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International Health Alerts 2026-1 Abstracts

Child Health

1. Am J Trop Med Hyg. 2026;114(4):787-95

Interventions to Prevent Post-Discharge Mortality among Children in Sub-Saharan Africa: A Systematic Review

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Post-discharge mortality (PDM), defined as deaths that occur in the weeks and months after hospital discharge, remains a critical, yet under-recognized, contributor to high childhood mortality rates in sub-Saharan Africa. However, a comprehensive understanding of effective interventions to prevent PDM is lacking. The aim for the present study was to evaluate the efficacy of published interventions to prevent PDM among neonates and children aged 0-18 years in sub-Saharan Africa. A systematic review was conducted to assess the efficacy of interventions for preventing PDM. The CABI Global Health, Cochrane Reviews, Cochrane Trials, ProQuest Dissertations and Theses, Embase, PubMed, and Web of Science databases were searched without language restriction. Publications that involved interventions for preventing PDM, included children, and were conducted in sub-Saharan Africa were included in the present study. Of 4,893 publications screened, 17 were included, with 12,938 participants in total (10.6% experienced PDM). The most common interventions included supplemental feeding programs, kangaroo mother care, antibiotic use, and micronutrient supplementation. Effectiveness varied within and between intervention types. Only two interventions resulted in statistically significant reductions in PDM: vitamin A supplementation for children with pneumonia (hazard ratio: 0.51; 95% CI: 0.29-0.90; low quality of evidence) and linkage to services for children with sickle cell disease (adjusted hazard ratio: 0.26; 95% CI: 0.08-0.83; low quality of evidence). No single intervention type provided consistent benefits across studies. Most interventions targeted children with specific diagnoses; however, some strategies addressed social determinants of health. Future research must prioritize cost-effective, scalable strategies across diverse sub-Saharan African settings to accelerate the prevention of PDM among children.

Climate Change and Health

2. BMJ 2026;392:s25

Editor's Choice

New Year's resolutions for the climate emergency

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How do we resolve the great challenges to health and wellbeing? Welcome to a BMJ special issue of resolutions. Our aim is to begin each year with a range of short essays on one of these great challenges. Inevitably, and most urgently, the climate emergency is the focus of our first ever cluster of New Year's resolutions.

We were inspired partly by Kim Stanley Robinson's landmark novel *The Ministry for the Future* (doi:10.1136/bmj.r2468), which imagines a subsidiary body being established in 2025 under the remit of the Paris Agreement. The task of "the ministry" is to find solutions to the climate emergency and to safeguard future generations. Robinson, in an exclusive interview with *The BMJ* (doi:10.1136/bmj.r2658), explains how the book is as relevant today as it was when written in 2019. Despite today's breakdown in the international order—with a world at the whim of military and technological might, a crisis in the cost of living, erosion of health systems, and widening inequalities—the climate emergency remains the risk that we're least prepared for and least willing to respond to.

Just as Robinson's ministry embarks on initiatives—legal and subversive—across diverse sectors, our articles explore the multipronged response required. We consider what might be done to deliver sustainable healthcare (doi:10.1136/bmj.r2645), reconfigure food systems (doi:10.1136/bmj.r2531), prepare for the unstoppable challenge of migration (doi:10.1136/bmj.r2456), manage the impact of AI

(doi:10.1136/bmj.r2606), work with legal systems (doi:10.1136/bmj.r2498), debunk technological myths such as carbon capture (doi:10.1136/bmj.r2662), and partner with our ancient ally and steward of the planet: the ocean (doi:10.1136/bmj.r2635).

But perhaps the most fundamental argument is made in Tim Jackson's rejection of the dominant global economic model (doi:10.1136/bmj.r2573). This is the model that drives Trump's invasion of Venezuela. It's the model that harms healthcare delivery in the UK and internationally (doi:10.1136/bmj.r2552). It's the model that perpetuates inequalities and buttresses our unwillingness to care for people and the planet. And what distorts our global priorities and accelerates the climate emergency, argues Jackson, is the runaway and dangerous pursuit of economic growth.

3. Lancet 2025;406(10521):2804-57

The 2025 report of the Lancet Countdown on health and climate change: climate change action offers a lifeline

Romanello M et al., Institute for Global Health, University College London, London, UK

Driven by human-caused greenhouse gas emissions, climate change is increasingly claiming lives and harming people's health worldwide. Mean annual temperatures exceeded 1.5°C above those of pre-industrial times for the first time in 2024. Despite ever more urgent calls to tackle climate change, greenhouse gas emissions rose to record levels that same year. Climate change is increasingly destabilising the planetary systems and environmental conditions on which human life depends. Authored by 128 multidisciplinary experts worldwide, the 2025 report of the Lancet Countdown on health and climate change is the ninth—and most comprehensive—assessment of the links between climate change and health. The data in this report reveal that, as the health risks and impacts of climate change break concerning new records, progress is being reversed across key areas, further threatening health and survival. However, the evidence in this report also exposes important opportunities to accelerate action and prevent the most catastrophic impacts of climate change.

People worldwide are facing unprecedented climate change health risks. Of the 20 indicators monitoring climate change-related health risks, 12 (60%) reached unprecedented levels in the latest year of data.

Despite these growing threats, climate change action not only remains inadequate, but also, in many cases, progress is reversing: of the 20 indicators and subindicators for which time-series data on climate change and health actions are available, 12 moved in the wrong direction in the latest year of data, and six show reversal of previous progress.

As a growing number of world leaders threaten to reverse the little progress to date, these incipient positive actions need to be reinforced and expanded for the world to continue to sustain healthy human lives. Panel 1 provides an overview of key priorities for different actors to drive the way to a healthier future. With climate change impacts growing, the health and lives of the world's 8 billion people are now at stake.

Other paper about this subject:

* Lancet 2026;407(10524):185-94

Lancet Countdown on health and climate change in Africa: an international collaboration for locally led research and action

Communicable diseases (Malaria and HIV/AIDS: see below)

4. Lancet 2026;407(10524):147-60

Zoliflodacin versus ceftriaxone plus azithromycin for treatment of uncomplicated urogenital gonorrhoea: an international, randomised, controlled, open-label, phase 3, non-inferiority clinical trial
Zoliflodacin Phase 3 Study Group: Luckey A et al., Global Antibiotic Research & Development Partnership, Geneva, Switzerland <aluckey@gardp.org>

Background: Development of new treatments for gonorrhoea is a global public health priority. We aimed to evaluate the efficacy and safety of zoliflodacin versus ceftriaxone plus azithromycin in patients with uncomplicated urogenital gonorrhoea.

Methods: In this phase 3, multinational, randomised, controlled, open-label, non-inferiority clinical trial, participants aged 12 years and older with clinical suspicion of uncomplicated urogenital gonorrhoea were eligible for inclusion. The trial was done in 17 outpatient clinics in Belgium, the Netherlands, South Africa, Thailand, and the USA. Participating countries with high disease prevalence were identified for participation in the study. Sites selected for participation were led by principal investigators with research experience, who were knowledgeable in HIV or sexually transmitted infections and treatment. Feasibility questionnaires and prestudy visits assessed sexually transmitted infection case management guidelines, clinical services, and resources (ie, facility, staff, proposed composition of the study team, standard sexually transmitted infection services offered at the site, assessment of laboratory capacity, research experience and ethical review of clinical trials). Eligible participants were randomly assigned (2:1) to receive a single dose of zoliflodacin 3 g (oral) or ceftriaxone 500 mg (intramuscular) plus azithromycin 1 g (oral). Treatment assignment was known to the participants and their treating clinicians; however, microbiology laboratory staff were masked and the sponsor's central study team were masked until after database lock. The primary endpoint was the proportion of patients with microbiological cure (eradication of *Neisseria gonorrhoeae*, determined by urethral or endocervical culture) at test of cure (TOC; day 6 $\pm$ 2) in the microbiological intention-to-treat population. The primary efficacy analysis declared non-inferiority if the upper bound of the two-sided 95% CI for the treatment difference (comparator minus zoliflodacin) fell below the 12% non-inferiority margin. The trial is registered with ClinicalTrials.gov, NCT03959527, and EudraCT, 2019-000990-22.

Findings: Between Nov 6, 2019, and March 16, 2023, 1011 patients were screened. 81 patients did not meet screening criteria and 930 participants were randomly assigned to zoliflodacin (n=621) or comparator (n=309). The mean participant age was 29.7 years (SD 9.4). 815 (88%) of 930 participants were assigned male at birth and 115 (12%) participants were assigned female at birth. 514 (55%) of 930 participants were Black or African American, 285 (31%) were Asian, and 113 (12%) were White. Microbiological cure rates at TOC in the microbiological intention-to-treat (urogenital) population (primary efficacy endpoint) were 460 (90.9%, 95% CI 88.1-93.3) of 506 participants for zoliflodacin and 229 (96.2%, 92.9-98.3) of 238 participants for comparator. The estimated difference between groups was 5.3% (95% CI 1.4-8.6) and the upper confidence interval limit was within the prespecified non-inferiority margin of less than 12%. Zoliflodacin was generally well tolerated and adverse events were similar between treatment groups. The most frequently reported treatment-emergent adverse events included headache (61 [10%] of 619 patients), neutropenia (42 [7%]), and leukopenia (24 [4%]) in the zoliflodacin group and injection site pain (38 [12%] of 308 patients), neutropenia (24 [8%]), and diarrhoea (22 [7%]) in the comparator group. The majority of adverse events were mild or moderate in severity. No serious adverse events were reported.

Interpretation: Zoliflodacin was non-inferior to ceftriaxone plus azithromycin for the treatment of uncomplicated urogenital gonorrhoea and had a similar safety profile. These data suggest a potential role for zoliflodacin as an effective oral treatment option for uncomplicated urogenital gonorrhoea.

5. Lancet 2026;407(10525):256-66

Maternal and neonatal outcomes after infection with monkeypox virus clade I during pregnancy in DR Congo: a pooled, prospective cohort study

Vakaniaki EH et al., Institut National de Recherche Biomédicale, Kinshasa, DR Congo.

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Background: Monkeypox virus (MPXV) has been linked to vertical transmission, but systematic data are scarce. We aimed to describe the sociodemographic, clinical, and virological characteristics and assess the frequency and determinants of adverse outcomes in pregnant women with MPXV clade I infection.

Methods: In this prospective cohort study, we pooled data from three cohort studies (MBOTE-SK, PREGMPOX, and Uvira mpox) and one randomised controlled trial (PALM007) conducted in the South Kivu, Maniema, and Sankuru provinces of DR Congo between Dec 29, 2022, and June 20, 2025. Pregnant women and adolescent girls with a PCR-confirmed diagnosis of mpox were followed up throughout hospitalisation for mpox, delivery, and until discharge during the postpartum period. We extracted data on sociodemographic characteristics, MPXV exposure, clinical and obstetric

presentation, and laboratory results. In a univariable analysis, we examined factors associated with the following adverse outcomes: spontaneous or missed abortion (<20 weeks of gestation), stillbirth (≥20 weeks of gestation), preterm birth (<37 weeks of gestation), live birth of a neonate with macroscopic mpox-like lesions, early (first 7 days) neonatal death, congenital anomaly, or maternal death (during pregnancy or discharge postpartum).

Findings: We collected data from 89 pregnant women in the first (25 [28%]), second (31 [35%]), and third (33 [37%]) trimesters across all four studies: MBOTE-SK (36 [40%]), PREGMPOX (24 [27%]), PALM007 (25 [28%]), and Uvira mpox (four [4%]). All participants recovered from mpox; no maternal deaths were reported. During hospitalisation for mpox, fetal loss was reported in 17 (19%) women. Final pregnancy outcomes were known for 69 (78%) participants; adverse outcomes were reported in 35 (51%) women (95% CI 38-63), including fetal loss in 31 (45%; 95% CI 33-57; 16 [52%] spontaneous abortions, four [13%] missed abortions, and 11 [35%] stillbirths). Of the 38 live births, four neonates had congenital mpox-like lesions; one infant died a few hours after birth. No preterm births or congenital abnormalities were recorded. MPXV infection during the first trimester was associated with a higher risk of adverse pregnancy outcomes than during the second (risk ratio [RR] 0·6 [95% CI 0·4-0·9]) and third (0·2 [0·1-0·4]) trimesters ($p=0·0008$). Adverse outcomes were also associated with high viral load in skin lesions (PCR cycle threshold ≤30; RR 3·5 [95% CI 1·0-12·3]; $p=0·045$), direct sexual contact with the index case (1·6 [1·1-2·4]; $p=0·026$), positive HIV status (2·0 [1·4-2·9]; $p=0·0002$), and the presence of genital lesions (1·9 [1·1-3·2]; $p=0·025$).

Interpretation: MPXV clade I infection in pregnancy is associated with a high risk of fetal loss and congenital infection, particularly during the first trimester. Targeted preventive and clinical strategies are urgently needed to protect pregnant women and their infants in settings that are endemic and epidemic for mpox.

6. Lancet 2026;407(10529):716-27

Seminar

Tetanus

Ergönül Ö et al., Koç University School of Medicine, Infectious Diseases and Clinical Microbiology, Istanbul, Türkiye <oergonul@ku.edu.tr>

Tetanus, although preventable by a highly effective vaccine, continues to cause 30 000–50 000 deaths annually. Global mortality has fallen substantially since the 1980s due to widespread vaccination efforts, yet adult disease persists, especially among those with weakened immune response, diabetes, and people who inject drugs. Diagnosis is still clinical, and management combines wound debridement, antibiotics, and antitoxin. However, key questions about prevention, diagnosis, and management remain unanswered. Recent trials suggest human and equine antitoxin perform equally, but shortages and high costs persist. Autonomic instability, once thought a late stage complication, is now defined early in the disease course, affecting the prognosis. Due to patients being in intensive care, complications such as nosocomial infections can increase the burden of the disease, reinforcing that vaccination, surveillance, equitable access, and new therapy options are vital.

7. Lancet 2026;407(10530):805-19

Seminar

Leprosy

Higueta NIA et al., Department of Medicine, University of Oklahoma Health Campus, Oklahoma City, OK, USA <nelson-agudelo-higueta@ou.edu>

Leprosy, also known as Hansen's disease, is a curable granulomatous condition caused by *Mycobacterium leprae* or *Mycobacterium lepromatosis*, disproportionately affecting impoverished communities across the globe. The bacteria's tropism for dermal histiocytes, endothelial cells, and Schwann cells causes neuronal and dermal damage that often results in disability, permanent disfigurement, stigma, and social exclusion. Despite important achievements in the understanding of the disease, its elimination has been hampered by the scarcity of sensitive diagnostic tools, suboptimal integration and implementation of coordinated and financially stable preventive interventions, persistent stigmatisation, and failure to efficiently and sustainably address the socioeconomic and

demographic factors associated with an increased risk of leprosy. In this Seminar, we provide an update on key public health and clinical aspects of the disease.

8. Lancet Glob Health 2026;Mar 11:S2214-109X(25)00534-0

The incidence and antimicrobial resistance of Shigella-attributable diarrhoea in young children in low-income and middle-income countries from the multicountry Enterics for Global Health (EFGH) Shigella Surveillance Study: a prospective, facility-based hybrid surveillance study
Yousafzai MT et al., Department of Pediatrics and Child Health, Aga Khan University, Karachi, Pakistan. Correspondence to Pavlinac PB <ppav@uw.edu>

Background: Shigella is a leading cause of dysentery and watery diarrhoea in low-income and middle-income countries (LMICs) with consequences beyond diarrhoea for children younger than 5 years, including environmental enteric dysfunction and linear growth impairment. We established the burden, serotypes, and antibiotic resistance patterns of Shigella-diarrhoea among young children in LMICs to inform vaccine trial planning and eventual vaccine introduction in high-burden countries. **Methods:** The Enterics for Global Health (EFGH) study was a prospective, facility-based hybrid surveillance study conducted from June 21, 2022, to Aug 25, 2024, across seven countries: Kenya, Malawi, Mali, The Gambia, Bangladesh, Pakistan, and Peru. Children aged 6-35 months presenting at selected health-care facilities with acute diarrhoea (three or more abnormally loose or watery stools in the last 24-h period lasting less than 14 days) were enrolled. We calculated care-seeking adjusted incidence estimates from contemporaneous population enumeration and by ascertaining health-care seeking patterns from a health-care utilisation survey conducted in children aged 6-35 months in the health-facility catchment area. We deemed Shigella to be attributable if detected by microbiological culture or by quantitative PCR (qPCR) using an ipaH quantification cycle threshold of less than or equal to 29.5 from rectal swabs. We determined antimicrobial resistance to commonly used antibiotics by disc diffusion. We calculated adjusted incidence for all participating country sites and by key subgroups of interest (age, diarrhoea severity, study month, Shigella species, and serotype). **Findings:** Of the 9476 enrolled children, 4316 (45.5%) were female and 5160 (54.5%) were male, 881 (9.3%) had Shigella detected by culture and 1870 (20.0%) by qPCR (among 9354 children with qPCR results available). Shigella flexneri dominated (497 [56.2%] of 881 by culture and 756 [39.4%] of 1870 by qPCR), with S flexneri 2a and S flexneri 6 being the most common serotypes by both methods. Across study sites, the adjusted incidences of Shigella-attributed diarrhoea by culture ranged from 2.7 per 100 child-years (95% CI 1.9-4.3) in Malawi to 11.7 per 100 child-years (8.3-24.2) in Peru and by qPCR ranged from 3.5 per 100 child-years (2.5-5.4) in Malawi to 26.9 per 100 child-years (19.0-40.9) in The Gambia. Shigella isolates exhibited resistance to WHO-recommended antibiotics for dysentery with variability across sites: ciprofloxacin (37.2% [range 14.0-74.0]), azithromycin (22.1% [1.2-34.2]), and ceftriaxone (16.2% [0.0-64.4]). **Interpretation:** Shigella-attributed diarrhoea is common among young children in LMICs, with its escalating antimicrobial resistance posing a serious threat to global public health. The leading quadrivalent vaccine candidates cover the majority of Shigella serotypes identified in this study. These data affirm both the need for Shigella vaccines and readiness of EFGH sites to conduct rigorous vaccine trials.

Conflicts and Humanitarian Crises

9. BMJ 2026;392:s1115

Opinion

The BMJ appeal 2025-26: Hospitals should be sanctuaries, not military targets
Kahindi DC, MSF, South Sudan

(Abbreviated)

MSF experienced eight targeted attacks in 2025 on its facilities and staff in the states of Central Equatoria, Jonglei, and Upper Nile, forcing the closure of two hospitals in Ulang and Old Fangak. Hospitals should be sanctuaries, yet in that moment, they became symbols of vulnerability. I felt an overwhelming sense of helplessness, knowing that patients who trusted us for care were now in grave

danger, and that our ability to provide even the most basic treatment had been shattered. The fear was palpable, but so were the anger and sorrow. These attacks not only endanger lives immediately; they erode the very foundation of humanitarian healthcare. No one should ever have to choose between seeking healthcare or avoiding hospitals for fear they're unsafe.

With international funding cuts to humanitarian and development programmes, and the precarious state of the national healthcare system, our presence in many areas of South Sudan is critical. In every location where we work, we witness huge gaps in health services where facilities are either non-functional or severely under-resourced. The whole health system is at breaking point. Without urgent action from the government and the international community, the consequences for the people of South Sudan will be catastrophic.

Other paper about this subject:

* BMJ 2026;392:s243

Iran: Attacking injured protestors and healthcare workers violates medical neutrality

10. BMJ 2026;392:e086040

Analysis Child mental health in conflict settings

Long term effects of childhood exposure to violence in fragile and conflict affected settings

Sharma N et al., Centre for Global Child Health, Hospital for Sick Children, Toronto, Ontario, Canada. Correspondence to ZA Bhutta <zulfiqar.bhutta@sickkids.ca>

Zulfiqar A Bhutta and colleagues argue that the response to children in fragile and conflict affected settings must move beyond event based framings to tackle cumulative and intergenerational adversity and contextually relevant opportunities for action.

Early exposure to armed conflict is a growing global crisis, with more than 460 million children living in armed conflict zones. Children in fragile and conflict affected settings face sustained exposure to violence, poverty, insecurity, family disruption, and service deprivation during sensitive periods of brain and psychosocial development, placing their mental health at heightened risk. This article builds on the work on health and nutrition in conflict settings done by BRANCH (Bridging Research and Action in Conflict Settings for the Health of Women and Children) Consortium. As part of the BMJ Collection on Child Mental Health in Conflict Settings, we describe how global responses fail to address the pathways through which early adversity in such settings affects children's mental health and development across the life course and generations. Other articles in the collection identify evidence based interventions and integration strategies to improve child outcomes and strengthen mental health systems.

Key messages

Conflict dismantles the familial, social, institutional, and environmental structures essential to child wellbeing.

This leads to cascading disruptions in brain development, stress physiology, attachment systems, and environmental learning.

Emerging epigenetic research suggests that trauma can be transmitted intergenerationally, shaped by maternal mental health, the caregiving environment, social conditions, and developmental timing. Dominant global response models and funding often favour short term interventions tailored to donor reporting cycles rather than the required longer term, system embedded care.

Recommendations for supporting children in fragile and conflict affected settings.

A trajectory aware model that is attuned to toxic stress, caregiver pathways, deprivation, and intergenerational transmission during concurrent crises requires: Long cycle response programming that repositions short term tools as bridges into systems embedded care. Family centred supports integrated with mental health and psychosocial support and social protection. Continuity across platforms (eg, primary care, schools, social protection). Long term funding for systems transformation tied to the humanitarian-development-peace nexus and national systems. Hybrid effectiveness-implementation and pragmatic trials, realist and mixed methods evaluations, longitudinal follow-up, and culturally anchored measures with study populations beyond western contexts. Data tracking with longitudinal indicators (eg, embed mental health and psychosocial support and early childhood development indicators in health and education management information systems).

Other paper about this subject:

* BMJ 2026;392:e086044

Analysis Child mental health in conflict settings

Integrating child mental health responses into recovery, development, and peacebuilding in fragile and conflict affected settings

11. BMJ Glob Health 2026;11:e018964

Implementation of essential newborn care in settings of high-intensity armed conflict: a systematic review.

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Introduction A disproportionate share of global neonatal deaths occurs in armed-conflict settings, where progress in reducing neonatal mortality remains slow. This systematic review aims to synthesise the literature on implementing essential newborn care (ENC) interventions in high-intensity armed conflict settings.

Methods We searched PubMed, CINAHL, Embase and the grey literature from January 2014 to March 2024. Eligible original studies in English implemented at least one component of ENC in settings experiencing high-intensity armed conflict. Data were extracted on study characteristics, ENC implementation and outcomes. Certainty of evidence was assessed using Grading of Recommendations, Assessment, Development and Evaluation (GRADE) for quantitative studies and GRADE-Confidence in the Evidence from Reviews of Qualitative Research for qualitative and mixed-method studies.

Results 32 studies were included, primarily from hospital settings (n=15, 47%) in Pakistan (n=6, 19%) and South Sudan (n=5, 16%). Interventions focused on health workforce (n=19, 59%) and service delivery (n=8, 25%), predominantly through community health worker training (n=27, 84%). Positive effects were observed for ENC coverage (8/10 studies) and health outcomes (7/12 studies), particularly for interventions promoting breastfeeding, skin-to-skin contact, chlorhexidine applications to the umbilical cord and quality improvement approaches. Neonatal resuscitation training showed variable effects. Key facilitators included local healthcare workers providing emergency supervision and the use of audio-visual or mobile technologies, while barriers included insecurity, conflict-imposed movement restrictions, violence against health facilities and workers, the inability of supervisors to access facilities and the community, population displacement and degradation of ENC quality.

Conclusion Implementation of ENC interventions, particularly breastfeeding promotion, Kangaroo Mother Care and cord care, that do not depend on functional health facilities can improve coverage and neonatal health outcomes in high-intensity armed conflicts, but requires adaptations to context-specific challenges. Strategies to strengthen the health workforce, leverage community health workers and integrate technology may enhance the delivery of lifesaving newborn care amidst armed conflict. Our review was limited by a lack of grey and non-English literature and studies on caring for small and/or sick newborns, implementation of comprehensive care packages and effectiveness evaluations. Further research is needed on comprehensive ENC packages and innovative approaches to overcome systemic barriers.

12. BWHO 2026;104(1):2-3

Editorial

Effective care for mothers and their babies during humanitarian crises

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Although global maternal and neonatal mortality have declined over recent decades, progress has stalled in contexts affected by conflict, fragility and displacement. The 29 countries with United Nations humanitarian response plans or flash appeals at the start of 2025 accounted for slightly less than one third of global births but contributed an estimated 58% of maternal deaths, 41% of stillbirths

and 39% of newborn deaths. These figures likely underestimate the burden in acute crises, where data are usually scarce.

The Global humanitarian overview was revised in June 2025 to acknowledge declines in foreign aid, increasing attacks on health and humanitarian workers, and deepening instability. Despite these challenges, a 2022 United Nations country-level survey demonstrated that even in crisis settings, progress is possible when maternal and newborn health are prioritized, financed and integrated into national systems and preparedness plans. We suggest that integration also requires coordinated action, accountability and sustained investment aligned with three principles.

First, strengthening leadership and prioritizing a continuum of care approach. Maternal and newborn health services in crisis settings face fragmented implementation and chronic underfunding. While some countries meet antenatal care coverage targets, postnatal care remains underprioritized, and stillbirth prevention is often absent from monitoring and planning frameworks. Meaningful progress requires a continuum of care approach, from pre-conception care to the postnatal period and beyond. Data are also essential to make maternal and newborn health visible.

Humanitarian and development actors must coordinate technical support aligned with national priorities. Initiatives such as Every woman every newborn everywhere provide technical assistance to over 55 countries to strengthen subnational planning and implementation. These efforts require predictable, multiyear financing, pooled funds or public–private partnerships to ensure continuity of essential maternal and newborn health services.

Second, integrating emergency response and recovery. Humanitarian emergencies require phased response strategies balancing immediate lifesaving interventions with longer-term system recovery. During acute emergencies, the minimum initial service package for sexual and reproductive health in crisis settings ensures essential standards for skilled birth attendance, emergency obstetric and newborn care, prevention of unintended pregnancies and care for small and sick newborns.

Availability of essential commodities, including interagency reproductive health kits, is critical. As crises stabilize, expanding access to integrated primary care, including quality antenatal and postnatal care as well as family planning, can mitigate health risks and revive community trust that is essential for health system recovery.

However, evaluations show persistent gaps: limited access to safe abortion care aligned with national legislation, insufficient emergency obstetric and newborn care, incomplete referral systems, supply-chain disruptions and inadequate funding. While national-level commitment to the minimum initial service package has grown, subnational implementation lags. Stronger partnerships are needed among humanitarian and development actors, local governments and host communities to reach the most vulnerable. Emergency interventions should strengthen, not bypass, national systems.

Third, protecting and sustaining the health workforce. In crisis settings, health workers face insecurity, constrained resources and personal risk, making their protection and retention both a humanitarian duty and a prerequisite for system recovery.

International humanitarian law requires protection of health workers and facilities. Governments, humanitarian agencies and parties to the conflict must ensure safe working conditions, adequate remuneration and psychosocial support, as well as investments in supervision, training and supply chains. Surge and rotational deployments, task-shifting and peer-support networks can strengthen workforce capacity in insecure environments.

Resolution WHA77.5, adopted in 2024, calls for accelerating progress towards reducing maternal, newborn and child mortality. The resolution was endorsed by 194 countries, reflecting collective resolve amid profound global upheaval and recognition that achieving global health targets depends on protecting every woman and newborn whether in conflict zones, displacement camps or communities affected by extreme weather events. Enacting this resolution is a humanitarian imperative and a prerequisite for global health equity. To do so, governments should convert commitments into actionable, budgeted national and subnational plans supported by sustained financing and robust monitoring, while donors and partners should align humanitarian and development funding to provide evidence-based guidance, operational support and accountability mechanisms.

13. Think Global Health 2026; March 20

Where the Iran War Could Disrupt Pharmaceutical Supply Chains

Yadav P, Hirschfeld A

<https://www.thinkglobalhealth.org/article/where-the-iran-war-could-disrupt-pharmaceutical-supply-chains>

Key message

The war in Iran and the wider Middle East is disrupting critical logistics corridors (the Strait of Hormuz and major Gulf air hubs), causing major delays and cost increases in global pharmaceutical supply chains. While immediate drug shortages—especially in the United States and the EU—are likely to remain limited in the near term thanks to inventory buffers, the conflict has exposed structural vulnerabilities in transport capacity, cold-chain logistics, and emergency supply systems.

Most vulnerable products/supply chains

- Cold-chain products such as vaccines, insulin, biologics, and cancer therapies, which must be kept between 2°C and 8°C and are highly sensitive to delays and temperature excursions.
- WHO emergency and humanitarian deliveries, already facing major funding and capacity gaps; the WHO emergency system is currently reported to have a 70% funding shortfall.
- Transit networks via Dubai and other GCC hubs: the GCC pharma market is valued at \$23.7B, with roughly 80% dependent on imports via GCC airspace and the Strait of Hormuz; Dubai alone has nearly 4 million tons of air-cargo capacity and could miss processing more than 10,000 tons of pharma air freight in March.
- Sea and air corridors for exporters such as India and Pakistan, which rely heavily on Middle East routes to supply destinations including the United States and Africa.

Global Burden of Disease Study

14. Lancet 2026;407(10523):31-52

Disease burden attributable to intimate partner violence against females and sexual violence against children in 204 countries and territories, 1990-2023: a systematic analysis for the Global Burden of Disease Study 2023

GBD 2023 Intimate Partner Violence and Sexual Violence against Children Collaborators: Flor LS et al., Institute for Health Metrics and Evaluation, University of Washington, Seattle, WA, USA
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Background: Violence against women and against children are human rights violations with lasting harms to survivors and societies at large. Intimate partner violence (IPV) and sexual violence against children (SVAC) are two major forms of such abuse. Despite their wide-reaching effects on individual and community health, these risk factors have not been adequately prioritised as key drivers of global health burden. Comprehensive reliable estimates of the comparative health burden of IPV and SVAC are urgently needed to inform investments in prevention and support for survivors at both national and global levels.

Methods: We estimated the prevalence and attributable burden of IPV among females and SVAC among males and females for 204 countries and territories, by age and sex, from 1990 to 2023, as part of the Global Burden of Diseases, Injuries, and Risk Factors Study 2023. We searched several global databases for data on self-reported exposure to IPV and SVAC and undertook a systematic review to identify the health outcomes associated with each of these risk factors. We modelled IPV and SVAC prevalence using spatiotemporal Gaussian process regression, applying data adjustments to account for measurement heterogeneity. We employed burden-of-proof methodology to estimate relative risks for outcomes associated with IPV and SVAC. These estimates informed the calculation of population attributable fractions, which were then used to quantify disability-adjusted life-years (DALYs) attributable to each risk factor.

Findings: Globally, in 2023, we estimated that 608 million (95% uncertainty interval 518-724) females aged 15 years and older had ever been exposed to IPV, and 1·01 billion (0·764-1·48) individuals aged 15 years and older had experienced sexual violence during childhood. 18·5 million (8·74-30·0) DALYs were attributed to IPV among females and 32·2 million (16·4-52·5) DALYs were attributed to SVAC among males and females in 2023. IPV and SVAC were among the top contributors to the global disease burden in 2023, particularly among females aged 15-49 years, ranking as the fourth and fifth leading risk factors, respectively, for DALYs in this group. Among the eight health outcomes

found to be associated with IPV, anxiety disorders and major depressive disorder were the leading causes of IPV-attributed DALYs, accounting for 5·43 million (-1·25 to 14·6) and 3·96 million (1·71 to 6·92) DALYs in 2023, respectively. SVAC was associated with 14 health outcomes, including mental health disorder, substance use disorder, and chronic and infectious disease outcomes. Self-harm and schizophrenia were the leading causes of SVAC-attributed burden, with SVAC accounting for 6·71 million (2·00 to 12·7) DALYs due to self-harm and 4·15 million (-1·92 to 13·1) DALYs due to schizophrenia in 2023.

Interpretation: IPV and SVAC are substantial contributors to global health burden, and their health consequences span a variety of individual health outcomes. Importantly, mental health disorders account for the greatest share of disease burden among survivors. Investing in prevention of these avoidable risk factors has the potential to avert millions of DALYs and considerable premature mortality each year. Our findings represent strong evidence for global and national leaders to elevate IPV and SVAC among public health priorities. Sustained investments are needed to prevent IPV and SVAC and to implement interventions focused on supporting the complex social and health needs of survivors.

15. PLoS Med 2025;22(11): e1004838

Editorial

Global Burden of Disease 2023: Challenges and opportunities for a growing collaboration

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<https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004838>

(Abstract by AI)

The article is an editorial discussing the Global Burden of Disease (GBD) 2023 report, the most comprehensive update of the long-running global health measurement project since it began in 1993. The GBD has grown dramatically in scope, now covering 204 countries, 660 subnational locations, and a wide range of diseases and risk factors.

Key points from the editorial:

1. Improved data and methods:

GBD 2023 includes more data sources than previous editions, better use of geospatial and remote-sensing methods, and a unified modeling system (“OneMod”). However, large gaps remain, especially in low- and middle-income countries where vital registration and routine data systems are weak.

2. New insights:

- Mortality in adults over 50 in Africa may have been previously overestimated.
- Young people in the Sahel show lower-than-expected life expectancy.
- Most countries recovered from COVID-19 excess mortality by 2023.
- Non-communicable diseases (e.g., heart disease, diabetes, stroke) continue to rise globally.
- DALYs attributable to major risk factors have increased significantly—up 30.7% since 2010.
- Obesity, mental health conditions, and environmental risks (heat, air pollution, lead exposure) are growing contributors to disease burden.

3. Challenges and limitations:

Many findings still rely heavily on modeled estimates due to limited real-world data, which can produce counterintuitive results—e.g., unexpectedly low child malnutrition burden estimates in conflict-affected countries like Yemen and Sudan compared to neighbors.

4. Opportunities:

The article emphasizes the need for countries to strengthen their own health information systems (e.g., registries, DHIS2), arguing that national ownership is essential for improved accuracy and policy relevance.

5. Conclusion:

The GBD remains a critical global public good, but its expanding scope makes high-quality, locally owned data systems more important than ever.

Health Financing (Including funding and funding reductions)

16. BMJ Glob Health 2026;11:e022235

US new playbook for global health: balancing national interest and global responsibility

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The recently unveiled America First Global Health Strategy represents a fundamental reorientation of US engagement in global health, framed as a ‘new playbook’ designed to safeguard US lives, prosperity and influence. Built around pillars of security, sovereignty and economic self-interest, the strategy emphasises bilateral agreements, co-investment and the global promotion of US health innovation. While positioned as a corrective to inefficiency and dependency in past aid programmes, this shift raises profound questions about equity, solidarity and the future of multilateralism in health governance. This analysis critically examines the implications of the US first approach through four inter-related lenses. First, the strategy’s security-first framing risks privileging outbreak containment over collaboration, potentially reinforcing a fortress mentality rather than fostering collective preparedness. Second, its critique of ‘dependency’ obscures the documented contributions of US programmes such as the President’s Emergency Plan for AIDS Relief and the President’s Malaria Initiative to health system strengthening, raising concerns that abrupt transitions could dismantle fragile gains. Third, the prioritisation of US innovation in commodity procurement highlights tensions between economic diplomacy and moral legitimacy, with the risk of crowding out local innovation ecosystems. Finally, the privileging of bilateralism over multilateralism may deliver short-term accountability but risks fragmenting global health coordination and undermining shared responsibility. At its core, global health security is indivisible; no nation can insulate itself indefinitely from cross-border threats. A strategy that prioritises national interests while relegating equity to the margins risks eroding US credibility and weakening global solidarity. We argue that only by integrating equity, reciprocity and multilateral collaboration into its ‘new playbook’ can the US safeguard both its own people and global health security.

Other paper about this subject:

Lancet 2026;407(10527):481-2

World Report

Fears that US global health deals harm reproductive health

Green A.

The USA's retreat from financing these services comes as other major donors, particularly the UK, are also reducing their support. With global reductions in maternal deaths already slowing, advocates warn that the US cuts could further disrupt maternal health services broadly and potentially contribute to a reversal of the gains of the past decades.

17. HPP 2026;41(1):122-5

Time to fully account for cost in monitoring financial protection and universal health coverage in low- and middle-income settings

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Financial protection is a core pillar of universal health coverage (UHC), yet current monitoring approaches in low- and middle-income countries (LMICs) largely focus on direct medical costs, neglecting direct transport costs and indirect time costs lost when seeking care. This commentary highlights the importance of fully accounting for these often-excluded costs, which disproportionately affect poorer and rural populations and can significantly hinder access to essential health services and lead to foregone care. We outline five priority areas for action, including improved measurement of transport and time costs through household surveys, methodological advancements in valuing time, increased investment in primary health care to reduce physical access barriers, adaptation of financing schemes and social protection programs to cover non-medical costs, and a multisectoral approach to

address structural determinants. Fully integrating these dimensions into financial protection metrics and policies is critical for ensuring more equitable progress toward UHC in LMICs.

18. HPP 2026;41(2):127–38

Expanding budget space to improve health outcomes in low- and middle-income countries: what role for tax expenditures?

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Recent evidence indicates that budget space for health can be improved through increasing government revenues, expanding the budget's health share, and improving expenditure efficiency through enhancing public financial management (PFM), with government revenue mobilization being the most substantial. Government revenue mobilization can be achieved by broadening the tax base, a key component of which is the rationalization of tax expenditures. Tax expenditures are preferential tax treatments, relative to a baseline tax regime, intended to achieve specific objectives by providing financial support to specific beneficiaries. They may, however, result in huge revenue losses, which could be otherwise invested in priority sectors, including health. In addition, tax expenditures ultimately exacerbate inequality, while also creating complexities that foster tax avoidance and evasion, all of which contribute to deteriorating health outcomes. In the context of scarce public finances in low- and middle-income countries, rationalizing tax expenditures can create the necessary fiscal space for development. This paper provides a first comprehensive analysis of the 'health costs' of tax expenditures by analysing the relationship between tax expenditures and health outcomes, with a focus on under-five and maternal mortality. Using data from 55 developing countries from 2000 to 2022, we find that an increase in tax expenditures leads to higher under-five and maternal mortality, especially in low-income countries. The results are robust to several instrumental variable strategies, alternative measures of tax expenditures, and alternative methods. We also find that PFM, through the quality of public administration, transparency in the public sector, and the efficiency of revenue mobilization, mitigates the corrosive effects of tax expenditures. A key implication of our findings is that understanding the 'health costs' of tax expenditures is a necessary precursor to eliminating wasteful tax expenditures, the benefits of which can contribute to expanding the budget space for health and improving health outcomes.

19. Lancet 2026;407(10523):18

World Report

Aid cuts hampering Nepal's tuberculosis care

Lateef S.

(Abbreviated)

Nepal is raising domestic spending after the tuberculosis programme lost 30% of its budget, leading to job losses and restricted services. US aid cuts left thousands of patients at risk, forcing the Himalayan nation to rely more heavily on its own resources. Nepal, which records about 16 000 tuberculosis deaths and an estimated 67 000 cases annually.

Nepal had long depended on US-backed support through The Global Fund to Fight AIDS, tuberculosis, and malaria. Nearly one-third of Nepal's \$51 million annual Global Fund allocation supports its tuberculosis programme, providing critical support for detection, treatment, and prevention. After Washington froze funding for The Global Fund, Nepal's tuberculosis programme lost nearly 30% of its budget, forcing the suspension of donor-funded tuberculosis clinics, critical screening, and community outreach campaigns that combat stigma and encourage treatment. Despite Government's support, the US-aid cut has forced several clinics to shut, disrupting the screening and treatment network across Nepal.

Tuberculosis remains among the top ten causes of death in Nepal. Yet, only 60% of patients were enrolled in treatment last year, and health officials warn that the rest remain undiagnosed or untreated, allowing the infection to spread through communities. In 2024, Nepal reported 39 118 confirmed tuberculosis cases, down slightly from 40 776 in 2023. However, the Global Tuberculosis Report estimated 67 000 new infections, leaving nearly 27 000 cases undetected.

Experts say that Nepal's unidentified tuberculosis cases and the absence of an active surveillance programme were a major challenge in reducing the transmission and burden of the disease. To ease staff shortages and stretch limited resources, Nepal has begun integrating tuberculosis services into the primary health-care system. Nepal's increased domestic funding signals a growing political commitment to health self-reliance.

Other paper about this subject:

World Report

Botswana's HIV services struggle

Green A.

For the non-governmental organisations that focused on the other components of the HIV response—prevention, community outreach, or services for vulnerable populations—their future is now in doubt. It is unlikely other donors are going to step in. Because Botswana is categorised as an upper-middle-income country, few are willing to channel funds there, reserving their money for poorer countries.

20. PLoS Med 2025;22(11):e1004794

Perspective: How can middle-income countries successfully transition away from international health aid?

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(Abbreviated)

Introduction

Recent cuts to global health aid have reignited the debate about the prospects of low- and middle-income countries (LMICs) successfully transitioning away from international health aid to domestic resources for health. From January to June 2025, the United States (US), the United Kingdom (UK), and other high-income countries made abrupt and drastic cuts to their health aid budgets that threaten progress in public health in recipient countries if not managed carefully. Countries also risk losing access to concessional aid when they experience economic growth and transition from low-income country (LIC) status to middle-income country status. In general, aid-receiving countries can experience both planned and abrupt aid cuts, which can be devastating.

In a previous article, we argued that this transition out of health aid, along with other transitions faced by LMICs, can negatively affect population health if not properly managed. These effects include increasing health inequalities arising from worsening health outcomes in marginalized populations and pockets of poverty within these countries. Since then, extensive research on transitions has been conducted, examining evidence on the factors that contribute to successful transitions, where funding gaps are bridged, program interruptions are minimized, and gains in population health outcomes are preserved. Among the many factors that contribute to successful transitions, three stand out: (i) Effective leadership; (ii) using domestic resources to close the financing gap created by the transition; (iii) realignment of country systems to new sources of domestic funding.

Although the three factors discussed in our piece are not the only ones affecting transition success, they are nonetheless important and have a disproportionately large impact on the likelihood of success. Successful transition experiences demonstrate that leadership, planning, and pre-transition investments in a country's financial, technical, logistical, and service delivery capacities are crucial to ensuring a smooth transition. Addressing institutional gaps is just as important as addressing funding gaps. Our research also revealed cases where transitions are almost always unsuccessful. The two most common are countries facing severe political instability and LICs that cannot bridge funding gaps. Political instability, such as that seen in fragile and conflict-affected states, appears to hinder successful transition. This may be due to the inability of such countries to inspire the necessary leadership for transition or because their leaders prioritize other issues.

Similarly, LICs are less likely to succeed in donor transitions than middle-income countries because (i) they significantly underspend on health; and (ii) their health sectors have high levels of donor dependency; 20 of the 25 LICs listed in the World Health Organization's Global Health Expenditure

Database depend on donors for 20% or more of their total healthcare spending. LICs, therefore, lack the resources to close the funding gap needed for a successful transition.

Conclusions

Lessons from previous donor transitions show that factors like governance, economic resilience, and financing systems influence a country's preparedness to transition successfully. Understanding these dynamics and developing tailored transition strategies can mitigate risks of backsliding in health outcomes.

Although donor exits can be catastrophic, this is not inevitable. Country examples have shown that adopting strong leadership and coordination principles, careful attention to closing funding gaps created by donor exits, and proper realignment of country systems to reflect the new funding realities can significantly reduce the negative impacts of donor exits.

21. PLoS Med 2022;22(11):e1004824

Perspective: From dependence to self-reliance: The future of the global tuberculosis response
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Just as tuberculosis services were recovering after the COVID-19 pandemic disruptions, abrupt funding cuts by G7 nations are putting progress at risk. These trends, while perilous, also reveal a turning point toward a more equitable, resilient, and self-reliant TB response, led by high-burden countries.

Introduction: Before the COVID-19 pandemic, tuberculosis (TB) was the world's leading infectious killer, causing 1.34 million deaths in 2019. During the pandemic, COVID-19 took the top spot, while simultaneously disrupting routine TB services. While TB programs have since begun to recover, abrupt funding cuts in 2025 threaten to undo years of progress.

The G7 nations plan to reduce aid spending by 28% in 2026 compared with 2024, the biggest cut in aid since the group's creation in 1975. Donor funding for TB in low- and middle-income countries has remained largely static since 2013, at about US\$1.1 billion per year. Although domestic financing accounts for 25%–94% of TB program costs (depending on the country), many critical activities, such as community outreach, specimen transportation, and TB preventive treatment, rely on donor support. Since donor contributions make up a greater share of TB financing than of overall health spending, TB programs remain acutely exposed to donor volatility. Funding cuts are also impacting the global AIDS response, and any scale-back of HIV services will consequently impact TB as well, given that HIV is a major risk factor for TB. As of 22 November 2025, only about 11.3bn have been pledged by donors towards the Global Fund's targeted budget of \$18bn for the 2026–2028 replenishment.

Conclusions: Abrupt aid cuts have exposed how fragile and donor-dependent the fight against TB remains. No disease affecting the poorest should be so vulnerable to political decisions beyond its borders. As global health financing evolves, the TB response must redefine itself as a strategic investment in health security, equity, and universal health coverage, while leveraging progress in new innovations. The future of the End TB response will not be decided in Washington or Geneva, but in New Delhi, Abuja, Pretoria, and Jakarta, where political will, domestic investments, and innovation can make sure that a TB-free world will be realized, not because of the benevolence from the Global North but more because of strategic self-determination and leadership from the Global South.

Health Policy

22. BWHO 2026;104(2):63-63A

Editorial

Improved long-term care provision in the context of population ageing
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(Abbreviated)

Population ageing is one of the major global transformations of the twenty-first century. By 2050, more than 2 billion people will be aged 60 years or older, with three quarters of this increase occurring in low- and middle-income countries. While this demographic shift reflects gains in life expectancy, a widening gap between life expectancy and healthy life expectancy means people spend later years with dependency, disability and poor quality of life, often requiring complex and sustained care. This gap presents challenges for health and social systems, highlighting the need for robust long-term care to support functional ability, dignity and well-being across the life course.

Despite rising care needs, long-term care remains underdeveloped and underprioritized in most countries. Strengthening long-term care is therefore a global priority, as emphasized through the United Nations Decade of Healthy Ageing (2021–2030), which calls for equitable, resilient and rights-based care for older people.

Long-term care systems worldwide face persistent challenges. Traditional family-based care is declining due to demographic and social changes such as smaller household sizes, labour migration and urbanization, particularly in low- and middle-income countries. Across all socioeconomic settings, unpaid caregivers (predominantly women) provide most care. Informal care remains indispensable but cannot replace comprehensive, high-quality long-term care systems.

Strengthening long-term care requires innovation, especially in low-resource settings. Community health workers can provide basic care support and link families to social services. Digital health tools can support care coordination and remote monitoring. Public–private partnerships may expand service availability while safeguarding equity and quality. Social protection schemes should align with long-term care through pension credits, caregiver allowances and subsidized services for low-income older adults.

Investing in long-term care is an investment in social resilience, health equity and human dignity. The UN Decade of Healthy Ageing provides both a mandate and momentum; decisive leadership and sustained commitment are now required to build accessible, accountable long-term care systems that meet the diverse needs of ageing populations worldwide.

23. HPP 2026;41(2):275-85

State-church partnerships as an innovative strategy in healthcare delivery for universal health coverage in sub-Saharan Africa: a scoping review

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Universal Health Coverage (UHC) remains a critical goal in sub-Saharan Africa (SSA), where healthcare systems face significant challenges. State-Church Partnership have emerged as an innovative strategy to address gaps in healthcare delivery, leveraging the extensive networks of Faith-Based Organizations to provide essential services, particularly in remote areas. This scoping review aimed to examine the existing models of State-Church Partnerships in healthcare delivery within SSA, their impact on UHC advancement, the challenges these partnerships face, and the emerging best practices. This review followed Arksey and O'Malley's framework and the PRISMA-ScR guidelines. We systematically searched peer-reviewed databases, including PubMed, Web of Science, Scopus, and CINAHL, for relevant studies published from inception until December 2024. Data were extracted and analyzed thematically using NVivo 12 to identify key themes related to state-church partnership models, their impact on UHC, implementation challenges, and emerging best practices. The review included eight studies which revealed that FBOs contribute between 30% and 70% of healthcare services in some regions, improving access, affordability, and equity. They play a critical role in maternal and child health, HIV/AIDS prevention, and health workforce training. However, challenges such as funding constraints, service quality variability, and limited policy integration hinder their effectiveness. Emerging best practices include enhanced government collaboration, community engagement, and capacity-building initiatives. In conclusion, State-Church Partnerships are vital in strengthening healthcare systems and achieving UHC in SSA. To maximize their impact, formalized policy frameworks, sustainable financing mechanisms, and quality assurance measures are essential. Strengthening state-FBO collaboration can bridge healthcare gaps and ensure equitable healthcare access.

24. HPP 2026;41(3):442-59

The impact of official development assistance for health on health outcomes: a rapid systematic review

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Low- and middle-income countries (LMICs) have received substantial amounts of Official Development Assistance for Health (DAH) to address domestic health funding gaps and improve access to universal healthcare. However, the effectiveness of DAH in improving health outcomes remains contested, with varying findings across studies due to differences in methodologies, data sources, and target populations. This systematic review synthesizes the existing evidence on the impact of DAH on health outcomes in LMICs, highlighting both the positive and negative effects, and identifying key mechanisms through which aid influences health. A total of 61 studies were included in the review, with a primary focus on maternal and child health outcomes. Despite methodological differences, the weight of evidence indicates a generally positive impact of DAH, particularly in countries with higher governance standards and better economic conditions. Our findings underscore the importance of contextual factors, such as governance and proximity to aid-funded projects, in shaping the effectiveness of health aid. To maximize the impact of DAH, policymakers need to strengthen donor coordination, align aid with national health priorities, and reinforce domestic health systems. Future research should focus on refining causal inference methods and exploring innovative aid-delivery mechanisms to sustain long-term health improvements.

25. Lancet 2025;406(10521):2727

Editorial

Universal health coverage: necessary, but not enough

(Abbreviated)

Universal health coverage (UHC) rests on a simple idea: every person, everywhere, should be able to access the health services they need without fear of financial ruin.

In 2015, this principle was woven into the Sustainable Development Goals (SDGs), with governments committing to expand service coverage and shield households from catastrophic health spending by 2030. Today, UHC stands as the organising vision for national health systems: a global commitment to equity, protection, and universality.

Yet translating this promise into reality has proven complex. Progress is measured through two indicators— service coverage (SDG 3.8.1) and financial hardship (SDG 3.8.2). The 2025 Global Monitoring Report shows that 4·6 billion people lacked essential health services in 2023, and 2·1 billion faced financial hardship in 2022.

UHC is an essential moral aspiration but pursuing its full vision at once can feel impractical. External assistance for health is drying up, and many low- income and middle-income countries face stagnant or shrinking domestic budgets, forcing hard choices about what to fund and what to forgo.

Without clearer prioritisation, there is a danger that UHC demands more than can be feasibly delivered.

How, then, can meaningful gains be achieved despite limited resources? The Global Health 2050 Commission shows the potential of a strategic focus. Concentrating on just 15 priority conditions— eight infectious and maternal health conditions, seven non-communicable diseases and injuries—could halve the number of premature deaths by 2050. A modular approach to services allows governments to build core capacities and expand coverage over time. Public financing of essential medicines, vaccines, diagnostics, and other key commodities can steer delivery of high-priority interventions, supported by intersectoral policies such as tobacco control—the single most powerful lever to reduce preventable deaths—and strengthened pandemic preparedness. Development assistance should reinforce national capacity for the poorest countries and global public goods. Together, these recommendations show that substantial, equitable health gains are possible long before full UHC is realised.

26. Lancet 2025;406(10522):2984-88

Lessons from Africa: health diplomacy in HIV prevention

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(Abbreviated)

This Lecture draws on over three decades of research across the intersecting and intertwined HIV, tuberculosis, and COVID-19 epidemics in South Africa that shaped national, regional, and global policy. From the outset, the research agenda and priority setting was informed by local data and locally led innovation, scientific excellence, and the premise that knowledge is a public good that should benefit all of humanity and cause no harm. In this Lecture, learnings from the Centre for the AIDS Programme of Research in South Africa (CAPRISA; a 22-year-old multi-institutional centre that advances globally relevant and locally responsive research in preventing HIV in young women and deaths in people co-infected with HIV and tuberculosis) and two of the highest priority public health challenges in sub-Saharan Africa (ie, HIV and tuberculosis) will be used to illustrate how a combination of factors contributes to translating scientific discoveries into impactful, evidence-based global health solutions. Among these factors are: local scientific leadership, synergistic partnerships and collaboration, national and international investments in research infrastructure, innovation with rigour, community co-design and co-ownership, and science communication and diplomacy.

As we confront the next generation of health challenges from climate-linked crises, antimicrobial resistance, emerging and re-emerging pathogens, and unprecedented population displacement from wars and conflicts, the CAPRISA model underscores what is possible when knowledge generation is grounded in local priorities, informed by global collaboration, and driven by a mission to serve humanity. This model exemplifies a whole-of-society approach to scientific engagement, effectively linking discovery to delivery and bridging local needs with global action. Now more than ever, we should sustain and scale up such efforts to create a more equitable, prepared and scientifically empowered world.

27. Lancet 2026;407(10525):267-308

The Lancet Commission on improving population health post-COVID-19

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(Abbreviated)

An increasing number of national and international commitments have failed to reduce three intimately interconnected major global threats to population health: non-communicable diseases, outbreaks of infectious diseases, and environmental degradation.

Non-communicable diseases cause more than 43 million deaths globally every year, of which 18 million are of people younger than 70 years. More than 70% of these deaths occur in low-income and middle-income countries (LMICs). To date, the official number of COVID-19 cases globally is more than 775 million, with more than 7 million deaths, although the absolute figures are likely to be far higher due to under-reporting. Environmental degradation is unravelling complex ecosystems, setting the world on a path to mass extinction, with the climate crisis creating an existential threat to human survival.

The Lancet Commission on improving population health post-COVID-19 was established to draw attention to the interactions between these three threats, the frequently shared structural factors underpinning them, and the opportunities for synergistic actions to address them. Having identified that the three systems of physical environment and transport, agriculture and food, and energy, underpin the three primary threats to population health, the Commissioners agreed upon three aims for the Commission to generate and synthesise evidence on actions needed to achieve: (1) healthy and sustainable physical environment and transport systems; (2) healthy and sustainable agriculture and food systems; and (3) healthy and sustainable energy systems.

These aims were used to create a framework to agree a set of objectives via a two-stage survey and modified Delphi exercise that resulted in a final list of ten objectives which were clustered under each of the three aims. In addition, we conducted supporting work: a rapid review of the evidence on drivers of, and policy levers for addressing, the three threats of non-communicable diseases (NCDs),

communicable disease, and environmental degradation; an expert elicitation exercise using semi-structured interviews with 26 international experts to identify potential actions; and two pieces of economic modelling on the impact of carbon pricing on agriculture and land use, as well as land use and transport. By synthesising evidence obtained from each of these sources we identified a set of recommendations for actions to take place within and, in many cases, across the three systems of physical environment and transport, agriculture and land use, and energy.

Recommendation 1: Replace harmful policies and interventions with actions to improve population health and the natural environment.

Recommendation 2: Enhance the effectiveness of governments, commercial actors, and civil society to improve population health and the natural environment.

Recommendation 3: Develop capability and capacity in systems-level responses to the three threats.

Conclusion: Acting on these recommendations would help slow the harmful trajectories created by the three threats at the core of this Commission. The recommendations need to be combined with other major shifts, such as universal health coverage, achieving sex, gender, and racial parity, and the eradication of poverty, each of which is necessary but not sufficient alone to generate the required sustainable improvements in population health and natural environments worldwide. The three threats we confront in this Commission have developed over many years, and we are aware of the difficult challenges involved in effectively addressing them, especially in the face of stagnating economies, populist politics, and the increasing influence of commercial actors. Concerted action by governments, combined with the engagement of civil society, has the potential to halt and start to reverse these harmful trends to create a more sustainable, fairer, and healthier world.

28. Lancet 2026;407(10526):388-468

The Lancet Commission on a citizen-centred health system for India

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(Abbreviated)

This report presents a key shift in the conventional narrative of the barriers to realising universal health coverage (UHC) in India: these are no longer driven by a lack of political will, underfunding, inadequate human resources and physical infrastructure, or low demand for health-care services. Instead, uneven quality of care, inefficiencies in spending, fragmented delivery, inadequate design and implementation of financial protection programmes, and poor governance emerge as key challenges. Our clarion call is for an integrated, citizen-centred health-care delivery system that is publicly financed and publicly provided as the primary vehicle for UHC, while shaping the private sector to leverage its strengths.

Variations in State and district health systems highlight the importance of decentralised processes in health system design, implementation, and evolution. Recognising this, we present our reforms as options for governments to choose from based on local realities, consultations with civil society and health-care providers, and refinement through continuing evaluation.

Reform action 1: enable meaningful citizen engagement by firmly building the health system upon people's participation.

Reform action 2: implement a citizen-centred health system through financing, purchasing, and service-delivery reforms in the public sector.

Reform action 3: engage the private sector to align with UHC goals.

Reform action 4: invest in and scale up diverse technologies to catalyse all the reforms needed for UHC.

Reform action 5: enable transparent and accountable governance of the entire health system through decentralisation and strengthened regulatory capacities.

Reform action 6: foster a learning health system by embedding reflexivity, participatory approaches, and leadership that champions continuous learning and improvement.

The way forward: a political and transformational agenda.

Many of our proposed reforms are already part of existing Central or State government initiatives, and their inclusion in this Commission serves as an endorsement of these policies. However, some of our

reform actions are novel, and we recognise that vested interests, fiscal constraints, implementation capacities, and ideological divides have the potential to slow or prevent progress on these actions. The Commission, therefore, emphasises that health system reforms are not merely technical—they are profoundly political. Their success will depend on strong leadership that aligns diverse interests, addresses resistance from powerful stakeholders, and fosters solidarity across sectors and political parties. Our recommendations must be carried forward through extensive consultations with civil society and other stakeholders across the country. Such dialogue is essential for assessing feasibility, ensuring acceptability, mitigating risks, and generating sustained political commitment. The Commission's call is clear: invest wisely, innovate boldly, and align reforms around citizens' Right to Health. With courageous political leadership and active citizen participation, India can ensure that its path to becoming a developed country is anchored in a resilient, inclusive, and citizen-centred health system.

HIV / AIDS

29. PLoS Med 2025;22(12):e1004806

Editorial

Treatment and prevention of HIV/AIDS: Unfinished business

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Since the inception of World AIDS Day in 1988, advances with antiretroviral drugs have revolutionized the landscape of HIV/AIDS treatment and prevention. In 2025, we reflect on progress made, highlight promising therapeutic developments, and look ahead to what is needed to end the AIDS epidemic.

After nearly four decades of progress with antiretroviral-based treatment and prevention for HIV, we now have truly transformational tools to end the HIV/AIDS pandemic as a major global health threat. History will judge us harshly should we squander this opportunity. The time is now to advocate for the US Congress to renew funding of the Global Fund and PEPFAR at robust levels to scale up LEN and other interventions. However, these programs cannot assume the entire burden of support alone. As more countries take control of their own HIV responses, innovative, talented, and creative people in numerous sectors must make ambitious commitments to procuring and delivering antiretroviral-based interventions. National governments, international agencies, donors, community groups, drug manufacturers, researchers, and implementers all have important roles to play in developing programs and processes for scaling up life-saving HIV treatments and prevention so that they reach all in need. Only with such a multi-pronged effort will we end the HIV/AIDS pandemic. (LEN: the long-acting HIV capsid inhibitor lenacapavir.)

Malaria

30. Am J Trop Med Hyg. 2026;114(3):410-2

Ensuring the Public Health Impact of Malaria Vaccination in High-Transmission Settings

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Two vaccines against *Plasmodium falciparum*, RTS,S and R21, have been recommended for widespread implementation by the World Health Organization. Both vaccines displayed safety and efficacy in clinical trials, and early RTS,S pilot implementation results suggested reductions in severe disease and death. However, RTS,S efficacy was lower in higher transmission settings during trials. Between- and within-site analyses suggest that reduced efficacy was partially due to greater natural immunity development in control groups in higher transmission settings, resulting in temporary periods of negative efficacy beginning approximately three years after the primary vaccine series. Results from RTS,S pilot implementation and seasonal administration for both vaccines are promising, but study designs have thus far precluded the identification of similar periods of negative efficacy.

Because we expect delayed malaria cases of unknown severity in vaccinated individuals during implementation in high-transmission settings, we recommend enhanced surveillance and interventions that supplement malaria vaccination to strengthen prevention.

31. Am J Trop Med Hyg. 2026;Mar 17:tpmd250417

Emerging Artemisinin Partial Resistance in Southern Africa

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A new focus of probable artemisinin-partial resistance (ART-R) has been identified in southern Africa, driven by the P441L mutation in the *Plasmodium falciparum* Kelch13 gene. This emerging cross-border cluster across Angola, Namibia, and Zambia represents the fourth major ART-R focus identified in Africa, adding to the previously reported foci in East Africa and the Horn of Africa. Findings from three new studies reveal 7.3%, 33%, and 47% prevalence of P441L in specific sites in Angola, Namibia, and Zambia, respectively. The Genomics of Malaria in the Elimination 8 project enabled harmonized, real-time molecular surveillance across five countries, providing actionable data for national malaria programs. Given past failures to contain chloroquine and sulfadoxine-pyrimethamine resistance, a timely response is critical. We recommend immediate treatment policy shifts, expanded surveillance, and regional coordination to prevent the spread of ART-R. This Perspective calls on global health actors to act decisively while resistance remains geographically limited.

32. Biosensors and Bioelectronics 2026;294:118228

pLDH to identify severity in imported malaria: Implementing smartphone video analysis for rapid clinical decision-making

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A rapid test using a mobile phone will be able to identify the most severe cases of imported malaria in minutes.

Researchers from URV and ISGlobal demonstrate that a key biomarker can anticipate disease severity and improve clinical decision-making

Malaria remains the parasitic disease that causes the most deaths worldwide. Although it is not endemic in countries such as Spain, imported cases are diagnosed every year among people who return from areas where the infection is common. These patients can rapidly progress to severe forms of the disease, but identifying in time which cases are at higher risk is not always easy, especially in settings where clinical experience is limited and initial symptoms are nonspecific.

A recent study led by a research team from Rovira i Virgili University (URV) and the Barcelona Institute for Global Health (ISGlobal), an institution supported by the “la Caixa” Foundation, provides a new tool to address this challenge: a system that combines rapid diagnostic tests with video analysis using a mobile phone, capable not only of detecting the infection but also of predicting which patients may develop severe forms of malaria in under six minutes.

Highlights

- Pan-pLDH identified as novel severity biomarker for imported malaria prognosis.
- High-throughput bead-based immunoassay validated biomarkers for malaria severity.
- Lateral flow assays enabled rapid malaria diagnosis and severity stratification.
- Smartphone video analysis of LFA achieved severity detection in <6 min.
- Rapid smartphone-based biosensing to improve clinical decision-making for malaria.

33. TMIH 2026;31(3):254-73

Artemisinin-Based Combination Therapies in East Africa: A Systematic Review of Quality, Clinical Efficacy, and Regulatory Progress Towards Sustainable Malaria Control

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Background: Malaria is a major public health issue in East Africa, leading to widespread illness and fatalities, especially among vulnerable populations such as children under 5 years of age and pregnant women. Artemisinin-based combination therapies (ACTs) are the primary treatment modality; however, their efficacy is undermined by the prevalence of substandard ACTs and the increasing risk of resistance. Therefore, it is crucial to improve evidence on quality, therapeutic efficacy, and regulatory performance to promote malaria control efforts in the region.

Methods: This systematic review followed PRISMA 2020 guidelines, with the protocol registered in PROSPERO (CRD420251135109). Literature was searched in PubMed and Google Scholar databases from July to September 2025. Methodological quality was appraised using MEDQUARG and STROBE. Two reviewers independently extracted data, resolving discrepancies by consensus. The extracted findings were synthesised narratively to identify key trends.

Results: A systematic review of 40 articles from Ethiopia, Kenya, Tanzania, and Uganda revealed considerable variation in the quality of Artemisinin-based combination therapies (ACTs). Across the four East African countries, a total of 3363 ACT samples were tested, of which 375 failed to comply with specification limits set for at least one physicochemical quality parameter. This corresponds to an overall failure rate of 11.2% (375/3363). Country-specific failure rates reflect the highest rate in Uganda (33.3% [16/48]), followed by Kenya (14.1% [10/71]), Tanzania (11.6% [333/2859]), and Ethiopia (4.2% [16/385]). This considerable variation could be attributed to the differences in prevalence, the number of studies conducted, study design, and sampling methodology. The reported poor quality of ACTs, major treatment options in managing malaria cases, could pose a public health threat. Though the studies conducted so far may not give a real picture of the magnitude of poor quality ACTs medicines and their impact on the treatment outcomes, the reports indicated that ACTs remain highly efficacious, with most therapeutic trials reporting polymerase chain reaction-corrected cure rates of $\geq 90\%$. As indicated in the literature, Artemether-lumefantrine consistently demonstrated strong treatment outcomes, while dihydroartemisinin-piperaquine provided extended prophylactic effects. However, emerging *Plasmodium falciparum* resistance, particularly K13 mutations associated with delayed parasite clearance, poses an ongoing threat to ACT effectiveness.

Conclusion: The findings of this study revealed that 11.2% of ACTs samples were found to be poor quality. The clinical data reflects that in East Africa, ACTs remain effective despite the prevalence of substandard and falsified ACTs and emerging resistance threatening long-term gains. Thus, strengthening regional regulatory harmonization, pharmacovigilance, molecular surveillance, and local manufacturing capacity is essential to combat resistance of ACT and ensure equitable access to quality-assured therapies.

Mental Health

34. BMJ 2026;392:s4

Editorial

Global trends in youth suicide

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Rising rates require evidence based and population level solutions.

Suicide is the third leading cause of death in young people. It accounts for more than 150 000 deaths each year worldwide, most of which occur in low and middle income countries (LMICs).

Concerningly, youth suicide rates seem to be rising in many countries, including in the UK. In India and China, which together account for around a third of the world's youth population, previously downward trends appear to have reversed.

Interpreting these trends is complex. Suicide data can be affected by numerous biases, and ecological studies, which examine exposures and outcomes at the group or population level and are fundamental to assessing population level drivers of suicide trends, have methodological limitations. Nonetheless, the global pattern of rising youth suicide rates warrants explanation.

Suicide related research has typically prioritised mental illness as a key determinant. However, for youth suicide prevention strategies to have the greatest global impact, it is essential to understand

trends in the underlying social determinants and incorporate evidence from India, China, and other LMICs.

35. Glob Ment Health (Camb) 2025;Nov 28:12:e14

Review

Global mental health and psychosocial support programming: An expert review of major implementation and funding challenges

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The global mental health (GMH) field aims to equitably improve mental health and well-being everywhere. This article reviews persistent common challenges hindering sustained, high-quality delivery of mental health and psychosocial support (MHPSS). Our focus is on programming that is funded or implemented by external organizations, typically universities or international non-governmental organizations from high-income countries. It is a consensus statement of MHPSS practitioners, programmers and researchers working for these organizations and some who are locally based who observe these programs in action. We comment on progress to date, barriers and recommendations for change and the importance of promoting sustained integration of MHPSS into health and social service systems through a comprehensive, recovery-oriented system of care. We call for prioritizing often-neglected issues (e.g., stigma, severe mental health conditions and neurodevelopmental conditions), strengthening workforce training and supervision and monitoring and evaluation systems to ensure program quality. The continued dominance of the Global North in shaping GMH programming priorities remains a concern. We advocate for a greater involvement of local workers and communities in agenda-setting for programs, culturally grounded implementation and long-term capacity building. Evidence-based practices must be met with contextual relevance, and comprehensive guidelines for sustained support are needed for development settings. For persistent funding challenges, we recommend clearer funder objectives, investment in in-house mental health expertise and funder coordination with prioritization of complementary programming. These recommendations are essential to realizing equitable, comprehensive, evidence-based and contextually grounded GMH programming.

36. Glob Ment Health (Camb) 2025;Dec 4:12:e145

Review

Self-harm and suicide prevention in humanitarian and fragile contexts: A systematic scoping review
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Suicide remains one of the leading causes of death globally, with growing evidence that humanitarian emergencies and fragile states, most of which unfold in low- to middle-income countries (LMICs), are associated with elevated risk of suicide. However, the few suicide-targeted interventions for use in humanitarian contexts remain both sparse and fragmented. This scoping review aims to identify and synthesise evidence from suicide and self-harm prevention interventions implemented in all types of humanitarian settings, globally, that have been evaluated for their effectiveness in improving suicide and self-harm-related outcomes. We systematically searched eight electronic databases, including two grey literature databases, and relevant organisational websites for records published through November 2024 and in any language. Screening was done using the Covidence platform, with each record independently screened by two reviewers. Among other preselected inclusion criteria, studies must have conducted a quantitative evaluation of the effectiveness of an intervention on improving suicide and self-harm-related outcomes during a humanitarian crisis to be included for data extraction. Data extraction and quality assessment were both conducted by two authors. In all, 6,209 records were screened at the title and abstract phase; 104 were included for full text screening; and 23 studies were included for data extraction. Most studies were conducted during the coronavirus disease 2019 pandemic (COVID-19), and in high-income countries. Evaluated interventions encompassed various approaches, including psychotherapeutic, practical, and pharmacological assistance, often employing multiple components. The majority targeted the general population, were delivered via remote modalities and relied on mental health specialists for their administration. Overall, 15 (65.2%)

interventions were associated with statistically significant positive effects on suicide and or self-harm-related outcomes. Promising approaches include cognitive behavioural therapy-based text services, skills-building programmes, and strategies that foster supportive environments for high-risk individuals. These findings highlight both promising approaches and critical gaps in suicide prevention efforts in humanitarian settings. The limited evidence base - particularly in LMICs and with particularly at-risk populations - alongside the increasing frequency of humanitarian crises, underscores the urgent need for future implementation and associated research of suicide and self-harm prevention initiatives within humanitarian contexts.

Non-Communicable Diseases

37. Lancet 2026;407(10533):1095-111

Review

Sickle cell disease

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Sickle cell disease is a genetic red blood cell disorder, affecting millions of people globally. This Seminar provides a comprehensive update on the disease, emphasising its complex pathophysiology involving sickle haemoglobin polymerisation, vaso-occlusion, haemolysis, and inflammation that lead to acute, life-threatening complications and progressive organ damage. We review the spectrum of the most frequent acute manifestations-vaso-occlusive crises, acute chest syndrome, stroke, and infections-alongside chronic complications affecting virtually all organ systems. Recent advances include expanded implementation of hydroxyurea in low-resource settings and the optimisation of hydroxyurea protocols, refined transfusion therapy, improved haematopoietic stem cell transplantation outcomes with alternative donor strategies, and gene therapies now approved for clinical use. Additionally, new drugs are being evaluated in clinical trials globally. We examine successful implementation strategies in low-income and middle-income countries using point-of-care diagnostics and integrated care models. Controversies and challenges include the management of sickle haemoglobin-C and haemoglobin S/β+ variants, cerebrovascular complication prevention, hydroxyurea use in pregnancy, and the transition from paediatric to adult care.

Ophthalmology

38. Lancet Glob Health 2026;14(3):e367-e377

Effective cataract surgical coverage in adults aged 50 years and older: empirical estimates from population-based surveys in 68 countries and modelled estimates for 2000-30

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Background: Cataract is the leading cause of blindness worldwide despite treatment being very cost-effective. To stimulate efforts to address the large unmet need for affordable, good-quality cataract services, member states at the 74th World Health Assembly endorsed a global target of a 30 percentage-point increase in effective cataract surgical coverage (eCSC) by 2030. In this Article, we report on progress towards that target.

Methods: We did a secondary analysis of 233 participant-level population-based survey datasets (Rapid Assessment of Avoidable Blindness [RAAB] surveys and other population-based cross-sectional surveys) from 68 countries (2003-24) to estimate eCSC with a cataract surgical threshold of worse than 6/18 pinhole visual acuity and a threshold of 6/18 or better for postoperative presenting visual acuity (eCSC6/18) for each country. Eligible studies included people aged 50 years and older, without any further age restrictions. eCSC was calculated as the number of people who had received surgery and had a good visual outcome as a proportion of all people who had received or were still to receive surgery. For countries with only one survey estimate available, we reported the survey as the country estimate; for each country with two or more surveys, we used more recent and nationally representative survey to generate estimates. We included 228 of 233 datasets (excluding five datasets

from the European region) in a mixed-effects logistic regression to estimate global and WHO regional temporal trends in eCSC6/18 from 2000 to 2030. For global estimates, we used eCSC in the Americas region as a proxy for the European region. We used 120 RAAB surveys that measured visual acuity at the 6/12 threshold to analyse causes of non-good outcomes (postoperative presenting visual acuity worse than 6/12) and estimated potential gains in eCSC (with a cataract surgical threshold of worse than 6/12 pinhole visual acuity and a 6/12 or better threshold for postoperative presenting visual acuity [eCSC6/12]) from correcting residual postoperative refractive errors. Potential gains were estimated by comparing eCSC6/12 calculated using postoperative presenting visual acuity with eCSC6/12 calculated using pinhole visual acuity (a proxy for visual acuity with optical correction of refractive error).

Findings: We used 130 studies to report 68 country estimates of eCSC6/18. Country estimates for eCSC6/18 from surveys ranged from 2.1% (95% CI 0.9-3.4) in Burundi (2024) to 77.7% (72.9-82.5) in Qatar (2023). Globally, we predicted eCSC6/18 of 48.2% (39.7-57.2) in 2025, increasing by 8.4 percentage points (8.1-8.6) between 2020 and 2030 (from 43.9% [36.6-51.2] to 52.3% [41.4-62.7]). Uncorrected refractive error accounted for a median 26.4% of non-good outcomes per survey; we estimated that treating this condition could yield a median 3.7 percentage-point gain in eCSC6/12 globally.

Interpretation: Global efforts are not on track to meet the target of a 30 percentage-point increase in eCSC between 2020 and 2030-immediate and substantial investment in cataract services is, therefore, required. Survey data indicated which elements of the cataract care pathway could be targeted for quality-improvement initiatives. A suite of cataract surgery quality indicators should be collected to better inform service providers.

Other paper about this subject:

Lancet Healthy Longev 2026:100800

Prevalence of death in people with vision impairment from cataracts before treatment: a case study from Kenya

Primary Health Care

39. Afr J Prim Health Care Fam Med 2025;Nov 9;17(2):e1-e6

From dreamers to doers: Navigating the doctoral journey in family medicine and primary care
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This article examines the transformative journey of pursuing a Doctor of Philosophy (PhD) in family medicine and primary care through the lived experiences of four African scholar-practitioners. Using the Hero's Journey framework, the authors reflect on the emotional, intellectual and structural aspects of doctoral education, highlighting the unique challenges faced by clinician-researchers in resource-limited settings. Each vignette illustrates the transition from dreaming to doing by navigating identity shifts, funding obstacles, methodological complexities, as well as the need to balance clinical service with academic development. The article offers practical insights for prospective doctoral degree candidates, including the importance of defining one's purpose, building supportive networks, and adopting adaptable strategies. It also calls for institutional reforms to enhance supervisory capacity and funding mechanisms. By merging personal narratives with reflective analysis, the authors aim to inspire and equip future doctoral candidates in family medicine and primary care, encouraging them to view their journey not just as an academic endeavour but as a pathway to leadership, thereby strengthening the discipline's knowledge foundation and enhancing primary care. This contribution serves as a guide for moving from aspiration to action, offering practical wisdom for navigating the complexities of doctoral education in African primary care contexts.

Sexual Reproductive Health and Rights

40. BMJ 2026;392:s327

Editorial

Eliminating female genital mutilation by 2030

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Elimination must build on locally driven, grassroots achievements.

Global efforts to eliminate female genital mutilation (FGM) stand at a crossroads, with uneven progress, commitments increasingly tested, and 4.5 million girls at risk of FGM in 2026 alone. Achieving elimination of the practice by 2030 (a sustainable development goal 1) looks unlikely without a big shift in political commitment, financing, and momentum in changing social norms. Nonetheless, the global community has consensus on ending FGM, and we must strive to achieve it. FGM is defined as the partial or total removal of, or other injury to, the external female genitalia for non-medical reasons. It offers no health benefits and is associated with immediate and long term health risks that include bleeding, infections, and complications for sexual, mental, and obstetric health. FGM is reported in at least 94 countries. It is internationally recognised as a violation of multiple human rights, including the rights to health, bodily integrity, freedom from violence, and freedom from discrimination, all of which supersede the right to express culture or tradition. More than half (62%) of the countries where FGM has been reported have enacted legislation prohibiting the practice, and seven countries (Benin, Cameroon, Ghana, Maldives, Niger, Togo, and Uganda) are on track to have no new cases by 2030. However, the pace of elimination in some countries remains stagnant, and in others it would need to increase over 10-fold to meet the zero goal by 2030. Data on FGM prevalence and typology in parts of South East Asia in particular, are limited, but available evidence indicates substantial numbers of women and girls are affected. Likewise, data from countries with diaspora populations or among marginalised groups, in both high and low income settings, are limited.

One barrier to elimination is a growing counter-movement from some Islamic and political leaders that frames FGM as a right to cultural or religious expression. Furthermore, sections of academia have pushed back against a standardised member state driven rights based agenda to end FGM, instead supporting a supposed diverse “culturally sensitive” and permissive stance. Others propose that certain types of FGM are non-harmful, and even promote the involvement of health workers to improve “safety.”

But leading Islamic bodies and scholars have delinked FGM as a religious rite. Moreover, arguments about an external agenda negate the historical achievements of locally driven grassroots efforts to abandon FGM, which have inspired a global movement on its elimination. Extensive evidence on health complications associated with FGM 4 shows why it is unethical for health workers to participate.

41. BMJ Glob Health 2026;11:e022365

Implementation of a decision aid to promote shared decision-making on mode of birth in low-risk pregnant women: a cross-sectional study within the QUALI-DEC hybrid trial

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Introduction Implementing shared decision-making (SDM) in maternity care remains challenging in low-income and middle-income countries (LMICs). Decision aids can support SDM, but evidence on their effectiveness in such settings is limited. We assessed the impact of a decision analysis tool (DAT) for pregnant women on mode of birth (MOB) within the QUALity DECision-making project, a multisite, multicountry pragmatic trial to reduce unnecessary caesarean sections.

Methods We conducted a cross-sectional survey among postpartum women considered at low risk for caesarean section in early pregnancy and who delivered in 32 hospitals across Argentina, Burkina Faso, Thailand and Viet Nam. Associations between DAT exposure and selected outcomes were analysed using multilevel, multivariate regression models adjusting for confounders and cluster effects.

Results Of 2368 women included, 249 (11%) had used it outside antenatal care visits, 212 (9%) had heard of but not used it, and 1907 (80%) had never heard of the DAT. Compared with women who had never heard of the DAT, users were more likely to identify at least three risks/benefits of each

MOB (adjusted OR (aOR) 1.9; 95% CI 1.3 to 2.8; $p=0.001$) and to communicate their preferred MOB to providers (aOR 2.3; 95% CI 1.5 to 3.6; $p<0.001$). DAT users were less likely to prefer caesarean section in late pregnancy (aOR 0.4; 95% CI 0.2 to 0.8; $p=0.006$) and reported higher birth experience and satisfaction scores (adjusted $\beta=1.9$; 95% CI 0.5 to 3.3; $p=0.006$).

Conclusions The use of the DAT was associated with improved knowledge, communication of birth preferences, lower caesarean preference and greater satisfaction, without adverse outcomes. Findings suggest that decision aids can strengthen SDM and promote respectful, women-centred maternity care in LMICs.

42. Lancet Glob Health 2026;14(2):e224-e232

Episiotomy and postpartum haemorrhage in women with moderate or severe anaemia: a cohort analysis of data from the WOMAN-2 trial

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Background: Women with anaemia have a higher risk of postpartum haemorrhage than those without anaemia. We examined the association between episiotomy and postpartum haemorrhage in women with moderate or severe anaemia.

Methods: We conducted a cohort analysis using data from the World Maternal Antifibrinolytic-2 (WOMAN-2) trial. Women with moderate or severe anaemia who were giving birth vaginally were recruited from 34 hospitals in Nigeria, Pakistan, Tanzania, and Zambia. On arrival at hospital, the participants' haemoglobin concentration was measured with a validated point-of-care haemoglobin test. Moderate anaemia was defined as a haemoglobin concentration of 70-99 g/L and severe anaemia as a haemoglobin concentration lower than 70 g/L. Episiotomy was defined as any perineal incision during delivery. Women were excluded from the WOMAN-2 trial if they were younger than 18 years and lacked consent from a guardian, had a known allergy to the trial intervention, had an indication or contraindication to the intervention, or were diagnosed with postpartum haemorrhage before the umbilical cord was clamped. The primary outcome was a clinical diagnosis of postpartum haemorrhage (estimated blood loss ≥ 500 mL or any blood loss causing haemodynamic instability), and the secondary outcome was calculated postpartum haemorrhage (estimated from peripartum change in haemoglobin concentration). We modelled the outcomes with multilevel logistic regression, adjusting for confounders with inverse probability of treatment weighting.

Findings: Between Aug 24, 2019, and Sept 19, 2023, 4355 (28.9%) of the 15 068 women recruited to the WOMAN-2 trial had an episiotomy. In primiparous women who had non-instrumental births, the incidence of episiotomy was 81.1% in Pakistan (2703 of 3335), 63.3% (307 of 485) in Nigeria, 28.5% (69 of 242) in Zambia, and 15.1% (111 of 735) in Tanzania. Clinically diagnosed postpartum haemorrhage occurred in 1034 (6.9%) of 15 066 participants, and calculated postpartum haemorrhage occurred in 1417 (9.5%) of 14 863. After adjustment for confounders, episiotomy was associated with clinically diagnosed postpartum haemorrhage (odds ratio 1.88, 95% CI 1.33-2.66) and calculated postpartum haemorrhage (1.63, 1.14-2.34).

Interpretation: Although WHO recommends against the routine use of episiotomy, many first-time mothers were given this procedure. Episiotomy might increase the risk of postpartum haemorrhage in women with moderate or severe anaemia. As anaemia is known to worsen the life-threatening complications of postpartum haemorrhage, the risks of routine episiotomy could be even greater in women with anaemia.

43. Lancet Glob Health 2026;14(3):e386-e394

Low-dose aspirin for preventing intrauterine growth restriction and pre-eclampsia in sickle cell pregnancy in Nigeria (PIPSICKLE): a randomised controlled trial

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Background: Pregnant women with sickle cell disease are at increased risk of intrauterine growth restriction (IUGR), pre-eclampsia, and sickle-related conditions. Low-dose aspirin might reduce some of these complications but has not been tested in sickle cell pregnancy. We aimed to investigate the effectiveness and safety of low-dose aspirin for preventing complications during pregnancy.

Methods: In a double-blind randomised controlled trial in 16 public health facilities in southwest Nigeria, pregnant women (aged ≥ 18 years) with haemoglobin SS (HbSS) or SC (HbSC) and carrying a singleton fetus between 12 weeks' and 28 weeks' gestation received daily 100 mg aspirin or placebo until 36 weeks' gestation or delivery and were monitored until 6 weeks' postpartum. The composite primary outcome comprised IUGR, perinatal mortality, or miscarriage. Analysis was done in the intention-to-treat population. The trial was registered in the Pan African Clinical Trial Registry (PACTR202001787519553) and ClinicalTrials.gov (NCT05253781).

Findings: Between July 1, 2020, and May 27, 2024, 619 pregnant women with HbSS and HbSC were screened, of whom 476 eligible women were recruited; 239 received aspirin 100 mg from a median gestational age of 19·0 (16·0-24·0) weeks and 237 received placebo from a median gestational age of 20·5 (15·5-25·0) weeks. 41 withdrew, died, or were lost to follow-up before 36 weeks' gestation.

There was no significant difference in the risk of the primary endpoint: 59 (27·1%) of 218 women in the aspirin group versus 54 (25·8%) of 209 women in the placebo group (risk ratio 1·05 [95% CI 0·75-1·46]). More sickle-cell crises occurred with aspirin than with placebo (mean frequency of 32·64 [SD 71·17] per 100 women with aspirin versus 30·38 [75·95] per 100 women with placebo, incidence rate ratio 1·04 [95% CI 1·01-1·08]). There were ten (4·2%) maternal deaths in the aspirin group versus two (0·1%) in the placebo group (risk ratio 4·96 [95% CI 1·18-20·92]).

Interpretation: Low-dose aspirin was not beneficial for preventing IUGR, perinatal mortality, or miscarriage in sickle cell pregnancy, although this conclusion is limited by late initiation of the medication after 16 weeks' gestation in three-quarters of the participants. Low-dose aspirin, however, increased sickle-related complications compared with placebo, thus studies to clarify its safety in pregnant women with sickle cell disease are required.

Miscellaneous

44. Lancet 2026;407(10531):909-14

Viewpoint

The paradox of trust in health care in the age of social media

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Health systems worldwide face two fundamental and connected challenges: pervasive misinformation and disinformation and eroding public trust. This erosion reveals a paradox at the heart of contemporary science–society relations: the more science succeeds in solving complex problems through rigour and institutional coordination, the more it alienates a public that values immediacy, authenticity, emotional resonance, and personal connection. Consequently, those most committed to scientific rigour—scientists, health-care institutions, professional societies, and public health agencies—are increasingly distrusted, whereas those least accountable—untrained influencers, unqualified individuals with financial motives or political agendas, and artificial intelligence bots—are deemed credible. This so-called trust paradox is amplified by engagement-driven social media environments that reward disinformation, immediacy, group identity, and authenticity over factual truth. The consequences are harmful health outcomes and misguided policy decisions. Addressing this paradox requires not only technical accuracy but also co-production from the outset, overarching horizontal communication, infrastructures for transparency and emotional resonance, and regulatory reforms for algorithms and digital environments.

45. Lancet Planet Health 2026;Mar 5:101415

Pesticide exposure among organic and conventional smallholder farmers in Costa Rica and Uganda: biomarker evidence on exposure determinants

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Background: Pesticides play a crucial role in pest control; however, exposure remains high, particularly among smallholder farmers in low-income and middle-income countries (LMICs) with little access to pesticide safety training. This study aimed to provide comparative biomarker-based

evidence from Latin America and Africa and identify actionable determinants of exposure to inform context-specific interventions and sustainable agricultural policies.

Methods: We collected urine samples from 601 conventional and organic smallholder farmers in Zarcero County, Costa Rica, and Wakiso District, Uganda, on two occasions during the primary spraying season. Samples were analysed for seven biomarkers of six commonly used pesticides: mancozeb (ETU); 2,4-D; glyphosate; pyrethroids (3-PBA, DCCA); diazinon (IMPy); and chlorpyrifos (TCPy). Structured questionnaires assessed sociodemographic, farm-related, and pesticide-related exposure determinants. Linear mixed-effects models were used to identify exposure drivers within and between the countries. The outcome variables were the concentrations of the seven biomarkers measured in urine samples from farmers in both Costa Rica and Uganda.

Findings: All pesticide biomarkers were detected in nearly all participants, confirming widespread exposure. Statistical evidence was found for the following associations: compared with Uganda, farmers in Costa Rica showed lower concentrations of fungicides and 2,4-D by 77-84%, while glyphosate and insecticide biomarkers were higher by 67-376%. Lower biomarker concentrations were significantly associated with organic and mixed farming practices (24-68%) and with previous training on pesticide safety (17-27%). In contrast, increasing age was consistently linked to higher herbicide and insecticide concentrations, and pesticide use within the last week was consistently linked to higher concentrations of all biomarkers.

Interpretation: Smallholder farmers in tropical LMICs are consistently and heavily exposed to pesticides. Evidence from this study highlights the urgent need for tailored interventions-including farmer training and promotion of organic practices-to reduce health risks. Integrating biomarker-based monitoring into planetary health strategies is essential to ensure more sustainable and equitable agricultural transitions in these vulnerable settings.