An Occasional Rural Miscellany

August 2016

The Heat takes its toll in rural areas across the Northern Hemisphere

We in Europe have been sweltering in extreme hot weather since late May, leading to unprecedented wildfires and droughts. As things stand there appears to be no likely improvement in the near future. Many of you living in naturally hot climates will wonder what the fuss is about.
Summer temperatures in the Northern Hemisphere have been creeping up over a number of years, almost certainly due to Climate Change. It's not only the richer countries of Western Europe that have been suffering but the impact on low and middle income countries has been even greater.
The impact of climate change will be greatest on rural areas and their vulnerable populations. 70% of the world's poorest people live in rural areas and three out of four people living in rural poverty rely on subsistence farming, relying on agriculture and natural resources for survival.
The higher temperatures will result in rising sea levels, increasing heat related deaths, droughts and the degradation of soils leading to reduced agricultural output. Rising temperatures will also reduce the time that farmers can spend working in the fields
The "Push" factor will result in people leaving their resource-dependent rural areas, creating new migration patterns to urban areas and crossing borders to other countries.
In India for example the extreme heat wave has taken its toll on remote villages. Recent investigation reports on record-breaking heatwaves in South Asia emphasised that heat-related deaths are heavily undercounted in rural, low-income farming villages. Isolated communities without air conditioning or rapid emergency transport suffer high casualties during heat spikes, prompting clinicians to demand dedicated heatstroke treatment centres in rural primary care networks.

I found this article in the Guardian

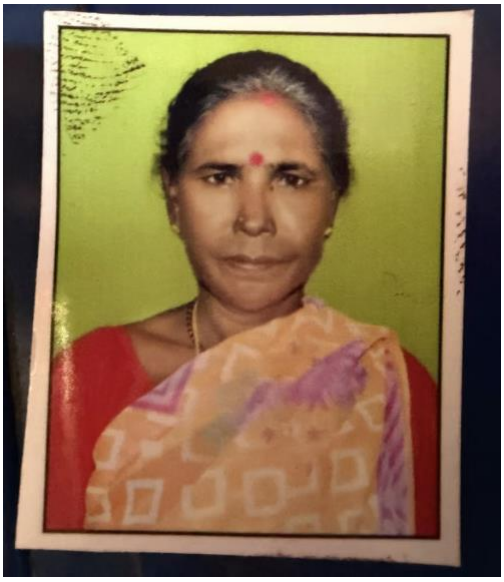
‘The heat took him from me’: India’s death toll rises amid escalating heat crisis

As extreme heat claims the lives of workers in India’s poorest areas, many fear the true mortality rate is being dangerously undercounted.

The morning air was already hot and cloying when Palli Mahalaxmi rose at about 5am. It was May, and in the summer heatwave that had engulfed this corner of southern India, even night-time did not give the villagers respite.

A single ceiling fan hung above Mahalaxmi, her husband and her son as they slept in a small windowless room made of thick concrete. Mahalaxmi set about preparing breakfast, and the family ate together from steel plates, just as they did every morning. Sweat dripped from their foreheads as the sun rose higher.

Just before 6am, Mahalaxmi filled up her water bottle and headed out to work. As others filed out of their small, brightly painted houses on to the dusty village road, Mahalaxmi greeted them, smiling and exuberant as always. Chatting as they walked towards the fields where they would be working that morning, the women covered their faces; it would be another painfully hot day.



Like many in Busabhadra, an impoverished rural village in the south Indian state of Andhra Pradesh, Mahalaxmi relied on a government scheme to provide her with work. The rural employment scheme, introduced 20 years ago, guarantees 100 days of paid work to poor households outside of cities and employs more than 80 million people across India.

Though the work was tough, manual labour in fields, on construction sites and in road building for just 180 rupees a day (£1.41) was still a lifeline to 50-year-old Mahalaxmi. With her husband unable to work, a disabled son and debt from her daughter’s wedding, the scheme kept them alive. She could not afford to miss a day.

That day Mahalaxmi and a group of women were digging a water reservoir by the river in rice fields with no trees to provide shade even as the temperature soared above 40C.

Working alongside Mahalaxmi was her friend Parvati Purilla, 45, who recalled that the only thing anyone could speak about that day was the heat, most of them exhausted before they got to work. “The heat was terrible and that makes the work very difficult,” said Purilla. “When you drink water, you just sweat it out immediately. Sometimes we got dizzy – but what choice do we have?” It did not take long for the women to run out of drinking water.

However, Mahalaxmi was not disgruntled. “She was the most active person in our group and always seemed happy,” said Purilla. “She never seemed to run out of energy and never complained of any aches or illnesses. She worked more than most of us.”

By 11am, the first shift of their day was over. The women headed home, exchanging few words due to their exhaustion. Mahalaxmi did not speak when she got home, but went straight to the bedroom where she collapsed in apparent sleep.
Unable to rouse her hours later, her husband, Palli Shyam Sundha Rao, rushed to find a doctor. Examining her lifeless body, the doctor concluded Mahalaxmi had died from heatstroke.
Continue reading:-
https://www.theguardian.com/world/2026/jul/29/extreme-heat-deaths-india-climate-crisis-environment#:~:text=Doctors%20across%20India%20said%20heat%20deaths%20were,the%20trees%2C%20but%20it%20made%20little%20difference.

Heat

By Hilda Doolittle

O wind, rend open the heat,
cut apart the heat,
rend it to tatters.

Fruit cannot drop
through this thick air—
fruit cannot fall into heat
that presses up and blunts
the points of pears
and rounds the grapes.

Cut the heat—
plough through it,
turning it on either side
of your path.

The Heat

by Zoe Bogart

When the heat comes, it falls
Just like a heavy tablecloth
Folding into little rivulets and sloppy waves.
But instead of landing on glossy wood
And billowing slightly under the chink of glass and china
Instead of rustling to the hum of pleasant conversation
The heat sinks into the rough, scarred road
Into the rough, scarred cars
Into the rough, scarred people.
The heat pours into their throats and ears.
It fills their lungs with a smothering staleness.
The heat blots out the conscientiousness
That made billy pick up the litter
That kept tracy from slamming the door.
Under heat, the lightness is lethargy

The buckled-up discontent bursts
And the delicate brain-curves unravel.

Wildfire

By Joan Kwon Glass (after Anne Sexton)

For three days, yellow haze has enveloped
the coast, bathing this city in unease,

coating our narrowing throats. Another year
has passed without you. Today, your daughter,

now ten, asked if you left a note.
More questions will come.

It is June, and I have never been brave.
Wildfires can cast their smoke across borders

but you stay dead. My grief stalls
at the edges of every map, a hammer

demanding I find new ways to remain a nail.
No one can say for sure how long

the forests will burn. I am finally less angry.
This feels like something else to mourn.

What will fill my lungs?

Stay inside, they say on the news.
Save your breath and imagine coordinates

that do not exist. Be an obedient nail.
Shut the windows tight, and wait.

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Global should also mean local

I have to congratulate Pratyush and colleagues on the great work that they are doing globally on rural health care. We must not however ignore regional and local communities and how they are already working to improve rural health care in their own domains.
There was a saying that we have all used for some time that reflects the diversity of Rural Health and Rural Practice around the world which said:

"Think Global but Act Local"

I have always believed that we should work to foster regional groups around the world based on each of the regions of WONCA and their regional WHO offices. The concept of rural is so

globally diverse and one approach does not fit all. Rural wellbeing has a very local flavour depending on where you are and it is influenced by culture, economics, universality of care, geography, demography, politics etc.....

EURIPA is the Rural Network for the continent of Europe. It was established in 1997 and has grown significantly since. It's been a long hard journey convincing urban colleagues in WONCA Europe of the importance of including rural communities and the rural practice.

Current estimates of the size of Europe's rural population varies between 25-30% yet until EURIPA was established no specific organisation represented the rural practice.
Europe is bigger than one might suggest, reaching eastwards across the Urals and into the Caucuses. Although we would consider our successes in Western Europe, we have much to do further east.

EURIPA has a permanent seat on WONCA Europe's Executive, ensuring that there is always a rural voice and an opportunity to Rural Proof its deliberations.

One of the recent crises has been the growing medical deserts reflecting the global issue that health care professionals are no longer attracted to rural practice.

EURIPA has an active research group and I include a recent plea to involve more grassroots health professionals in rural research.

The diversity of rural health needs across the world necessitates the need for similar groups in every WONCA and WHO Region. We must work hard to foster the establishment and growth of Regional Rural Wonca Groups.

EURIPA's Research Priorities for 2025–2028

- Artificial intelligence in rural primary care: complementing clinical judgment and promoting equity
- Use of technology in rural primary care to enhance continuity of care and reduce health inequalities
- Enhancing diagnostic confidence through evidence-based near-patient diagnostics in rural general practice
- Multidisciplinary teams in rural primary care across Europe: achieving a needs-based workforce planning approach to inform skill-mix required to meet community needs
- Awareness and perceptions of social prescribing to address social determinants of health in rural and underserved areas among healthcare students in European universities

If you are interested to get involved, you can become a member and contact us at secretary@euripa.org

The European Rural and Isolated Practitioners Association

Are you interested in research in rural primary care?

https://www.europa.org/page/home

EURIPA is a representative WONCA Europe network founded by family doctors to address the health and wellbeing needs of rural communities and the professional needs of those serving them across Europe.

Members are involved in various research projects . The projects encompass topics relevant to health and primary health care delivery in rural areas such as rural social and political determinants of health, education and workforce, and innovative service delivery models to overcome geographical barriers.

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News from AfroPHC

Hidden Maternal Health Crisis Deepens in DR Congo as Ebola Outbreak Becomes the Country's Largest on Record

(Source: PMNCH/UNFPA, 26 July 2026)

UNFPA reports that maternal deaths in Ituri Province, Democratic Republic of the Congo, have more than doubled since 25 May 2026, rising from an average of 3.1 to 5.8 deaths per week, as fear and stigma linked to the country's Ebola outbreak keep pregnant women away from health facilities. Around 63,700 pregnant women are in affected areas, and Ebola infection during pregnancy carries a near-100% fetal loss rate. Midwife Francine Evhe said: "Despite the severity of Ebola, I have a duty as a midwife to support women and girls and to save lives." UNFPA humanitarian specialist Pacifique Kigongwe said: "When health services are overwhelmed and fear keeps people away from healthcare, it is women, girls and children who pay the highest price." The crisis is compounded by insecurity, conflict, repeated displacement and funding cuts to humanitarian operations. Separately, WHO said on 2 August 2026 that the Ebola outbreak itself is now "the largest recorded Ebola virus disease outbreak in the country," with 3,605 confirmed cases and 1,587 deaths as of 30 July — a 44% case fatality rate — spreading from Ituri into four further provinces. ... read more .

More Worth Exploring

Nigeria's Federal Government releases ₦32.88bn to sustain primary healthcare nationwide (Source: Tribune Online, July 2026)
Nigeria's Federal Government approved disbursement of ₦32.88 billion under the Basic Healthcare Provision Fund (BHCPF) for the second quarter of 2026, at the 15th Expanded Ministerial Oversight Committee meeting chaired by Coordinating Minister of Health and Social

Welfare Prof. Muhammad Ali Pate. The fund has supported the upgrade of more than 3,000 primary healthcare centres, emergency medical services for over 130,000 Nigerians, and expansion of national health insurance coverage from around 15 million to over 22 million beneficiaries. ... read more .

9th WONCA Africa Region Conference announced for Gaborone, Botswana
(Source: woncaafrica2026.org)
The 9th WONCA Africa Region Conference will be held in Gaborone, Botswana on 10–11 September 2026, under the theme "We Are One: Africa United to advance planetary health through collaboration and resource alignment in Primary Health Care." Co-chaired by Dr Claire Brockbank and Prof Billy Tsima, the conference will bring together family doctors, primary health care providers, educators, researchers and policymakers, with a pre-conference PRIMAFAMED session and French-language support for francophone participants. ... read more .

Kenya to showcase Taifa Care Model at 13th East Africa Healthcare Federation Conference
(Source: ZAWYA press release, August 2026)
Kenya's Health Cabinet Secretary Hon. Aden Duale and the Kenya Healthcare Federation, led by Chairperson Dr Kanyenje Gakombe, will represent the country at the 13th East Africa Healthcare Federation Conference and International Health Exhibition, to be held in Ethiopia from 21–23 August 2026 under the theme "Resilience: Building the East African Health Economy." Kenya plans to showcase its Taifa Care Model, covering reforms in health financing, digital health, primary health care and strategic partnerships in pursuit of universal health coverage. ... read more .

Strengthening rural health information systems in West Africa
(Source: HIFA email, 4 August 2026)
Dr Uzodinma Adirieje of Afrihealth Optonet Association shared an analysis on HIFA arguing that routine health information systems (RHIS) in rural West Africa remain undermined by weak infrastructure, intermittent electricity, limited connectivity and fragmented reporting, forcing frontline workers to prioritise clinical care over administrative logging. The piece points to the West African Health Organization's work consolidating health indicators across the 15 ECOWAS member states as an example of standardised data architecture, and argues that transitioning from donor-driven digital health projects to state-funded, institutionalised systems is the benchmark for sustainable RHIS maturity in the region. ... read more .

WHO study finds foodborne disease burden comparable to TB, HIV and malaria
(Source: HIFA email, 4 August 2026)
Neil Pakenham-Walsh shared on HIFA a new WHO data synthesis published in The Lancet Global Health, covering 42 foodborne infectious and chemical hazards for 2000–21, which concludes that "foodborne diseases cause a burden similar to that from tuberculosis, HIV and AIDS, or malaria" and that countries need to prioritise strategies to improve food supply safety. Pakenham-Walsh commented that required measures include food hygiene training among those who store, prepare and cook food, citing a related 2023 review that found inadequate knowledge among street food vendors in low- and middle-income countries. ... read more .

WHO Bulletin's August issue published, covering asthma/COPD guidance and emergency health workforce readiness
(Source: WHO Bulletin email, 3 August 2026)
The World Health Organization's Bulletin (Volume 104, Number 8) was published on 3 August 2026, including an editorial by Tara Ballav Adhikari, Mohammad-Mahdi Rashidi, Patricia Alupo, Alarcos Cieza and Sarah Rylance on new WHO guidance for asthma and chronic obstructive pulmonary disease, and a call for papers by Flavio Salio, Abdi Rahman Mahamud, Sara Hersey and Chikwe Ihekweazu on preparing an emergency-ready health workforce. ... read more .

HIFA welcomes Nnamdi Umelo as new Nigeria Country Representative
(Source: HIFA email, 31 July–2 August 2026)
Nnamdi Umelo, a medical student at Usmanu Danfodiyo University Teaching Hospital in Sokoto, Nigeria, introduced himself on HIFA as the network's newly appointed Country Representative for Nigeria. HIFA coordinator Neil Pakenham-Walsh welcomed him, noting that Nigeria currently has 1,583 members on HIFA and that the network looks forward to growing this further with his help. ... read more .

WHO health financing progress matrix assessment for South Africa (2025)
(Source: Google Scholar Alert / WHO IRIS, 2026)
A WHO report titled "Health financing progress matrix assessment, South Africa 2025: summary of findings and recommendations" assesses South Africa's progress against recognised benchmarks for sustained movement towards universal health coverage. Per the available summary, the report addresses equitable and integrated pooling arrangements and the strengthening of strategic purchasing. *(Google Scholar alert notification — full report text not independently verified beyond this summary.)* ... read more .

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Report from the 9th Ibero-American Congress of Family Medicine

Dr Juan Carlos Perozo García

I feel that I have known this remarkable clinician and educator from Venezuala for a long time but sadly, I have not met him. Its one of the benefits of global communications and

social media. Dr Juan Carlos is 2026 Montegut Scholar, Secretary for Inter-Institutional Relations of the Venezuelan Society of Family Medicine (SOVEMEFA) and Coordinator of the Working Group on Rural and Community Medicine of CIMF,
He attended the 9th Ibero-American Congress of Family Medicine, held in the city of Asunción, Paraguay, from 22 to 25 July 2026.
This is his report:

“I extend my most sincere and heartfelt thanks to the World Organization of Family Doctors (WONCA) for awarding me the prestigious Montegut Scholarship, an invaluable distinction that made my participation possible in the 9th Ibero-American Congress of Family Medicine, held in the city of Asunción, Paraguay, from 22 to 25 July 2026. This institutional support was not only a decisive stimulus in academic and professional terms, it was also a vital channel for raising the profile of Venezuelan family medicine within the Ibero-American context and for building networks of international cooperation, while at the same time becoming a platform for the exchange of knowledge, experience and culture that enriches the soul.
It was a very well structured and comprehensive programme. Over the days of the congress, I had the opportunity to take part directly and prominently in several central activities. First, I joined the panel "Weaving links between University and Community in Ibero-America", an academic exchange of the highest level, where I shared reflections and analysis alongside distinguished colleagues and leading figures from Argentina, Brazil, Colombia, Cuba, Chile, Spain and Venezuela.
During this session we examined in depth how universities strengthen their links with the community through comprehensive medical training, participatory research and university social responsibility. The diversity of experiences shared allowed us to build collective knowledge around the integration of teaching and clinical care, and around the need to train health professionals with a strong sense of place and social commitment, able to understand local knowledge and to generate the active and productive participation of communities. In my own case, this contribution draws on my years of academic preparation and work at the Francisco de Miranda National Experimental University (UNEFM) in Falcón state, Venezuela, an experience that has given me direct understanding of the importance of drawing the university and the community closer together, and of strengthening training that is committed to the social and territorial reality of our country.
Another central contribution was in the Forum dedicated to the Working Groups of the Ibero-American Confederation of Family Medicine (CIMF). As Coordinator of the Working Group on Rural and Community Medicine, I presented the lines of action, the progress and the strategic goals we are pursuing to raise the profile of health realities in the region's rural settings. This session highlighted the urgency of connecting local knowledge with daily clinical practice, ensuring that the specialty responds with equity, social justice and adaptability to the needs of the most remote and vulnerable populations, understanding that this requires a committed and thoroughly trained team, which makes institutional support a vital component.
I also took part in the meeting on certification and recertification, which addressed a subject of great importance for the region, on the road towards the first meeting of governing bodies for certification and recertification in Ibero-America, to be held on 22 and 23 October 2026 in Bogotá, Colombia. This session allowed us to reflect on the need to strengthen the processes of accreditation and professional recognition, as part of the regional commitment to quality, continuing professional development and excellence in the training and practice of family medicine.

In the field of continuing medical education and personal development, I had a deeply enriching experience taking an active part in the Workshop on Leadership led by Dr Viviana Martínez-Bianchi and Dr María del Pilar Astier. This meeting was an extraordinary space to discuss and understand the pressing need to build the kind of leadership our communities and organisations require, with the emphasis that leadership growth should take place with the support, guidance and mentorship of experts, in order to steer the processes of transformation in primary care effectively.

In the area of institutional governance, I took on with a strong sense of duty the responsibility of representing Dr Luis Jaua, president of the Venezuelan Society of Family Medicine (SOVEMEFA), in my capacity as Secretary for Inter-Institutional Relations of our organisation, during the CIMF Executive Session. Being present at this senior meeting allowed me to witness and support at close hand the extraordinary organisational effort led by the president of the CIMF, Dr Dora Bernal, together with the members of the Executive Committee and the representatives of the Confederation's 20 member countries, confirming a professional cohesion and a strategic vision of great significance for the future of family medicine on the continent.

I want to highlight that the whole congress programme was marked by impeccable scientific organisation, with carefully developed and interesting topics. This academic excellence was accompanied throughout by the unrivalled warmth of the Paraguayan people and the faultless work of the Local Organising Committee, ably led by Dr Federico Lezcano, who ensured an outstanding welcome for all international delegates.

I close this account by reaffirming my commitment and by sending a message of deep fellowship and hope to family doctors across the whole Ibero-American region and, very especially, to my colleagues in Venezuela. To all those who give of their vocation day after day in every clinic, classroom and rural community of our country: family medicine is the beating heart of health systems and the beacon that guides social equity. The experience of this congress shows us that we are not alone, that the dedicated work we carry out from our own territories resonates within, and contributes to, an interconnected global network. Let us keep building, with scientific rigour, transformative leadership and human sensitivity, the strong, dignified and committed primary care that our families and communities deserve, under the motto Oñondivepa, "all together".

This congress has without doubt been an event without precedent that places the name of family medicine in the region on the highest ground. The experiences, alliances and academic exchanges achieved will serve as direct inspiration and a driving force for the development of the specialty in Venezuela, both in universities and in community practice. I reiterate my

gratitude to WONCA for placing its trust in me and making this important experience of Ibero-American integration possible.
Dr Juan Carlos Perozo García
Secretary for Inter-Institutional Relations of the Venezuelan Society of Family Medicine (SOVEMEFA)
Coordinator of the Working Group on Rural and Community Medicine of the CIMF"

Read Dr Juan Carlos Perozo García's WONCA Featured Doctor profile

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WONCA Young Family Doctors NCD Fellowship

THE NCD FELLOWSHIP BEGINS: WONCA is delighted to announce that the first cohort of the Young Family Doctors NCD Fellowship is now under way. Seven early-career family doctors, drawn from six WONCA regions, begin a ten-month programme to build their leadership and clinical skills in the prevention and management of noncommunicable diseases in primary care. The fellowship is an initiative of the WONCA Special Interest Group on Noncommunicable Diseases, chaired by Dr Mona Osman, and is supported by an independent educational grant from AstraZeneca. This is just the beginning: we will share more about the fellows and their projects as the programme progresses.

Together, they will design and implement locally-grounded quality improvement projects, participate in monthly educational workshops, and engage in structured mentorship throughout the programme. Two of the six workshops will be open to the broader primary care community worldwide.
https://www.globalfamilydoctor.com/News/NCDFellowshipFirstCohort.aspx

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Conferences and Events

15th EURIPA Rural Health Forum
1- 3 October 2026 • Cartagena, Spain

https://forum.euripa.org/

Welcome to our fourth Newsreel for the 15th EURIPA Rural Health Forum!
We are delighted to be able to tell you that EURIPA has received a record number of abstracts, which were also of outstanding quality,for this year's 15th EURIPA Rural Health Forum.
The response from the rural and isolated practice community across Europe has been exceptional, both in volume and in scientific quality.
A record-breaking response! With 91 abstracts from 21 countries.
EURIPA 2026 promises to deliver our strongest scientific programme to date.
From original research and practical workshops to innovative case discussions, Cartagena will showcase the diversity, creativity and resilience of rural primary care across Europe.

The 15th EURIPA Rural Health Forum will be held in Cartagena, Spain, from October 1–3, 2026. Themed "Embracing Rural Diversity", this major healthcare event brings together professionals, researchers, and community leaders to address the specific healthcare and wellbeing challenges faced by rural populations.

Event Details and Registration

- **Location:** El Batel Congress Centre, Cartagena, Spain
- **Dates:** October 1–3, 2026
- **Registration:** Early bird rates apply until August 20, 2026, with fees set at €50 for students and €175 for young doctors and other healthcare professionals. You can secure your spot via the EURIPA Forum Registration

The deadline for abstract submission: 14 June 2026

What's next?

The enthusiasm shown by our community has been truly inspiring. Alongside a record number of high-quality abstracts, we have received an excellent response to both the EURIPA Bursary Scheme and the launch of the Rural Exchange Programme.
It is particularly encouraging to see so many young family doctors eager to contribute to the future of rural healthcare through research, collaboration and international exchange.
Successful abstract and bursary applicants will be notified by 9 August 2026, while successful applicants to the EURIPA Rural Exchange Programme will be informed from 15 August 2026 onwards, following the completion of the matching process.
Once the review process is complete, we look forward to unveiling the full scientific programme.
A first look at the programme!
The programme for the Forum is developing, and we are pleased to announce our four keynote speakers:
-Viviana Bianchi, President, WONCA World
-Gabriella Civico, Director, Centre for European Volunteering (CEV)
-José María Pérez Toribio, General Subdirector of Marine Social Action, Marine Social Institute, Ministry of Inclusion, Social Security and Migrations
-Theadora Koller-Swift, Senior Technical Lead/Unit Head, Health Equity, WHO Europe

The speakers will be reflecting the title of the Forum "Embracing Rural Diversity" and the two sub themes of

- Rural diversity across Europe and within communities
- Diverse approaches to delivering rural primary care.

The two panel discussions will be led by:
-Defining Rurality: Juan Rafael Morillas Martínez, General Practitioner and Director of Marquesado Health Center, Andalusian Health Service and Anette Fosse, Director National Centre for Rural Medicine, Norway.
-A vision for the future of rural primary care: Guillermo Viguera Alonso, General Practitioner in Illuerca Health Center, Aragonese Health Service; Member of the Young Researcher Doctors group in SEMFYC; Member of the Aragón Primary Care Research Network (GAIAP) and David Halata, GP Czech Republic and EURIPA Executive Committee member.

Why you shouldn't miss EURIPA 2026

- Connect with rural colleagues from across Europe
- Learn from internationally recognised speakers
- Discover innovative ideas to improve rural healthcare
- Build new collaborations through research and the Rural Exchange Programme

- 🏛️ Experience the unique history and Mediterranean atmosphere of Cartagena

https://www.euripa.org/

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9th World One Health Congress

September 4-7, 2026, Lisbon, Portugal
Organized by the Global One Health Community, the 9th World One Health Congress will bring together a global community of experts dedicated to advancing One Health science and policy. Over the course of four days, the Congress will feature a dynamic and forward-thinking agenda, with parallel tracks covering One Health science, antimicrobial agents and resistance, and the science-policy interface, among other critical topics. This leading international forum will foster discussions on major One Health challenges, facilitate the exchange of cutting-edge research, and highlight policy developments shaping the future of health for humans, animals, and the environment. https://globalohc.org/9WOHC
https://globalohc.org/9WOHC

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Other Conferences:

9th WONCA Africa Region Conference
Gaborone, Botswana
Dates: 10 – 11 September 2026.
Submit your abstract by 28 February 2026.

East Mediterranean Region Conference
Cairo, Egypt
Dates: 29 - 31 October 2026.

WONCA WORLD CONFERENCE 2027
Cape Town, South Africa
Dates: 3 - 7 November 2027

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Education, Webinars, Videos and Podcasts

The Lancet Voice

What's happening in Latin America?

What are the major stories in health in Latin America? Lancet editors Niall Boyce and Miriam Sabin and Lancet Regional Health: Americas Editor-in-Chief Taissa Vila are joined by Harvard University's Marcia de Castro to discuss challenges, resilience, and innovation.
https://www.thelancet.com/audio-do/whats-happening-latin-america

Research integrity in the age of AI

Retracted articles hit a high of 10,000 in 2023, representing an increase of almost ten times in ten years. The introduction of AI brings incredible benefits to science, but could also add to the seemingly endless tide of papers that are fraudulent, misleading, or just plain wrong. What can journals such as The Lancet do to rise to this challenge, keeping the scientific record accurate, honest, and transparent? Editors Niall Boyce and Sabine Kleinert are joined by Professor Lex Bouter from Vrije Universiteit Amsterdam, and Professor Mai Har Sham of the Chinese University of Hong Kong to discuss a new Lancet Commission.
https://www.thelancet.com/audio-do/research-integrity-age-ai

Science Podcast

\Health care in Malawi after USAID's end, and a rocky exoplanet with an atmosphere

First up on the podcast, we continue our coverage of the fallout from cuts to the U.S. Agency for International Development (USAID), this time focusing on how one of the largest recipients of aid is coping 18 months later. Contributing Correspondent Catherine Offord talks about her trip to Malawi and the efforts to strengthen their health infrastructure in the wake of funding shocks.
https://www.science.org/content/podcast/health-care-malawi-after-usaid-s-end-and-rocky-exoplanet-atmosphere?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=podcast&et_rid=1169729274&et_cid=6014374

Nature Podcasts

Briefing Chat: The 30 year-legacy of a science icon — Dolly the sheep

Nature staff discuss the landmark moment when a mammal was first cloned from an adult cell — plus, the first direct observation of ocean-floor crust being created.
https://www.nature.com/articles/d41586-026-02185-1

Togetherness: How cooperation built the world

Science journalist Rowan Hooper joins us to talk about symbiosis and the importance of organisms working together.
In this episode, we speak with science journalist Rowan Hooper, whose book Togetherness: Symbiosis and the Hidden Story of Life's Greatest Collaborations takes a deep-dive into the world of cooperation between organisms.
In the book, he argues that collaboration in nature has often been overlooked in favour of competition, and that organisms working together have played a crucial role in making the world the way it is.
https://www.nature.com/articles/d41586-026-02067-6

NEJM Podcasts

Products That Pose Health Risks — Can Litigation Protect Us When Government Fails?

We've been here before, at least twice.
A powerful and influential corporation was reaping large profits from a lucrative product that posed a health risk; both Congress and the executive branch of the U.S. government seemed unable to correct the problem, or chose not to. Governmental paralysis had led to impotence, as paralysis often does. Eventually, it was the victims themselves who achieved accountability. Some were represented by state attorneys general, others by aggressive private lawyers. They wielded the cudgel of litigation to demand justice, and it worked: the responsible companies were forced to pay out enormous sums for purveying products that created a health hazard. People speculated that the outcome might unleash a tsunami of litigation that could finally bring justice to millions of other victims whose well-being was seriously damaged by a corporate environment that prioritized profits over users' health. It looked as if these court cases might finally bring an end to the many years of legislative and regulatory inaction that had allowed the problem to fester for so long.
https://www.nejm.org/doi/full/10.1056/NEJMp2604841?query=TOC&cid=DM2459146_NEJM_Non_Subscriber&bid=-678085706

Rural Road to Health Podcast

Prof Alexandra Johnstone & Dr Daniel Crabtree - Rural Food Environments- Rural Road to Health
https://theruralroadtohealth.blog/podcast/

Prof Alexandra Johnstone and Dr Daniel Crabtree are from Scotland. Prof Johnstone is Chair in Human Nutrition at the University of Aberdeen. She is currently leading on a UKRI Transforming Food Systems Grant focusing on Food Insecurity and Obesity. Dr Crabtree is a Research Fellow with the NIHR-funded Health Determinants Research Collaboration Aberdeen and has previously worked with the University of Aberdeen and the University of the Highlands and Islands. Episode summary: 01.30 Alex and Dan share more about their background and their interest in rural communities 04.10 What are food environments and why do they matter? 10.20 How might rural food environments be different? 14.30 How is food insecurity being managed in Scotland and the UK? 18.00 How does inequity impact rural food environments? 20.30 How much is climate change impacting food security for the UK and globally? 26.10 What are some of the key issues when thinking about food insecurity and obesity? 33.00 What is the role of local retailers? 38.00 What impact does less access to healthy food have in rural and remote communities? 41.30 What are some key insights and policy recommendations from their work? Key Messages: Food environments are everything from the farm to the fork or from soil to sewage. It involves numerous stakeholders. We have a huge proportion of people living with obesity, it has a higher prevalence in areas of social deprivation. It is not about blaming individuals but about how we can change the food environment to make it easier to make healthy choices. BridgeAct was a project which developed an interactive toolkit for transforming food systems, it helps decision makers plan effective impact delivery strategies. It was tested by Aberdeen city council. Food insecurity having the fear of not having enough food to feed your family over the next week. Food security is more about imports and exports and having food available at a national level. Remote and rural communities do encounter unique challenges when trying to access healthy and affordable food. This can include disruptions to long food supply chains, often this impacts island communities more often. Food delivery services are more common in urban areas but in rural and remote areas they are often not available. People living in rural and remote communities depend on cars and fuel to access supermarkets. The food can be more expensive but so can the cost of petrol. Public transport can be unreliable or non-existent. Food that is produced in rural farming communities is often not consumed there but sent away for packaging and then potentially resold to them. Surveys of people have shown that low prices on healthy and sustainable foods, particularly staples, would help families plan their food purchases allowing for better food budgeting and meal plans. There is complexity around promoting healthy food, there is no uniform definition of what a healthy sustainable food would be. When oil prices increase this has a huge impact on spending in rural and remote areas, not just for food purchases, but also the ability to get to work or take children to school. Global warming impacts food production and our ability to have enough food to feed our populations. It impacts food systems and health systems and people's ability to stay well. Vertical farms have controlled environmental conditions, they may not be the most environmentally friendly solutions as they require electricity, but they do allow communities to grow food all year round. Investment in local food production may be a way to improve local food system resilience. Local communities of practice may also be useful for practices and strategies to guard against food shortages. The ask for retailers is to offer a range of foods that are both healthy and environmentally sustainable, this would include fresh food but also frozen and tinned produce which has a longer shelf life. The paradox of food insecurity and obesity, someone with a limited income to spend on food, they are more likely to make choices to buy the foods with the lowest cost. These tend to be foods high in fat, sugar and salt, this then drives rise in obesity. Food costs have increased by 40% in the last five years. This means people rely on discounts and offers which are often for unhealthy foods. If a community only has a small local convenience store, then you will struggle to access fresh nutritious food. The food there is also often much more expensive. Rural and

remote populations do not always have the option to choose a different retailer if they are not satisfied with what is available, however many accept that this is part of life in those communities. The local retailer also has an important role in those communities as they can often provide much needed spaces for social interactions. Explored facilitators and barriers to accessing healthy food for older adults living in rural and remote areas. Barriers around price, distribution and access, however older adults may be less inclined to cook for themselves. Lunch clubs can be ways to improve social connection and nutrition. In the tourist season on the islands this can lead to food shortages and requires a change to meal plans. Price is the greatest barrier preventing healthy food purchasing. Policymakers could level the playing field and compel all supermarkets to price healthy foods in line with inflation to ensure more equitable access for all. Legislation to prioritize healthy food promotion. Reducing ultraprocessed food and prohibiting them to be placed on the shelves at promotional prices. Prioritize long term funding commitment for local initiative in rural and island communities. Investment in community food preparation and storage facilities, this can help buffer impacts of shocks to local food systems. Supporting communities of practice and making food supply chains more resilient. Contact info for Prof Johnstone and Dr Crabtree Thank you for listening to the Rural Road to Health! Rural Health Compass https://theruralroadtohealth.blog/podcast/

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New articles published in Rural and Remote Health

Health professional productivity in Ethiopian hospitals: evidence from a multicenter time–motion study

Health worker productivity is a core determinant of health system performance, especially in low- and middle-income countries where shortages of skilled professionals constrain service availability and quality. Efficient utilization of available working hours is particularly critical in rural and remote settings, where geographic isolation, limited resources, and staffing shortages intensify system pressures. This Original Research study reports on the results of a multi-site time–motion assessment in public and private hospitals, including rural hospitals, across Ethiopia. By quantifying productive and non-productive time and examining associated factors such as experience, training, supervision, and workload, this study provides

context-specific insights crucial for informing workforce optimization in Ethiopia's rural health system.
https://www.rrh.org.au/landing/newarticle10953/lin/

10344 - Latin America - Association between very high altitude and frailty syndrome in rural community residents of Junín Department, Peru

Providing for the healthcare needs of an aging population represents one of the most important challenges of the 21st century. In Peru, frailty syndrome, which becomes more common with age, has been found to be more prevalent in high-altitude Andean communities than elsewhere in Peru. This Original Research article investigates the association between very high altitude and frailty syndrome in rural community residents of the central Peruvian Andes.

10666 - Europe - Building a lifesaving network: public access defibrillation across the challenging terrain of Crete

In Greece, every public service, private enterprise or organization where large numbers of people gather is obliged to have an automatic external defibrillator (AED), and CPR training is mandatory for sport trainers, lifeguards and employees of large organizations. Despite this, several issues continue to hamper the effectiveness of public access defibrillation (PAD), including lack of awareness and training and inaccessible or out-of-service AEDs. To overcome these issues, an innovative initiative aimed at establishing an effective PAD program was recently launched in Crete. This Project Report describes the establishment of, and results from the first 8 months of implementation for, the first organized PAD program in Greece.

Consumer-driven approach to determining health research priorities: what matters most to people living in rural Australia?

Rural, regional and remote (henceforth rural) communities face unique health challenges, including limited access to healthcare, workforce shortages, and higher disease burden. Consumer and community involvement (CCI) is essential for addressing real-world health needs and fostering equity, yet its role in shaping research priorities remains largely underexplored, particularly in rural contexts. This study aims to identify consumer priorities for rural health research in Australiaand to describe the process and learnings of a novel approach to promoting involvement of rural consumers in health research.
https://www.rrh.org.au/journal/early_abstract/9949/

Are there more healthcare workers in our community? A phenomenological exploration of factors influencing local hospital and primary care worker re-engagement in rural Australia

The local healthcare workforce is critical to rural communities, which face more complex health conditions than urban counterparts. Workforce shortages exacerbate strain on rural healthcare systems and create service access barriers. To date, retention and recruitment strategies have struggled to resolve staffing issues. This study investigated an overlooked

local resource: hospital and primary health care workers previously employed or working at less than full-time capacity in rural Queensland. We explored barriers and enablers to increasing their working hours or returning to the workforce.
https://www.rrh.org.au/journal/early_abstract/10203/

Farmer in a rural area in France with pneumonia and atelectasis treated by prolonged antibiotic therapy

Community-acquired pneumonia are frequent and sometimes fatal. Prompt biological recognition of pathogen is rarely possible, and recommendations are to use clinical presentation to determine the need for hospitalization and the choice of antibiotic. While pulmonary radiography should be performed for every clinical suspicion of community acquired pneumonia, CT is recommended in case of severe presentation, difficult diagnosis or suspicion of complications or cancer. However, during the first wave of Covid-19, CT were widely used for early triage of patients allowing discovery of atypical pneumonia aspects.
https://www.rrh.org.au/journal/early_abstract/10425/

What role does family medicine play in rural health advocacy? A scoping review

An estimated 2 billion people are living in rural areas around the globe that do not have adequate access to essential health services. This can adversely affect their health and is recognised as a significant cause of health inequities experienced by rural populations. Internationally, advocacy for improved access/ has increasingly been recognized as a fundamental responsibility of family medicine practitioners. They often see and are required to respond to gaps in the various social determinants of health affecting their patients and disproportionately affecting marginalised communities. With the existing geographic inequities in access to healthcare and a growing retention and recruitment crisis of the rural healthcare workforce, it is necessary to understand the scope and capacity of advocacy within rural family medicine and address the pressing issues affecting rural populations. The study aims to summarise the role family physicians have played in advocating for rural healthcare enhancement while highlighting strategies and interventions that have allowed for capacity building in the field.
https://www.rrh.org.au/journal/early_abstract/10639/

Can rural exposure to general practice influence career aspirations? A study with former participants of the ‘Excellent Project’, Germany

The shortage of general practitioners (GPs) and the aging population in Germany that requires increasing amounts of medical care is creating considerable strain on the German healthcare system. The lack of young doctors in general practice poses challenges to the healthcare of the population . The 'Excellent-Project' aims to draw interest in the field of general practice/family medicine and rural work among medical students. The project provides structured and supervised internships designed to present general practice not only as a valuable professional choice and as an attractive and fulfilling career option in rural settings.
https://www.rrh.org.au/journal/early_abstract/10491/

Papers from other journals

The Lancet: Country ownership without fiscal justice is responsibility without resources
Recent debates in global health, including reproductive health, have embraced an attractive proposition: as donor assistance contracts, countries in the Global South might finally define their own health priorities, build locally owned systems, and move beyond donor dependence. This argument has gained traction across global health discourse, including recent family planning commentaries that propose country ownership, domestic financing, localisation, and integration into universal health coverage as measures of success after the end of US foreign aid.1,2
We agree that the Global North-dominated, donor-driven model of global health is untenable;3 it has focused on charity rather than justice, fragmented health systems, distorted priorities, weakened public institutions, and made essential services vulnerable to electoral politics in donor countries. The old model should not continue, and any new model must place Global South leadership at the centre.3However, the next model should not confuse country ownership with the offloading of fiscal and moral responsibility and the abandonment of solidarity. The language of country ownership should not permit Global North nations to hoard resources, disengage from common-good initiatives, or absolve themselves of obligations for wealth redistribution, reparations, and restitution.4
Ownership of priorities does not necessarily translate into ownership of the resources required to implement them. In some large Global South countries (such as China, Brazil, and India), resources are less likely to be an issue, but that is not the case with many low-income countries. A Ministry of Health might have the authority to define a rights-based family planning agenda and still lack the fiscal means to pay nurses, maintain supply chains, integrate abortion and post-abortion care, or strengthen primary health care. Having the freedom to implement but not having the resources to effectively do so means that any sovereign idea of country ownership returned to Global South nations can become a facade for abandonment.
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00175-0/fulltext?dgcid=raven_jbs_aip_email

Nature: How to end poverty and protect Earth: inside the debate tearing up economics
The idea of prosperity without growth is gaining traction among researchers. So why are many economists sceptical?
Imagine a world in which nearly 90% of the population earns twice as much, while working half as many hours, as they do today. One in which the poorest half's share of global wealth increases, while billionaires' share decreases. All while capping global warming at 1.8 °C above pre-industrial levels by 2100. That's the vision laid out by researchers at the Paris-based World Inequality Lab in their Global Justice Report, a modelling study released last month1.
The report proposes financing the plan through global taxes on the very rich, with revenues going into a fund to support health, education and the shift to sustainable development, including transitioning from fossil fuels to renewable energy. It also proposes the creation of a new international currency to end some of the financial advantages that wealthy countries enjoy at the expense of poor ones.
Another report, presented to the United Nations last month, goes further. The Roadmap for Eradicating Poverty Beyond Growth2 calls for escaping the "trap of growthism", the idea

that progress depends on continuously increasing gross domestic product (GDP). It has been endorsed by more than 1,000 signatories, including Nobel laureate and economist Joseph Stiglitz at Columbia University in New York City.
“People are realizing that just pursuing growth and hoping that it will reduce poverty and inequalities is not working,” says the report’s lead author, Olivier De Schutter, the UN’s outgoing special rapporteur on extreme poverty and human rights.
But many economists are critical of the reports, with some dismissing them altogether. Nature spoke to researchers who have differing views on the role of economic growth in tackling poverty and climate change.
Here’s what they had to say:
https://www.nature.com/articles/d41586-026-02216-x?utm_source=Live+Audience&utm_campaign=69935b4cfc-nature-briefing-daily-20260716&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The lancet: When evidence meets artificial intelligence
Evidence-based medicine (EBM) integrates clinical expertise, patient values, and best available research evidence, yet classical trial-based approaches struggle to accommodate the scale, heterogeneity, and structural constraints of contemporary health systems. The rapid expansion of biomedical data is positioning artificial intelligence (AI) as an extension of evidence generation rather than a replacement for epidemiologic reasoning. This state-of-the-art Review examines how AI is beginning to reshape the methodological and ethical foundations of EBM through multimodal data integration, target trial emulation, and simulation-based modelling, while emphasizing that predictive performance does not ensure causal validity or clinical benefit. Implementation depends on rigorous epidemiologic design, integration within clinical informatics systems, and effective human–machine collaboration. In the Americas, fragmented health systems and uneven digital infrastructures constrain representativeness and equitable deployment. AI will not transform EBM on its own; its constructive role requires governance reform, transparent validation, and structural change to prevent the reinforcement of existing inequities.
In 1996, Sackett et al. defined Evidence-Based Medicine (EBM) as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients”1 This framework brought together clinical expertise, patient preferences, and empirical evidence into a structured framework for medical decision-making. Nearly three decades later, EBM has transformed clinical practice but faces persistent challenges: limited generalizability of randomized controlled trials (RCTs), the dominance of statistical over clinical significance, and difficulties translating population-level findings to individual patients.2–4
At the same time, the exponential growth of biomedical data from electronic health records (EHRs), digital devices, omics technologies, and imaging archives has both exposed and expanded the boundaries of traditional EBM.5–7 This convergence of EBM’s structural constraints with the data revolution has catalyzed the rise of data science and artificial intelligence (AI) as new analytical tools to synthesize information and generate actionable insights.8 These technologies do not replace EBM; rather, they extend its reach while inheriting its structural and epistemic limitations.
Recent reviews have addressed AI in healthcare from technical, ethical, or regulatory perspectives, including algorithmic bias,9 real-world data infrastructures,10 large language models,11 surveillance systems,12 and governance frameworks13 (see Table 1). However, these discussions often remain
https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(26)00102-X/fulltext?dgcid=raven_jbs_etoc_email

NEJM: Love and Death

It's December during my final year of residency, and I am ready to be done with intensive care units (ICUs). I am tired of the blood gases. I am tired of performing procedures I am not good at. I am tired of the sunless days that melt into weeks. But mostly I am tired of the death. I have recently completed a month each in the cardiac ICU and the pediatric ICU, and now am wrapping up a month in the medical ICU.

I first became accustomed to death, in all its permanency, when I stalked these halls as an intern. At that time, in the spring of 2020, I cared for endless rows of intubated patients. I built bonds with families over days and weeks, but once a patient died, I learned I would barely see or hear anything more about them. The paperwork was signed, the body was whisked downstairs, and the good intern moved on to the next patient. Any relationship with the patient, any special compassion, was tossed like a disposable stethoscope. Somewhere in the recesses of my mind, a void would open. But voids, like empty beds and open lists, have a habit of being filled by the humdrum torrent of residency.

This time through the ICU, the causes of illness are more diverse, but the death seems just as prevalent. I watched the slow failure of a young father's bone marrow transplant. The nurse printed out the telemetry strip so his child could have a keepsake of his final heartbeat. I listened to a 20-something man with interstitial lung disease beg his mother, who had been standing vigil for days, to go home and rest. In his final act of love, he then asked to remove his face mask, so he could spare her witnessing his final suffering. And I responded to an elderly woman's last request, as her lungs filled with fluid, for a breath of fresh air before the end. Though the modern hospital is equipped to provide many amenities, fresh air is not one of them. As a paltry substitute, I offered the imminent sunrise. Motivated, she propped herself up facing eastward and sat alongside her son, watching in silence before gently drifting off. These were just a few of many deaths, and each leaves me with that small sense of emptiness. I fear I will not remember the patients I have lost, and I fear it is far too crass to try to keep track.

Naturally, my holiday assignment is the medical ICU. Nights. Just like the month of day shifts I have just completed, but maybe with a few more codes and death exams. How lucky am I?

On Christmas Eve, one of the new patients is Cassie, a 29-year-old woman admitted through the emergency department with skin yellow-bronze and lactate in the double digits. Between labored breaths, with tremulous voice, she tells her story. She was just diagnosed in October with metastatic lung cancer. It has taken a few weeks to get into care, and then a few more for staging. Her insurance has limited her ability to find doctors, and she struggles to find childcare.

https://www.nejm.org/doi/full/10.1056/NEJMp2516818?query=TOC&cid=DM2458153_NEJM_Non_Subscriber&bid=-687384706

The Lancet: WHO estimates of the global, regional, and national burden of 42 foodborne infectious and chemical hazards, 2000–21: an updated data synthesis

Foodborne diseases are important causes of illness and death. The first estimates of their burden were published by WHO in 2015. We updated WHO estimates of the global, regional, subregional, and national foodborne disease burden caused by 42 infectious and chemical hazards in 2021, including time trends for 2000–21.

We provide a high-level summary of foodborne disease burden, expressed as incidence, deaths, and disability-adjusted life-years (DALYs). Data for burden estimation were provided from a WHO-commissioned series of systematic reviews on the incidence, aetiology, sequelae, and case fatality or mortality of the hazards. Data were analysed using hierarchical

meta-regression modelling with geographical clustering and a global linear time trend, disease-specific computational models, and uncertainty propagation through Monte Carlo simulations to calculate 95% uncertainty intervals. Attribution to foodborne transmission was principally based on a structured expert judgement process. Economic impact was measured as lost productivity.
For 2021, foodborne transmission of the 42 hazards caused 866 million (95% uncertainty interval 680–1090) illnesses, 1·52 million (0·783–2·51) deaths, and 57·1 million (39·4–81·1) DALYs. Inorganic arsenic, lead, and non-typhoidal Salmonella enterica (diarrhoeal and invasive disease) resulted in the most DALYs. The greatest burden of foodborne disease was in the African and South-East Asia regions. The incidence in children younger than 5 years was 2·7 times higher than in people aged 5 years or older, resulting in 4·3 times the rate of DALYs. The total burden from all hazards decreased over time. In 2021, these 42 hazards resulted in productivity losses of US$310 billion in nominal terms, and US$647 billion after adjusting for purchasing power parity.
Foodborne diseases causes a burden similar to that from tuberculosis, HIV and AIDS, or malaria. The high burden of both communicable and non-communicable foodborne diseases requires countries to prioritise developing strategies to improve the safety of the food supply.
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00156-7/fulltext?dgcid=raven_jbs_etoc_feature_langlo

Academia Medicine and Health: Perceived impact of regular short-term medical missions: a qualitative study in Uganda
While short-term medical missions (STMMs) are widely used to deliver humanitarian healthcare in low- and middle-income countries, existing research has largely focused on one-off interventions and has highlighted ongoing concerns related to sustainability, continuity of care, ethical practice, and local capacity building. The emerging model of recurring, regular STMMs remains underexplored. This study investigates the perceived impact, challenges, and systemic contributions of such missions through a qualitative case study of Mission of Hope in Uganda.
We employed a qualitative case study approach, combining semi-structured interviews with international medical volunteers (n = 6) and a focus group discussion with local partners (n = 10). The study adhered to EQUATOR guidelines for qualitative research, ensuring rigorous data collection and analysis.
Six themes and 21 subthemes were identified. Key barriers included financial constraints, infrastructural limitations, volunteer turnover, and resistance to new technologies. Participants reported perceived benefits including improvements in quality of care, local capacity building, and strengthened cross-cultural relationships. The role of trust, continuity, and humility in long-term effectiveness was emphasized. Ethical concerns related to patient autonomy, data privacy, and sustainability were also noted.
Regular STMMs were perceived by participants to offer advantages over traditional one-off missions by enabling iterative learning, deeper local engagement, and potentially more sustainable contributions to healthcare delivery—provided they are ethically designed and collaboratively managed. Findings inform future policy, funding models, and ethical frameworks for humanitarian medical initiatives.
https://www.academia.edu/3070-3530/3/1/10.20935/AcadMedHealth8152

The Lancet: Severe anaemia in African children: look beyond under-fives
In The Lancet Global Health, Kelvin M Abuga and colleagues1 report a 26-year hospital surveillance study of severe anaemia and invasive bacterial infection in 84 348 paediatric admissions at Kilifi County Hospital, on the coast of Kenya. The analysis spans the

introduction of Haemophilus influenzae type b (in 2001) and 10-valent pneumococcal (in 2011) conjugate vaccines, a marked decline in Plasmodium falciparum transmission, and the establishment of a dedicated sickle cell disease (SCD) clinic. Severe anaemia was identified in 19·8% of admissions and was associated with greater odds of in-hospital death (adjusted odds ratio 2·1) and bacteraemia (adjusted odds ratio 2·7) than with those for mild or no anaemia. As malaria transmission declined, the age distribution of severely anaemic children shifted upwards: the proportion aged 5 years or older rose from 16·4% in the high-transmission era (1998–2003) to 44·7% in the low-transmission era (2010–24).

Three features of the analysis merit attention. First, the scale and duration of systematic blood culture surveillance are among the longest in sub-Saharan Africa. Second, more than 90% of children with severe anaemia had malaria, malnutrition, or SCD, all established contributors to severe anaemia, suggesting that their prevention could substantially lower its incidence. Third, the pathogen-specific associations extend well beyond the established link with non-typhoidal Salmonella. Severe anaemia was associated with adjusted odds ratios of 6·1 for non-typhoidal Salmonella, 5·7 for Escherichia coli, 4·3 for H influenzae, 3·5 for Streptococcus pneumoniae, and 2·1 for Klebsiella pneumoniae. Each 1 g/dL decrease in haemoglobin was associated with a 14% increase in the odds of all-cause bacteraemia, with the steepest gradients for siderophilic pathogens (organisms whose growth and virulence are enhanced by greater iron availability). These findings are consistent with the iron-availability hypothesis proposed by the authors,[2] in which severe anaemia leads to reduced hepcidin levels, increased erythrophagocytosis, and a transient rise in non-transferrin-bound iron. H influenzae and S pneumoniae are uncommon in severe malarial anaemia, but are well described in children with malnutrition, SCD, or HIV infection,[3] and should be considered in severely anaemic children with these risk factors.

The time-trend and subgroup analyses are highly informative. Three further findings stand out. First, both in-hospital mortality and bacteraemia risk associated with severe anaemia have intensified with declining malaria transmission: across the high-transmission to low-transmission eras, the adjusted odds ratio for in-hospital death rose from 1·5 to 2·6, that for all-cause bacteraemia from 2·4 to 3·3, and that for H influenzae bacteraemia from 3·3 to 8·7. Second, in children with co-occurring HIV infection and severe anaemia, the adjusted odds ratios for pathogen-specific bacteraemia reached 29·1 for non-typhoidal Salmonella, 32·8 for E coli, and 76·9 for H influenzae, showing HIV-associated severe anaemia as a particularly high-risk group. Third, the proportion of severe anaemia admissions with SCD rose from 5% in the high-transmission era to 31% in the low-transmission era. These findings argue for point-of-care SCD testing in severely anaemic children, alongside expanded newborn screening.

https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00157-9/fulltext?dgcid=raven_jbs_etoc_email

Nature: Polio should have been eradicated by now. What's plan B?

Amid funding cuts and political barriers, researchers are asking whether the campaign can ever succeed, and what to do next.

Ten years ago, the virus that causes polio seemed to be on its way to extinction. In August 2016, Nigeria experienced its last two cases of the wild virus, leaving it circulating only in Afghanistan and Pakistan. Amid global excitement, Hamid Jafari, who at the time directed polio operations and research at the World Health Organization (WHO) predicted of Pakistan: "We may be looking at months — months, not years — before we eradicate polio in this country".

Since then, however, eradication targets have come and gone: 2019, 2023, 2025. Last month was the latest missed target to stop transmission. In the past decade, more than US$3 billion

has been spent fighting the virus in Afghanistan and Pakistan, where billions of doses of oral vaccine have been administered. Campaign leaders hoped that polio would finally disappear during last winter's low-transmission season. But that didn't happen; 14 new cases have been reported so far this year.

Fresh challenges now threaten the endgame, such as an unprecedented funding shortfall, and, from New York to rural Pakistan, a growing hesitancy towards vaccines.

Although the WHO said last January that eradication was "within reach", most researchers interviewed by Nature for this article are very concerned about the chances of success. "In theory, eradication is possible, but in practice, it is not," says Kimberly Thompson, who studies health economics at Kid Risk, a non-profit consultancy in Orlando, Florida, that models polio transmission and eradication.

So will we ever rid the world of polio, or is it time for plan B?

The effort to eradicate polio relies on the oral polio vaccine (OPV) — a drop of liquid containing live, attenuated poliovirus. Giving it to children both protects them from disease and stops the virus from spreading by blocking its replication in the gut. A population immunity level of about 90% is needed in vulnerable areas for the virus to peter out. A different vaccine, the inactivated polio vaccine (IPV), contains killed strains and is given as an injection. It is administered globally, in both vulnerable and polio-free areas, and protects against disease but doesn't stop transmission.

In rare cases, the attenuated virus in OPV can mutate to regain virulence, meaning that it can lead to cases of vaccine-derived polio and paralysis. Where immunity is poor, vaccine-derived polio can spread through communities. Ultimately, the strategy is to eradicate wild poliovirus with oral vaccine and then to carefully withdraw that vaccine without triggering vaccine-derived polio, while using IPV to insure against such outbreaks.

https://www.nature.com/articles/d41586-026-02229-6?utm_source=Live+Audience&utm_campaign=1829c1eb48-nature-briefing-daily-20260722&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Science: An AI can invent entirely new languages. But is it creative?

Researchers debate whether tool produces genuinely novel tongues, or simply spits out a remix.

In his spare time, Joseph Windsor, a theoretical linguist at the University of Calgary, is an enthusiastic "conlanger"—someone who constructs entirely new languages, such as the alien tongues used in science fiction movies and fantasy novels. It's a time-consuming craft that requires both rigor and creativity, he says: constructing a coherent set of grammatical rules but also inventing novel words that strike just the right tone. "Grammar can tell you whether and where a word belongs," Windsor says. "It cannot tell you whether it feels right."

Now, an artificial intelligence (AI) system that can construct new languages is fueling debate over the role of human creativity in language construction—and whether an AI conlanger can replicate that imaginative leap.

That ongoing discussion, most recently at last week's Annual Meeting of the Association for Computational Linguistics, centers on an AI tool built on large language models (LLMs) known as ConlangCrafter. The researchers who built ConlangCrafter "wanted to harness AI's ability to make up things to create these completely new—and sometimes wonderfully strange—alien languages that we might not have come up with ourselves," says Gašper Beguš, a computational linguist at the University of California Berkeley, who led the team. They also wanted to explore whether AI-crafted languages could help reveal how LLMs reason—and whether that reasoning produces genuinely original ideas or simply spits out a sophisticated remix.

To create a new language, ConlangCrafter first writes itself a language sketch or rulebook. It defines everything from the sounds the language contains to how words are arranged in a sentence and its grammatical rules. Then, a random-number generator nudges the AI toward unusual combinations found across the world's languages, preventing it from falling back on familiar patterns. Using those rules, the AI invents words and translates English into the new language. It then checks whether its own translations obey the grammar it wrote. If they don't, it revises the rulebook and tries again. Using those rules, ConlangCrafter can generate everything from humanlike languages to more speculative ones; so far, it has produced dozens, including a language for alien cephalopods that communicate through color changes and tentacle gestures instead of sound.
https://www.science.org/content/article/ai-can-invent-entirely-new-languages-it-creative?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=distillation&et_rid=1169729274&et_cid=6010842

Academia Medicine and Health: Medicine and health: a necessary reunion
Medicine has always known, on some level, that it is not enough. The physician who treats the wound but ignores the conditions that produced it has done something—but not everything. The scientist who maps the pathogen but not the poverty in which it thrives has answered one question while leaving the larger one unasked. This tension—between medicine as it is practised and health as it might be understood—is as old as the discipline itself. What has changed, across the past century, is that the world has progressively formalised its understanding of what health actually requires. It is a tension this journal has decided, with the addition of a single word, to formally acknowledge.
The World Health Organization's Constitution of 1948 made the first and most consequential move: defining health not as the absence of disease but as a state of complete physical, mental, and social well-being [1]. Revolutionary for its time, the definition was also deliberately ambitious—its authors understood that aspiration precedes achievement. It drew immediate criticism for its breadth, its apparent utopianism, and its resistance to measurement. Those criticisms were not wrong. But the definition's enduring power lies precisely in what it refused: the reduction of health to a clinical transaction.
A progressive widening of that refusal followed. The Alma-Ata Declaration of 1978 embedded health in social and economic development, named peace as its active prerequisite, and demanded that communities—not only health systems—be its agents [2]. The Ottawa Charter of 1986 went further still, identifying peace, shelter, education, food, income, a stable ecosystem, and social justice as health's fundamental conditions [3]. Global Health, emerging as a field in the late twentieth century, extended the frame beyond national borders, insisting that health inequity anywhere was a concern everywhere. And One Health—perhaps the most radical expansion yet—dissolved the boundary between human, animal, and environmental health entirely, recognising that the well-being of each is inseparable from the well-being of all.
These were not merely definitional refinements. Each represented a shift in who counts, what counts, and who bears responsibility. Each made health more inclusive, more ecological, more political, and more human. Together they describe a concept that has been moving, consistently and deliberately, away from the clinic and toward the world.
https://www.academia.edu/3070-3530/3/2/10.20935/AcadMedHealth8277

RUKHSANA Media: Behind every door, a story of pain: One of Afghanistan's few female doctors reflects on her work

Every morning at first light, Manizha* picks up her medicine bag and heads out to villages in rural Afghanistan where, if it weren't for her and her team, most women would not see a doctor from one year to the next.
The 29-year-old, whose real name we are withholding for her protection, visits her patients in their homes, going from house to house to deliver services they would otherwise not be able to access.
For many, confined to their homes because of Taliban restrictions, family or societal pressure or a mix of all three, her visits are a lifeline. As one of the few remaining female doctors working in Afghanistan, where the Taliban have stopped all higher education and most forms of paid employment for women, she performs a crucial role.
She treats women of all ages and from different backgrounds, meaning no two days of her job are the same. Many have been internally displaced, which is common in Afghanistan after decades of conflict, and some are former refugees who've returned home, not always willingly.
Yet there is one common theme: most of her patients have chronic conditions that could have been treated successfully if they had been caught much earlier.
"These are women who have lived with pain for years, to the point that suffering has become part of their everyday lives," says Manizha.
Her employer is a humanitarian organisation that we are not naming for her and her team's security. Already, she says, she and the other women she works with face harassment by the Taliban. Their work in remote rural areas of the country exposes them to further dangers that they know the authorities would not protect them from.
In rural Afghanistan, access to medical care has always been an issue, especially for women. Now, Manizha says, the challenges of poverty and underdevelopment have been compounded by the restrictions the Taliban has imposed on female healthcare workers and by global funding shortages.
https://rukhshana.com/en/behind-every-door-a-story-of-pain-one-of-afghanistans-few-female-doctors-reflects-on-her-work/?utm_source=Live+Audience&utm_campaign=f9fbc91fb3-nature-briefing-daily-20260724&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Nature: Book Review: The rise of evidence-based medicine and the 'mavericks' who championed it
Beyond Belief: How Evidence Shows What Really Works *Helen Pearson* Princeton Univ. Press (2026)
An impeccably researched account describes how clinical trials have transformed health and social policy.
Cementing the use of evidence in health and public policy has taken decades of challenging work. Fifty years ago, physicians commonly thought that babies should sleep on their fronts — advice popularized by US paediatrician Benjamin Spock and others. It took a synthesis of observations and case studies to show that this was wrong: babies should sleep on their backs to minimize the risk of sudden infant death syndrome (SIDS). More than 50,000 deaths across the United States, Europe and Australasia could have been prevented had this evidence been combined and put to use sooner.
Beyond such data, the randomized controlled trial (RCT) is usually the gold standard for medical or public-policy evidence. Including a control group against which to compare interventions shows what would have happened without it. Combining many trials into a meta-analysis gives practitioners and policymakers more confidence in whether a drug or treatment works.

In Beyond Belief, journalist and science communicator Helen Pearson (who is an editor at Nature) presents an accessible account of how such practices spread. Covering topics from policing to child development, she focuses on outcomes that everyone cares about, be those safer neighbourhoods or better childbirth procedures.

This book is not a technical treatise, and nor should it be. As researchers know, the details of RCTs soon get technical once their basic principles have been explained. But Pearson pulls off a narrative feat. Anyone can read and enjoy the book, yet there are nuggets for experienced readers. The background research is impeccable. The only slip I noticed is the statement that "by 1964, around 25 out of every 1,000 children in the United States were dying from sudden infant death syndrome or SIDS" — in fact, this number is the rate of deaths from all causes, with SIDS being a small fraction.

The book shares many examples of successes, in which solid evidence has corrected long-accepted bad practice. A 2002 Women's Health Initiative trial1showed that hormone replacement therapy (HRT), widely prescribed to prevent heart disease on the basis of previous observational studies2, actually increased the risk of cardiovascular disease and breast cancer.

Similarly, a systematic review of nine randomized trials3 done from the 1970s to the 1990s showed that an anti-crime programme adopted by many US states backfired in practice. Known as Scared Straight, the initiative involved sending children at risk of criminality into prisons to speak with incarcerated people. But, in the end, participants were more likely to offend than those in the control group.

https://www.nature.com/articles/d41586-026-02153-9?utm_source=Live+Audience&utm_campaign=3e39b9ef50-nature-briefing-daily-20260713&utm_medium=email&utm_term=0_-33f35e09ea-50521540

NEJM: Bundibugyo Virus Disease in 2026 — Clinical and Public Health Responses

Bundibugyo virus is a relatively rare orthoebolavirus that has caused only two previously recognized disease outbreaks but remains capable of producing severe epidemic disease with substantial mortality. The 2026 outbreak of Bundibugyo virus disease in the Democratic Republic of Congo has highlighted persistent challenges in the detection of filovirus disease outbreaks, as well as in diagnosis, clinical management, and the public health response, particularly in resource-limited settings. As with other filovirus infections, effective control of the Bundibugyo virus disease outbreak depends on rapid identification of cases, laboratory confirmation of infection, isolation of cases, contact tracing, infection-prevention measures, protection of health care workers, and community engagement. Although no licensed vaccines or approved therapeutics specific to Bundibugyo virus disease are currently available, advances in supportive care have improved outcomes during recent filovirus disease outbreaks. Experimental evidence from studies involving nonhuman primates, serologic investigations with human samples, and monoclonal antibody research suggests that vaccines and therapeutics developed against Ebola virus may provide cross-protective activity against Bundibugyo virus. These observations support prototype-pathogen approaches to preparedness while underscoring the need for continued development of pathogen-specific countermeasures. The current outbreak reinforces the principle that a successful response to filovirus disease requires integration of medical countermeasures, clinical care, surveillance, diagnostics, and coordinated multinational public health operations.

https://www.nejm.org/doi/full/10.1056/NEJMra2607216?query=TOC

The Lancet: Lived experience and global health architecture reform: from afterthought to cornerstone

Global health architecture reform is underway, and we are worried. In March 2026, WHO called for comments[1] on its plan to reimagine global health as part of the UN80 process. The first draft of the framework did little to suggest seizing this moment to address root causes and longstanding issues that hamper the impact of WHO. Our greater concern was the absence of any reference to lived experience as either a principle or a constituent group. Despite indications of the WHO commitment to engagement,[2] the framework made no mention of those whom the new architecture is meant to serve.

We are a group of health professionals and advocates from the Global North and South, all living with non-communicable diseases and other chronic conditions. All of us have worked in leadership and expert roles in global health. We share a common sense of exasperation, bordering on outrage, that the insights of the lived experience community are so often an afterthought, even in light of growing evidence[3] to suggest that outcomes are improved when those using the systems aid in their design. There was no meaningful mention of us in the initial proposal or subsequent draft; following our protests, a cursory reference was added to the document that was prepared for the World Health Assembly. At best, we anticipate tokenistic inclusion in later phases.

The existing global architecture continues to privilege established institutional actors, technical experts, and those with access to resources and networks. People most affected by health inequities—the frontline experts—face barriers to engaging virtually or in person, including language bias and technical complexity, inadequate financial support for participation, visa restrictions,[4] and restricted and late access to decision-making platforms. This pattern is not incidental; it is systemic.

https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00161-0/fulltext?dgcid=raven_jbs_aip_email

NEJM: Andes Virus — A Clinical Review

Andes virus (ANDV) is the sole orthohantavirus with documented human-to-human transmission. We summarize the epidemiology and clinical features of ANDV infection and review best practices in clinical management, as based on published expert consensus guidelines, field experience, and clinical trials. We also evaluate currently available and investigational treatments (including the use of antiviral agents), assess emerging monoclonal antibody therapies, and outline prospects for vaccine development. Finally, we discuss important infection prevention and control measures.

Andes virus (ANDV) is a member of the species Orthohantavirus andesense and the only orthohantavirus with documented human-to-human transmission. Orthohantaviruses are trisegmented, negative-sense, single-stranded RNA viruses.[1] Rodents are the primary natural reservoir, although the virus has also been found in other small mammals, including moles and shrews. Like other orthohantaviruses in the Western hemisphere, infection with ANDV may cause hantavirus pulmonary syndrome (previously also known as hantavirus cardiopulmonary syndrome), which is associated with a high case fatality rate (25 to 40%). Survival depends on host and viral factors; early identification of hantavirus pulmonary syndrome followed by initiation of optimal supportive care has been associated with better outcomes in severe cases.[1-7] This review summarizes the epidemiology, clinical features, diagnostics, infection-prevention considerations, and emerging therapeutics for ANDV infection.

The first known cases of ANDV infection in humans were documented in Argentina and Chile in 1995, after which hantavirus pulmonary syndrome was recognized as an endemic zoonosis in the Southern Cone of South America.[7-9] Cases of human infection cluster in focal areas where ANDV is hyperendemic, but the majority of cases of hantavirus pulmonary syndrome across Argentina and Chile appear to be caused by other orthohantaviruses.[1,7,10–

13 Human infection primarily occurs through inhalation of aerosolized rodent excreta or direct contact with contaminated materials (Figure 1). Cases have traditionally been associated with exposure to rodent-infested rural dwellings or structures, landfills, dumps, or poorly ventilated spaces where aerosolization of contaminated dust may occur. Less common routes of human infection include inoculation during rodent bites and human-to-human transmission.3
https://www.nejm.org/doi/full/10.1056/NEJMra2606651?query=TOC&cid=DM2457153_NEJM_Non_Subscriber&bid=-698055834

BMJ Open: A systematic review of the scope and impact of rural primary healthcare innovations using digital health technology

Objectives Digital technology in primary healthcare service delivery can enhance accessibility, service delivery and health outcomes in rural populations. The objective of this systematic review is to review and synthesise the scope and impact of digital health technology innovations within rural primary healthcare settings.
Design Systematic review.
Data sources Articles published on PubMed, PsycINFO, Cochrane Central, SCOPUS, Web of Science, EMBASE and CINAHL between January 2013 and October 2025 were searched using key search terms.
Eligibility criteria Patient, intervention, context, outcome model criteria guided article eligibility. Included articles were undertaken in rural populations, used digital health technology for treatment or management, explored the impact of digital health technology on rural primary healthcare and reported on healthcare outcomes. Included articles were in the English language and presented peer-reviewed primary research.
Data extraction and synthesis Extraction was performed using a bespoke standardised template by multiple reviewers. Quality assessment was undertaken using the Mixed Methods Appraisal Tool. Descriptive analysis and conventional inductive content analysis were applied to quantitative and qualitative data, respectively. The review is written in accordance with the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols statement guidelines.
Results 66 studies were included in the review. Most studies were conducted in the USA (n=26). Most studies focused on adult patient populations, with limited representation of Indigenous (In=3) and paediatric populations (n=2). Telemedicine/telehealth interventions using audio, video or both were the most common (n=36). Remote patient monitoring or point-of-care testing was integrated into 21 studies. Physical health conditions, particularly diabetes (n=17), cardiovascular diseases (n=11) and general primary healthcare concerns (n=13) were commonly reported. Others reported on areas including mental health, hypertension, obesity and pregnancy care.
Conventional inductive content analysis identified key themes: cost and time effectiveness, quality healthcare provision, consumer acceptance from both patients and practitioners, and healthcare service provider perspectives. Uptake barriers included staff workload and patient non-compliance, while facilitators encompassed process standardisation and practitioner acceptance and endorsement. Consumer acceptance was linked to satisfaction, willingness to engage and improved health outcomes and well-being.
Conclusions Digital health interventions in rural primary healthcare offer significant potential to improve healthcare delivery, reduce costs and enhance patient access, satisfaction and health outcomes. However, careful consideration of factors such as feasibility, consumer and practitioner acceptance, and recognition of limitations is crucial for successful implementation. The review underscores the importance of flexible policies to support emerging digital healthcare solutions, including the integration of artificial intelligence.

Overall, digital health interventions offer a promising avenue to improve healthcare outcomes in rural areas and should be prioritised for government funding and investment.
https://bmjopen.bmj.com/content/16/1/e097874

The lancet: How (not) to organise a panel at a global health conference
Global health is unfortunately not very global—a contradiction that becomes most evident at global health conferences. Although convened to advance the field of global health, these conferences often say more about whose perspectives are valued and whose are not, reflecting the inequities in power and privilege that global health ought to redress. Striving for parity—be it geography, gender, income, or age—also risks tokenism where inclusivity is performative rather than purposeful. Although guidance on how to organise a global health conference exists,[1–5] most stop short at organising panels. Inspired by Desmond Jumbam's satire on writing about global health,[6] here is how (not) to organise a panel at a global health conference.
Treat the 'global' in global health as a metaphor, not a geographical mandate. In 2024, 60% of speakers at the World Health Summit came from Germany, Switzerland, the USA, the UK, and France.[7] Never mind that these countries only hold roughly 7% of the world's population; this is where global health happens (and luckily for you, their names are easier to pronounce).
If you cannot find a woman panellist, it is probably because they do not exist. Panellists should be selected for their expertise, so when you end up with an all-men panel, it is safe to assume they represent the natural distribution of expertise, similar to how 97% of Nobel Prize laureates in science are men.[8] Even if you do find a woman, she is probably too junior (only 15 years of experience), or too senior (more experience than the male panellists), or too focused on gender (she will make everything awkward), or has young children (she is behind in her career). But if you fear someone might complain about a 'manel', find a woman to moderate. Most women wait most of their career to get an invitation to moderate a panel they could contribute expertise to themselves. They get to ask all the questions and answer none of them. To be seen and not heard, that is what aspiring women want. And if you think moderating is too much for a woman, just appoint a second moderator (not another woman, you already have one on stage). Now, no one will notice your panel is all men.
Throw in a youth panellist for a 'fresh perspective'. Find a youth who ticks multiple boxes, so if anyone asks, you can say you have women, Global South, and youth representation. Remind everyone they are just at the beginning of their career and cue them last, after the real experts have finished monologuing. Better yet, dedicate an entire panel towards the end of the conference
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00101-4/fulltext?dgcid=raven_jbs_etoc_email

Science Direct: Health and Place: Rurality, healthcare and crises: Investigating experiences, differences, and changes to medical care for people living in rural areas
Healthcare provision in rural areas is a global challenge, characterised by a dispersed patient population, difficulties in the recruitment and retention of healthcare professionals and a physical distance from hospital care. This research brings together both public and doctor perspectives to explore the experience of healthcare across rural Scotland, against the backdrop of contemporary crises, including a global pandemic and extreme weather events. We draw on two studies on rural healthcare provision to understand how healthcare services have been experienced, changed and might move on after periods of short- and longer-term change caused by such crises. We highlight the importance of communicating service changes to aid in setting healthcare expectations and advocate a mixed approach to the

introduction of digital solutions to best balance access to services in rural areas with the challenges of digital connectivity and literacy.
Providing rural areas1 with appropriate health services is a key challenge for governments across the globe (Hanlon and Kearns, 2016). Rural areas can be characterised (Weinhold and Gurtner, 2014) by dispersed low population numbers, lack of economies of scale, difficulties in the recruitment and retention of healthcare professionals, and uneven infrastructure development. The COVID-19 pandemic offers a new lens through which to consider strengths and weaknesses of contemporary rural society (Maclaren and Philip, 2021), including healthcare, and how it has thrown challenges in rural places (Malatzky et al., 2020a) into sharper relief in relation to other place-based social, cultural, economic, environmental, and political issues. Whilst the initial aim of this project was to solely consider the COVID-19 pandemic, the storms of 2021 and 2022 - which we go on to discuss - present an additional factor to consider within the context of evaluating the impact of sudden and unexpected challenges on the delivery of rural healthcare.
https://www.sciencedirect.com/science/article/abs/pii/S1353829224000455

The Lancet: From fragmentation to integration: regional health governance in southeast Asia
Southeast Asia's regional health governance has evolved into a dense but weakly integrated system of overlapping institutions. This Health Policy paper maps the regional health governance of the Association of Southeast Asian Nations (ASEAN) as an evolving health regime complex, tracing the historical origins of regional health governance to the early 20th century and examining developments from 1980 to 2024. The study also identifies two structural features: functional specialisation along with persistent fragmentation and structural asymmetry, in which external actors dominate technical and agenda-setting roles while ASEAN retains coordination authority. Although recent reforms under the ASEAN Post-2015 Health Development Agenda have improved institutional alignment, system-wide coherence remains poor. Strengthening regional health governance will require institutional rationalisation to reduce duplication and strengthen underdeveloped functions, alongside a rebalancing of external engagement to restore regional ownership of policy priorities. The analytical approach developed in this Health Policy paper offers a transferable framework for other regions facing institutional proliferation. Policy efforts should shift from expanding arrangements towards managing complexity through coordination, functional differentiation, and clearer authority structures.
Over the past four decades, an increasingly dense network of arrangements has been constructed to address cross-border health issues at regional and global levels.[1–5] Southeast Asia, defined as the region comprising the member states of the Association of Southeast Asian Nations (ASEAN),[6,7] faces substantial health challenges,[8–10] along with geographical volatility, cross-border mobility, and marked social, economic, and political diversity, thus creating an institutionally complex landscape for regional health governance.[11,12] ASEAN, established in 1967 as a political and economic cooperation framework, initiated formal health coordination in 1980 through the Manila Declaration on Collaboration on Health.[13] Regional cooperation has since expanded beyond emerging infectious diseases to include broader health priorities such as health system strengthening and non-communicable diseases, resulting in an increasingly complex institutional system.[14,15] This broader regional ecosystem includes intergovernmental bodies, technical agencies, collaborative networks, and non-governmental organisations (NGOs) operating across southeast Asia. Although the expansion of regional arrangements is often viewed as institutional inclusiveness and adaptive capacity,[16] the expansion has also introduced coordination challenges

https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00176-2/fulltext?dgcid=raven_jbs_aip_email

Nature: What The Odyssey reveals about ancient science — from botany to psychiatry
From intelligent ships to clues about eclipses, Homer's The Odyssey reveals how Bronze Age Greeks understood the world.
In The Odyssey, Homer records the earliest imaginings of autonomous ships guided by what sounds remarkably like artificial intelligence to modern readers. The ships of the Phaeacians, which carry Odysseus home to Ithaca, "know every city, every fertile land". They "have no steersmen', and "know by instinct what their crews are thinking and propose to do".
Homer's epic tells the adventures and mishaps of Odysseus as he struggles home from the Trojan War. Along with its prequel, The Iliad, it is a foundational piece of literature with roots as far back as 1600 BC. But for all The Odyssey's fantastical tales of monsters and magic, it also gives glimpses into the science, medicine and technology of the Homeric world.
Here, Nature looks at how researchers are finding the truths behind the legend.
After being transmitted orally for centuries, The Odyssey was written down during the Iron Age, around 800 BC. Accordingly, it reflects an anachronistic mix of metalwork, from iron knives and gates to bronze spears and swords that reveal its late Bronze Age roots. There are also hints of steel production.
In one passage, Odysseus and his men plunge a spear into the Cyclops's eye and the hot stake sizzles like when a blade is quenched in water to strengthen it during smithing: a technique that works for steel, but not for pure iron or bronze. Whoever composed that passage, suggests Michael Wright, a craftsman and ex-curator at the Science Museum in London, "witnessed the preparation of a tool with a steel edge".
Archaeologists have found other details that echo Homer's text during excavations of the Mycenaean Palace of Nestor near Pylos, Greece. These include vessels made from a mix of bronze, silver and gold, and a rare depiction of a 'fenestrated' axe with holes in, dating to around 1450 BC. The holes might explain a puzzling archery challenge that takes place after Odysseus finally returns home, involving shooting an arrow through a line of twelve axes.
"The more we excavate, the more we confirm," says archaeologist Sharon Stocker at the University of Cincinnati in Ohio.
The Odyssey argues for the existence of long-distance trading networks between late Bronze Age civilizations. Archaeologists didn't find evidence of such trade until the 1980s, when they discovered a fourteenth-century BCshipwreck at Ulu Burun in southern Turkey, packed with luxury treasures from Europe, Africa and Mesopotamia.
Such archaeological discoveries show that people from the eastern Mediterranean were "voyaging all over the Mediterranean much earlier than we would have believed", says Brendan Foley, a naval and maritime archaeologist at Lund University in Sweden.
The shipwreck was a small, slow cargo ship, around 15 metres long. Odysseus's ship had 50 oarsmen, implying it was a much longer, narrower ship optimized for speed, says Foley.
https://www.nature.com/articles/d41586-026-02275-0?utm_source=Live+Audience&utm_campaign=f9fbc91fb3-nature-briefing-daily-20260724&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Planetary Health: Planetary Health Research Digest.
Sea-land breeze
Sea-land breeze (SLB) is a key circulation system that helps regulate the temperature of coastal cities and mitigate urban heat islands. Given that more than 50% of the global urban population lives within 100 km of the coast, this feature will be instrumental in shaping and

maintaining coastal urban liveability in the years ahead. Climate change, however, continues to drive unprecedented environmental shifts—including rising sea-surface temperatures (SSTs)—and the impacts on SLB remain unclear. To investigate further, Yunting Xiao (Tianjin University, China) and colleagues simulate SLB evolution across 18 major coastal megacities under varying SSTs.

Their research indicates that rising SST reduces SLB days in over 67% of megacities under various climate scenarios, with mid-latitude cities showing the largest declines at approximately 29–45%. Overall, Xiao and colleagues' work highlights that although SLB enhances thermal comfort through humidity regulation, urban heat island mitigation, and pollutant dispersion, persistent SST amplification reduces SLB intensity and frequency and intensifies urban heat stress. The authors, therefore, emphasise that climate action must be implemented to mitigate SST rise.

Highway expansion

While transportation is recognised as a major source of the world's greenhouse gases through both vehicle emissions and the building of road infrastructure, the impact of transportation via urban heat islands (UHIs) has received far less attention. Given that multiple factors—such as land use change, industry productions, and commercial and residential developments—collectively drive up urban temperatures, Bo Yang (University of California Santa Cruz, CA, USA) and colleagues seek to quantify the environmental impacts of highway expansion on the UHI effect in the San Francisco Bay Area.

By analysing satellite-based thermal and meteorological data from 1 year before and after the construction of 11 major highway expansion projects, the researchers find that highway widening (ie, adding lanes and removing vegetation) is a major driver of intensifying urban heat. The authors highlight that these results provide actionable guidance for policy and planning for the future, underscoring the importance of integrating UHI mitigation strategies for highway expansion projects—such as preserving existing vegetation, incorporating green buffers along highway corridors, and using reflective or permeable paving materials.

Repetition and belief

Misinformation and disinformation have long served as powerful tools of manipulation and coercion. In recent decades, however, the internet has dramatically amplified their reach and potency, with artificial intelligence (AI) now threatening to make the problem worse. One way in which AI stands to do this is through sheer volume and repetition of misinformation. Aiming to assess whether repetition influences people's assessments of truth, Yangxueqing Jiang (The Australian National University, ACT, Australia) and colleagues examine whether repeated exposure increases belief in climate-sceptical claims, even among those who endorse the scientific consensus.

Across two experiments involving 172 participants—more than 90% of whom endorsed climate science and were more inclined to believe climate-aligned claims—a single repetition was sufficient to increase the perceived truth of all claims. The researchers found that repetition made climate science-aligned claims appear more true and climate-sceptic claims appear less false. The authors distil their findings into one clear recommendation for science communicators: do not repeat false information. Instead, repeat what is true and enhance its familiarity.

Childhood stunting

Childhood stunting is most often the result of malnutrition and disproportionately affects children from low-income and middle-income countries. In 2022, an estimated 149 million children younger than 5 years were stunted worldwide. While the role of climate change in driving undernutrition is increasingly recognised, analyses using reliable attribution-based measures of anthropogenic warming, rather than observed climate variability, remain rare. To

address this gap, Nabin Pradhan (University of Notre Dame, IN, USA) and colleagues examine data from 424,498 children across 34 African countries between 2004 and 2020. The researchers find that anthropogenic warming is positively associated with increased childhood stunting—with a 1°C increase linked to a 3·45% rise in stunting rates. However, their data show that inequality is a stronger and more consistent predictor of childhood stunting across all settings. Given that climate change is also shown to widen socioeconomic inequalities, these findings point to potentially compounding impacts on child health. The authors conclude that tackling inequality, alongside targeted investment in education, sanitation, and household resilience, could substantially reduce stunting rates and safeguard child health as global temperatures continue to rise.
https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00077-X/fulltext?dgcid=raven_jbs_aip_email

Nature: Africa's response to this Ebola outbreak shows how to shape global health
Countries elsewhere must learn from the continent's example and combat disease outbreaks by working together, not by closing borders.
The latest outbreak of Ebola in the Democratic Republic of the Congo (DRC) and Uganda is one of the largest on record, with more than 1,700 cases confirmed since April. Dozens of governments and health organizations are supporting the public-health response, caused by the Bundibugyo species of Ebola virus. Their approaches reveal how global health is evolving after US cuts to international aid.
After closing the US Agency for International Development and cutting budgets for medical projects overseas in 2025, the US federal government is now focused on preventing Ebola from crossing its own borders. In May, it imposed travel bans for foreign nationals entering from the DRC, Uganda and South Sudan. A field hospital in Kenya was funded to hold exposed and infected Americans locally, rather than repatriating them. Canada and the Bahamas have also imposed travel bans.
The Africa Centres for Disease Control and Prevention (Africa CDC) and the World Health Organization (WHO) have criticized these travel bans as lacking a scientific basis. Evidence shows that such restrictions do little to contain the spread of Ebola (C. Poletto et al. Euro Surveill. 19, 20936; 2014). They often create economic harm by disrupting supply chains, cross-border trade and tourism (Y. L. Bazak et al. BMJ Glob. Health 9, e013900; 2024).
By contrast, the approach coordinated by Africa CDC centres on evidence-based measures such as community reporting, case isolation and infection-control protocols in health-care facilities — all coupled with community engagement. In my view as an expert in pandemic-preparedness governance who worked on vaccine access during the COVID-19 pandemic, this cooperative model is the most effective and ethical way to deal with future epidemics and pandemics. Other nations must support it.
https://www.nature.com/articles/d41586-026-02148-6?utm_source=Live+Audience&utm_campaign=b6aaf3e0d1-nature-briefing-daily-20260715&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Climate change and malaria in west Africa: a review of strategies to handle one of the world's most prominent anthroponoses
Climate change is intensifying the threat of malaria in Africa by altering the geographical range, seasonality, and transmission intensity of the disease. Rising temperatures promote mosquito breeding and parasite development, whereas extreme weather events, particularly flooding, disrupt control efforts and create breeding sites, enabling their spread into previously unaffected highland areas. These factors pose an evolving public health challenge. Malaria-control strategies, often designed for stable climatic conditions, risk being outpaced

by rapid environmental changes. However, little is known regarding how national policies integrate climate adaptation into strategic planning. We qualitatively analysed national malaria strategic plans and related policy documents from 11 west and central African countries, published between 2015 and 2025. We assessed incorporation of climate and weather information into malaria surveillance, early-warning systems, and vector-control planning. Although most countries recognise the influence of climate and seasonality on malaria transmission, explicit integration of climate data into planning and surveillance remains scarce. Ghana and Nigeria use advanced data-driven approaches, including predictive agent-based modelling and subnational stratification, to guide interventions, whereas Togo, Benin, Senegal, and The Gambia show emerging progress. However, most national malaria strategic plans remain reactive rather than predictive because of data, technical, and coordination gaps. This Review highlights policy and implementation gaps in integrating climate adaptation within malaria-control programmes. We recommend climate-resilient malaria strategies centred on enhanced surveillance, integrated meteorological forecasting, and strengthened institutional capacity to support adaptive, evidence-based interventions.

For decades, the fight against malaria in Africa has shown robust progress while facing ongoing challenges. Climate change and verified socioeconomic influences, such as poor health facilities, poverty, funding, and insecticide resistance, are worsening the situation.[1–4] The relationship between a warming planet and malaria is complex, with climate change acting as both a direct ecological driver and a major disrupter of malaria-control efforts.[1,4] In some regions in west Africa, these factors create a difficult scenario in which rising temperatures and altered rainfall patterns increase malaria transmission,[5,6] although the risk has been projected to decrease in other regions.[4] Africa has some of the highest rates of malaria globally and now faces a changing threat that requires total rethinking of control strategies at the policy level.[7–9] WHO's 2025 World Malaria Report showed that Africa accounted for more than 95% of the global malaria case burden in 2024, totalling 282 million cases. Five countries made up approximately half of all global cases: Nigeria (25·9%), the Democratic Republic of the Congo (12·6%), Uganda (4·8%), Ethiopia (3·6%), and Mozambique (3·5%).[10]

Nigeria is a global epicentre of malaria, representing an estimated 25·9% of all cases worldwide. Its large population and favourable climate for year-round transmission makes Nigeria an essential country in the fight against malaria.[10] Ghana (2·5%), Cameroon (3·0%), Burkina Faso (3·1%), and Guinea (1·7%) frequently report some of the highest malaria burdens. Heavy rain seasons in Burkina Faso and parts of northern Ghana and Cameroon can lead to sharp spikes in transmission.[11] Senegal, Benin, and Togo have made considerable progress by implementing strong control programmes, yet their populations remain susceptible to climate-related resurgences. Success in controlling malaria has been achieved in Senegal, although challenges persist because of irregular rainfall patterns.[11] In the Congo Basin, including Gabon and the Democratic Republic of the Congo, high rainfall and humidity support continuous transmission.[12,13] Gabon has a smaller population but has a high incidence rate owing to its equatorial rainforest climate.[11] The Gambia, similar to Senegal, has greatly reduced its malaria burden;[11] however, flooding along the Gambia River can create new mosquito breeding grounds, potentially reversing progress.[1,3]

https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00057-4/fulltext?dgcid=raven_jbs_aip_email

AP News: Workers at an Ebola treatment center in Congo strike over unpaid salaries and bonuses

Dozens of people working at an Ebola virus treatment center in northeast Congo went on strike Monday over unpaid salaries and bonuses, posing a new challenge for the fastest-growing Ebola outbreak ever recorded on the continent.

Congo since May has been battling the outbreak of a type of Ebola with no approved treatment or vaccine. Last week, the Congolese health minister, Roger Kamba, said the virus had spread to two more provinces.

The striking staff at Rwampara General Hospital in Ituri province, the epicenter of the outbreak, includes epidemiologists, case investigators, drivers and gravediggers who say they have not been paid by Congolese authorities. The protesting staff shut the hospital and blocked the road leading to it, even burning a tire outside.

“We don’t know how it is possible to not have been paid for two months,” Bahati Claude, a health worker at the hospital told The Associated Press. “We don’t want to give up the job.”

The treatment center is different from the one in Ituri where a study of two badly needed treatments began earlier this month.

Congolese authorities declared the Ebola outbreak on May 15, after the disease had been transmitting for weeks without official detection, according to the World Health Organization. The outbreak is caused by the rare Bundibugyo virus, and the delay in confirming the outbreak came in part because tests were done for a more common type of Ebola.

During a visit to Ituri last week, Congo’s health minister said the government is verifying a list of those working to control the outbreak, as some unrelated names have been added to the payroll.

“We must ensure that these payments reach the right people,” Kamba said. “We have faced a few challenges, notably changes to the lists, which have led to complaints from people saying they are not being paid even though they are working. We have the means to sort this out.”

There are 1,926 confirmed cases in the country, including 702 deaths, according to Congolese authorities.

Meanwhile, WHO Director-General Tedros Adhanom Ghebreyesus posted Monday on X that a second U.S. citizen, a humanitarian worker in eastern Congo who had contracted Ebola, was transferred to Germany. The first American to test positive for the virus was a doctor working in Congo during the early weeks of the outbreak.

https://apnews.com/article/congo-ebola-workers-strike-salaries-b29edd0d7a98e05eaed1d76fa9ef2e20?utm_source=Live+Audience&utm_campaign=b6aaf3e0d1-nature-briefing-daily-20260715&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Japan's health system toward 2040: structural challenges and a renewed social contract

Japan's universal health coverage system has supported healthy longevity, but now confronts institutional stagnation: widely recognised structural pressures persist without reform of its core architecture. A multidisciplinary working group of 25 experts from Japan and the Western Pacific identified three interdependent structural challenges perpetuating policy inertia. These comprise a volume-driven, hospital-centric delivery model sustained by fee-for-service incentives, rigid budget allocation, and underdeveloped health technology assessment; fragmented data infrastructure and eroded public trust undermining evidence-informed governance; and institutional insularity limiting global interdependence. We propose a Vision 2040 framework with three goals: transitioning to an open, community-based ecosystem prioritising daily functioning and wellbeing; establishing trust and scientific independence as foundations of governance; and ensuring equity through circular innovation, in which Japan contributes to and learns from regional health networks by integrating global

learning with domestic value assessment. Nine recommendations provide a roadmap for governance reform, data integration, reimbursement realignment with societal value, and reciprocal workforce partnerships. Reconstructing the social contract underpinning universal health coverage is central to sustainability across ageing Western Pacific societies.
Japan's healthcare system has long been recognised as a widely cited model for Universal Health Coverage (UHC), instrumental in achieving a society with healthy longevity.1 It now confronts structural pressures that challenge its foundational principles—universal access, equity, and financial risk protection. By 2040, more than one in three Japanese residents will be aged 65 and older,2with healthcare and long-term care expenditures projected to reach historically unprecedented levels. Rapid population ageing and increasing fiscal constraints3,4 intersect with broader resilience risks shared across the Western Pacific, including natural disasters, emerging infectious diseases, and geopolitical instability. Together, these pressures challenge a delivery model designed for the disease patterns and social conditions of the 20th century, exposing growing tension within the implicit social contract underpinning Japan's post-war health system: the expectation that UHC can be sustained without fundamental redistribution of roles, risks, and responsibilities among government, providers, and households. As the burden of disease shifts decisively toward chronic conditions,5 multimorbidity,6 and integrated community-based care needs,7 the capacity of this legacy system to respond effectively is increasingly in question.
https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(26)00124-0/fulltext?dgcid=raven_jbs_aip_email

BMC Medicine: Evidence of unreliable data and poor data provenance in clinical prediction model research and clinical practice
Clinical prediction models are often created using large routinely collected datasets. It is essential that prediction models are developed with appropriate data and methods and transparently reported to ensure that decisions are based on reliable predictions. Kaggle is a popular competition and data repository website where users learn and apply analysis skills on a range of datasets.
We identified two large, publicly available Kaggle datasets, on stroke and diabetes, that lack clear data provenance, but are widely used in clinical prediction models in peer reviewed publications. We used exploratory analyses to examine the quality of data and reporting of information using nine items from the TRIPOD+AI statement checklist.
Data provenance assessment using nine TRIPOD+AI items revealed major deficiencies, with minimal details for either dataset including no information on when, where, why or how the data were collected. The authenticity of both datasets could not be verified and have no reliable provenance of authenticity and should not be used for informing research or practice. From these two datasets, we found 125 clinical prediction model studies. Three prediction models had evidence of use in clinical practice, one model was cited in a medical device patent, and the models were cited in 86 review articles.
We recommend that journals and data repositories mandate data provenance reporting to safeguard published research. Prediction models based solely on inauthentic or unreliable datasets should never be used to directly inform decisions on patient care.
https://link.springer.com/article/10.1186/s12916-026-04981-y

The Lancet: Planetary Health: Pandemic impacts on protected rainforests and rural communities with variable health and livelihood support in West Kalimantan, Indonesia: a mixed-methods approach combining household surveys and remote sensing

Community support programmes can simultaneously improve human and ecosystem health. However, whether and how supported communities maintain these sustainable trajectories during major disruptions remains unclear. We used a mixed-methods approach to document how the COVID-19 pandemic impacted rural communities and protected rainforests in West Kalimantan.
We surveyed 1016 households across six villages with non-governmental organisation (NGO)-affiliated health–livelihood support and four nearby unaffiliated villages to understand their pandemic experiences and logging activity. We also independently estimated weekly forest loss in protected rainforests in 28 NGO-affiliated and 698 unaffiliated villages using satellite imagery.
The pandemic created an economic shock, whereby 50% of households lost income, struggled with increased costs of basic needs, or both. We expected this shock to increase the amount of logging; however, the average forest loss across West Kalimantan decreased by 39% after the pandemic declaration. This decrease was due to the combined effects of the global timber market crash in early 2020, pandemic travel restrictions, and heavy precipitation in 2020 and 2021. Before the pandemic, the average forest loss was 52% lower in NGO-affiliated villages than in unaffiliated villages, with this difference increasing to 68% during the pandemic. Correspondingly, NGO-affiliated households were more likely to report having alternative sustainable livelihoods, several sources of external support (eg, loans), and access to affordable health care and less likely to report increased spending on basic needs during the pandemic.
Health and livelihood support can buffer communities during major disturbances, sustaining progress towards improved human wellbeing and forest conservation.
https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00028-8/fulltext?dgcid=raven_jbs_aip_email

Academia Medicine and Health: The destruction of healthcare in armed conflict: policy implications and accountability
This Perspective examines how the destruction of healthcare systems in armed conflict produces enduring public health harm and broad human insecurity. Drawing on social medicine, sociological theory, governance scholarship, and field observations from Afghanistan, it argues that attacks on healthcare infrastructure and personnel result in not only the loss of clinical services but also in the erosion of social and moral worlds of care. The paper advances three interrelated claims: first, that healthcare institutions function both as clinical and social infrastructures; second, that their destruction generates disproportionate psychosocial, gendered, and intergenerational harms extending far beyond immediate morbidity and mortality; and third, that the persistence of such attacks reflects abject failures in international protection and accountability mechanisms. Particular attention is given to the consequences for women and children, including preventable death, disability, and psychosocial distress with constrained possibilities for recovery and social ways of belonging. These harms are compounded by weakened international accountability, which has increasingly normalised attacks on healthcare as a feature of war rather than a violation demanding intervention.
https://www.academia.edu/3070-3530/3/2/10.20935/AcadMedHealth8372

The Lancet: A systematic review of Nipah virus disease epidemiological parameters, outbreaks, and mathematical models
Our systematic review, based on PRISMA guidelines (PROSPERO CRD42023393345), characterised the epidemiology, outbreaks, and mathematical models of Nipah virus, an important public health threat in south and southeast Asia. We searched PubMed and Web of

Science from database inception to March 14, 2025, and extracted 243 parameters, 89 risk factors, 39 models, and 23 distinct outbreaks from 119 papers. IgG seroprevalence estimates in the general population ranged from 0% to 12·5%. Nipah virus causes severe disease, with pooled case–fatality ratio estimates ranging widely from 9·1% (95% CI 0·2–41·3) in Singapore to 81·9% (95% CI 71·9–88·9) in Bangladesh. The infection timeline and clinical course of Nipah virus remain poorly characterised; we estimated a median incubation period of 8·77 days (165, 95% CI 7·53–10·02) from eight estimates in seven articles with sufficient information. Transmission parameter estimates were scarce, and all but one of five central estimates of the basic reproduction number were less than one. Nipah virus mathematical models (39) were rarely fitted to data (eight). All extracted information is accessible via our R package, epireview.

Infectious diseases pose a continuous threat to global health security, with grave societal and economic consequences.[1–3] To guide pandemic preparedness, WHO has prioritised pathogens with epidemic and pandemic potential for research and development, including Nipah virus, a henipavirus in the Paramyxoviridae family.[4]

Nipah virus causes severe encephalitis and respiratory disease by spreading throughout the body and infecting blood vessel lining cells and neurons, by viral attachment to ephrin-B2 and ephrin-B3 receptors.[5] Damage to the vascular endothelium, invasion of the CNS, and suppression of early immune responses lead to rapid multiorgan injury,[6] a capacity for late neurological relapse in those with previous Nipah virus infection, and post-infection sequelae.[7]

The Malaysian Nipah virus (NiV-M) strain was first identified in 1998, in peninsular Malaysia via an outbreak in commercially farmed pigs, which spread nationally due to pig movements[8] and repeated spillover into humans, and to Singapore via exported pig meat.[9,10] Most human cases resulted from exposure to pigs[11] and the outbreak was contained with livestock movement restrictions and pig culling.[12] Between its emergence in 1998 and control in 1999, 283 cases of acute encephalitis, a severe symptom of Nipah virus, and 109 deaths were reported in Malaysia, with many possible undetected infections.[6,13,14] A further 11 cases and one death were reported in Singapore[15] during this period. The outbreak resulted in long-term changes to pig farming in Malaysia, which has remained Nipah virus-free since 2001.[16]

https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(26)00239-2/abstract?dgcid=raven_jbs_aip_email

Science: Invasive species' environmental impacts are more severe in the Global South

Non-native invasive species have outsized environmental and economic impacts. More invasive species are recognized in the Global North, where research money and effort are higher, but this bias may underestimate invasive species impacts in the Global South. Bacher et al. compared the average reported severity of invasive species impacts across countries. They found higher impact severity in the Global South, particularly in smaller countries, but also in large, high-income developing economies, where economic activity may offer opportunities for species introductions. Impact severity was negatively related to governance, and Global South nations, on average, had lower capacity to prevent and respond to invasive species. These findings highlight the need for increased research and management of invasive species in the Global South. —Bianca Lopez

Invasive alien species (IAS) are a major threat to biodiversity, yet their impact distribution remains poorly understood. Global biodiversity assessments suggest the highest impacts in wealthy countries of the Global North, but this is only inferred from IAS numbers, reflecting research bias. Using a new global database of standardized impact measures, we calculated average impact severity per country and found that it is higher in the Global South despite

more than twice as many reports in the Global North. Weak governance and limited management capacity are the main drivers of high impact severity. Emerging economies with rapid economic growth but poor governance are particularly vulnerable. Failure to recognize the Global South as facing the highest IAS impacts diverts attention away from the most threatened regions.

The introduction of species into regions outside their native range—a process known as biological invasion—represents one of the major drivers of biodiversity loss (1). Some of these species become invasive and pose harm to the environment, society, or economy, with far-reaching consequences for biodiversity and human well-being. Up to now, these invasive alien species (IAS) contributed to 60% of all documented global species extinctions and caused economic costs exceeding USD 400 billion in 2019 (2). The ongoing increase in the number of newly introduced species (3, 4) and associated rises in environmental and economic impacts (5, 6) indicate that current policy and management efforts are insufficient to halt biological invasions globally. Effective and targeted management requires a robust understanding of the geographic distribution and magnitude of IAS impacts.

https://www.science.org/doi/10.1126/science.aed0603?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=distillation&et_rid=1169729274&et_cid=6025061

The Lancet: Christine Kafando: fighting for children with HIV in west Africa

Christine Kafando was the first person to talk publicly about living with HIV in Burkina Faso and helped to set up one of the first community organisations for people living with HIV in the landlocked west African country. But by 2003, she felt the need for a new organisation focused on the needs of mothers and children. “There was no treatment and the youngest children died quickly”, she told The Lancet Child & Adolescent Health. “It was hard to see a family come in with their children and after 2 or 3 weeks the child was no longer there. And nobody was worried about it.”

There was limited understanding of the importance of antenatal testing, paediatric medications were not available, and there were no services to help children who were growing up with HIV. The organisation Kafando founded, L’Association Espoir pour Demain (Hope for Tomorrow Association), sent its members to antenatal clinics to encourage HIV testing, then helped newly diagnosed mothers understand the result and access care. As children grew up, it provided material and emotional support and encouraged them to stay in school. Yet, the gains have been modest. “20 years later, children are still being left behind—not just medically and mentally, but also in terms of their basic safety and protection”, Kafando said. Less than a third of children with HIV receive antiretroviral treatment, they face challenges growing up with a stigmatised health condition, and some have been abandoned or neglected following family breakdown.

Laeitia Somé, a young woman who was born with HIV, said Kafando had been a constant presence since her childhood. “She gave me hope—she made me feel that anything was possible in life”, she said. “Thanks to her, I went to school, I can read, and I know how to get on in life…” Somé summed up Kafando in this way: ”She's a fighter, a courageous woman, a mother of many children who makes sure they are protected, who gives them love and affection, and who helps them become themselves—to fight and become someone in society.”

Ramata Ouedraogo met Kafando when she tested HIV positive while pregnant in 2004. “She reassured me because when I went there, I had completely lost hope. I kept thinking of the images they showed on TV—that I would end up like that, and how people would look at me”, she said. “But she really lifted my spirits, she made me regain confidence in myself, and I began to live in a new way.” With the support of Kafando and the association, Ouedraogo

took antiretrovirals in pregnancy and gave birth to a boy who does not have HIV. Kafando helped her find a paediatrician, organised a sponsorship to help with school fees and other costs, and built a relationship with her son—he is now 21 years old, and they are still in contact. Ouedraogo is now a community health mediator in the association and provides similar support to new generations of parents and children.
https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(26)00196-3/fulltext?dgcid=raven_jbs_aip_email

Nature: How I use statistics and my law degree to fight human-rights abuses
Some 50 years after exposing gender discrimination in US academics' retirement benefits, Mary Gray works as a statistician and social-justice campaigner.
Mary Gray has applied statistical and legal arguments to make recommendations for how governments and organizations can address genocide and other human-rights atrocities, as well as workplace discrimination. Now in her 80s, her career as a lawyer, statistician and mathematician at the American University in Washington DC continues. "In spite of the fact that I have a lot of white hair, I'm not retired yet," she says.
Some researchers focus on a handful of narrowly defined problems. But Gray's work is vast in comparison.
She has trained investigators for the International Criminal Court in the Hague, the Netherlands, to determine the extent of human-rights violations and genocide. Closer to home, she has worked to combat sex-, race- and age-based discrimination and to create opportunities in US academia for people from diverse backgrounds.
As founding president of the Association for Women in Mathematics from 1971 to 74, Gray established networks and support for female colleagues and advocated for a more equitable and inclusive culture across the discipline. In 2022, when the association established its Mary and Alfie Gray Award for Social Justice — which is named after Gray and her mathematician husband, who died in 1998 — the organization described Mary Gray as having "lived her life in the pursuit of mathematics excellence and social justice". Alongside her academic research and teaching, Gray has volunteered with both Amnesty International and Statistics Without Borders, an organization that provides pro bono statistics and data-science services to improve human welfare worldwide.
Several years after publishing her PhD thesis on abstract mathematics (titled Radical Subcategories) in 1967, she had a realization. "I was never going to, I would say win a Nobel prize, except there are no Nobel Prizes in mathematics," she says. Instead, she found a natural fit when asked by colleagues to work on some statistical problems about whether there was sex or race discrimination in the selection of White House fellows — young professionals undertaking work-experience placements at the highest levels of the US federal government. So she bolstered her background in statistics and decided to focus on "more practical applications", she says.
Many researchers would be satisfied with dual expertise in mathematics and statistics. But it was one issue — inequitable retirement benefits for men and women — that fuelled Gray's decision to earn a law degree.
https://www.nature.com/articles/d41586-026-02079-2?utm_source=Live+Audience&utm_campaign=8e99e5d359-nature-briefing-daily-20260730&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: New chapter in rabies vaccine development
It has been more than 140 years since Pasteur, Vulpian, and Grancher conducted the first successful human immunisation against rabies with a live-attenuated vaccine derived from dried rabid rabbit spinal cord material. The current modern purified cell culture and

embryonated egg-derived rabies vaccines were developed between the 1960s and 1980s. These inactivated rabies vaccines are highly immunogenic, induce a robust and long-lasting B-cell memory, and are highly effective in preventing rabies.1 However, the high costs and the current requirement for at least two doses preclude the use of rabies pre-exposure vaccination (PrEP) in large-scale public health interventions. It has been estimated that programmatic rabies PrEP would only become cost-neutral in settings with a high incidence of dog bites, of more than 5000 per 100 000 people, whereas in most endemic settings, incidence typically varies between 10 and 130 per 100 000 people.1 The new simian adenovirus-vectored ChAdOx2 RabG rabies vaccine might represent the start of a new chapter in modern-day rabies vaccine development.

In The Lancet Infectious Diseases, Adam J Ritchie and colleagues2 report interim results of a phase 1b/2 dose-escalation, partly randomised, open-label study of the safety and immunogenicity of a single dose of the candidate rabies vaccine ChAdOx2 RabG in Tanzanian adults (n=63) and children (n=111). The comparator was a licensed Vero-cell based whole inactivated rabies virus (IRV) vaccine that was given intradermally at two anatomical sites in a single-visit (adults and children) or at two sites in two visits 7 days apart (children only). Ritchie and colleagues2 demonstrated that a single dose of ChAdOx2 RabG vaccine was well tolerated and maintained seropositivity in most adults and all children for at least 1 year.2 In adults, the day 365 geometric mean rabies virus neutralising antibody (VNA) titres were 2·0 (95% CI 1·4–2·9) after ChAdOx2 RabG vaccination (5 × 1010 virus particles; full dose) and 0·4 (0·2–0·7) after single-visit IRV vaccination (geometric mean ratio 5·1 [2·5–10·4]; p<0·0001). In children, day 365 geometric mean VNA titres were 6·1 (4·5–8·2) after ChAdOx2 RabG (full dose) and 0·7 (0·5–1·1) after single-visit IRV vaccine (geometric mean ratio 8·6 [5·4–13·9], p<0·0001). These results are highly promising and a welcome development in the prevention of human rabies mortality.

https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(26)00137-4/fulltext?dgcid=raven_jbs_etoc_email

The Lancet: Global health suffers when corporate AI sovereigns reign

In 1600, Queen Elizabeth I granted the East India Company a royal charter and a monopoly over trade across much of the known world. For more than a century, the relationship was mutually advantageous: the Crown received revenue, access to rare commodities, and unparalleled geopolitical reach; the Company received protection, legitimacy, and the coercive backing of a state. By the mid-18th century, it became something very different. The Company maintained its own army, territories, and foreign policy, and increasingly operated in ways that were counter to the objectives of the Crown, resulting at times (due to its unconstrained, singular objective of maximising profits) in the deaths of millions.1

Today, the world's largest technology firms are at the precipice of a similar transition: towards becoming firms that function as corporate sovereigns whose power derives from the control of indispensable digital infrastructure and the algorithms that shape the attention economy, rather than from physical territory.2 The concentration of power is stark. A single firm (Nvidia) supplies between 80 and 90% of the chips on which advanced artificial intelligence (AI) models are trained;3 a handful of hyperscale providers (Microsoft Azure, Amazon Web Services, Google Cloud) operate the data centres in which those chips run;3 and a small number of laboratories (eg, OpenAI, Anthropic, Google DeepMind, DeepSeek), almost all American-owned, use those data centres to produce the frontier AI models on which others build.

These layers are less separate than they appear. A dense web of cross-investment now binds them, with chipmakers taking equity in the laboratories that buy their processors, and cloud providers and laboratories acquiring stakes in one another while committing to purchase each

other's services; analysts have estimated that interlocking arrangements of this type are worth more than US$800 billion.4 The effect is a tendency towards vertical integration achieved through finance rather than a formal merger, drawing nominally competing entities into a single, mutually dependent interest.

We expect that two structural features will characterise AI firms' transition to pseudo-sovereign status. These firms will increasingly occupy every position in their own oversight, building the systems, funding the safety evidence5 (based on evidence from a preprint), staffing the advisory bodies, and drafting the standards meant to constrain them.6 They will also become jurisdictionally mobile in ways territorial regulators and sovereign governments are not, using digital infrastructure and complex corporate structures to obfuscate the residency of data and software in an effort to escape true oversight.

In that context, a health system that adopts a frontier AI solution for triage, imaging, or clinical decision support—such as the Horizon 1000 initiative seeks to roll out in Rwanda7—does not necessarily acquire a substitutable tool but rather creates a dependency on a supply chain it neither controls nor can reproduce. The risks are especially acute in the global health context because upfront philanthropic support, especially when provided by the frontier AI companies that stand to benefit most, increases the likelihood of three specific risks.

https://www.thelancet.com/journals/landig/article/PIIS2589-7500(26)00092-0/fulltext?dgcid=raven_jbs_aip_email

The Lancet: Not snowflakes: Gen Z reflections on rising youth mental ill-health

Public commentary often portrays young people as a fragile "snowflake generation," supposedly less resilient than our elders. These claims collapse under empirical scrutiny: across countries in the Western Pacific region, data show rising proportions of young people meeting criteria for mental disorders.1

This Viewpoint accompanies the companion article by Birrell, Slade and colleagues, which reports that between 2007 and 2022 the proportion of young Australians meeting criteria for a mental disorder rose from 23.4% to 36.2%, with suicidal thoughts and behaviours more than doubling.2 The question is therefore not whether youth distress is increasing, but how those increases should be interpreted.

To inform interpretation of those findings, the study team engaged the Matilda Centre Youth Advisory Board (YAB), a diverse national group of young people with lived and living experience of mental health and substance use through their own experiences, families, and communities.3 The YAB was consulted to explore potential drivers of increasing rates of distress and the social narratives surrounding youth mental health, including the "snowflake generation" stereotype.

Rejecting deficit framings, insights from the YAB highlight how economic insecurity, precarious work and housing, the lingering productivity and educational impacts of COVID-19, and the double-edged influence of digital media that may intensify youth distress. The data demand we stop pathologising a generation reacting rationally to irrational conditions. We refuse to frame a generation's pain as personal failure.

Together with my YAB colleagues, I counter the "snowflake generation" characterisation by arguing that rising youth distress may reflect a growing mismatch between the expectations placed on young people and the increasingly unstable social and economic systems they must navigate.

By centring youth voices, this Viewpoint reflects the principle of "nothing about us without us": as a priority population, young people must be embedded in research and policy settings, with the goal to enable leadership in areas that directly impact our lives.3

https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(26)00130-6/fulltext?dgcid=raven_jbs_aip_email

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