Global networking creates opportunities to engage with colleagues and institutions beyond the continent through international conferences, research collaborations and global health organisations.

Such connections can provide access to scholarships, fellowships, research grants and exposure to new technologies and innovations. They can also broaden perspectives and introduce health professionals to different approaches to education, research, policy and healthcare delivery.

However, global networking should be based on mutual respect and partnership rather than dependency. African professionals and institutions should engage as equal partners, bringing their knowledge, experiences and solutions to global conversations.

The objective should not simply be to gain opportunities from international networks, but also to contribute to them.

Practical Networking Skills for Students and Early-Career Professionals

Networking can seem intimidating, particularly for students who are meeting senior professionals for the first time. However, it is a skill that can be learned and developed.

1. Introduce Yourself Clearly

A simple 30-second introduction can make a strong first impression. Introduce yourself, explain what you are interested in and indicate why you would like to connect.

For example:

"My name is Ruth. I am a second-year medical student interested in maternal health and medical education. I would love to learn about your work."

A clear introduction gives the other person an opportunity to understand who you are and how your interests may connect with theirs.

2. Ask Good Questions

Thoughtful questions are one of the most effective ways of developing a professional conversation. Rather than focusing only on yourself, demonstrate genuine interest in the other person's experience.

Questions such as *"What inspired your career path?"*, *"What advice would you give a student interested in this field?"* or *"How can students get involved?"* can open meaningful conversations.

People may forget a person's name, but they are more likely to remember someone who showed genuine curiosity and interest.

3. Follow Up

One of the most common networking mistakes is meeting someone and then disappearing. A new connection becomes meaningful when it is maintained.

Following up within about 48 hours can be as simple as sending a thank-you email, a LinkedIn invitation or a short message referring to the conversation.

Follow-up demonstrates professionalism and helps transform a brief encounter into an ongoing relationship.

4. Give Before You Ask

Networking should not be based entirely on what one can receive. Young professionals should look for opportunities to contribute.

This may involve volunteering, assisting with projects, providing student perspectives or helping organise professional events. Offering one's time, skills or ideas creates value and demonstrates commitment.

Networking is not only about receiving opportunities; it is also about creating opportunities for others.

5. Build a Professional Digital Presence

Professional relationships increasingly extend beyond face-to-face encounters. Students and early-career professionals should therefore establish a credible digital

presence.

A professional email address, an updated curriculum vitae and a current LinkedIn profile are useful starting points. Professional behaviour on social media is equally important because one's online presence can influence how potential mentors, employers and collaborators perceive them.

Networking and Mentorship

Networking creates opportunities, while mentorship helps individuals grow within those opportunities.

Students should seek different types of mentors, including peers, near-peer mentors, faculty mentors and international mentors. A mentor can guide, challenge, connect and advocate for a mentee.

Mentorship does not necessarily have to involve one senior person providing all the answers. Different mentors can provide different forms of support at different stages of a career. Models such as AfriMentor (https://www.medxmentor.org/) demonstrate the potential of structured mentorship to support professional development and leadership.

The most important step is to be intentional about identifying people whose experience and values align with one's aspirations.

Common Networking Mistakes

Students and early-career professionals often make several avoidable mistakes. These include waiting until graduation to begin networking, contacting people only when they need something, focusing exclusively on senior professionals, ignoring peers and failing to follow up after making a connection.

Effective networking is a long-term process. It should begin early and be sustained consistently.

Importantly, professional relationships should be built on integrity, service and genuine interest. A network based only on personal gain is unlikely to be sustainable.

Turning Networking into Action

Networking becomes more effective when it is translated into specific actions. Every student or early-career professional can begin with a simple personal networking action plan:

- Identify one person you will connect with this month.
- Identify one professional organisation you will join.
- Identify one potential mentor you will approach.
- Attend one conference, webinar or professional event during the year.

These actions may appear small, but consistent efforts can gradually build a strong professional network.

Conclusion

The African proverb, "If you want to go fast, go alone; if you want to go far, go together," captures the essence of networking and collaboration in health sciences.

Healthcare professionals face challenges that are too complex for individuals or institutions to solve alone. Strong networks enable professionals to share knowledge, develop research collaborations, mentor the next generation, access opportunities and create solutions that are relevant to their communities.

For students and early-career professionals, the message is simple: start now. Start locally, connect regionally and contribute globally. Build relationships based on integrity, service, curiosity, trust and collaboration.

A degree may open doors, but relationships can determine how far one walks through them. The future of healthcare will depend not only on what health professionals know, but also on who they learn from, who they collaborate with and what they are willing to contribute to the wider health community.

Africa HEALTH

Africa Health Journal (AHJ) is a review journal that does not publish original articles with some exceptions.

The target audience is frontline health practitioners and policy makers in governments. Teachers and students in academic institutions will also find the content of the AHJ of interest. Online and print editions are published quarterly. There are also dedicated social media platforms with a big following from a global audience.

The journal seeks to cover a wide range of subjects from clinical care topics to health services management, education, and has a section on CPD related to the content in the current issue. The AH covers anything of relevance to a busy physician or senior health professional practising in Africa.

Articles of 1800-2100 words are most commonly published. Illustrations and photographs are important, (we deliberately try not to be too text intensive) and these are best sent as JPEG or PDF files (please submit high resolution (300dpi) CMYK illustrations and photographs, Images taken from websites are of a low resolution and not suitable for print.

Please send the article by email to africahealth@achest.org. Articles should be saved as a Microsoft Word document. Illustrations and photographs should be sent as additional attachments to the Word document.

Referencing should be numerical and in the Vancouver style. If you prefer, it is acceptable to simply append a list of 'For further reading' rather than adopting the more formal referencing style.

Please note that all articles submitted to AHJ are deemed to have been offered exclusively to the journal, unless otherwise stated. Copyright in papers published will be vested in the publishers. The Editor reserves the right to alter articles at his discretion.

The silent epidemic in maternal health: why more pregnant women need hepatitis B screening

Introduction:

Millions of pregnant women across Africa are screened for HIV and syphilis during antenatal care, but most are never tested for hepatitis B despite 240 million people living with the virus globally. The disease can progress silently for years, increasing the risk of severe liver complications and preventable transmission to newborns during childbirth. This press release from Abbott explores how integrated point of care testing during routine pregnancy visits could help identify undiagnosed infections and support elimination efforts, building on the same system that helped Africa make progress against mother to child HIV transmission.

Hepatitis B remains one of the world's most underdiagnosed infections. [1]Untreated hepatitis B can remain silent for years while increasing the risk of severe liver disease and preventable infant infection.[1,2] Integrated point-of-care testing during antenatal care visits presents an important opportunity to identify undiagnosed infections and support measures aimed at reducing transmission to newborns.[2,3]

A pregnant woman attending her first antenatal care (ANC) appointment will often be screened for conditions that could affect her health and the health of her unborn child, including HIV and syphilis, but not always for hepatitis B virus (HBV) infection. This is not because hepatitis B is rare; in fact, quite the opposite. Millions of people worldwide are living with chronic hepatitis B infection, yet many remain unaware of their infection because the disease can progress silently for years without symptoms.[1] As a result, infection is often diagnosed only after serious liver complications develop.[1]

Late diagnosis increases healthcare costs, may limit treatment options and contributes to preventable illness and death.[1] For pregnant women, delayed diagnosis creates an additional risk of vertically transmitting the virus to their babies during childbirth.[2] That missed opportunity is why hepatitis B needs to be seen not only as a liver disease, but as a maternal and child health priority. For healthcare companies such as Abbott, there is an opportunity to help health systems make every ANC touchpoint work harder by bringing reliable, rapid and integrated testing closer to the point of care.

The central question is no longer whether hepatitis B can be detected, prevented or managed. It can. The question is whether health systems are using routine moments of care, especially pregnancy, to find the infection early enough to enable interventions that can improve outcomes for mothers, infants and families.



Revac-B mcf Vaccine

Hepatitis B is often silent, but its consequences are not. [1]ANC offers a critical window to prevent mother-to-child transmission through timely immunoprophylaxis. [2],Integrated testing can help expand access while reducing practical barriers for patients and frontline healthcare workers.[3] Africa has the tools to change the trajectory; now systems must scale them.[1,3]

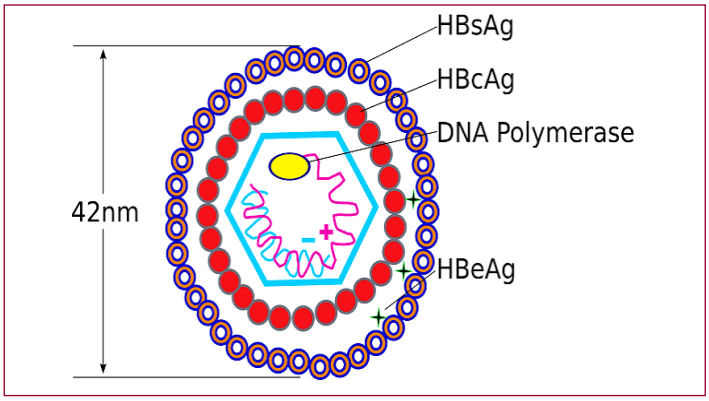
The cost of not knowing

Hepatitis B remains one of the world's most significant infectious diseases despite being preventable and treatable. According to the World Health Organization's (WHO) Global hepatitis report 2026, an estimated 240 million people were living with chronic hepatitis B in 2024, and the WHO African Region accounted for 68% of new hepatitis B virus infections globally.[1]

Behind these numbers are people who may be asymptomatic for years while the virus quietly damages the liver. When hepatitis B is not detected, the first sign of illness may be cirrhosis, liver cancer or liver failure. [1]For families, delayed diagnosis may contribute to repeated clinic visits, rising treatment costs, lost income and the emotional burden of managing a condition that could have been identified much earlier.

"Hepatitis B challenges health systems because it is often invisible until the consequences are severe," says Dr. Evans Mathebula, Senior Medical Affairs Manager at Abbott's rapid diagnostics business in Africa. "If we wait for symptoms, we have waited too long. The priority should be to make hepatitis B screening routine, accessible and connected to care, particularly at moments when people are already engaging with the health system."

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Hepatitis B Virus structure, *courtesy of Microbiology Info*

This is especially important in maternal care. Pregnancy represents one of the most important opportunities to identify previously undiagnosed hepatitis B infection. For many women, ANC is among the few periods of regular engagement with the healthcare system.[2] This visit already serves as an important screening and health education opportunity and can facilitate preventive interventions. Many African countries have made important progress in preventing mother-to-child transmission of HIV. That progress shows what is possible when testing, treatment, policy and community trust are aligned. Hepatitis B now needs the same systems discipline, because the antenatal care clinic may be one of the few reliable points of contact between a pregnant woman and the health system.

This approach aligns with the WHO's triple elimination initiative, which encourages countries to eliminate mother-to-child transmission of HIV, syphilis and hepatitis B together, rather than through fragmented disease-specific programmes.[3] It recognises a simple reality: healthcare systems across Africa continue to face constraints, workforce pressures and laboratory challenges. In this context, adding new screening priorities must be practical and sustainable. Additionally, pregnant women should not have to navigate three separate pathways when one integrated screening moment can support identification of multiple risks and enable timely care during a single encounter.[3]

An integrated antenatal panel that screens for HIV, syphilis and hepatitis B from a single finger-prick is one example of how health systems can simplify access while maintaining a comprehensive standard of care.[3] For mothers, it can help reduce the risk of missed results and clarify next steps. For healthcare workers, it can support faster decision-making at the point of care when linked to appropriate follow-up pathways. For newborns, timely identification of maternal hepatitis B can support measures that reduce the risk of exposure and enable timely preventive action.

"The most powerful public health interventions are those that fit naturally into the realities of existing care," adds Mathebula. "The easier it is for healthcare workers to identify hepatitis B during a single antenatal visit, through the use of an integrated panel, the sooner patients can be considered for appropriate follow-up care. We are not only improving diagnosis; we are giving clinicians the information they need to support mothers, help reduce the risk of infant infection and strengthen confidence in the health system."

A hopeful path to elimination

For too long, hepatitis B has remained overshadowed by other infectious diseases despite its scale and impact. The tools needed to prevent transmission, diagnose infection and support long-term management already exist.[1] What remains is the challenge of finding the millions of people who are living with this virus without knowing it, starting with those accessing maternal and primary healthcare.

To move from awareness to action, policymakers and healthcare leaders should prioritise routine hepatitis B screening in antenatal care, support point-of-care testing in decentralised settings, strengthen linkage to treatment and ensure newborns receive timely protection.[1,3] These are practical steps that can turn a silent infection into a manageable health issue and help prevent transmission to the next generation.

Eliminating hepatitis B as a public health threat will require more than technology alone. It will require political will, domestic investment, continued education to increase awareness, trusted community engagement and health systems designed around people's real lives. But the path is clear: if one antenatal care visit can identify risk, enable timely care and support measures that help reduce a child's risk of infection, then it is one of the most powerful opportunities public health has to change two lives at once.

About Abbott: Abbott is a global healthcare leader that helps people live more fully at all stages of life. Our portfolio of life-changing technologies spans the spectrum of healthcare, with leading businesses and products in diagnostics, medical devices, nutritionals and branded generic medicines. Our 122,000 colleagues serve people in more than 160 countries.

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Small samples, large questions: how Stanford's Holden Maecker is using immune profiling to study African health

Introduction:

For many clinicians and public health teams, the immune system is visible mainly when something has already gone wrong: a severe infection, a complicated pregnancy, a poor vaccine response, a child with persistent inflammation, or a patient who does not recover as expected. Standard laboratory tests are essential, but they usually capture only part of the immune picture.

A growing field of immune profiling aims to provide a broader view. Instead of measuring one marker at a time, researchers can now measure patterns across immune cells, cytokines and soluble proteins. The aim is to understand the biological state of a patient or study population: how the immune system responds to infection, how pregnancy reshapes inflammation, how nutrition affects immune development, and why some individuals recover while others progress to severe disease.

For African health research, this approach is relevant to several areas, including maternal and child health, HIV, sexually transmitted infections, malaria, dengue, chikungunya, malnutrition and environmental exposure. These conditions are often closely linked to immune function, but advanced immune monitoring has historically been concentrated in highly resourced laboratories.

Holden Maecker, Professor of Microbiology and Immunology at Stanford University and Director of the Human Immune Monitoring Center, has spent much of his career working on how to measure the immune system more comprehensively and reproducibly. The Stanford centre he leads provides immune-monitoring technologies including mass cytometry, flow cytometry, Luminex, Olink and NULISA-based immunoassays, as well as genomic assays such as single-cell RNA sequencing.

"What we'd really like to end up with is some kind of metrics of what constitutes a good human immune system," Maecker said in an interview. That question, he added, can apply to "specific disease risk", healthy ageing, cancer immunotherapy, or whether a patient may be a good candidate for an immune intervention.

The same question can also be asked in global health research: what does a resilient immune system look like in the face of infection, pregnancy, undernutrition and environmental stress?

From single markers to immune patterns

Cytokines are small proteins used by immune cells to communicate. They help coordinate inflammation, antiviral responses, wound healing and immune regulation. In clinical practice, however, cytokine testing is still relatively limited. A single inflammatory marker may suggest that something is wrong, but it rarely explains the wider pattern of immune activity.

Maecker is interested in the pattern itself. "When you start to look at a whole lot of different cytokines or other secreted proteins, you see patterns," he said. "And that's extremely interesting."

This shift from single markers to immune patterns is important because many diseases and health states do not produce a simple on/off signal. Pregnancy, for example, is not an immunologically neutral state. It requires tolerance of the fetus while still protecting the mother and newborn from infection. HIV, even when suppressed by antiretroviral therapy, may influence baseline immune status. Sexually transmitted infections may alter inflammation in ways that affect pregnancy outcomes. In children, a small blood sample may contain information about exposure to mosquito-borne viruses or other infections.

The challenge is to measure enough biology to see meaningful patterns, without making testing so broad, expensive or technically complex that it becomes impractical. That balance matters for health systems and research settings where laboratory resources, staffing and sample logistics can be constrained.

Pregnancy, infection and cytokines in Botswana

One example of this work comes from Botswana. In a 2022 paper in The Journal of Infectious Diseases (2), Maecker and colleagues reported plasma cytokine profiles among pregnant women in Botswana in relation to Chlamydia trachomatis infection, HIV status and gestational age.

The study was small and exploratory, involving plasma samples from 37 women at their first antenatal visit. Researchers measured 80 cytokines using a multiplex immunoassay. Fifteen women had C. trachomatis infection and 10 were living with HIV on antiretroviral therapy with viral load below 400 copies/mL.

The authors reported that 17 of 80 cytokines showed significant findings across the analyses. FLT3 ligand differed by chlamydia infection status, while several cytokines differed by HIV status. Other cytokines were associated with gestational age. The study also identified an interaction between chlamydia infection status and gestational age for resistin, a protein linked to inflammation and metabolism.

The immediate clinical message was not that these markers are ready for routine antenatal decision-making. The authors described the pilot as hypothesis-generating and noted that larger prospective studies would be needed. But the work demonstrated feasibility: plasma samples could be used to study immune mechanisms that may connect infection, inflammation and preterm birth risk.

For clinicians and researchers, this illustrates the value of immune profiling as a research tool. It can help identify

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biological pathways that deserve further study, patient groups that may differ immunologically, and pregnancy-related immune changes that may interact with infection.

Microsampling and children in Kenya

A second Africa-focused example comes from Msambweni, Kenya, where Maecker and collaborators studied immune responses to chikungunya and dengue viruses in children. The 2025 study published in Immunohorizons[1] used a miniaturized automated whole-blood cellular analysis system together with mass cytometry and flow cytometry.

The sample-sparing element is important. The system was designed to process 250 µL of whole blood for high-throughput cellular analysis. In the field study, researchers processed 133 whole-blood samples from a pediatric cohort known to have previous exposure to chikungunya and/or dengue viruses. The samples were analysed under unstimulated conditions and after stimulation with viral peptide pools.

The study found measurable virus-specific immune responses, including cytokine responses in gamma-delta T cells. The authors concluded that the approach could support detailed immune-function assessment in pediatric populations and resource-limited settings where sample volumes are limited.

This type of microsampling, or sample-sparing whole-blood processing, addresses a practical barrier in paediatric and field research. Children cannot be treated as small adults when it comes to blood collection. In many research settings, sample volume, transport, processing time and cold-chain logistics influence what science is possible.

If advanced immune profiling requires large blood volumes and immediate processing in specialised laboratories, its use will be limited. Smaller sample volumes, automated processing and more robust workflows may make such research more feasible in settings where childhood infections are common.

Platforms that make broader immune profiling possible

At the Stanford Human Immune Monitoring Center, Maecker's team uses several platforms for multiplex immune and protein measurement, including NULISA-based assays. The centre's role is not only to provide access to individual technologies, but to support studies that require standardized, reproducible measurement of cytokines and other soluble proteins across many samples.

For Maecker, the value of newer multiplex approaches lies in the ability to measure a focused but informative set of proteins. Rather than attempting to measure the entire proteome in every study, he points to what he describes as "a nice sweet spot with a few hundred proteins" that can cover a biological area such as inflammation or central nervous system disease "without getting so broad and so expensive that it becomes untenable."

In practical terms, this can help researchers move from isolated biomarkers toward biological patterns. In the NIH-supported IMPACC study of hospitalized COVID-19 patients, Maecker said NULISA made it possible to include all interferon alpha proteins as well as other key proteins that were missing from other platforms used in the project. This gave the researchers "a much broader view of what proteins were associated with severe COVID and/or death versus mild infection."

Automation is also relevant for studies that need consistency across many samples. Maecker noted that a fully automated workflow can support reproducibility and reduce technician time. "We've just never had that luxury before of being able to just load the samples and walk away," he said.

These features are particularly relevant when immune profiling is applied to population and global health research. In studies involving infants, children, pregnant women or rural communities, the constraints are often practical: small sample volumes, limited opportunities for repeat sampling, transport conditions, local laboratory capacity and the need for comparable results across sites. Platforms that can generate sensitive, multiplex data from small volumes of plasma or serum may therefore help extend advanced immune profiling beyond large specialist centres, provided that issues of cost, training, maintenance, data analysis and local research leadership are addressed.

Implications for African health research

Immune profiling is not ready to replace routine clinical judgement, microscopy, rapid diagnostic tests or basic laboratory services. Its role, at least for now, is mainly as a research tool that can help explain biological mechanisms and generate better evidence for prevention and treatment.

For this approach to be useful in African health research, several practical factors are important. African cohorts need to be included early and meaningfully, since immune profiles are shaped by geography, infection history, nutrition, age, genetics, environment and health-system context. Sample-sparing and automated technologies need to be evaluated in relation to paediatric blood volumes, field collection, transport, storage, staff time and cost. Capacity building is also important, including local data generation, analysis, interpretation and scientific leadership.

The future is unlikely to be one in which every clinic measures hundreds of cytokines for every patient. A more realistic near-term role is for immune profiling to identify useful patterns, validate them across relevant populations, and help translate selected findings into practical tools for prevention, diagnosis and monitoring.

Maecker's work begins with a broad question: what does a good immune system look like? In African health research, answers to that question may come from studying immune responses in the contexts where they are shaped most strongly in mothers, infants and children facing infection, nutrition challenges and environmental exposures in real-world settings.

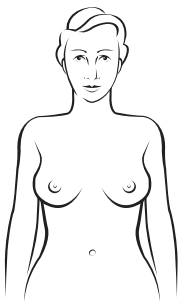
If immune profiling can become more sample-sparing, reproducible and locally useful, small blood samples may provide larger insights into maternal, child and infectious disease health.

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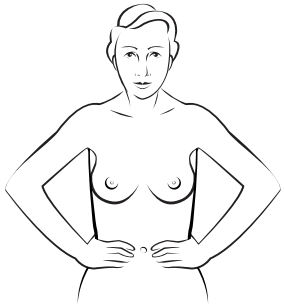
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Breast Self-Awareness (BSA)

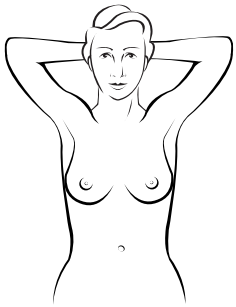
Choose a day each month that will be easy to remember and make breast self-awareness a regular part of your good health routine. Breast self-awareness is also important in women with breast implants.



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.



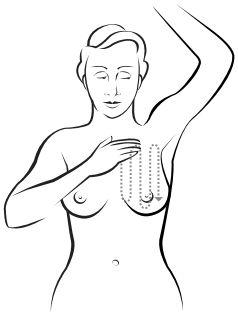
C. Looking in the mirror, raise your arms and rest your hands behind your head. This allows you to see the underside of your breasts.



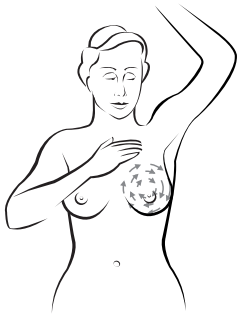
D. Place your left hand on your waist, roll your shoulder forward and reach into your underarm area and check for enlarged lymph nodes (small glands that fill with fluid when you have an infection). An enlarged node would feel like a corn kernel or a bean. Also check the area above and below the collar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

Landmark global study reveals critical inequities in access to dermatological care

First comprehensive global assessment by the International League of Dermatological Societies (ILDS) and L'Oréal Dermatological Beauty and spans 158 countries and 97% of the world's population.

Only one in six countries worldwide has enough dermatologists to meet the healthcare needs of its population, with wealthier nations almost nine times more likely to have adequate dermatology workforce levels versus lower-income countries, according to the first comprehensive global assessment of access to skin health.

Published in JAMA Dermatology, the Global Access to Skin Health Observatory Study, a collaboration between the International League of Dermatological Societies (ILDS) and L'Oréal Dermatological Beauty, examines the distribution of dermatologists alongside barriers to accessing dermatological care, training, and specialist services across 158 countries, representing 97% of the world's population.

More than two billion people worldwide live with skin disease, one of the most common health conditions globally and among the top ten leading causes of disability. Yet 74% of countries report that skin health is not a national government priority. The Study supports implementation of the World Health Assembly's 2025 Resolution on Skin Diseases as a Global Public Health Priority, providing data to help move from commitment to action.

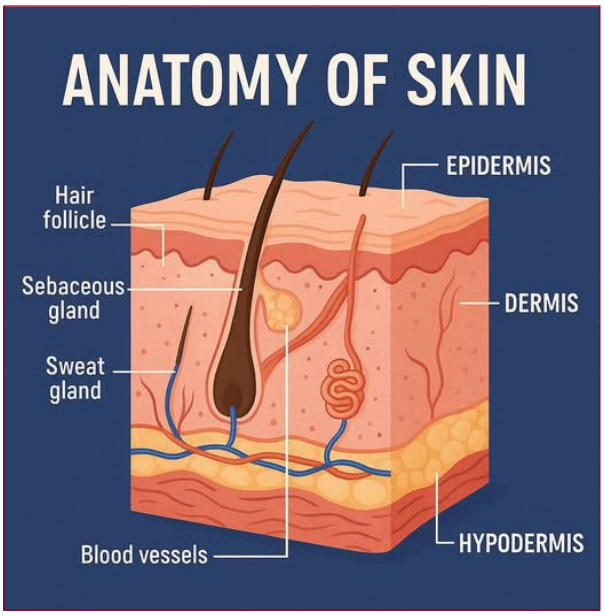
A global shortage of dermatologists

The Study establishes an evidence-based benchmark for the dermatology workforce needed to provide adequate care. Globally, there are an average of just 2.66 dermatologists per 100,000 people, compared with the 5.63 per 100,000 the Study estimates are needed for adequate care, leaving the vast majority of countries over 80% below the benchmark.

The disparities are particularly stark between higher- and lower-income countries. Dermatologist density ranges from just 0.37 per 100,000 people in low-income countries to 5.05 in high-income countries. No countries in Africa or South-East Asia currently reach the benchmark.

The scale of the disparity can be seen in countries with similar populations. Australia and Niger each have around 27 million people, yet Australia has more than 600 dermatologists, while Niger has just eighteen. Similarly, Japan and Ethiopia each have populations of around 130 million, but Japan has more than 7,000 dermatologists, compared with around 200 in Ethiopia.

Access to specialised services is also severely limited in economically disadvantaged countries, with an estimated



Skin anatomy

90% reporting inadequate access across dermatological subspecialties, including paediatric dermatology, dermatological surgery and dermatopathology.

Dr. Esther Freeman, the Study's Principal Investigator, Vice Chair of the International Foundation for Dermatology (IFD), and Associate Professor of Dermatology at Harvard Medical School said: "This is the first time we are turning anecdote into data we can act on. The Global Access to Skin Health Observatory gives us, for the first time, a truly data-driven view of what access to care looks like for the billions of people living with skin disease around the world. Where you live should not determine your access to skin health but today, it does. Our job is to identify these gaps and work together as a global community to address them."

A growing crisis of dermatological deserts: where you live can determine your access to care

The inequalities are not only between countries, but within them. Globally, 79% of dermatologists are based in urban areas, rising to 91% in low-income countries, leaving rural and remote populations significantly underserved. This distribution can lead to "dermatological deserts" or areas with severely limited access to skin health services.

Access is further constrained by the concentration of dermatologists in the private sector, limiting availability for patients reliant on public health systems.

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Overall, 42% of countries report poor or extremely inadequate access to dermatological care, rising to around two-thirds among the world's lowest-income countries. Critically, the burden of skin disease is highest precisely where access to care is lowest.

Non-specialists filling the gap

Where dermatologists are absent, care frequently falls to primary care physicians, nurses, pharmacists and community health workers. Primary care physicians often have equal or greater responsibility for diagnosing and treating skin conditions, despite many non-specialist providers receiving little or no formal dermatology training.

This task-shifting reflects widespread workforce shortages: 89% of low-income countries and 94% of African countries report insufficient provider capacity. At the same time, professional standards for dermatologists are largely consistent worldwide: 89% of countries require both a medical degree and formal dermatology residency training. This suggests inequalities are being driven by systemic barriers to expanding the dermatology workforce rather than differences in professional qualifications.

The Study also identifies significant gaps in dermatological education. In the African region, approximately half of countries (46%) have no dermatology training programs.

From evidence to action

The findings identify concrete opportunities for change, including expanding regional dermatological training programmes, upskilling frontline healthcare workers, and leveraging AI and telemedicine to bring diagnosis and specialist expertise for diverse skin tones closer to underserved patients.

The Study data is housed within the Skin Observatory Data Explorer, an interactive platform enabling ministries of health, organisations, researchers and other stakeholders to access and analyse the data. Users can filter information by country, region and other variables, share insights and download information for reports, presentations and strategic planning. New data will be added over time, enabling the Observatory to track progress and support long-term change. The full results and interactive Skin Observatory Data Explorer are available at skinobservatory.org

Professor Henry W. Lim, President of the ILDS, said: "The findings of the Study support the implementation of the World Health Assembly Resolution on Skin Diseases as a Global Public Health Priority. The Study will continue to grow, with data added over time, helping us track progress and support long-term change. With skin diseases among the top ten leading causes of disability worldwide, we invite all stakeholders to work with us to turn this vital knowledge into positive outcomes for those living with skin diseases."

Myriam Cohen-Welgryn, President of L'Oréal Dermatological Beauty, said: "As the world leader in dermocosmetics, we have both the power and the responsibility to act. L'Oréal Dermatological Beauty is committed to increasing access to skin health in the world and supporting the dermatologists and healthcare workers driving change around the world because access to skin health should be a right, not a privilege. We are proud to support the Global Access to Skin Health Observatory through our Act For Dermatology programme."



Large pigmented basal cell carcinoma,
Courtesy of Richard P. Usatine, MD

The Global Access to Skin Health Observatory is a collaboration between the ILDS and L'Oréal Dermatological Beauty through the L'Oréal Act For Dermatology programme.

About the International League of Dermatological Societies (ILDS)

The ILDS has 242 member organisations across 113 countries, representing more than 170,000 dermatologists and other dermatology professionals worldwide. It holds 'official relations' status with the World Health Organization (WHO) and champions the inclusion of skin health in global health policy – promoting education, clinical care, research and innovation globally.

About the International Foundation for Dermatology (IFD)

The IFD was established by the ILDS to improve skin health in underserved regions of the world. It supports projects all over the world including Africa, the Asia Pacific region and South America. The IFD is critical to helping the ILDS achieve its goal of 'Skin Health for the World.'

About L'Oréal Dermatological Beauty

L'Oréal Dermatological Beauty is dedicated to pioneering sustainable and life-changing dermatological solutions for all. This mission is brought to life through its portfolio of five iconic, complementary brands: La Roche-Posay, CeraVe, Vichy, SkinCeuticals, and Skinbetter Science. Leveraging unparalleled scientific leadership and long-term partnerships with healthcare professionals worldwide, LDB delivers advanced skin and haircare solutions tailored to every individual need, from addressing skin pathologies to enhancing aesthetic well-being. L'Oréal Dermatological Beauty is committed to increasing access to skin health worldwide through its programme L'Oréal Act For Dermatology, a €20 Million investment in global skin health initiatives.

Movement as a bridge back to myself

Gilbert Elvis Oloo writes a personal essay about anxiety, loneliness, unemployment and why physical education must become a community lifeline.

I do not always think my way out of anxiety. Sometimes, I have to move my way through it.

When I am thoughtful, lonely, unemployed, or carrying too much stress, my mind can become crowded. Questions about the future repeat themselves. Time feels unusually heavy. Yet I have learned something important from my own body: if I step onto a soccer field, pick up a basketball, enter a swimming pool, or simply run, the pressure begins to change form.

The problem may not disappear. What changes is my relationship to it. Instead of sitting still inside anxious thoughts, I give that energy somewhere to go. My breathing grows loud, my heart works harder, and my attention returns to what is directly in front of me: the ball, the next stride, the water, the next breath. Afterward, I often return to my situation with a steadier mind and a clearer sense of direction.

The short burst that interrupts the spiral

I am especially drawn to high-intensity activity in short bursts, the kind that makes me breathe hard through my mouth. A sprint, a fast basketball sequence, a demanding swim interval, or a period of hard running creates an immediate physical task. During difficult periods, I can sometimes run five miles more easily than I would expect. It is as though the emotional pressure becomes fuel.

This is my lived experience, not a universal prescription. Still, it raises a serious research question: can carefully designed bursts of vigorous activity help some people interrupt rumination, regain attention, and feel capable again? Reviews of physical-activity research report reductions in anxiety and depressive symptoms across many forms of exercise, with some evidence that higher intensity may produce larger improvements for some people. But intensity is not automatically better for everyone, and the right dose, setting, health screening, and personal choice matter.

What interests me most is the transition: anxious energy becomes purposeful effort; breathlessness becomes evidence that I am present; and finishing the activity gives me a small but real achievement. That sequence may help explain why movement can restore a sense of control when unemployment has weakened routine, identity, confidence, and hope.



Courtesy of Victor Chijioke

Unemployment is more than the absence of a paycheck

Unemployment can remove several supports at once: income, daily structure, professional identity, social contact, and the feeling of being needed. Anxiety asks, "What happens next?" Loneliness answers with silence. The result can be a loop: stress leads to withdrawal; withdrawal reduces movement and connection; inactivity leaves more time for rumination; and rumination makes action feel harder.

Sport can interrupt that loop at several points. It creates a reason to leave the room. It gives the day an appointment. It offers visible progress when job applications produce no immediate result. Team activities create low-pressure social contact because people can

Gilbert Elvis Oloo is a Kenyan physical educator and multi-sport coach with a Bachelor of Education in Physical Education and Mathematics.

connect around a shared task rather than having to explain their lives. Most importantly, movement can remind a person that unemployment is a circumstance—not a complete identity.

Why creativity sometimes arrives after exertion

I also notice that these periods of movement and reflection can make me highly creative. Ideas appear while I run, after I swim, or when I return from basketball. I do not believe exercise magically solves every problem. My working theory is simpler: demanding movement temporarily narrows attention to the body and the present moment. When the mental noise settles, thoughts that were competing for space may reorganize. The mind returns to the problem with distance, energy, and a fresh angle.

This relationship deserves careful study. Researchers could measure mood, rumination, perceived control, creative idea generation, and social connection before and after different activity formats. They could compare short vigorous drills, moderate continuous exercise, team play, swimming, and non-exercise social sessions. They should also ask participants what the experience means to them, because numbers alone cannot explain why one person feels liberated by a sprint while another feels safer beginning with a walk.

ABCDE: Anxiety Beaten Correctly through Drills and Exercise

ABCDE is the community concept I want to develop from this experience. The word "beaten" expresses determination, but "correctly" is essential: the goal is not to punish the body, deny emotion, or claim that sport replaces therapy. It is to use safe, progressive, enjoyable movement as one practical tool within a wider network of support.

ABCDE would welcome people experiencing anxiety, loneliness, unemployment, major life transitions, or loss of routine. It would be affordable, beginner-friendly, and connected to local parks, schools, recreation centers, pools, gyms, coaches, employment services, and mental-health professionals.

The goals I intend to achieve

- Help participants interrupt anxious rumination through structured, achievable movement.
- Rebuild weekly routine, confidence, and a sense of progress during unemployment or transition.
- Reduce loneliness by creating consistent, welcoming activity groups with shared goals.
- Offer several entry points—soccer, basketball, swimming, walking, running, and adaptable drills—so people can choose what feels safe and meaningful.
- Explore when short high-intensity bursts are helpful, for whom they work, and how they compare with moderate activity.
- Measure changes in anxiety, mood, belonging, self-efficacy, attendance, creativity, and readiness to re-engage with work or education.
- Train physical educators and coaches to recognize distress, respond without stigma, and refer participants to qualified care when needed.
- Build an evidence-informed model that communities can adapt without expensive equipment or elite facilities.



Courtesy of Victor Chijioke

What a community ABCDE session could look like

1. Arrive and check in: A private, optional mood rating and a simple question: What does your body need today?
2. Choose an intensity lane: Gentle, moderate, or vigorous options, with no shame attached to any choice.
3. Move with purpose: Short drills, small-sided games, swim or run intervals, mobility work, and recovery breaks.
4. Connect without pressure: Partner or team activities that encourage names, encouragement, and cooperation rather than forced disclosure.
5. Reflect and reset: A brief cool-down, breathing period, and written or spoken reflection on mood, ideas, and the next constructive action.
6. Link to support: Clear pathways to counseling, crisis

services, employment assistance, education, and other community resources.

Making participation easier

Many programs fail before the first drill because they ask too much at the door. A person who is anxious, isolated, short of money, unfamiliar with a facility, or ashamed of being out of shape may not enter a competitive gym. Integration must therefore be designed, not assumed.

- Keep the first session free and allow walk-ins without complicated registration.
- Provide loaner equipment, transit support where possible, and sessions at different times.
- Use welcoming language such as "move and reset," not labels that make participants feel diagnosed.
- Offer buddy entry, women-only or culturally specific sessions where communities request them, and accessible adaptations for disability or chronic conditions.
- Celebrate attendance, consistency, courage, and teamwork—not only speed, weight, or athletic ability.
- Let participants help design the drills. Ownership strengthens dignity and belonging.
- Create referral partnerships while protecting privacy; coaches should support, not act as therapists.

A proposal to study the idea

I envision a 12-week pilot with adults experiencing unemployment, loneliness, or elevated everyday anxiety. Participants could attend two or three sessions each week and select a preferred activity lane. A responsible evaluation would combine short validated questionnaires with attendance, retention, interviews, and reflective journals. It would examine not only whether scores change, but why people stay, what makes them feel safe, whether social connections continue outside sessions, and whether participants re-engage with job seeking, study, volunteering, or community life.

The pilot should include medical readiness procedures, qualified instruction, emergency protocols, and a mental-health referral pathway. It should not promise a cure. Anxiety can require professional assessment and treatment, and vigorous exercise may be inappropriate for some people without clinical guidance. ABCDE should complement care—not compete with it.

The wider lesson

Physical education is often treated as a school subject, a fitness requirement, or preparation for competition. I see something larger. It can be education for emotional regulation, social connection, resilience, and return. A community does not need to wait until a person is employed, confident, or mentally settled before inviting them to move. Movement itself may be one of the bridges back.

My own experience begins with a crowded mind and a simple decision: find a ball, enter the water, or start running. I breathe hard. I focus. I return different—not because every problem is solved, but because I am again able to meet the problem as myself.

That is the promise I want ABCDE to investigate: not exercise as an escape from life, but movement as a way back into it.



Courtesy of Victor Chijioke

Evidence informing this perspective

1. World Health Organization. Physical activity. WHO notes that regular physical activity can improve mental health, quality of life, and well-being. https://www.who.int/health-topics/physical-activity
2. World Health Organization. Mental health at work. Decent work can provide livelihood, purpose, achievement, routine, relationships, and inclusion. https://www.who.int/news-room/fact-sheets/detail/mental-health-at-work
3. World Health Organization. Social isolation and loneliness. WHO identifies loneliness as a widespread public-health concern across age groups. https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/social-isolation-and-loneliness
4. Singh, B., et al. (2023). Effectiveness of physical activity interventions for improving depression, anxiety and distress: an overview of systematic reviews. British Journal of Sports Medicine, 57(18), 1203–1209. https://bjsm.bmj.com/content/57/18/1203
5. Shvedko, A., Whittaker, A. C., Thompson, J. L., & Greig, C. A. (2018). Physical activity interventions for treatment of social isolation, loneliness or low social support in older adults: a systematic review and meta-analysis. Psychology of Sport and Exercise, 34, 128–137. https://doi.org/10.1016/j.psychsport.2017.10.003

Author's note: This article combines lived experience with an evidence-informed proposal. It is not medical advice. Anyone with severe or persistent anxiety, thoughts of self-harm, concerning physical symptoms, or uncertainty about vigorous exercise should seek qualified professional support.

General Medicine

Use of herbal medicine by caregivers in the management of children with sickle cell disease in Mulago National Referral Hospital - Uganda.

Abstract: The study investigated the use of herbal medicines among caregivers of children with sickle cell disease attending Mulago National Referral Hospital in Uganda. The authors note that SCD is a major public-health problem in sub-Saharan Africa and that complementary and alternative medicines are commonly used in chronic disease. The study examined the prevalence of herbal medicine use and factors associated with its use among caregivers. The findings highlight the importance of understanding caregivers' treatment practices and beliefs when designing comprehensive SCD care in Uganda.

Reference

Lubega M, Osingada CP, Kasirye P. Use of herbal medicine by caregivers in the management of children with sickle cell disease in Mulago National Referral Hospital - Uganda. Pan Afr Med J. 2021;39:163. doi:10.11604/pamj.2021.39.163.20740.

Hydroxyurea therapy in adult Nigerian sickle cell disease: a monocentric survey on pattern of use, clinical effects and patient's compliance.

Abstract: This Nigerian study assessed the pattern of hydroxyurea use, clinical and haematological effects, and patient compliance among adults with SCD. The study was undertaken because hydroxyurea has important therapeutic potential but its use in African settings requires consideration of local clinical practice and patient adherence. The authors concluded that hydroxyurea can provide important clinical and haematological benefits, while adherence and appropriate monitoring remain important considerations in its use.

Reference

Adewoyin AS, Oghuvwu OS, Awodu OA. Hydroxyurea therapy in adult Nigerian sickle cell disease: a monocentric survey on pattern of use, clinical effects and patient's compliance. Afr Health Sci. 2017;17(3):730-739. doi:10.4314/ahs.v17i3.20

Sickle cell disease: reappraisal of the role of foetal haemoglobin levels in the frequency of vaso-occlusive crisis.

Abstract: This retrospective longitudinal study from the Korle-Bu Teaching Hospital in Ghana examined the relationship between foetal haemoglobin (HbF) levels and frequency of vaso-occlusive crises in adults with SCD. Eighty-three patients aged 15–65 years were studied over 30 months. Higher HbF levels were associated with fewer crises, supporting the role of HbF in modifying disease severity. However, the investigators could not establish a definitive threshold HbF level that reliably predicts protection from crises.

Reference

Antwi-Boasiako C, Frimpong E, Ababio GK, Dzudzor B, Ekem I, Gyan B, et al. Sickle cell disease: reappraisal of the role of foetal haemoglobin levels in the frequency of vaso-occlusive crisis. Ghana Med J. 2015;49(2):102-106. doi:10.4314/gmj.v49i2.7.

Frequency of red blood cell allo-immunization in transfused patients with sickle cell disease in Africa: a systematic review with meta-analysis.

Abstract: This systematic review and meta-analysis examined the frequency of red blood cell allo-immunisation among transfused patients with SCD in Africa. Blood transfusion is an important treatment for severe SCD complications but repeated transfusion can result in allo-antibody formation, potentially complicating future transfusions. The review highlights allo-immunisation as an important issue for transfusion services caring for African patients with SCD and provides evidence relevant to improving transfusion strategies and blood-matching practices.

Reference

Nwagha TU, Ugwu AO, Nweke M. Frequency of red blood cell allo-immunization in transfused patients with sickle cell disease in Africa: a systematic review with meta-analysis. Afr Health Sci. 2024;24(3):417-429. doi:10.4314/ahs.v24i3.46.

Caregivers' beliefs about hydroxyurea influence its usage among children with sickle cell disease: a cross-sectional study in Dar-es-Salaam, Tanzania.

Abstract: This cross-sectional study conducted in Dar es Salaam examined caregivers' beliefs about hydroxyurea and how these beliefs influence its use among children with SCD. The study is particularly relevant to implementation of evidence-based SCD treatment in African settings because availability of effective medicines does not necessarily translate into their uptake. Understanding caregiver perceptions, concerns and treatment beliefs can help clinicians and programmes develop better counselling and adherence interventions.

Reference

Ally M, Jonathan A, Yonazi M, Balandya E. Caregivers' beliefs about hydroxyurea influence its usage among children with sickle cell disease: a cross-sectional study in Dar-es-Salaam, Tanzania. Pan Afr Med J. 2025;52:31. doi:10.11604/pamj.2025.52.31.45975.

Exploring the quality of life of caregivers of children with sickle cell disease in a secondary health facility in Ghana.

Abstract: This qualitative study explored the burden experienced by caregivers of children with SCD at a secondary health facility in Ghana. Eleven caregivers participated. Four major dimensions of burden emerged: financial, psychological, social and physical. Financial and psychological burdens had particularly substantial effects on caregivers' quality of life. The authors argue that support for families affected by SCD should extend beyond medical treatment to include psychosocial and other forms of caregiver support.

Reference

Salamat ST, Mahama H, Asabi J, Asante L. Exploring the quality of life of caregivers of children with sickle cell disease in a secondary health facility in Ghana. Ghana Med J. 2025;59(4):219-226. doi:10.4314/gmj.v59i4.6.

Treatment for sickle cell disease in Africa: should we invest in haematopoietic stem cell transplantation?

Abstract: This Pan African Medical Journal commentary examines the potential role of haematopoietic stem-cell transplantation in the treatment of SCD in Africa. The authors discuss the substantial burden of SCD on the continent and consider transplantation alongside other disease-modifying approaches, including hydroxyurea. They highlight the need to consider the feasibility, cost, infrastructure and specialist capacity required for transplantation within African health systems.

Reference

Pule G, Wonkam A. Treatment for sickle cell disease in Africa: should we invest in haematopoietic stem cell transplantation? Pan Afr Med J. 2014;18:46. doi:10.11604/pamj.2014.18.46.3923.

Implications of COVID-19 infections in sickle cell disease.

Abstract: This review discusses the implications of COVID-19 infection in people living with SCD, with particular attention to the African context. The authors highlight the substantial burden of SCD in sub-Saharan Africa and the increased vulnerability of affected individuals to complications such as acute chest syndrome, pulmonary complications and sepsis. The article emphasises the challenges of managing SCD during infectious disease outbreaks in resource-constrained settings.

Reference

John NA, John JE. Implications of COVID-19 infections in sickle cell disease. Pan Afr Med J. 2020;36:81. doi:10.11604/pamj.2020.36.81.23776.

Health Professions Education

Emotional impact of cadaver dissection: a survey in a medical college in western Nepal..

Abstract: Objectives: Adverse physical and psychological effects to human dissection have been reported in many studies. In Nepal, the basic science subjects are taught in an integrated manner in the first four semesters of the MBBS course. Studies on the attitudes of medical students towards anatomy dissection are lacking in Nepal. The present study was carried out to obtain information on the present and initial perception of medical students on exposure to anatomy dissection and the association, if any, of the perception with demographic factors. Methods: The study was carried out among the first, second and third semester students at the Manipal College of Medical Sciences, Pokhara using the appraisal of life events (ALE) scale in February 2005. Sixty-three first semester, 57 second and 65 third semester students successfully completed the questionnaire and their responses were taken up for analysis. Information on sex, age, nationality, religion, food habits, occupation of parents and selection procedures of respondents was collected. The parameters loss, challenge and threat were measured on first exposure to dissection and at the time of the study. The scores were compared among different categories of students ($p< 0.05$). Results: 185 of the 225 students (82.2%) successfully completed the questionnaire. The median initial loss, challenge and threat scores were 2, 19 and 4 respectively. The median present loss, challenge and threat scores were 1, 20 and 0 respectively. The present threat score was higher among second semester students. The initial loss was higher among Indians and the present challenge score was higher among vegetarians. Conclusions: The loss and threat score were low compared to that reported in a previous study. The challenge scores were higher than those reported previously. Majority of students considered anatomy dissection as a significant life experience and one which was largely positive. Further studies with a larger student population and in other medical colleges are required.

Reference

Vijayabhaskar P, Shankar PR, Dubey AK. Emotional impact of cadaver dissection: a survey in a medical college in western Nepal. Kathmandu Univ Med J (KUMJ). 2005 Apr-Jun;3(2):143-8. PMID: 16415610..

Medical students' attitudinal changes towards cadaver dissection: a longitudinal study.

Abstract: Background: Recently, not only the medical school curriculum but also medical students' attitude towards cadaver-based learning of anatomy has changed. This investigation is therefore designed to analyse students' attitudes towards human cadaveric dissection before and after exposure to dissection. Methods: A longitudinal survey was conducted among second year medical students in 2010 at the college of Medicine and Health Sciences, University of Gondar. All second year medical students (n=147) were included in the study where their attitudes were surveyed at three time points (one week prior to dissection session, a week after the initiation of dissection and eight weeks after the second survey). Three standardized and pretested questionnaires prepared in English were used to collected relevant data from the subjects. Results: Out of the 147 students 85.7% were males. The subjects' age ranged between 18 and 23 with a mean and standard deviation of 19.5±1 years. This study has revealed that among majority of the students fear and nausea have decreased while their interest and excitement has increased on subsequent exposure to dissection ($P<0.05$). About 75% of students considered the dissection room as slightly or highly stressful. Smell of the cadaver and eye irritation as a result of the chemicals in it were the major aspects identified as making the dissecting room stressful. The result also showed that almost all (99%) considered cadaver dissection had very important educational value for anatomy learning.

Conclusion: In the majority of the students fear and nausea had decreased while interest and excitement had increased on subsequent exposure to dissection. It also showed that chemical odour and eye irritations were the leading factors which create discomfort in the dissection room even though anatomical dissection by itself was not considered as a stressor. Thus, instructors are recommended to adequately prepare students mentally and emotionally before the commencement of the dissection session for an exciting and stress free anatomy learning though dissection.

Reference
Mulu A, Tegabu D. Medical students' attitudinal changes towards cadaver dissection: a longitudinal study. Ethiop J Health Sci. 2012 Mar;22(1):51-8. PMID: 23066333; PMCID: PMC3448296.

Medical students as research participants: Student experiences, questionnaire response rates and preferred modes.

Abstract: Background. Research projects frequently include students, a potentially vulnerable population, as participants. Objectives. To determine University of the Free State (UFS) medical students' experiences as research participants. Response rates to and preferences for hard copy and electronic questionnaires were also investigated. Methods. All 804 UFS undergraduate medical students in 2020 were approached to participate in this cross-sectional survey. Fourth- and fifth-year students and one-half of the third-year class were approached in person to complete anonymous hard copy questionnaires in a class setting. First- and second-year students and the other half of the third-year class were contacted electronically to complete anonymous electronic questionnaires. Results. Response rates to hard copy questionnaires were at least ~45% of the entire year group (and >70% of those to whom the questionnaire was distributed in class) compared with approximately a third of those contacted electronically. Students who responded to electronic questionnaires preferred electronic completion, whereas those who responded to hard copy questionnaires preferred the hard copy format, except fifth-year students. The majority of students (except those in their first year) had previously been approached to participate in research projects. Between a fifth and a third of all year groups indicated that they had refused participation at least once. More than a third of fifth-year students experienced insufficient time to decide on participation. Up to a quarter of third- to fifth-year groups had felt pressurised to participate. Conclusion. Hard copy questionnaires in class, the preferred data collection method for many students, produced better response rates but placed potential pressure on students to participate.

Reference
Joubert, G. ., Steinberg, W. J. ., & van der Merwe, L. J. . (2022). Medical students as research participants: Student experiences, questionnaire response rates and preferred modes. African Journal of Health Professions Education, 14(3), 106–110. Retrieved from https://www.ajol.info/index.php/ajhpe/article/view/235206.

Nursing students' perceptions of support and active learning regarding simulation-based education in Lesotho: A quantitative study.

Abstract: Background. Simulation has taken centre stage in health sciences education in the context of the increasing adoption of a competency-based curriculum. Simulation replicates facets of the real world in an interactive manner that allows students to learn clinical skills and develop clinical reasoning skills in a safe learning environment. Facilitators have a responsibility to provide adequate instructional and psychological support to the students, while facilitating active and self-directed learning in the simulation environment. Objective. To explore and describe students' perceptions of support and active learning regarding simulation-based education (SBE) in Lesotho. Methods. A quantitative descriptive exploratory study was conducted using a validated questionnaire. A total of 275 nursing students participated in the study. A stratified systematic random sampling method was used and data were analysed using SPSS version 27. Results. The majority of participants (87.9%) had a positive perception of support that was offered prior, during and after simulation, which they appreciated. Active learning was also perceived positively, as most of the participants indicated that they actively participated in, and not merely observed, simulation. The results showed significant associations between an opportunity given to students to discuss simulation objectives with the teacher and various institutions ($p<0.05$ ($p=0.01$)). Institutions with trained simulation facilitators provided students the opportunity to discuss simulation objectives with their teacher. Conclusion. The study showed that student support and active learning are essential when conducting SBE. Supporting students and actively involving them in the learning process lead to effective learning.

Reference
Moabi PS, Mtshali NG. Nursing students' perceptions of support and active learning regarding simulation-based education in Lesotho: A quantitative study. Afr Jrnl Health Prof Educ [Internet]. 2022 Nov. 1 [cited 2026 Sep. 16];14(3):111-4. Available from: https://www.ajol.info/index.php/ajhpe/article/view/235207.

Student review of doctor-patient communication skills training in a South African undergraduate medical programme.

Abstract: Background. Barriers to the training of doctor-patient communication in the South African (SA) context have been well explored through qualitative research at several SA medical schools. However, this aspect of training has not been reviewed in a systematic way by a large number of students. A student review of doctor-patient communication skills training in the undergraduate medical programme of a medical school in SA was obtained to improve training and identify further research needs. Objective. To investigate doctor-patient communication skills training in the undergraduate programme of a medical school in SA to identify shortcomings and further research needs. Methods. A descriptive, cross-sectional design was used. Data were collected through an anonymous questionnaire based on Harden's extended vision of the curriculum. Printed anonymous questionnaires, distributed to all the fourth- and fifth-year undergraduate medical students, were analysed quantitatively. Open-ended questions were analysed qualitatively using grounded theory. Results. The sample comprised 106/132 fifth-year students (response rate 80.3%) and 65/120 fourth-year students (response rate 54.2%). Frequent training in history-taking was reported by >75% of students, while >60% reported infrequent training in breaking bad news. More than 50% of participants indicated that senior doctors seldom or never modelled patient-centred communication in the clinical teaching milieu. Students preferred experiential learning to didactic methods. Conclusion. Medical students want to see patient-centred communication unequivocally modelled in the clinical setting. A greater

emphasis on practical training in context-specific communication skills is required. Positive role-modelling is needed in the clinical environment.

Reference

Swinfen D, Labuschagne M, Joubert G. Student review of doctor-patient communication skills training in a South African undergraduate medical programme. Afr Jrnl Health Prof Educ [Internet]. 2022 Nov. 1 [cited 2026 Sep. 16];14(3):115-21. Available from: https://www.ajol.info/index.php/ajhpe/article/view/235208.

Maternal Health

Maternal and child healthcare coverage and trends: refugee vs. non-refugee districts in Uganda

Abstract: Background: Uganda hosts the largest refugee population in Africa, placing considerable pressure on district health systems. This study examined differences in maternal and child health (MCH) coverage between refugee-hosting and non-refugee-hosting districts and assessed the influence of government financing and health-system performance. Methods: The researchers retrospectively analysed routine health-facility MCH data from Uganda's District Health Information System and district-level Primary Health Care expenditure data from 2020–2023. Indicators included antenatal care, institutional delivery, postnatal care and childhood immunisation. Results: Refugee-hosting districts generally had modestly higher coverage of antenatal care, institutional deliveries, postnatal care, measles vaccination and the composite coverage index. Government expenditure and health-system performance were positively associated with MCH coverage. Adjusted analysis showed that ANC4 coverage was 7.4 percentage points higher in refugee-hosting districts. Conclusion: Routine health information can be used to monitor MCH coverage at district level. Government investment and health-system performance appear important determinants of MCH service coverage.

Reference

Nsubuga R, Kananura RM, Wasswa R, Birabwa C, Ogwal J, Dotse-Gborgbortsi W, et al. Maternal and child healthcare coverage and trends: refugee vs. non-refugee districts in Uganda. Confl Health. 2026;20:42. doi:10.1186/s13031-026-00780-7. (Springer Link)

Motherhood in crisis: lived experiences of mothers with babies admitted to a neonatal intensive care unit in Northern Uganda

Abstract: Background: Mothers whose newborns are admitted to neonatal intensive care units (NICUs) often experience emotional distress, uncertainty and separation from their babies. Little is known about these experiences in low-resource settings in Northern Uganda. Methods: A descriptive phenomenological study was conducted among 10 mothers whose babies had been admitted to the NICU at Lira Regional Referral Hospital for at least three days. In-depth interviews were conducted and analysed thematically. Results: Four major themes emerged: emotional grief related to the baby's hospitalisation, the burden of hospitalisation, satisfaction with healthcare received, and changes in the maternal role and support systems. Mothers described fear, uncertainty and hopelessness. Financial hardship, prolonged hospitalisation and separation from family intensified these experiences. Compassionate healthcare, spirituality and hope were important coping mechanisms. Conclusion: Maternal experiences during NICU admission are strongly influenced by communication with healthcare workers, the baby's clinical condition, hospital requirements and social support. Improved communication, essential supplies and interpersonal support may improve maternal experiences.

Reference

Namukwana B, Abeja CJ, Ekung E, Nabasirye CK, Nyeko R, Auma AG, et al. Motherhood in crisis: lived experiences of mothers with babies admitted to a neonatal intensive care unit in Northern Uganda. BMC Pregnancy Childbirth. 2026;26. doi:10.1186/s12884-026-09620-1. (Springer Link).

Acceptability and uptake of COVID-19 vaccines among pregnant and lactating women seeking services at a tertiary public hospital in Kampala, Uganda

Abstract: Background: Although vaccination during pregnancy and lactation is recommended for several vaccines, evidence on COVID-19 vaccine acceptance and uptake among pregnant and lactating women in sub-Saharan Africa remains limited. Methods: A cross-sectional study was conducted among 424 pregnant and lactating women attending maternal and child health services at Kawempe National Referral Hospital in Kampala. Data were collected between May and July 2023 and analysed using modified Poisson regression. Results: Approximately 51.6% of participants had received at least one COVID-19 vaccine dose, while 48.4% were willing to receive the vaccine. Only 2.4% of lactating women had received COVID-19 vaccination and none had received it during pregnancy. Previous COVID-19 testing and having a vaccinated household member were associated with vaccine uptake. Conclusion: COVID-19 vaccine acceptance and uptake among pregnant and lactating women remained suboptimal despite relatively high acceptance of other maternal vaccines. The authors recommend targeted communication, addressing safety concerns and using trusted information sources to improve vaccine confidence.

Reference

Katana EB, Laker Odongpiny EA, Simbwa BN, Nsubuga EJ, Namayanja J, Muhindo R, et al. Acceptability and uptake of COVID-19 vaccines among pregnant and lactating women seeking services at a tertiary public hospital in Kampala, Uganda. BMC Pregnancy Childbirth. 2026;26. doi:10.1186/s12884-026-09708-8. (Springer Link)

Person-centered care across the maternal health continuum: evidence from a cross-sectional analysis of baseline data from the CPIPE trial in Kenya and Ghana

Abstract: Background: Person-centred maternal healthcare encompasses respectful, responsive and supportive care throughout pregnancy, childbirth and the postpartum period. This study assessed the extent of person-centred care in Kenya and Ghana. Methods: The study analysed cross-sectional baseline data from 1,999 postpartum women in Kenya and Ghana.

Validated scales assessed person-centred antenatal, maternity and postnatal care. Results: Mean scores were approximately 71 out of 100 across antenatal, maternity and postnatal care. Communication and autonomy were the lowest-performing domains. Fewer than 20% of women experienced optimal person-centred care across any phase of the maternal care continuum. Higher socioeconomic status, care in health centres or faith-based facilities and continuity of care were associated with higher scores. Conclusion: Person-centred maternal healthcare was suboptimal across the continuum, particularly among vulnerable women. Provider training, supportive facility environments, accountability mechanisms and continuity of care were identified as potential approaches for improvement. (ScienceDirect).

Reference

Afulani PA, Okiring J, Ongeri L, Aborigo RA, Ogolla BA, Moro A, et al. Person-centered care across the maternal health continuum: evidence from a cross-sectional analysis of baseline data from the CPIPE trial in Kenya and Ghana. Lancet Reg Health Afr. 2026;6:100074. doi:10.1016/j.lanafr.2026.100074. (ScienceDirect).

Mapping neonatal vulnerability using the Small Vulnerable Newborn (SVN) framework-secondary analysis of PRISMA Pakistan study.

Abstract: Background: Despite progress in global neonatal mortality, South Asia continues to lag behind in reducing neonatal deaths. The Small Vulnerable Newborn (SVN) framework has been proposed to integrate preterm birth (PT), small for gestational age (SGA), and low birth weight. However, there is lack of data on the burden and risk factors of SVN in Pakistan, a country which has one of the highest neonatal deaths globally. This study aimed to estimate the incidence of SVN, and identify risk factors among pregnant women in Pakistan. Methods: This secondary analysis leverages data from PRISMA (Pregnancy Risk Infant Surveillance, and Measurement Alliance)—Pakistan. Women presenting ≤20 weeks gestation and, with birth weights recorded within 72 h post-delivery were analysed. Newborns were classified into categories of SVN. Multinomial and binomial regression models were used to examine associations between maternal characteristics and SVN categories, as well as neonatal mortality. Findings: The overall incidence of SVN was 46% (n = 771) with Term + SGA being the most common category (n = 461, 27.5%), followed by PT + AGA (n = 210, 12.5%) and PT + SGA (n = 41, 2.5%). Maternal undernutrition (MUAC <23 cm) increased the risk of SVN by 17% (aRR 1.17, 95% CI 1.05–1.31). SVN also emerged as a significant predictor of neonatal mortality, quadrupling the risk (aRR 4.52, 95% CI 2.42–8.46). Interpretation: This study adds to the growing body of evidence on Pakistan's alarming burden of SVN, with every second newborn at risk. Identification and targeted interventions are imperative to mitigate adverse birth outcomes and optimize child growth and development..

Reference

Malik H, Yazdani N, Kumari S, Jamal SA, Kashif M, Mazhar A, Hoodbhoy Z. Mapping neonatal vulnerability using the Small Vulnerable Newborn (SVN) framework-secondary analysis of PRISMA Pakistan study. Lancet Reg Health Southeast Asia. 2025 Jan 25;33:100535. doi: 10.1016/j.lansea.2025.100535. PMID: 39911163; PMCID: PMC11795797.

Surgery

Systematic review of the Lancet Commission on Global Surgery indicators with quality assessment of modelled estimates.

Abstract: Background: The Lancet Commission on Global Surgery defined six indicators with 2030 targets to monitor national surgical-system performance. This systematic review evaluated national reporting and achievement of these benchmarks and assessed the quality of modelled estimates. Methods: Seven bibliographic databases and government websites from 48 countries committed to National Surgical, Obstetric, and Anaesthesia Plans were searched. Studies reporting national estimates of the Commission's indicators were included. Results: Of 4245 records identified, 44 studies were included. Access to timely essential surgery was reported for 94 of 217 countries, with 39% meeting the benchmark. Specialist surgical workforce density was reported for 167 countries, with 50.3% meeting the benchmark. Surgical volume was reported for 124 countries, with 31.5% meeting the benchmark. Financial-risk-protection indicators were reported for only five countries, and none met either benchmark. Modelled studies frequently lacked transparency regarding data sources, statistical methods and validation. Conclusion: Reporting of global surgery indicators remains sparse and uneven, particularly in low- and middle-income countries. Integrating surgical indicators into national health information systems should be a priority.

Reference

Anyomih TT, Agbeko AE, Aregawi AB, Chu K, Crawford R, Harrison EM, et al. Systematic review of the Lancet Commission on Global Surgery indicators with quality assessment of modelled estimates. Br J Surg. 2026;113(3):znaf289. doi:10.1093/bjs/znaf289. (PubMed)

NIHR Global Health Research Unit on Global Surgery and the GlobalSurg Collaborative. Safety and equity in scaling minimally invasive surgery worldwide in 109 countries using cholecystectomy as a tracer procedure: a prospective cohort study.

Abstract: Background: Minimally invasive surgery is expanding worldwide, but evidence on how to implement it safely and equitably across different health systems remains limited. This study investigated health-system factors associated with safe implementation using minimally invasive cholecystectomy as a tracer procedure. Methods: A multicentre prospective cohort study was conducted among adults undergoing cholecystectomy in 1218 hospitals across 109 countries. More than 10,000 healthcare workers collected data using measures mapped to WHO health-system building blocks and the Global Patient Safety Action Plan. Results: Among 52,187 patients, adjusted procedure-specific complication rates varied 40-fold between hospitals, from 0.3% to 12.1%. National income level was not independently associated with complications. Local simulation-based training facilities, intraoperative safety and communication strategies, and on-site CT diagnostic capability were

associated with safer outcomes. Conclusion: Safe implementation of minimally invasive surgery varies considerably between hospitals worldwide. Local simulation-based training, safety systems and diagnostic capacity are important modifiable factors for improving surgical safety, particularly in resource-constrained settings.

Reference

NIHR Global Health Research Unit on Global Surgery and the GlobalSurg Collaborative. Safety and equity in scaling minimally invasive surgery worldwide in 109 countries using cholecystectomy as a tracer procedure: a prospective cohort study. Lancet Glob Health. 2026;14(2):e199-e212. doi:10.1016/S2214-109X(25)00476-0. (PubMed)

Multivessel coronary artery bypass grafting via small thoracotomy versus sternotomy (MIST): an investigator-initiated, international, open-label, randomised controlled trial.

Abstract: Background: Coronary artery bypass grafting traditionally requires median sternotomy. Minimally invasive cardiac surgery through a small thoracotomy might improve recovery, but randomised evidence has been limited. Methods: MIST was an international randomised controlled trial conducted at seven centres in Canada, India, China, Germany, the USA and Japan. Adults with multivessel coronary artery disease who were suitable for either minimally invasive CABG or conventional sternotomy CABG were randomly assigned to the two approaches. The primary outcome was patient-reported physical recovery at one month using the SF-36 Physical Component Summary score. Results: Of 176 patients enrolled, 170 were randomised: 86 to minimally invasive CABG and 84 to sternotomy CABG. At one month, the minimally invasive group had a higher mean SF-36 physical-component score than the sternotomy group. There were no deaths or strokes in either group through 12 months.Conclusion: In selected patients undergoing multivessel CABG, minimally invasive surgery through a small thoracotomy was associated with improved patient-reported physical recovery at one month without an apparent safety penalty through 12 months. (ScienceDirect)

Reference

Ruel M, Nambala S, Guo MH, Verevkin A, Rabindranauth P, Kikuchi K, et al. Multivessel coronary artery bypass grafting via small thoracotomy versus sternotomy (MIST): an investigator-initiated, international, open-label, randomised controlled trial. Lancet. 2026;408(10556):711-720. doi:10.1016/S0140-6736(26)01288-2. (PubMed).

Robotic-arm-assisted versus conventional total knee replacement (RACER-Knee): a pragmatic, multicentre, participant-masked and assessor-masked, superiority, randomised controlled trial.

Abstract: Background: Robotic systems are increasingly used during total knee replacement, but whether they improve clinical outcomes compared with conventional instruments remains uncertain. This study assessed the clinical efficacy and cost-effectiveness of robotic-arm-assisted knee replacement. Methods: A pragmatic, participant- and assessor-masked randomised controlled trial was conducted at ten hospitals in Great Britain involving 33 surgeons. Patients with advanced knee osteoarthritis were randomly assigned to conventional or Mako robotic-arm-assisted total knee replacement. The primary outcome was the Forgotten Joint Score at 12 months. Results: Of 807 patients screened, 339 were randomised: 168 to robotic-assisted surgery and 171 to conventional surgery. At 12 months, the mean Forgotten Joint Score was 49.2 in the robotic group and 50.2 in the conventional group. The adjusted difference was −1.5 points (95% CI −7.5 to 4.5; p=0.62). Serious adverse events occurred in 16 participants in each group. Conclusion: In this trial, robotic-assisted knee replacement was more costly and did not provide a clinically meaningful improvement in patient-reported outcomes at 12 months compared with conventional knee replacement.

Reference

Parsons H, Metcalfe A, Griffin J, et al. Robotic-arm-assisted versus conventional total knee replacement (RACER-Knee): a pragmatic, multicentre, participant-masked and assessor-masked, superiority, randomised controlled trial. Lancet. 2026;408(10558):924-934. doi:10.1016/S0140-6736(26)00986-4. (ScienceDirect).

Volume-controlled ventilation versus pressure-controlled ventilation with volume guarantee in emergency surgery: a randomized controlled trial.

Abstract: Background: Emergency laparotomy carries a high risk of postoperative pulmonary complications. Pressure-controlled ventilation with volume guarantee may improve respiratory mechanics compared with conventional volume-controlled ventilation, but its effect on patient outcomes is uncertain. Methods: In this single-centre randomised controlled trial in India, 106 adults undergoing emergency laparotomy were assigned to pressure-controlled ventilation with volume guarantee or conventional volume-controlled ventilation. The primary outcome was postoperative pulmonary complications within seven days.Results: The median postoperative pulmonary-complication score did not differ significantly between groups. Pulmonary complications occurred in 3.8% of patients receiving pressure-controlled ventilation with volume guarantee compared with 17% receiving conventional volume-controlled ventilation. The pressure-controlled strategy improved respiratory-system compliance and reduced mechanical power and driving pressure during surgery. Conclusion: Pressure-controlled ventilation with volume guarantee improved intraoperative respiratory mechanics but did not significantly reduce postoperative pulmonary complications. The relatively small sample means that larger studies are needed to establish whether the physiological improvements translate into meaningful clinical benefits.

Reference

Jassal N, Bhattacharjee S, Choudhary N, Duggal S, Prasad G, Kashyap L, et al. Volume-controlled ventilation versus pressure-controlled ventilation with volume guarantee in emergency surgery: a randomized controlled trial. Surgery. 2026;198:110438. doi:10.1016/j.surg.2026.110438. (PubMed)

CPD Challenge

Questions

Q1 Hydroxyurea Therapy in Sickle Cell Disease: Based on the available evidence on the use of hydroxyurea therapy among adults with sickle cell disease, which of the following is most important for achieving the benefits of treatment?

a. Avoiding all blood transfusions during treatment
b. Adherence to treatment and appropriate clinical monitoring
c. Maintaining low fetal hemoglobin levels
d. Using hydroxyurea only during vaso-occlusive crises
e. Discontinuing treatment once symptoms improve

Q2 Simulation-Based Education in Competency-Based Curricula: Regarding the introduction of simulation-based education into a competency-based curriculum, which of the following approaches is most likely to support effective learning?

a. Having students primarily observe simulations conducted by experienced facilitators
b. Minimizing discussion of learning objectives to allow students to discover them independently
c. Providing instructional and psychological support, actively involving students in the simulation, and encouraging discussion of the learning objectives
d. Conducting simulations without facilitator involvement to promote complete student independence
e. Focusing primarily on technical skills while leaving clinical reasoning to conventional classroom teaching

Q3 Communication Skills Training: Based on the available evidence on communication skills training, which curriculum change would most directly address an important gap identified by students?

a. Increasing didactic lectures on communication while reducing experiential learning
b. Increasing training in history-taking while reducing opportunities for practical communication
c. Increasing opportunities for practical, context-specific communication training and positive role-modelling by senior doctors
d. Allowing students to develop communication skills independently without observing practicing clinicians
e. Focusing communication training primarily on written communication rather than patient encounters

Q4 Global Surgery Indicators: Based on a systematic review of the Lancet Commission on Global Surgery indicators, which action would most directly address a major gap identified by the review?

a. Prioritizing an increase in the number of specialist surgeons without routinely measuring other indicators
b. Replacing national surgical indicators with hospital-level patient-satisfaction measures
c. Integrating surgical indicators into national health information systems and strengthening routine reporting
d. Relying primarily on modelled estimates because national data are generally unavailable
e. Focusing exclusively on increasing surgical volume as the principal measure of surgical-system performance

Q5 Robotic-Assisted Total Knee Replacement: In considering the adoption of an expensive robotic system for total knee replacement, which interpretation of the RACER-Knee trial is most appropriate when discussing the evidence with clinical and hospital management teams?

a. Robotic-assisted surgery should replace conventional knee replacement because it significantly improves patient-reported outcomes
b. Robotic-assisted surgery reduced serious adverse events compared with conventional surgery
c. Robotic-assisted surgery produced a clinically meaningful improvement in the Forgotten Joint Score at 12 months
d. Robotic-assisted surgery was more costly but did not demonstrate a clinically meaningful improvement in the primary patient-reported outcome
e. The trial demonstrated that robotic-assisted surgery is ineffective for all patients undergoing knee replacement

Answers

1. b).
2. c).
3. c).
4. c).
5. d).

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