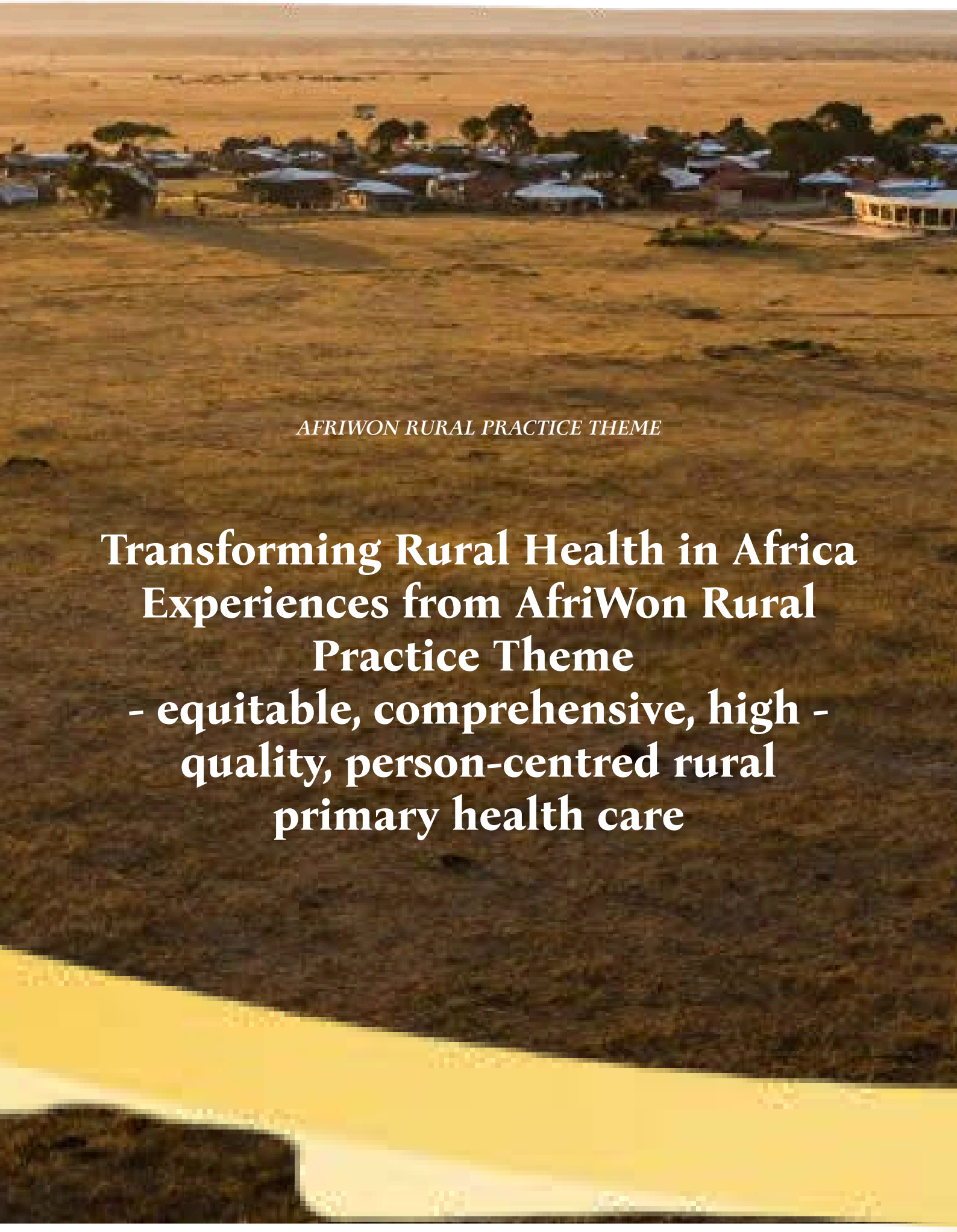

AFRIWON RURAL PRACTICE THEME

Transforming Rural Health in Africa Experiences from AfriWon Rural Practice Theme - equitable, comprehensive, high - quality, person-centred rural primary health care

August 2026

Afriwon Rural Theme Highlights

Family Medicine Where It Matters Most:
Communities, Continuity and Change
Botswana | Kenya | Nigeria | Uganda | Tanzania

Afriwon Renaissance
The Voice of Young Family Doctors Across Africa

Contents
What's Inside This Issue

From the Consultation Room to the Community

Rural inequity, innovation and resilience — the Family Physician as clinician, educator, mentor, advocate and system leader

Across Africa, Family Physicians are stepping beyond the walls of clinics and hospitals into the heart of the communities they serve. Rural practice is not simply a posting — it is a calling that demands the full spectrum of our professional identity. We are clinicians managing undifferentiated illness with limited resources. We are educators shaping the next generation of practitioners. We are mentors guiding young doctors through complexity. We are advocates speaking for the voiceless in health systems that too often overlook the margins.

Innovation and resilience define the rural Family Physician. Where others see inequity, we see opportunity — to listen, to adapt, and to lead. The stories gathered across Botswana, Kenya, Nigeria, Uganda and Tanzania in this edition ask a single, urgent question: Are we truly responding to the realities of people's lives? The answer, as this newsletter shows, is yes — one community, one family, one consultation at a time.

Empowering Youth in Boteti West

A New Era in Reproductive Health

Teenage pregnancy remains one of the most pressing public health challenges in Boteti West, Botwana. Young women in rural communities face compounding barriers — limited access to sexual and reproductive health (SRH) information, social stigma, and inadequate support structures — leaving many without the care and guidance they urgently need.

In response, the Rakops Youth Service Centre was established as a dedicated, safe space for young people in the community. Anchored in the principles of family medicine, the Centre brings together health workers, educators, social workers and community leaders to address the root causes of teenage pregnancy and provide holistic, youth-friendly care.

Comprehensive Support

The Rakops One-Stop Youth Response

The Rakops Youth Service Centre was designed as a safe, welcoming one-stop environment where young people can access the full range of support they need. At its core, the Centre provides comprehensive sexual and reproductive health (SRH) information aud care — equipping adolescents with the knowledge and services to make informed decisions about their bodies and futures.

For survivors of gender-based violence and abuse, dedicated survivor support pathways ensure that no young person faces trauma alone.

The Centre's integrated model addresses HIV/AIDS prevention, testing and linkage to care alongside trauma counselling for young people navigating difficult personal circumstances. Economic counselling helps tackle the financial and social drivers that so often push adolescents toward vulnerability.

By uniting clinical care, psychosocial support and community education under one roof, the Rakops Centre embodies the Family Medicine principle of treating the whole person — not just the presenting condition.

The Team Behind the Change Meet the Multidisciplinary Team at Rakops Youth Service Centre

A dedicated group of professionals working together to transform youth health in Boteti West

MS KOBE

- *Social Worker*
- *Addressing socioeconomic barriers and connecting vulnerable youth with community resources, survivor support and protective services.*

MR PAUL

- *Youth Friendly Services Nurse*
- *Delivering frontline SRH care, HIV/AIDS education and trauma-informed nursing support directly to young people in a safe, welcoming environment.*

MR MBANGA

- *Principal Education Officer*
- *Bridging the gap between schools and health services, ensuring young people receive integrated education and health support within the community.*

MRS TOPO

- *Guidance & Counselling Teacher*
- *Providing psychosocial support and counselling to young people navigating reproductive health challenges and life decisions.*

DR MANDISA TENEGO

- *Family Physician*
- *Leading clinical care and coordinating the multidisciplinary response to teenage pregnancy and sexual and reproductive health at the Rakops Youth Service Centre.*

The Launch

Rakops Youth Service Centre — 6 August 2026

The Rakops Youth Service Centre was officially launched on 6 August 2026, bringing together a broad coalition of stakeholders committed to transforming adolescent health in Boteti West. The launch drew support from local government, community leaders, and the private sector — with Lucara Diamond and Debswana providing vital corporate backing that made the one-stop youth facility a reality. Representatives from health, education, and social services attended alongside young people from the surrounding community, marking a milestone in integrated youth-centred care.

What's Next

- *Community awareness campaigns targeting schools, families and traditional leaders across Boteti West*
- *Establishment of a local research hub to document and analyse the drivers of teenage pregnancy in the district*
- *Development of evidence-based implementation strategies tailored to the socioeconomic realities of rural Botswana*
- *Expansion of partnerships with NGOs, faith-based organisations and district health management teams*
- *Ongoing monitoring and evaluation to measure impact on teenage pregnancy rates, SRH uptake and youth well-being outcomes*

Rural Family Medicine

The roles that define Family Physicians in rural African communities

AfriWON Rural Practice Framework

TRAIN	MENTOR	RESEARCH	ADVOCATE
Build clinical skills in rural health workers	*Guide the next generation of rural doctors*	*Generate local evidence to improve care*	*Champion equitable rural health policy*

PARTNER	CONNECT	LEAD	INNOVATE
Collaborate with communities and systems for impact	*Link patients, families and health networks together*	*Drive health-system change from the frontline*	*Adapt solutions to local context and resources*

Building the Rural Health Workforce Apprenticeship and the Six Roles of the Rural Family Physician in Kenya

In Kenya's rural communities, the family physician is far more than a clinician. Through a structured apprenticeship model, doctors-in-training are immersed in the full complexity of primary care - learning not just to diagnose and treat, but to lead, teach, and advocate.

The apprenticeship approach places learners directly where care happens: in under-resourced facilities, remote health posts, and communities where undifferentiated presentations are the norm and diagnostic tools are limited.

The rural family physician embodies six essential roles:

- *Clinician - delivering comprehensive, continuous care*
- *Educator - training the next generation at the bedside*
- *Mentor - guiding junior doctors through complexity*
- *Researcher - generating evidence from real-world practice*
- *Advocate - championing equitable access and policy change*
- *Leader - strengthening health systems from within*

Together, these roles define what it means to build a resilient rural health workforce across Africa.

Apprenticeship

Learning Where Care Happens

In rural Kenya, the apprenticeship model places trainees at the centre of real care—not simulated scenarios. Undifferentiated presentations arrive daily: a child with fever and no clear source, a woman with chest pain and no ECG, an elder whose symptoms span multiple systems. Trainees learn to reason under uncertainty, prioritising with limited diagnostics and making decisions that matter immediately.

Community problems—malnutrition, gender-based violence, substance use—present alongside clinical illness. Trainees develop the adaptability to hold both the biomedical and the social in view simultaneously.

The apprenticeship model is not passive observation. Trainees take ownership of patient panels, follow cases longitudinally and receive real-time feedback from supervising family physicians. This builds clinical reasoning that textbooks cannot replicate.

Leadership emerges naturally. When a trainee coordinates a difficult discharge, advocates for a patient's referral or facilitates a community dialogue, they are practising the full scope of family medicine—clinician, communicator and system navigator at once.

Adaptability, resourcefulness and compassion are not soft skills here. They are core competencies, forged in the daily reality of rural primary care.

Learning Beyond Hospital Walls

Social Determinants and the Whole-Person Lens in Rural Kenya

Effective rural family medicine demands that physicians look beyond the clinic door. In Kenya's rural settings, a patient's health is shaped as much by what they eat, where they live, and who they are as by any presenting complaint. Trainees at Tenwek and similar rural sites quickly learn to ask: Is this child malnourished because of illness — or is illness the consequence of food insecurity at home? Cultural beliefs, seasonal migration patterns, and deeply rooted community norms all influence whether a patient returns for follow-up, accepts a referral, or discloses symptoms at all.

Financial pressures compound every clinical decision. Transport costs, out-of-pocket consultation fees, and lost daily wages mean that many families delay care until a condition is advanced. The rural family physician learns to negotiate care plans that are not only clinically sound but economically feasible. Recognising these determinants — nutrition, culture, migration, and financial constraint — transforms the consultation from a transaction into a partnership, and equips the next generation of doctors to address the true drivers of poor health outcomes across Africa.

Teaching the Next Generation

Mentorship, POCUS and Education as Health-System Strengthening at Tenwek Hospital

At Tenwek Hospital in rural Kenya, family physicians are doing more than treating patients — they are shaping the next generation of rural health workers. Through structured mentorship programmes, trainees are immersed in the realities of under-resourced settings: undifferentiated presentations, limited diagnostics, and communities with complex social needs.

Point-of-care ultrasound (POCUS) has become a cornerstone of this teaching approach. With access to advanced imaging often limited in rural contexts, POCUS equips trainees with a practical, portable skill that transforms clinical decision-making at the bedside.

Mentors at Tenwek model clinical reasoning, adaptability, and compassionate leadership — demonstrating that excellence in family medicine is not defined by technology alone, but by the depth of the doctor-patient relationship.

"Investing in education is investing in the health system itself. Every trainee we equip becomes a multiplier of quality care across communities that would otherwise go without."

— Family Physician, Tenwek Hospital, Kenya

This model of education-as-strengthening reflects AfriWON's conviction that training rural family doctors is one of the highest-leverage interventions available to African health systems.

When Communities Become Partners

Family Physicians, traditional leaders and community mobilisation in Nigeria

In rural and peri-urban Nigeria, Family Physicians are discovering that lasting health improvements begin not in the clinic but in the community. Engaging traditional and community leaders - chiefs, elders, religious figures and ward heads - has become a cornerstone of effective primary care delivery.

These leaders shape social norms, influence health-seeking behaviour and command the trust of entire communities. When they champion maternal care, immunisation or early referral, families listen. When they challenge harmful practices, change follows.

Family Physicians working within AfriWon's Rural Practice Theme have embraced a structured approach to community partnership. Rather than imposing clinical agendas, they enter communities as learners first - understanding local beliefs, economic pressures and existing healing systems before offering new pathways to care.

This model of shared leadership and mutual accountability is proving transformative. Mobilisation through trusted voices reduces barriers of stigma, distance and mistrust, bringing previously unreached populations into the health system. Communities are not passive recipients - they are active drivers of their own health outcomes.

Community Engagement Pathway

How Family Physicians Partner with Communities: Building trust, mobilising leaders & improving access through structured community engagement

The Five-Step Pathway

PARTNERSHIP PATHWAY

LISTEN → BUILD TRUST → PARTNER → MOBILISE → IMPROVE ACCESS

MOBILISE → IMPROVE ACCESS

Activate community champions to drive immunisation, ANC attendance, early referral, disease surveillance and NCD prevention at household level.

BUILD TRUST → PARTNER

Establish ongoing relationships with community gatekeepers. Co-design health initiatives so that communities are genuine partners, not passive recipients.

LISTEN

Engage traditional leaders, community members and households to understand local norms, beliefs and health-seeking behaviours before any intervention.

Community Health Champions

Where Family Physicians and traditional leaders unite Mobilising communities for lasting health impact

Champion Areas

STIGMA REDUCTION & NCD PREVENTION

Community champions reduce stigma surrounding non-communicable diseases and promote healthy lifestyles, making prevention a shared community value.

EARLY REFERRAL & SURVEILLANCE

Community mobilisers support timely referral pathways and strengthen disease surveillance networks, enabling rapid response to health threats.

IMMUNISATION & ANC

Traditional leaders champion childhood immunisation uptake and encourage antenatal care with skilled birth attendance, reducing maternal and child mortality.

When Communities Become Partners

The most durable health gains come not from prescriptions alone, but from trust built between clinicians and the communities they serve

- **Key lessons from Nigeria community engagement**

Key Lessons

BRIDGING CLINICAL & COMMUNITY

- *Family physicians are uniquely positioned to bridge clinical expertise and community leadership—translating evidence into culturally grounded action and amplifying community priorities within the health system.*

TRUST & SHARED LEADERSHIP

- *Building trust with traditional leaders, community health workers and families creates shared ownership*
- *Equity and accountability follow when communities have a real voice in decisions that affect their health.*

COMMUNITIES AS PARTNERS

- *Communities are not passive recipients of care.*
- *When engaged as genuine partners, they co-design solutions, hold systems accountable, and sustain health gains long after the clinician leaves.*

Taking the Hospital to the Homestead

Buliisa HC IV: Treat the Person, Not the Number

In Bulisa District, the Family Medicine team of Buliisa Health Centre IV recognised that clinic walls alone could not contain the full scope of care their patients needed. Chronic absenteeism, missed immunisations and deteriorating maternal outcomes pointed to a deeper truth: the barriers keeping people from care were not clinical - they were social.

Housing instability, unsafe water sources, food insecurity, absent family support, unaffordable transport and the sheer distance to the nearest facility were quietly determining health outcomes long before any patient reached a consultation room.

The response was bold and practical: take the hospital to the homestead. Through structured community outreach, the team began meeting patients where they lived - assessing not just symptoms but circumstances. Every home visit became an opportunity to understand the full picture: who cooks, who earns, who travels, who is afraid.

This shift - from counting patients to knowing people — transformed the team's approach to primary health care. Affordability, proximity and trust became as central to the care plan as diagnosis and treatment. Buliisa HC IV became a model of what comprehensive, person-centred rural health care can look like when it truly responds to people's lives.

Taking the Hospital to the Homestead

Buliisa HC IV: Treat the Person, Not the Number

The ecology of the patient

Consider an older man who arrives at the outpatient department with severe hypertension. Prescribe medication and ask him to return in a month, and you may have treated a number rather than a person. Ask where he lives, whether he lives alone, how far he walks for clean water, what he eats and whether he can afford transport for follow-up, and the prescription becomes a realistic care plan.

This is the ecology of the patient, and it is the premise on which Buliisa Health Centre IV reshaped its approach to rural care. Health-worker shortages, fragile infrastructure, poverty, long distances and limited supplies cannot be solved by a prescription pad. Closing the gap required a different understanding of where care should happen.

"Treat the person, not the number."

Learning from community-based systems

Community-oriented health systems show the value of bringing prevention and basic care closer to where people live. Uganda's decentralised primary healthcare policy reflects this logic. District Health Teams provide integrated supportive supervision to facilities and communities, combining clinical mentorship, data review, logistics and community follow-up. Outreach and mentorship therefore become part of routine district oversight rather than optional extras.

Distance to the nearest facility were quietly determining health outcomes long before any patient reached a consultation room.

Five Principles of Person-Centred Rural Care:

Guiding the Buliisa HC-IV outreach model: treating the whole person within their community household & life context

Care Principles in Practice

COMMUNITY-ORIENTED
Village Health Teams and community intelligence guide where care goes, who is reached and which households are most at risk.

COMPREHENSION
Services address prevention, promotion, curative and rehabilitative needs across all ages and conditions — not single-disease verticals.

PERSON-CENTRED
Care begins with the individual — their housing, water, food, support networks, transport access and ability to afford treatment.

Rural barrier	Buliisa response
Health-worker shortage	VHTs, community health workers, LC1 leaders and parish chiefs joined teams led by the Family Physician.
Weak infrastructure	Care moved to villages rather than being routed through an outpatient department too small for six villages at once.
Poverty and distance	Transport costs and travel time were reduced by bringing services to homesteads.
Limited supplies	Prevention and early treatment reduced avoidable repeat visits and pressure on stock.
Staff attitudes	A shared outreach vision aligned staff around common goals rather than individual roles.

Data Before Departure

Before each outreach, Village Health Teams (VHTs) provide community intelligence: unimmunised children, pregnant women not attending ANC, individuals with hypertension or diabetes, and HIV/TB defaulters. This data-driven preparation ensures no household is overlooked and every visit is purposeful.

Uganda Impact
40% → 12%
immunisation dropout rate.

Uganda
Outreach

Measurable Change

IMMUNISATION

Immunisation dropout rates fell from over 40% to just 12% following community outreach, VHT engagement and proactive household follow-up in Buliisa.

FACILITY DELIVERIES

Facility deliveries rose from 25-30 per month to approximately 70 per month, reflecting increased trust and access to skilled birth attendance.

MALARIA & REACH

Over 20% malaria positivity detected through active screening. Previously disengaged households and DRC refugee families now seeking earlier, consistent care.

Beyond the Prescription

Voice from the Frontline — Dr Murtaza Lamuwalla

Working in a semi-urban setting in Tanzania has taught me that Family Medicine is about making the best possible use of available resources while ensuring that every patient receives holistic and continuous care. Building long-term relationships with patients and their families is immensely rewarding. It has also deepened my appreciation of the trust placed in us as Family Physicians.

Continuity in real life

One recurring challenge is caring for people with chronic conditions such as hypertension and diabetes who struggle to attend regular follow-up appointments. Work commitments, transport costs and wider financial pressures can make consistent attendance difficult. Limited insurance coverage may further restrict access to essential services.

These realities have taught me to look beyond the prescription and understand the circumstances that shape a patient's ability to follow a care plan. We work collaboratively with patients to develop realistic and sustainable approaches, offer practical health education and involve family members where appropriate.

Strengthening the wider team

I have also come to value the importance of building the capacity of the broader healthcare team. Through training and mentorship of medical officers and clinical officers, we seek to improve standards of care and strengthen communication with patients. These seemingly small interventions can improve adherence, support continuity and prevent avoidable complications.

"Family Medicine is not defined by the resources available, but by the ability to understand each patient within the context of their life."

What the work has reinforced

My experience in Tanzania has reinforced my belief that Family Medicine is defined by relationships: understanding the person behind the condition, remaining present across episodes of care and strengthening primary healthcare through teamwork and community engagement. Resources matter, but the quality of our listening, our continuity and our willingness to adapt care to a patient's life are equally fundamental.

FRONTLINE REFLECTION

Good chronic care begins when a technically sound plan also becomes a plan the patient can realistically follow.

Beyond the Prescription

Voice from the Frontline — Dr Murtaza Lamuwalla

Dr Murtaza Lamuwalla practises family medicine in Tanzania where the realities of rural primary care go far beyond clinical diagnosis. Continuity of care is central to his work — returning patients are not strangers but known individuals whose lives, struggles and contexes shape every consultation. Yet continuity is fragile. Costs, limited insurance coverage and the challenge of follow-up mean patients often disengage before treatment is complete.

"To truly care for a patient, you must understand their life - not just their symptoms. When you know that a mother cannot afford the bus fare to return for review, or that a father skips his medication because the pharmacy is three hours away, you begin to prescribe differently. Mentoring the next generation of family doctors means teaching them to see the whole person, not just the presenting complaint."
— Dr Murtaza Lamuwalla, Family Physician, Tanzania

One Continent. Different Settings. Shared Principles. Five Countries. Five Contexts. One Common Vision for Equitable Person-Centred Primary Health Care Across Africa

Country Themes at a Glance

BOTSWANA - LISTEN

- *Listen to your community*
- *The Rakops Youth Service Centre was built on understanding what young people actually need*
  - *safe spaces, trusted adults, and integrated SRH care delivered without judgement*

NIGERIA - TRUST

- *Trust is the gateway. Family Physicians who engage traditional leaders and community champions unlock immunisation uptake, ANC attendance, early referral and disease surveillance—none of which is possible without earned trust.*

TANZANIA - SEE THE WHOLE PERSON

- *Beyond the prescription lies the person*
- *Dr Lamuwalla's practice reminds us that continuity, cost barriers, insurance gaps and life context are inseparable from clinical care*

KENYA - TRAIN

- *Train where care happens*
- *Tenwek Hospital's apprenticeship model embeds doctors in rural realities, building workforce capacity through mentorship, POCUS skills and learning from undifferentiated, complex presentations*

UGANDA - TAKE CARE OUTWARD

- *Bring the hospital to the homestead*
- *Buliisa HC IV's outreach model- guided by VHT intelligence and real data-reached unimmunised children, defaulters and DRC refugee households who had never accessed facility care*

SHARED PRINCIPLES

- *Across all five settings:*
  - *community partnership,*
  - *data-informed outreach*
  - *mentorship*
  - *advocacy*
  - *person-centred continuity*

These unite AfriWon members as clinicians, educators and system leaders

Spotlight: Dr Adeleye Babarinsa

Dr Adeleye Babarinsa is a Family Physician and rural health advocate based at Baptist Medical Centre, Saki, Nigeria.
He is the Co-Founder and Executive Director of Creating Healthy Communities and Kinship (CHECK) Medical Mission, where he leads initiatives aimed at improving access to quality healthcare in underserved rural communities.
His work brings together Family Medicine, community engagement and strategic partnerships to deliver medical, surgical, rehabilitation and health-promotion services to rural populations.
With interests in rural and remote medicine, community-oriented primary care, health systems strengthening, leadership and medical education, Dr Babarinsa continues to advocate for sustainable and culturally responsive models of healthcare across Africa.

Spotlight: Dr Otim Peter

Dr Otim iis a dedicated Senior Medical Officer and HSD In-Charge at Buliisa HC IV, currently training as a Family Physician. He is committed to delivering patient-centred care with a focus on quality, safety, and equitable access to health services for rural communities.

- *Championing patient-centred care and CQI to strengthen service delivery at HC IV level*
- *Reducing immunization dropout through community engagement, outreach, and robust follow-up systems*
- *Promoting safe deliveries and maternal-newborn health, ensuring 24/7 EmONC*
- *Strengthening health systems for improved accessibility, data-driven decisions, and integrated primary healthcare*

Committed to Quality · Accessible Health Services · Safe Deliveries · Zero Immunization Dropout

Spotlight: Dr Fridah Kitui

Dr Fridah Kiptui is a Family Physician with a strong passion for medical education, rural primary healthcare and the training of Family Physicians and multidisciplinary primary care teams.

She currently serves as Deputy Program Coordinator for Family Medicine at Tenwek Hospital and as Associate Faculty in the Department of Family Medicine at Kabarak University. Through these roles, she contributes to the education and mentorship of healthcare professionals, with a particular focus on strengthening the capacity of clinicians serving rural and underserved communities.

Dr Kiptui also has a deep interest in chronic disease care. At AGC Tenwek Hospital, she leads Advanced HIV Care and Diabetes Care, working to ensure that patients receive care that is affordable, accessible, high-quality and safe across the life course.

Her work reflects a strong commitment to comprehensive, patient-centred primary care and to building resilient healthcare teams capable of responding to the diverse health needs of their communities.

A passionate advocate for lifelong learning, Dr Kiptui believes that continuous professional growth is fundamental to achieving excellence in the service of humanity. Through her contribution to the AfriWon Renaissance Rural Theme Team, she brings together her interests in rural Family Medicine, clinical education and chronic disease care to help strengthen primary healthcare across Africa.

Meet the Team Leading the AfriWon Renaissance Rural Theme

Championing stronger rural primary healthcare, equitable access, and context-responsive Family Medicine across Africa.

Dr Susan Wanjiku

Afriwon Renaissance Rural Theme Lead

Dr Susan Wanjiku is a Family Physician and Medical Superintendent at Molo Sub-County Hospital in Nakuru County, Kenya. She holds a Master's degree in Family Medicine from the University of Havana and a Postgraduate Diploma in Diabetology from the University of Wales. She is currently pursuing an MSc in Diabetology.

A Hospital Management Fellow, Dr Wanjiku received specialised leadership and management training through the Japan International Cooperation Agency (JICA) at Kyushu and St Mary's Hospitals in Japan. In her current role, she leads multidisciplinary initiatives to strengthen primary healthcare, with particular emphasis on non-communicable diseases and community-based health services.

Her work includes:

- *Supporting community health outreach programmes*
- *Strengthening patient support groups*
- *Promoting community empowerment in preventing and managing chronic diseases*
- *Advancing evidence-based diabetes care*
- *Improving access to high-quality healthcare*
- *Strengthening health systems at the grassroots level*

Through her clinical practice, academic development and health-system leadership, Dr Wanjiku is committed to advancing diabetes care and improving health outcomes for individuals and communities affected by chronic diseases.

Dr Emmanuel Addo Asante

Afriwon Renaissance Deputy Rural Theme Lead

Dr Emmanuel Addo Asante is a Specialist Family Physician with over 10 years of experience in comprehensive primary care, preventive medicine and health promotion in Ghana.

He currently serves as Acting Medical Superintendent and Family Physician Specialist at Bortianor Polyclinic in Accra, where he manages a broad range of primary care conditions and supports specialised clinics in geriatrics, sickle cell disease and asthma. He is also involved in clinical audit, research and collaboration with national health-data teams.

His academic and professional training spans Family Medicine, Public Health, Health Administration, Epidemiology, Global Governance and Leadership. He holds an MPH from the University of Ghana and has completed additional executive training through GIMPA and the University of Washington.

Dr Asante has a growing research portfolio, with interests in HIV, tuberculosis, stigma, family resources and viral-load suppression. His work reflects a strong commitment to strengthening evidence-based primary healthcare and improving outcomes for underserved populations.

As Deputy/Assistant Rural Theme Lead within AfriWon Renaissance, he brings clinical leadership, research experience and a health-systems perspective to advancing equitable Family Medicine across Africa. Outside medicine, he enjoys classical music, reading, research and cycling.

AfriWON Renaissance newsletter

Meet the people shaping the newsletter.

Dr Nantale Peace Atangwa

EDITOR IN CHIEF

RESEARCH & CLINICAL AUDIT THEME LEAD
ASSOCIATE CONSULTANT PUBLIC HEALTH
• MOROTO REGIONAL REFERRAL &
KARAMOJA SUBREGION
FAMILY PHYSICIAN

Leads the editorial vision and brings rural family medicine voices into focus.

Dr Thando Agape Dube

CO-EDITOR

IMAGE & COMMUNICATIONS THEME LEAD
FAMILY PHYSICIAN
DEMENTIA CARE COACH
GERIACTRICS & GERONTOLOGY

Shapes clear, engaging stories that connect community practice, learning, and action.

Where Do We Go From Here?

Share your story with the AfriWON community

Join the Rural Practice Theme Group

Mentor a young family doctor in your region

Lead or participate in community-based research

Connect across borders — one continent, shared principles

AfriWON: The Voice of Young Family Doctors Across Africa

Email:

afriwon@wonca.com/afriwon.secretariat@gmail.com

Social:

Instagram: @afriwonrenaissance

X/Twitter: @theRealAfriWon

LinkedIn: AfriWON Renaissance

Facebook: AfriWON Renaissance

Upcoming: AfriWON Rural Practice Symposium 2026