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International Health Alerts 2026-3 Abstracts

AI-assisted health care

1. Lancet 2026;407(10545):2340-4

Review

Who's really in the loop? Rethinking oversight in AI-assisted health care

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Human-in-the-loop oversight is widely invoked as a safeguard against potential harm from artificial intelligence (AI) used in health care, yet it functions more as symbolic reassurance than substantive protection. We argue that human-in-the-loop fails for three interconnected reasons: AI used in health care can amplify existing structural inequities at unprecedented scale, intersectional harms elude detection by oversight models premised on neutral singular reviewers, and clinicians operate under constraints that preclude meaningful interrogation of algorithmic outputs. Drawing on actor-network theory, feminist epistemology, and political philosopher Iris Marion Young's social connection model of justice, we show that current governance individualises responsibility while obscuring institutional complicity. We propose three pathways towards more substantive accountability: co-reasoning frameworks that position AI as one voice in clinical deliberation, community-owned governance with authority to suspend harmful systems, and institutional liability structures that redistribute responsibility from clinicians to the organisations that design and deploy these tools.

Three quotes from the text for clarification.

Health-care decision making is a dense assemblage of patients, clinicians, data infrastructures, institutional protocols, and regulatory bodies. Algorithms do not simply process neutral data; they operationalise institutional logics and historical biases. When oversight personnel validate discriminatory outputs without examining underlying assumptions, they become part of what the sociologist Ulrich Beck termed “organised irresponsibility”: harm that emerges from systemic interactions while accountability becomes difficult to assign.

The limits of human-in-the-loop oversight do not surface in the same way across health systems. Much of the empirical evidence about these failures comes from high-income countries, yet AI is being increasingly introduced in settings marked by severe workforce shortages, insufficient regulatory capacity, fragmented infrastructures, and long histories of inequitable access to care. In many low-income and middle-income countries, clinicians care for extraordinarily large patient loads with constrained time and diagnostic resources. In those settings, oversight models premised on continuous human availability are structurally unrealistic and possibly risk-enhancing. Global inequities also appear upstream: systems trained in high-income settings are exported to regions whose disease patterns, demographics, and clinical pathways differ markedly from those in the training data, creating conditions some scholars describe as digital colonialism.

The crucial question for AI in health care is no longer whether a human is in the loop, but whether infrastructures of oversight genuinely protect the individuals at greatest risk, instead of relying on the comforting fiction that a clinician beside the algorithm is enough. Oversight must move from ritual to real responsibility if it is to be worthy of the trust patients already place in these systems.

2. Lancet 2026;408(10554):572-6

Review

Global advances in health artificial intelligence: a workforce imperative

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The global health workforce is approaching a breaking point, driven by administrative overload, inefficient workflows, burnout, and accelerating retirements, with a projected global shortfall of 11 million health professionals by 2030. This urgency coincides with the rapid emergence of clinical artificial intelligence (AI) tools, especially generative systems now embedded in documentation,

triage, and workflow support. Therefore, AI should be framed less as a substitute for clinicians than as a retention strategy that preserves careers, expertise, and the human core of care. High-impact uses include ambient documentation, coding support, scheduling and demand prediction, claims and billing support, and inbox triage-tools that can reduce clerical burden and return time to caring, teaching, and leadership. Workforce shortages also create an ethical and geopolitical dilemma; reliance on international recruitment can deepen global inequities, whereas responsible AI deployment might ease competition for scarce talent and expand capacity in lower-resource settings. Yet, AI will not fix dysfunctional systems by default; poorly designed implementation can shift burdens, erode confidence, and widen gaps in health-care quality, access, and clinician wellbeing. Practice must remain clinician-led, patient-centred, and grounded in shared decision making. The policy priority is expertise amplification, not workforce replacement.

Child Health

3. BMJ Glob Health 2026;11(8):e024101

Performance in reducing child stunting in Africa: a stochastic frontier analysis of 54 countries over the past two decades (2000-2022)

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Introduction. Africa remains off-track to meet 2030 stunting targets despite relative economic growth. We aimed to quantify the ‘nutrition conversion gap’, the efficiency with which national resources are translated into stunting reduction, and examine factors associated with technical inefficiency across 54 African nations.

Methods. This longitudinal panel study (2000–2022; N=1134 country-years) used stochastic frontier analysis to estimate a health production frontier, defined as the maximum achievable health production score (100–stunting prevalence). Inputs (gross domestic product (GDP) per capita, dietary adequacy and maternal education) were modelled as 3-year weighted moving averages. Technical inefficiency was modelled as a function of lagged diarrhoea incidence, electrification, urbanisation and political stability.

Results. Significant performance heterogeneity exists across the continent. High technical inefficiency ($\gamma=0.976$, $\lambda=6.33$) accounted for 97.6% of the observed nutritional disparities. Low GDP elasticity ($\beta=0.042$, $p<0.001$) suggests economic growth alone is an insufficient standalone strategy for stunting eradication. Senegal and Somalia achieved near-optimal efficiency despite low national wealth, whereas nations like Equatorial Guinea and Botswana exhibited high systemic inefficiency despite significant economic resources. Electricity access was significantly associated with a narrower conversion gap ($p<0.001$). Furthermore, political stability in the absence of institutional reform correlated with increased inefficiency ($\delta=0.39$, $p<0.001$).

Conclusion. Nutritional progress is profoundly decoupled from national wealth. Policy must pivot from aggregate resource accumulation towards mitigating systemic bottlenecks, specifically infection control and electrification. Strengthening health system efficiency through decentralised, community-led models represents a more potent roadmap for human capital development than simple macroeconomic expansion.

4. Lancet 2026;408(10554):545-57

Oral step-down, optimal drug, and total duration of antibiotic treatment in African children hospitalised with severe community-acquired pneumonia (PediCAP): a factorial randomised controlled trial

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Background: WHO recommends 5 days of intravenous antibiotics for children hospitalised with severe community-acquired pneumonia (CAP). We aimed to investigate the safety of a step-down to different oral antibiotics and the shortest effective duration.

Methods: PediCAP was an open-label, parallel group, 2×5 factorial randomised controlled trial of children aged 2 months to 6 years hospitalised with severe CAP without complicating factors in 13 hospitals across five sub-Saharan African countries. Children weighing 3-30 kg and with point-of-care C-reactive protein of more than 10 mg/L were randomly assigned (5:5:1) to either a step-down from intravenous antibiotics to oral amoxicillin (250 mg) or amoxicillin-clavulanate (co-amoxiclav; 200 mg amoxicillin to 28.5 mg clavulanate) via dispersible tablets twice daily (superiority comparison) for five total (intravenous plus oral) durations (4-8 days; non-inferiority comparison), or a 5-day, fixed-duration, intravenous-only treatment (non-inferiority comparison). Children were stepped down when clinically improved and able to take oral antibiotics. Clinicians could change antibiotics if clinically indicated. The primary outcome was the proportion of readmission or death at day 28 (non-inferiority margin vs intravenous only: +10%). The study was registered with the ISRCTN registry (ISRCTN63115131) and is complete.

Findings: Between Dec 7, 2020, and Aug 14, 2023, 2248 children were screened for eligibility and 1101 were randomly allocated (480 [43.6%] girls and 621 [56.4%] boys). The primary outcome was available in 1055 (95.8%) children. For children in the step-down groups, the mean total antibiotic exposure was 6.0 days (SD 3.5) in the 4-day group, 6.8 days (4.2) in the 5-day group, 7.4 (3.6) in the 6-day group, 8.3 days (3.4) in the 7-day group, and 9.2 days (2.9) in the 8-day group ($p < 0.0001$), with 140 (68.6%) of 204, 151 (76.3%) of 198, 167 (85.2%) of 196, 179 (89.5%) of 200, and 186 (91.6%) of 203, respectively, stepping down within their randomised duration ($p < 0.0001$). Primary outcomes occurred in 33 (6.9%) of 475 in the co-amoxiclav group, 27 (5.6%) of 484 in the amoxicillin group, and six (6.3%) of 96 in the intravenous-only group, with both oral step-down strategies non-inferior to the intravenous-only strategy (upper 95% CIs of 6.0 for co-amoxiclav and 5.7 for amoxicillin) and no evidence of superiority for co-amoxiclav over amoxicillin (adjusted risk difference 1.3% [95% CI -1.8 to 4.4]; $p = 0.40$). Primary outcomes occurred in eight (4.1%) of 194 in the 4-day group, ten (5.3%) of 190 in the 5-day group, 16 (8.5%) of 188 in the 6-day group, 16 (8.3%) of 193 in the 7-day group, and ten (5.2%) of 194 in the 8-day group; all durations were non-inferior to the 8-day group (all upper 95% CIs $\leq 6.0\%$). There was no evidence of consistent differences in adverse events for oral antibiotic or duration comparisons. For antibiotic-related or serious adverse events, there was one (1.0%) in the intravenous-only group and 12 (2.5%) in the amoxicillin group (adjusted risk difference -2.3% [95% CI -4.2 to -0.3]; $p = 0.025$), and 16 (3.4%) in the co-amoxiclav group (+0.8% [-1.2 to 2.8]; $p = 0.42$); rates increased with randomised duration (slope estimate +0.9% [0.1 to 1.7]; $p = 0.032$).

Interpretation: For sub-Saharan African children hospitalised with severe CAP without complicating factors, a strategy of stepping down upon clinical improvement to oral amoxicillin after initial intravenous antibiotics, with a total treatment duration of 4-5 days, is non-inferior to WHO-recommended 5-day intravenous treatment.

5. Lancet Glob Health 2026;Sep 1:104031

Hypoxaemia and mortality in children with lower respiratory infection in low-income and middle-income countries: systematic review and meta-analysis

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Background: Hypoxaemic lower respiratory infections (LRIs) are a leading cause of childhood mortality, with the highest burden in low-income and middle-income countries (LMICs).

Hypoxaemia-low peripheral capillary oxyhaemoglobin saturation (SpO_2) is a marker of severity, and WHO recommends hospitalisation and oxygen administration for patients with $SpO_2 < 90\%$. We aimed to update estimates from a 2015 systematic review and meta-analysis examining the association between hypoxaemia and mortality among children with LRIs in LMICs by incorporating studies published over the subsequent decade and evaluating mortality risk across multiple SpO_2 thresholds.

Methods: We conducted a systematic review with meta-analysis by searching PubMed, Embase, LILACS, Global Index Medicus, Web of Science, and Scopus for peer-reviewed studies published between Jan 1, 2015, and June 18, 2025, with combined terms related to pneumonia, children, mortality, and LMICs. We also included selected earlier studies through citation checking. Eligible studies reported associations between hypoxaemia and mortality in children younger than 5 years with LRIs in LMICs. We excluded case reports and case series with fewer than five deaths, studies focused

exclusively on the neonatal period, and those limited to children with specific comorbidities or to postoperative patients, for consistency with the original review. Two reviewers independently screened studies, extracted data, and assessed quality. Eligible studies were combined with those from the original review and analysed using random-effects models to estimate odds ratios (ORs) by hypoxaemia threshold subgroup. The protocol was registered on PROSPERO (CRD42023433946). Findings: We identified 7734 records; 26 new studies met inclusion criteria and were combined with 18 from the original review. The 44 studies were published between 1993 and 2024 and were primarily from Africa (25 [57%] of 44) or Asia (19 [43%]); some studies spanned multiple locations. Data from 33 studies including 155 633 participants were included in the primary meta-analysis. Hypoxaemia of any threshold was associated with higher odds of LRI mortality (OR 4·36 [95% CI 3·52-5·39]) compared with no hypoxaemia. For SpO₂ <90% versus 90-100%, OR for death was 4·75 (95% CI 3·42-6·58). For SpO₂ 90-94% versus 95-100%, mortality risk was more than twice as high (OR 2·27 [95% CI 1·22-4·25]). Heterogeneity was substantial (I² 64-85% across analyses), and eight (24%) of 33 studies in the primary meta-analysis had a high overall risk of bias; however, a sensitivity analysis restricted to studies with low or moderate risk of bias yielded similar results. Interpretation: SpO₂ <90% strongly predicts mortality in children with LRIs in LMICs. Children with SpO₂ 90-94% also have elevated risk, suggesting that paediatric LRI and pneumonia treatment algorithms should consider management at this hypoxaemia threshold.

6. PLoS Med 2026;23(7):e1005175

Re-emergence of vaccine-preventable diseases in the post-elimination era

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(AI Summary)

Vaccine-preventable diseases (VPDs)—most prominently measles, poliovirus, and diphtheria—are resurging globally and threatening decades of public health progress. Driven by pandemic-related disruptions, access barriers, and growing vaccine hesitancy, several countries have recently lost their disease-elimination status. Because re-emergence risk is highly concentrated in localized, under-immunized sub-populations, controlling this threat requires fine-grained surveillance, targeted local interventions, and tailored community engagement rather than broad, top-down policies alone.

Key Takeaways:

- * Drivers of Re-Emergence: Global declines in routine childhood immunization—exacerbated by misinformation, political polarization, and healthcare disruptions—have heightened the risk of localized outbreaks.

- * Pathogen-Specific Risk: Re-emergence depends on a pathogen's basic reproduction number (R_0) and global incidence. Highly transmissible diseases like measles ($R_0=10$ –20) require substantially higher population coverage to prevent local transmission compared to less transmissible diseases like rubella ($R_0=4$ –7).

- * Spatial Heterogeneity: Outbreaks in re-emergent settings are geographically localized rather than uniformly distributed. For example, despite a record number of US measles cases in 2025, fewer than 1% of US counties accounted for 20 or more cases.

- 4* Targeted Interventions: Macro-level coverage data (national or state-level) masks vulnerable clusters. Accurate risk assessment requires granular data at the school district or municipal level to guide local vaccination campaigns and community outreach.

- * Mitigation & Public Health Engagement: Reversing vaccine hesitancy requires two-pronged action: individual patient engagement (e.g., motivational interviewing by clinicians) and population-level strategies (e.g., partnering with trusted community leaders and removing structural access barriers). Core Areas for Future Research. Addressing Vaccine Hesitancy: Developing and evaluating context-specific interventions tailored to distinct socio-demographic groups.

Conflicts and Humanitarian Crises

7. PLoS Med 2026;23(6):e1005156

The well-worn path from armed conflict to measles resurgence
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(AI summary)

Armed conflicts inflict damage far beyond direct violence by crippling health systems and triggering infectious disease outbreaks. Measles serves as a sensitive stress test for health system performance—because of its high transmissibility, outbreaks instantly expose gaps in routine immunization and disease surveillance.

Key Takeaways

* The "Zero-Dose" Vulnerability:

- While 20% of the global birth cohort lives in conflict-affected areas, these regions account for over half of the world's 14.5 million "zero-dose" children (infants who have not received a single basic DTP vaccine dose).

* Why Measles Spreads Rapidly in War Zones:

- Extreme Transmissibility: A single case can infect up to 18 people, requiring a 95% vaccination coverage to maintain herd immunity.
- Lethal Synergies: Malnutrition, highly prevalent in conflict zones, contributes to 45% of fatal measles cases, pushing case fatality rates up to 33% in complex emergencies.

* The Indirect Pathway & Delayed Impact (SEM Model):

- Research by Tozan & Headley shows conflict impacts measles burden primarily indirectly by eroding socioeconomic structures (GDP, education, life expectancy) and driving mass displacement.
- 3-Year Lag: The association between conflict and measles outbreaks peaks around 3 years later, as persistent insecurity and governance collapse gradually build up a large pool of susceptible, unvaccinated children.

* Methodological Challenges:

- Data Undercounting: Conflict damages surveillance systems, meaning official statistics likely underestimate actual cases. The populations facing the greatest violence are often the most "epidemiologically invisible."

Conclusion & Key Recommendation

Measles acts as a sentinel event for broader post-war infectious disease crises. Sustaining and adapting routine immunization and disease surveillance in conflict zones must be treated as an immediate emergency response, rather than a secondary task delayed until post-war reconstruction.

Foodborne diseases

8. Lancet Glob Health 2026;14(8):103987

WHO foodborne disease estimates 2000-21: bridging the burdens of infectious and non-communicable diseases

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Foodborne diseases are a major and preventable cause of global morbidity and mortality, disproportionately affecting children and other clinically vulnerable populations. Addressing this burden requires coordinated, multisectoral systems that integrate health, agriculture, environment, trade, and consumer protection to drive effective policy action. The 2010 WHO global estimates of foodborne diseases, published in 2015, were the first comprehensive attempt to quantify the worldwide impact of infectious pathogens and chemical hazards commonly transmitted via food and provided estimates of incidence, mortality, and disability-adjusted life-years.

The 2026 edition of the WHO foodborne disease estimates build on the methods used in the 2015 edition with substantial methodological advancement.

This edition presents five articles with core results: an overarching assessment of the global, regional, and national burden of 42 foodborne infectious and chemical hazards (including detailed analyses of

14 foodborne diarrhoeal hazards, eight non-diarrhoeal enteric hazards, 12 parasitic hazards, and nine chemical hazards). These papers are complemented by methodological and systematic review articles published elsewhere, which collectively underpin the final results.

The 2026 edition of the WHO foodborne disease estimates reaffirm that foodborne diseases remain a major global health challenge but one that is increasingly measurable, preventable, and actionable. Sustained commitment, aligned priorities, and strong multisectoral collaborations are essential to translating these estimates into impactful public health gains. These updated estimates provide a robust foundation for prioritising interventions, guiding policy, and advancing universal efforts to ensure the safety of food for global health and wellbeing.

Articles in this edition

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

WHO estimates of the global, regional, and national burden of eight foodborne non-diarrhoeal enteric disease hazards, 2000–21: an updated data synthesis

WHO estimates of the global, regional, and national foodborne burdens of 14 invasive parasitic diseases, 2000–21: an updated data synthesis

WHO estimates of the global, regional, and national burden of 14 foodborne diarrhoeal enteric hazards, 2000–21: an updated data synthesis

WHO estimates of the global, regional, and national disease burden of nine foodborne chemicals, 2000–21: an updated data synthesis

9. Lancet Glob Health 2026;14(9):104016

Market-source pathogens in traditional food markets, 2000-25: a systematic review and meta-analysis

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Background: Traditional food markets, often referred to as wet markets, live poultry markets, or farmers' markets, remain a major source of animal-origin foods and fresh produce in many low-income and middle-income countries (LMICs). These markets bring humans, domestic animals, wildlife, and the environment into close contact and have been repeatedly implicated in the emergence of zoonotic and foodborne diseases. Yet, the overall global burden, pathogen spectrum, and risk gradients within these settings have not been comprehensively quantified.

Methods: We conducted a systematic review and meta-analysis of studies published between Jan 1, 2000, and Oct 31, 2025, following the PRISMA 2020 reporting guidelines. We searched major English and Chinese databases for cross-sectional or baseline studies reporting the detection of zoonotic or foodborne pathogens in traditional food markets or related retail settings. Studies were excluded if they were not conducted in traditional markets, had non-extractable data, had a sample size of fewer than 20, had intervention-related outcomes, had duplicate populations, or did not have prevalence or detection rate reporting. Data were extracted as detection records, defined as unique pathogen-sample type-market setting combinations. Study quality was assessed with the Joanna Briggs Institute tool for prevalence studies. We used random-effects meta-analysis of logit-transformed proportions to estimate pooled prevalence and 95% CIs overall and across major subgroups. Heterogeneity was assessed with I^2 and τ^2 , and meta-regression was used to examine temporal trends and associations between study quality and prevalence. Robustness was assessed with leave-one-out analyses and small-study effects.

Findings: We included 247 studies comprising 597 detection records from 41 countries across 16 regions. The global pooled prevalence of market-source pathogens in traditional markets was 15.32% (95% CI 13.96-16.80). By pathogen kingdom, pooled prevalence was 19.41% (16.21-23.08) for bacteria, 8.40% (7.15-9.83) for viruses, and 27.05% (21.91-32.89) for parasites. Regionally, prevalence was highest in southeast Asia (23.09% [18.43-28.52]), followed by south Asia (15.52% [10.06-23.20]) and east sub-Saharan Africa (14.54% [7.13-27.40]). By market type, fish and seafood markets showed the highest pooled prevalence (37.87% [26.05-51.33]), and by sample type, the highest estimates were observed in fish and seafood, raw meat, and environmental samples. Lower

estimates were observed in cooked foods, fruit and vegetables, and worker samples, suggesting a gradient from animal and environmental reservoirs towards ready-to-eat foods and humans. Meta-regression showed no significant global linear temporal trend in prevalence, whereas higher methodological quality was associated with lower reported prevalence. Leave-one-out analyses suggested that no single study substantially altered the overall findings.

Interpretation: Traditional markets represent persistent global hotspots for zoonotic and foodborne pathogens, particularly in LMICs and high-risk food chains. The observed exposure gradient highlights crucial intervention points. These findings support a One Health-oriented framework for risk assessment and targeted surveillance, while emphasising the need for harmonised, prospective, multipathogen studies.

Health Policy / Health Finances

10. BWHO 2026;104(9):651-3

A transdisciplinary research agenda for resilience

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(AI summary)

Health system resilience has increasingly been understood as the capacity of health systems to absorb, adapt to, and recover from acute shocks, particularly following the COVID-19 pandemic. However, this crisis-oriented framing may overlook the persistent pressures that shape health system functioning in everyday life. This article proposes a conceptual shift from viewing resilience primarily as a response to acute shocks toward understanding it as the capacity to adapt and transform under chronic and accumulating stress. Stressors such as ageing populations, multimorbidity, antimicrobial resistance, climate-related pressures, workforce shortages, and fragile supply systems continuously challenge health systems and may have substantial long-term effects on population health. The article emphasizes the importance of examining everyday practices, particularly the work of frontline health workers who continually adapt formal systems and limited resources to maintain care. It argues that resilience should be understood not simply as maintaining the status quo, but as a process of incremental transformation. The authors further call for resilience to be re-politicized by addressing inequalities, power relations, and the unequal distribution of the costs of adaptation. Learning from low- and middle-income countries, where health systems have long operated under chronic constraints, is highlighted as an important source of theoretical and practical insight. The article concludes that future resilience research should focus on how health systems sustain and transform everyday operations under accumulating stress, rather than concentrating predominantly on preparedness for acute crises.

11. HPP 2026;41(7):1080-7

Understanding informal payments in the health sector in Malawi: results of a multidistrict household survey

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In Malawi, health services are officially free at the point of use, but patients often make informal payments to access services or obtain medicines. These payments undermine equity and trust in the health system. This study examined for the first time the prevalence, types, and determinants of informal payments among Malawians who had recently used health services. We conducted a multidistrict cross-sectional household survey in four districts chosen to reflect urban and rural Malawi. Households containing someone who had been hospitalized in the previous 6 months were interviewed using a structured questionnaire. Descriptive analyses identified the types and prevalence of informal payment, while multivariable logistic regressions identified factors associated with informal payments. Overall, 17% of respondents reported paying for services that are officially free. Informal payments are most often for medicines (52%), consumables (24%), and consultations (24%). Female respondents and those living in urban areas were significantly more likely to report giving informal payments, while those with higher levels of education were less likely. Participants with a

good or very good financial situation were more likely to make such payments. Significant geographical variations were observed, with higher probabilities in Mchinji and Mzimba than in the Blantyre district. Nearly one in five Malawians reported making informal payments to access health services, questioning the formal policy that these are free. These findings highlight the need for governance reforms, greater accountability, and community awareness to reduce informal payments and promote equitable access to care.

12. HPP 2026;41(7):1307-33

Assessing intervention effects on healthcare-related financial protection in low- and middle-income countries: a rapid evidence review

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Financial protection is a key goal for universal health coverage, but globally, this indicator has been lagging, especially for low-income households. Understanding how to improve it is urgent. This rapid evidence review examined the effectiveness of interventions, which affected financial protection in health across low- and middle-income countries (LMICs). A systematic search of published literature identified empirical studies reporting on outcomes such as out-of-pocket expenditure (OOPE), catastrophic spending, impoverishment, and care foregone for financial reasons, with data extracted and categorized using structured tools. A narrative synthesis was used to interpret the evidence. The review included 214 studies published between 1999 and 2024, covering interventions in 39 countries. About one-quarter of studies assessed equity, often revealing mixed or regressive effects. Financial protection is affected through multiple channels, but evaluations still largely focus on health-sector-specific interventions, failing to examine potentially impactful wider policies. Insurance schemes were the most studied intervention type, with mixed results. Demand-side financing, such as vouchers or cash transfers, and user fee reforms often struggled to benefit the poorest due to structural barriers and indirect costs. Provider payment reforms were more likely than other categories to show adverse effects, including unintended supplier behaviour changes that drove up OOPE and costs to the system. Less frequently evaluated interventions, such as social protection and behaviour change programmes, showed some positive effects. Whilst no single intervention consistently ensured financial protection, the evidence points to the value of interventions that act across multiple sectors and health areas. Designing reforms with an explicit objective of improving financial protection, with local context, system capacity, and equity in mind and adjusting based on continuous monitoring, can support achievement of improved and equitable financial protection.

Key messages

- No single intervention consistently ensures financial protection, which is a multi-sectoral outcome. Health-sector-specific interventions, such as insurance or fee removals, often fail because they do not address the broader structural barriers that keep households vulnerable. Governments must adopt multi-pronged, context-specific strategies that address health system factors, broader social determinants, and social protection.
- Financial protection is affected through multiple channels, but evaluations still largely focus on 'classic' health financing interventions such as insurance, neglecting to study potentially impactful wider policies.
- Policymakers should make financial protection an explicit objective and ensure it is monitored in a disaggregated way.

13. HPP 2026;41(8):1358-74

Exploring the roles of informal healthcare providers in urban settings to improve access and quality of care for the urban poor: experience from Bangladesh, Ghana, Nepal, and Nigeria

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Though informal healthcare providers (IHPs), often defined as unregistered and not formally trained, are heavily utilized by low-income urban residents and present an opportunity to address the urban primary care gap, these providers are rarely prioritized or integrated into health systems. This paper

explores IHPs' role in urban settings across four rapidly urbanizing low- and middle-income countries: Bangladesh, Nepal, Nigeria, and Ghana, to enhance understanding of their potential within health systems and promote their integration to improve access and quality of care for the urban poor. We studied published and unpublished articles and policy documents to compare informal provider types, roles, services, and target populations in each country. We then present case studies illustrating how these providers support healthcare for urban poor. A narrative synthesis was applied to describe the included documents/literature and results, while quantitative data were analysed using STATA version 16. OpenStreetMap basemaps were employed to illustrate informal providers' locations within urban areas. Our findings show that across the four countries, there is substantial evidence that informal providers contribute significantly to health service delivery by bridging the care gap, particularly for socially and economically disadvantaged urban populations. They serve as the first point of contact, offering a wide range of health services, including preventive, curative, and restorative services. However, they are loosely defined and lack robust standards, protocols, professional training, and accreditation. Informal providers play a critical, though varied, role in the delivery of healthcare across the countries studied, facilitating access to care where it might otherwise be unavailable or unaffordable. Initiatives to strengthen the informal sector, e.g. linking or integrating with the formal sector, have the potential to improve healthcare access and quality for the urban poor.

14. Lancet 2026;407(10547):2554-76

Review

The UCL-Lancet Commission on Migration and Health: review of the state of progress

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Although progress towards implementation of international agreements since publication of the UCL-Lancet Commission on Migration and Health in December, 2018, has been slow, global trends in migration and forced displacement have continued to rise. However, the COVID-19 pandemic showed that reaching refugees and migrants with health interventions is feasible with political will. The benefits of refugee-inclusive and migrant-inclusive health-care systems during emergencies (eg, COVID-19 and the war in Ukraine) are apparent, with numerous examples of inclusive policy making being rapidly introduced and innovative models developed to support health-care access, including preventive measures such as vaccination. Lessons from these successes should be learned and incorporated into future policy and practice. However, global political and financial uncertainty and disruption-combined with multiple conflicts and natural disasters-have increased individuals' need to move, which will continue to be exacerbated by the climate crisis. Although new conflicts and exacerbations of existing ones have led to a rise in forced displacement within and across national borders, labour migration has also risen dramatically, with the pandemic highlighting the health and social needs of these groups globally. The need for strong leadership and accountability, engagement of policy makers in the highest-level fora, and improved access to quality health services for refugees and migrants has never been greater. In this Review, nearly 8 years after the UCL-Lancet Commission on Migration and Health was published, we renew our call for action to: (1) improve health-care access and optimise outcomes for refugees and migrants by emphasising health in all migration and forced displacement policies; (2) establish data systems to monitor progress, together with appropriate use of new technologies to improve access, prevent harm, and safeguard privacy; (3) support research on adaptation to and mitigation of the health consequences of climate change on refugees and migrants; and (4) renew focus on the political determinants of health outcomes for people on the move. At this pivotal moment, with geopolitical, sociodemographic, and environmental turmoil, political leaders and societies can shape a better future by leveraging the human capital of migrants and upholding the human rights and dignity of all.

HIV/AIDS

15. Lancet 2026;408(10550):93

Editorial

Ending HIV: a reality check

(Abbreviated)

The fifth UN High-Level Meeting on HIV/AIDS (June 22–23) saw the agreement of a new Political Declaration on HIV/AIDS. In it, countries expressed commitments to end AIDS as a public health threat by 2030, mobilise adequate resources, achieve the 95–95–95 targets, and accelerate equitable access to comprehensive HIV prevention, among other provisions. Speaking to the press ahead of the meeting, Winnie Byanyima, Executive Director of UNAIDS, identified the four foundations of global HIV control that she hoped countries would support: multilateralism, sustained financing, protection of rights, and access to innovations. The difficulty for the Declaration is that each of these four dimensions is facing stark opposition, if not outright reversal.

The overall progress in controlling HIV/AIDS over the past 25 years is nothing short of incredible. Equally, the pandemic unarguably remains a major threat to health. An estimated 40·9 million people live with HIV, with 1·2 million new infections in 2025. 570 000 people died from AIDS last year. And yes, we have the countermeasures and know-how to end HIV. But the systematic under-mining and deprioritisation of HIV control will almost certainly result in more cases, more illness, more deaths, and more harm to those with HIV and their families, friends, and communities. Just last year, UNAIDS estimated that cuts to PEPFAR alone could lead to an additional 6·6 million new HIV infections and 4·2 million AIDS-related deaths by 2029.

Setting ambitious targets is a hallmark of global health. The drive to meet them shapes political, economic, and health agendas and they have helped to spur some of the most transformative advances in human wellbeing. But care is needed to avoid a sliding from the ambitious into the unrealistic.

16. Lancet 2026;408(10554):505

World Report

HIV care suffers under Senegal anti-gay law

Nakweya G.

(AI summary)

This article examines the impact of Senegal's newly introduced anti-gay legislation on HIV prevention and treatment services. The harsher penalties for same-sex relations have created widespread fear of arrest, discrimination, and abuse, leading many LGBTQ+ people, particularly men who have sex with men, to avoid HIV testing, treatment, and prevention services. Some patients have fled the country or struggled to obtain antiretroviral medication, while community health workers providing HIV services have also been arrested. The article highlights concerns that reduced access to health care could increase HIV transmission and reverse previous progress in HIV control. HIV prevalence among men who have sex with men has already increased substantially, while stigma and criminalisation further discourage individuals from seeking care. Public health experts argue that punitive laws are incompatible with effective HIV prevention and undermine both human rights and public health. The article concludes that decriminalisation, accessible and non-discriminatory health services, and protection of vulnerable communities are essential to maintaining progress in HIV prevention and treatment.

17. Lancet Glob Health 2026;14(7):103943

Sustaining progress in HIV care in Africa with a transition to enabled self-care: a modelling study

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Background: The funding crisis for HIV services in east, central, southern, and west Africa means that innovative strategies for continuing prevention and care for HIV are needed. One such strategy is enabled self-care: the provision of free HIV self-tests, pre-exposure prophylaxis (PrEP), tenofovir-lamivudine-dolutegravir for post-exposure prophylaxis (PEP), and antiretroviral therapy (ART) provided in local pharmacies and by community-based health workers. We modelled the introduction of a policy of transition to enabled self-care compared with continuation of current service provision. Methods: We used an established individual-based model (HIV Synthesis) to simulate HIV epidemics in 1000 setting scenarios representing diversity in setting characteristics across east, central, southern, and west Africa, and uncertainty in parameter values. For each setting scenario, we simulated 100 000

people aged ≥ 15 years between 1989 and 2076. The model incorporates ART access informed by studies of barriers to accessing clinics. Our main outcomes included the number of adults testing for HIV in a 3-month period, PrEP and PEP use, coverage of people on ART, HIV-related deaths, HIV incidence, perinatal transmission, disability-adjusted life-years (DALYs), and costs. We chose a 50-year time horizon to capture the full effects of the policies. For each setting scenario, we performed three replicate runs for each of the two policies and for each policy took the mean across the three runs.

Findings: Our model estimated that transitioning to enabled self-care would lead to increases in testing from a median of 5.0% (90% range 2.3-11.5) of adults testing per 3 months to 12.7% (6.6-21.1), an increase in PrEP and PEP use (+0.5% of adults [0.0-2.2]), and an increase in ART coverage for people with diagnosed HIV (+1% [0-3]) with enhanced benefits in those previously without access to PrEP and testing services. Enabled self-care was predicted to result in a median 18% (90% range 4-33) fewer HIV deaths, and a relative rate of 0.73 (0.52-0.94) in terms of HIV incidence per 100 person-years over 10 years. Overall, over a 50-year time horizon, enabled self-care was predicted to cut discounted programme costs by US\$6.0 million (5.6-6.5; a 7% decrease), avert 34 000 (32 200 to 36 000) DALYs, and be cost-effective (at a cost-effectiveness threshold of \$300 per DALY averted) in 95% of setting scenarios. The mean undiscounted annual cost per adult in the population per year across setting scenarios was \$12 (median \$11 [90% range 6-22]). The higher the HIV prevalence was in a setting scenario, the more cost-effective the policy was found to be (odds ratio 1.41 [95% CI 1.25-1.60] per 1% higher HIV prevalence).

Interpretation: Introduction of community access to self-tests and antiretroviral drugs through a transition to enabled self-care is very likely to be cost-effective in most settings in east, central, southern, and west Africa; enable incidence declines to be sustained at reduced cost; and increase equity of access to HIV services. Policy makers who wish to consider such a policy will need to evaluate its feasibility in their own country settings.

Infectious Diseases

18. Am J Trop Med Hyg 2026;115(2):383-6

The Critical Need for a Comprehensive Post-Exposure Care Bundle following Rabies Exposure: A Report of Two Cases

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Rabies is a zoonotic disease that is almost always fatal but can be prevented; it disproportionately affects areas of Asia and Africa with limited resources. Post-exposure prophylaxis (PEP) failures continue to cause avoidable deaths despite advancements in vaccination techniques. Two rabies deaths in which vaccination was not enough to prevent death are reported in the current study: one in an adult bitten by a wolf and another in a child bitten on the face by a stray dog. Critical shortcomings in comprehensive care, such as improper wound suturing, poor wound management, and a failure to administer rabies immunoglobulin (RIG), are highlighted in both cases. Both patients' rabies infections were verified using histopathological and molecular analyses. These incidents underscore the crucial importance of a comprehensive "rabies care bundle" that encompasses active vaccination, passive immunization with RIG, and thorough wound care. To avoid similar results and preserve public trust in rabies vaccination programs, it is crucial to increase clinician awareness, ensure that all PEP components are accessible, and adhere to WHO guidelines.

Other paper about this subject:

Am J Trop Med Hyg 2026;Sep 17:tpmd260343

Wound-Only versus Weight-Based Rabies Immunoglobulin in Post-Exposure Prophylaxis: A Quasi-Randomized Assessor Blind Non-Inferiority Trial

19. BMJ Glob Health 2026;11(9):e023050

Mpox in Africa: one year continental response outcomes and way forward

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Background. Following the declaration of mpox as both a global and continental public health emergency in August 2024, the Joint Incident Management Support Team (IMST), co-led by the Africa Centres for Disease Control and Prevention (Africa CDC) and the WHO, was activated in Kinshasa, DRC to coordinate the continental mpox response. This article highlights the first year's epidemiological and operational findings.

Methods. Key performance indicators across eight IMST pillars (coordination, surveillance, laboratory, case management, infection prevention and control, risk communication and community engagement (RCCE), vaccination and research) were descriptively analysed using data from 28 African Union Member States from January 2024 to August 2025.

Results. A total of 49 803 confirmed cases and 240 deaths (CFR 0.5%) were recorded across 28 countries. The response was supported with US\$977 million as tracked by the IMST. Operational achievements included 87% surveillance completeness, 72% contact tracing completeness and improved average laboratory turnaround time from >5 days to 2 days. Laboratory testing capacity expanded from 2 to 27 sites in the DRC and from 1 to 56 decentralised sites in Burundi. RCCE activities reached 50 million people in 21 countries, with vaccine acceptance among high-risk groups rising from 44% to 87%. Operational research achievements included a responsive and functional research coordination mechanism, 24 (92%, 24/26) multi-country clinical and operational research studies implemented and 60% completion rate of the research data and material sharing framework for Africa. Only 938 000 doses (32%) of the 3.1 million vaccine doses delivered were administered.

Conclusion. The joint continental IMST is a new benchmark for response governance, successfully mobilising resources and scaling up diagnostics under unified co-leadership. On the other hand, the evaluation revealed persistent structural challenges in last-mile vaccine delivery, contact tracing (due to stigma/funding) and weak regional collaborative research including fragmented regional research priorities. Future focus must shift from emergency action to durable, sustained investment in national and sub-national health security architecture using a multisectoral whole of government approach.

20. BWHO 2026;104(6):371-371A

Editorial

A case for using spatial evidence in waterborne disease control

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AI summary

Cholera remains a major public health challenge in low- and middle-income countries, particularly across sub-Saharan Africa, where disease burden is highly concentrated geographically. Although spatial epidemiology has generated increasingly detailed cholera risk maps, a persistent gap remains between identifying geographic hotspots and translating this information into effective intervention and preparedness decisions. This article proposes a spatial lens that bridges spatial epidemiology and implementation science by incorporating geographic, environmental, infrastructural and social context into the design and delivery of cholera interventions. Such an approach can guide the strategic siting of treatment facilities and water, sanitation and hygiene infrastructure, account for seasonal and climate-related constraints, support locally differentiated intervention strategies, and enable dynamic allocation of resources as outbreaks evolve. Integrating climate risks, including floods and droughts, can further strengthen anticipatory preparedness. A spatial lens can also provide a common operational framework for coordinating health, water and sanitation, education and municipal sectors around shared geographic priorities. However, effective implementation requires community engagement, sustained financing, governance mechanisms and multisectoral decision-making platforms. Moving beyond hotspot identification towards spatially informed implementation could improve the equity, timeliness and effectiveness of cholera prevention, preparedness and response and may provide a transferable framework for other geographically determined infectious diseases.

21. JAMA 2026;336(1):69-70

Chikungunya

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Chikungunya virus is a mosquito-borne alphavirus found in tropical and subtropical regions of the world that has caused outbreaks in more than 100 countries, with disease characterized by fever and disabling joint symptoms. In addition to causing disease in residents living in chikungunya risk areas, infections may occur in travelers to these areas; viremic travelers may then introduce chikungunya virus into new regions, including the US, where mosquitoes may spread infection locally. Global travel; sequence variations that improve viral infectivity, dissemination, and transmission; and climate-related warming that enhances factors related to transmission (eg, increased mosquito survival, expanded range of mosquitoes, faster viral replication) have led to increases in chikungunya cases and geographic areas affected. Infection usually provides long-lasting immunity. Described are the epidemiology, transmission, diagnosis, management and prevention.

Conclusions

Chikungunya virus, which is transmitted to humans primarily via mosquito bites, has undergone a rapid expansion in distribution worldwide, causing increased numbers of local outbreaks and infection of travelers to transmission areas. Chikungunya causes symptoms in most patients and may lead to disabling joint pain. Management involves supportive care, and chikungunya vaccination should be considered for individuals at high risk of exposure.

22. JAMA 2026;336(4):277

WHO Issues Guidelines for Treating Ebola and Marburg Viruses
Anderer S.

The World Health Organization (WHO) released its first comprehensive guidelines on the clinical management of filovirus disease, which includes all Ebola and Marburg viruses.

The guidelines were published to help health care workers treating patients with filovirus disease amid an outbreak of Bundibugyo virus disease in the Democratic Republic of the Congo. Developed through global expert consultations, the guidance includes 16 evidence-based recommendations that highlight the importance of early supportive care to produce better outcomes and increase patient survival, particularly in the absence of licensed vaccines and treatments for Marburg, Bundibugyo, and Sudan virus diseases.

Key practical recommendations from the WHO for addressing filovirus disease include using laboratory tests to identify problems such as hypoglycemia, managing dehydration and shock, treating co-occurring bacterial infections, and providing structured follow-up. The WHO said in a press release that “optimized supportive care can reduce complications and provide the foundation on which all other clinical interventions are delivered.”

23. Lancet 2026;407(10547):2485-6

World Report

Life and death in an Ebola virus disease treatment centre

Burki T.

(Abbreviated)

Dedicated treatment facilities are a cornerstone of an Ebola virus disease outbreak response, but conditions are extremely difficult and taxing for health workers.

One thing everyone who works in an ebola treatment centre (ETC) agrees on: it is unbearably hot in there. Personal protective equipment (PPE) is designed to prevent even the smallest amount of liquid from penetrating. But if liquid cannot get in, it also cannot get out. From the moment you are fitted into the PPE, the clock is ticking. It does not take long before you are soaked through.

Daytime temperatures in the part of DR Congo where Ebola virus has broken out are around 30°C at this time of year. According to Jean-Paul Mangion, an emergency doctor at Médecins Sans Frontières (MSF), that leaves no more than 30–40 min before working in full PPE becomes a problem.

The physical barrier between the physician and the patient complicates efforts to build a connection.

It is when the PPE is being removed that health workers are at the highest risk of being infected with Ebola virus. The decontamination process is painstaking and time-consuming; it typically involves repeatedly dousing protective equipment with chlorine and ensuring the caregiver's hands are thoroughly washed. A few flecks of blood are more than enough to transmit the virus. What you touch acquires enormous significance.

According to Oliver Johnson, an academic in global health at King's College London “The Sierra Leonean staff were facing challenges that were much more intense than the international workers. If I had died, it would have been devastating for my family, but they would not have gone into desperate poverty. For health-care workers from Sierra Leone, that was a real possibility. The stakes were so much higher for them, even when it came to matters of life and death”.

Johnson urges international organisations to ensure they treat all infected workers in the same way. “In Sierra Leone, if an international worker got sick, it was all about getting them the best treatment. But when one of our colleagues from Sierra Leone got sick, it was all about contact tracing and containment. That racial divide did not go unnoticed”, he told *The Lancet*. “We are asking health workers in DR Congo to take tremendous risks. These are people without life insurance or any kind of safety net for their family. The very least they deserve is the very highest standard of care if something goes wrong. I am not hearing that said often enough.”

24. *Lancet Glob Health* 2026;14(7):103907

Review

Sex-specific presentation, epidemiology, and control of schistosomiasis in women and adolescent girls
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Schistosomiasis presents a major public health problem for women and adolescent girls in endemic areas, particularly tropical and subtropical regions. Many sex-specific effects of schistosomiasis are due to *Schistosoma haematobium*, which primarily affects the genitourinary tract. Deposition of schistosome eggs in genital tissue causes female genital schistosomiasis (FGS), a chronic gynaecological condition that affects over 40 million women and girls. Women and girls living with FGS face intersecting challenges that compound its adverse effects. Disabling genital symptoms include pain, abnormal discharge, menstrual irregularities, and subfertility. These symptoms affect daily activities, impose financial burdens, and harm intimate relationships. Women and girls face stigma and isolation due to the similarity of FGS symptoms to sexually transmitted infections. Health systems in endemic areas are poorly equipped to consider, diagnose, and treat FGS, and women and girls are often excluded from schistosomiasis control strategies. Multifaceted approaches targeting schistosomiasis in women and girls are urgently needed.

Other paper about this subject:

Lancet Glob Health 2026;14(7):103932

Review: Schistosomiasis in pregnancy and lactation

25. *TMIH* 2026;31(7):843-67

Infectious Agents of Non-Malarial Febrile Illnesses in 20 African Countries, 2019-2024: A Systematic Review and Meta-Analysis

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Background: The growing attention to non-malarial febrile illnesses (NMFIs), driven by the decline in malaria cases across the African continent, has revealed pathogens previously overshadowed by the burden of malaria. Recent outbreaks, the resurgence of diseases and the rising antimicrobial resistance burden, compounded with data gaps in previous studies, have underscored the need to closely examine this area in recent times

Methods: We searched for articles through PubMed, Scopus, ScienceDirect and Web of Science databases to identify the common causative agents of NMFIs and estimate their proportional morbidity rates (PMRs) in Africa, stratifying agents across setting (rural vs. urban), population status (inpatient

vs. outpatient) and outbreak status. We included studies that enrolled patients presenting with acute undifferentiated fever defined as fever without an identified alternative cause.

Results: We analysed 101 studies comprising 68,905 febrile patients across 20 African countries, most with high risk of bias. Viruses were most frequently reported, with dengue and chikungunya viruses showing high PMR estimates of 6.8% (95% CI: 2.7%-16.2%) and 24.1% (95% CI: 7.0%-57.1%) respectively. Bacteria were less common (pooled PMR: < 5% each) but predominated among inpatients (80.4%), with *K. pneumoniae*, *S. aureus*, *E. coli* and *S. pneumoniae* most frequently reported and often resistant to penicillins, fluoroquinolones and 3rd-generation cephalosporins. Among outpatients, viral infections dominated (82.9%), particularly dengue and chikungunya in urban and outbreak contexts. In rural areas, *S. pneumoniae*, *C. burnetii* and *Borrelia* spp. were common bacterial causes, while dengue, Crimean-Congo haemorrhagic fever and Rift Valley fever viruses predominated. Despite the predominance of molecular methods, most studies included the use of both molecular and serological methods.

Conclusion: The causative agents of NMFI in Africa are enormous and context-specific. These findings highlight the need to move beyond malaria-centric fever management toward context-specific diagnostic and surveillance strategies. Methodological harmonisation is necessary to yield reliable summary estimates in future studies.

Malaria

26. Am J Trop Med Hyg 2026;115(4):658-9

How Should We Treat Severe Malaria in the Setting of Artemisinin Partial Resistance?

Rosenthal PJ et al., Department of Medicine, University of California, San Francisco, California, USA

Artemisinin partial resistance (ART-R) threatens the control of falciparum malaria, but its impact on the treatment of severe malaria has been unclear. Two recent studies in Uganda have considered associations between PfK13 mutations linked to ART-R and treatment outcomes in children hospitalized with complicated or severe malaria and treated with intravenous artesunate. Children infected with ART-R parasites experienced delayed parasite clearance compared to those infected with drug-sensitive parasites. However, clinical outcomes, including mortality, length of hospital stay, incidence of subsequent febrile illness, and incidence of readmission did not differ between children infected with ART-R or drug-sensitive parasites. Therefore, at present treatment with intravenous artesunate should remain the standard-of-care to treat severe malaria in sub-Saharan Africa, even in the setting of ART-R, although continued study of treatment efficacy is warranted.

27. BMJ 2026;394:e100502

Editorial

Scaling up malaria vaccines in Africa

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While vaccine development has been a success, equitable delivery remains a barrier.

Sustained investment in malaria control has more than halved the global malaria mortality rate over the past 25 years and reduced incidence by 19%. However, this falls short of global targets of a 75% reduction in both rates by 2025 compared with 2015 levels, hampered by increasing levels of drug and insecticide resistance.

As Sorgho et al highlight, incorporating malaria vaccines into an integrated malaria control strategy (encompassing vector control, chemoprevention, diagnosis, and treatment) could significantly accelerate progress. WHO currently recommends two vaccines, RTS,S and R21/Matrix-M (R21), with more under development seeking to interrupt disease transmission or reduce disease burden through other mechanisms. However, developing and manufacturing vaccines is only a starting point; translating these breakthroughs into sustained population-level impact requires effective, efficient, and equitable delivery through countries' health systems while engaging communities to build awareness and trust.

Since WHO's recommendations, the introduction of these vaccines has been one of the most successful rollout programmes in the history of Gavi (The Vaccine Alliance).

Other paper about this subject:

BMJ 2026;393:e084166

Clinical Review State of the Art Review: Advances in the development of malaria vaccines

28. Lancet Glob Health 2026;14(7):103939

Adaptive intervention strategies for malaria vector control in western Kenya: a cluster, sequential, multiple-assignment, randomised, open-label trial

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Background: Many regions in Africa continue to experience a high malaria burden, highlighting the need for improved intervention tools adapted to local eco-epidemiological contexts. The aims of this study were to develop and evaluate adaptive intervention strategies for malaria vector control tailored to these local conditions.

Methods: This two-stage, cluster, sequential, multiple-assignment, randomised, open-label trial comprised 84 clusters in Muhoroni and Nyakach, subcounties of Kisumu County, western Kenya. Each cluster included 500-600 residents in an area of approximately 2 km² and all residents in the clusters were invited to participate in the study. In stage 1, clusters were randomly assigned, in a 1:1:1 ratio, to standard pyrethroid-based long-lasting insecticidal nets (LLINs; henceforth standard LLINs) alone, piperonyl butoxide-treated LLINs (henceforth PBO nets), or standard LLINs plus annual indoor residual spraying (IRS), stratified by subcounty. Due to the nature of the interventions, masking to intervention was not feasible. Clusters with an adjusted incidence rate ratio (aIRR) of 0·8 or more were classified as non-responders. Non-responding clusters were re-randomised in stage 2. The non-responding clusters from the stage 1 PBO nets group were re-randomised, in a 1:1 ratio, to receive either supplemental microbial larviciding or annual IRS. The non-responding clusters from the stage 1 standard LLINs plus annual IRS group were re-randomised, in a 1:1 ratio, to either IRS twice per year (henceforth biannual IRS), or enhanced IRS annually, which included spraying both indoor residential structures and peridomestic resting structures not covered by routine IRS. The coprimary outcomes were clinical malaria incidence at 1-6 months, 7-12 months, and 13-18 months post-intervention, assessed through active surveillance of cohort populations once every 2 weeks and analysed in all participants with available data. Although the study procedures posed minimal risk to participants, adverse event data were regularly reviewed.

Findings: Between March 8, 2021, and Aug 31, 2024, the study enrolled 47 614 participants (51·8% male, 48·2% female) from 14 246 households in 84 clusters. In stage 1, PBO nets significantly reduced malaria incidence at 1-6 months post-intervention (aIRR 0·75, 95% CI 0·69-0·81; $p<0\cdot0001$) and at 7-12 months post-intervention compared with standard LLINs (aIRR 0·87, 95% CI 0·80-0·95; $p=0\cdot0012$), and standard LLINs plus annual IRS was more effective than standard LLINs alone at 1-6 months (aIRR 0·74, 95% CI 0·68-0·81; $p<0\cdot0001$). In stage 2, among stage 1 non-responding clusters, adding annual IRS to PBO nets was more effective than supplementing with larviciding at 13-18 months (aIRR 0·89, 95% CI 0·81-0·97; $p=0\cdot0081$). When added to standard LLINs, enhanced IRS was more effective than biannual IRS 13-18 months post-intervention (aIRR 0·67, 95% CI 0·56-0·80; $p<0\cdot0001$). Overall, the four adaptive intervention strategies significantly reduced clinical malaria incidence compared with standard LLINs (all $p<0\cdot01$). Adaptive strategies starting with PBO nets had greater and more sustained incidence reductions than strategies beginning with standard LLINs plus annual IRS. No adverse events or serious adverse events were recorded.

Interpretation: This trial supports replacing conventional pyrethroid-only LLINs with PBO nets as the first-line malaria control strategy. In moderate-to-high-risk settings, additional annual IRS or microbial larviciding could be implemented to further reduce malaria burden.

Mental Health

29. Br J Psychiatry 2026;229(1):60-8

Effectiveness of peer support for people with severe mental health conditions in high-, middle- and low-income countries: multicentre randomised controlled trial

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Background: Some trials have evaluated peer support for people with mental ill health in high-income, mainly English-speaking countries, but the quality of the evidence is weak.

Aims: To investigate the effectiveness of UPSIDES peer support in high-, middle- and low-income countries.

Method: This pragmatic multicentre parallel-group wait-list randomised controlled trial (registration: ISRCTN26008944) with three measurement points (baseline and 4 and 8 months) took place at six study sites: two in Germany, and one each in Uganda, Tanzania, Israel and India. Participants were adults with long-standing severe mental health conditions. Outcomes were improvements in social inclusion (primary) and empowerment, hope, recovery, health and social functioning (secondary). Participants allocated to the intervention group were offered UPSIDES peer support.

Results: Of the 615 participants (305 intervention group), 337 (54.8%) identified as women. The average age was 38.3 (s.d. = 11.2) years, and the mean illness duration was 14.9 (s.d. = 38.4) years. Those allocated to the intervention group received 6.9 (s.d. = 4.2) peer support sessions on average. Intention-to-treat analysis showed effects on two of the three subscales of the Social Inclusion Scale, Empowerment Scale and HOPE Scale. Per-protocol analysis with participants who had received three or more intervention sessions also showed an effect on the Social Inclusion Scale total score ($\beta = 0.18$, $P = 0.031$, 95% CI: 0.02-0.34).

Conclusions: Peer support has beneficial impacts on social inclusion, empowerment and hope among people with severe mental health conditions across diverse settings. As social isolation is a key driver of mental ill health, and empowerment and hope are both crucial for recovery, peer support can be recommended as an effective component of mental healthcare. Peer support has the potential to move global mental health closer towards a recovery- and rights-based orientation.

Non-communicable Diseases

30. Geneva Health Files 2026;August 18

End The Global Double Standards in Diabetes Care

Raffert O et al.

Global health activists are urgently calling for the World Health Organization to eliminate the "two-tier system" of diabetes care that leaves millions without access to life-saving treatment. The core of this campaign, detailed in a guest essay in the Geneva Health Files by Canadian activists from Voices in Action (VIA) Diabetes, is the demand to include insulin analogue pens as a standard first-line treatment option in the WHO's forthcoming guidelines for type 1 diabetes.

Despite insulin being indispensable for survival, the quality of care a person receives today depends almost entirely on where they live and their financial capacity. While high-income nations have largely transitioned to modern, portable, and accurate insulin analogue pens, low-resource settings often rely on complex vials and syringes. This disparity is perpetuated by a market oligopoly dominated by three pharmaceutical giants—Eli Lilly, Novo Nordisk, and Sanofi—which has created significant availability barriers globally.

The narrative of this crisis is one of preventable suffering. Older insulin delivery methods are difficult to use, particularly for those with limited eyesight, and carry a higher risk of error. In contrast, insulin pens offer superior dosing accuracy and portability. Recent studies in low-income regions, such as Mali, have demonstrated that switching to analogue pens significantly improves glucose control and reduces life-threatening diabetic ketoacidosis.

Crucially, the argument for change is no longer just ethical but also economic. Contrary to the belief that modern treatments are too expensive, a 2024 study revealed that delivering analogue insulin via reusable pens can cost 30% less than traditional vial insulin. This means low-income countries are currently spending more on outdated, less effective care.

The WHO stands at a pivotal moment. Having already added insulin analogues to its Essential Medicine List, the organization now has the opportunity to issue definitive guidelines that mandate the

use of insulin pens. By doing so, the WHO could signal that these devices are vital for public health, compelling countries and corporations to ensure affordable global access. Ending this double standard is not only a moral imperative but a practical necessity that the WHO must lead.

31. TMIH 2026;31(8):953-65

Task-Shifting to Nurses for Hypertension Control in Rural Sub-Saharan Africa: A Narrative Review of Effectiveness and Implementation Challenges

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Background: Rising cardiovascular morbidity and mortality in rural sub-Saharan Africa are largely attributable to insufficient awareness, treatment and control of hypertension. The delivery of care is further constrained by health system limitations, including shortages of physicians, inadequate infrastructure, challenges in medication supply chains and geographical barriers to access. As a tactic to increase access, adherence and continuity of care, task-shifting hypertension management to nurses—often with the assistance of community health workers—has become popular. The evidence on the efficacy and implementation difficulties of nurse-led hypertension therapies in rural Sub-Saharan African settings is compiled in this narrative review.

Methods: To investigate task-shifted and nurse-led hypertension care in rural SSA, a narrative evaluation was carried out. Terms associated with task-shifting, nurse-led care, hypertension and rural SSA were used to search PubMed, Scopus, Web of Science and Embase. Studies that met the eligibility requirements reported implementation results or patient outcomes. The effectiveness of the intervention, implementation difficulties and enabling variables were highlighted in the narrative synthesis of the data.

Results: In rural Sub-Saharan Africa, nurse-led and task-shifted treatments enhanced medication adherence, blood pressure control and continuity of care. Protocol-driven nurse management, patient education, follow-up monitoring and assistance from mobile health tools or community health professionals were common elements. Drug stockouts, scope-of-practice limitations, inadequate training, supervision and partial integration into primary care were among the implementation obstacles. Alignment with current health systems, community involvement and structured mentoring were among the facilitators.

Conclusion: Evidence from rural Sub-Saharan Africa indicates that task-shifting hypertension care to nurses is feasible and, when adequately supported, can improve key care processes and outcomes. To optimize the potential benefit of nurse-led hypertension management in rural settings, it is imperative to address health system bottlenecks, improve training and supervision and align regulatory frameworks with task-shifting strategies.

Pharmaceuticals / AMR

32. PLoS Med 2026;23(8):e1005218

Antimicrobial stewardship in low- and middle-income countries: Access versus adherence

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(AI summary)

The World Health Organization (WHO) sees antimicrobial resistance (AMR) as a major public health threat, especially in low- and middle-income countries (LMICs) where it causes around 5 million deaths each year. The burden of infectious diseases and weak health systems in these regions contribute to the misuse of antibiotics and the rise of resistance. The WHO Global Action Plan highlights the importance of antimicrobial stewardship to maintain the effectiveness of current medications, recommending the use of evidence-based guidelines for prescribing.

A recent study, the Lao AntiMicrobial Prescribing Application (LAMPA) trial, examined the use of a smartphone app for antibiotic guidelines in six hospitals in Laos. This trial showed that adherence to guidelines was limited, with 17.0% in the standard group and 25.6% in the intervention group. However, the smartphone app alone did not significantly improve adherence. The study identified that

while the app provided access to guidelines, merely having guidelines available is not enough to change prescriber behavior.

Several challenges were noted in the trial, such as the timing during the COVID-19 pandemic affecting implementation and the lack of individual prescriber behavior measurement. While prescribers found the guidelines simple and accessible, they engaged with the app infrequently, often relying on their clinical experience over the guidelines. Factors like established prescribing habits and limitations in health system resources also played a role.

The trial concluded that merely increasing access to guidelines through technology is insufficient to improve adherence; a multifaceted approach is necessary. Additionally, issues like limited diagnostic resources and concerns about medication quality further complicate prescribing practices in LMICs. National action plans should enhance microbiological capacity and regulate antibiotic quality to support effective antimicrobial stewardship.

Primary Health Care

33. Lancet Prim Care 2026;2:100198

Comment

Patient vignettes: an underused yet powerful tool for assessing and improving quality of primary care
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(AI summary)

The article argues that vignette-based assessments can strengthen the evaluation and improvement of primary care quality. Primary care is fundamental to universal health coverage, equity, and resilient health systems, and its quality is commonly assessed through the five core attributes (5Cs): first-contact accessibility, continuity, comprehensiveness, coordination, and person-centredness.

Existing assessment methods, including patient surveys, administrative data, and clinical audits, provide useful but incomplete information. Patient-reported measures capture how people experience care but may not show whether care is timely, evidence-based, coordinated, or appropriately connected across different services. Administrative data document service use but provide limited information about interpersonal care and coordination, while clinical audits can be difficult to standardise and implement at scale.

The article proposes patient vignettes—standardised hypothetical patient scenarios—as a complementary method. Vignettes can simulate an entire care pathway and help identify weaknesses in how the 5Cs function together. They may also facilitate comparisons between health systems and reveal opportunities for policy and service improvement. The Esther model in Sweden, which uses a fictional patient journey to bring patients, health professionals, and managers together around the question “What is best for this person?”, is presented as an example of how vignettes can support person-centred care and co-production.

However, vignettes have limitations. What people say they would do in a hypothetical situation may differ from their actual behaviour (the know–do gap), and scenarios need to be adapted carefully to different cultural and health-system contexts. Vignettes may also inadequately capture empathy, trust, and other interpersonal aspects of care.

The article therefore concludes that vignettes should not replace existing assessment methods but should be used alongside patient surveys, administrative data, clinical records, and qualitative research. Their greatest value may be both evaluative and educational: bringing stakeholders together to understand care pathways, identify problems, and develop solutions. Used in this way, vignettes can contribute to a more person-centred, learning-oriented, and improvement-focused approach to primary care quality.

Sexual and Reproductive Health and Rights

34. BMJ Glob Health 2026;11(8):e021127

Projections of human papillomavirus (HPV) vaccination impact on non-cervical cancer outcomes among women in 117 low- and middle-income countries: a modelling study

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Introduction. Human papillomavirus (HPV) is a leading cause of both cervical and non-cervical cancers, including anal, oropharyngeal, vaginal and vulvar cancers. While most HPV vaccination impact assessments have focused on preventing cervical cancer among women, the broader benefits of vaccination against other HPV-attributable cancers in low- and middle-income countries (LMICs) remain less explored.

Methods. We used a static cohort model to assess the potential health impact of bivalent HPV vaccination on HPV-attributable female non-cervical cancers in 117 LMICs from 2030 to 2100. The model incorporated country-specific data on cancer mortality, HPV type distribution, demographic projections and vaccine coverage. Sensitivity analyses were performed to account for uncertainties in cancer incidence, cancer mortality and HPV type distribution.

Results. Our projections suggest that HPV vaccination could contribute to prevention of approximately 590 000 cases of anal, 880 000 cases of oropharyngeal, 1.27 million cases of vaginal and 2.18 million cases of vulvar cancers over the analytic period. In total, 3.02 million deaths from these non-cervical cancers among women could be averted by 2100. The African region is expected to see the largest relative reductions in both cases and deaths while the European region showed the smallest gains. By the end of the century, 58 countries are projected to reach at least a 25% reduction in anal cancer mortality compared with just 25 countries for oropharyngeal cancer. These findings reflect substantial regional disparities in both burden and vaccination impact.

Conclusion. HPV vaccination holds considerable promise in reducing the burden of non-cervical cancers among women in LMICs, especially in regions with high incidence and limited access to care. Recognising and harnessing these broader benefits can strengthen the public health case for scaling up vaccine access, implementing region-specific strategies and investing in equitable healthcare systems to decrease global disparities.

35. BMJ Glob Health 2026;11(8):e022849

Long-acting reversible contraception, condom use and sexually transmitted infections in developing countries: a multi-country serial cross-sectional analysis using demographic and health surveys
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Introduction. Unintended pregnancy and sexually transmitted infections (STIs) are major public health issues in developing countries. While long-acting reversible contraception (LARC) effectively prevents unintended pregnancy, there is limited evidence from large multinational studies on its association with condom use and STI-related outcomes. This study aimed to investigate the association between LARC use, condom use and STIs among women in developing countries.

Methods. This serial cross-sectional study extracted data from Demographic and Health Surveys (DHS), a series of nationally representative household surveys conducted in developing countries. The analysis included women aged 15 to 49 years, with data on contraceptive methods and demographics. Generalised linear mixed effect models (GLMMs) were used to estimate adjusted prevalence ratios (aPRs) for condom use and self-reported STI-related outcomes, comparing LARC users with both non-LARC users and oral contraceptive users. Subgroup analyses were conducted at the individual level and at the country level.

Results. Data from 2 171 884 women across 31 countries were analysed. Overall, the prevalence of self-reported STI-related outcomes was 7.4%, 3.9% of participants used LARC, and 7.5% of participants reported consistent condom use. LARC users were significantly less likely to use condoms compared with non-LARC users (aPR=0.40, 95% CI 0.30 to 0.53) and compared with oral contraceptive users (aPR=0.61, 95% CI 0.48 to 0.78). LARC use was associated with a higher prevalence of STI-related outcomes compared with non-LARC users (aPR=1.19, 95% CI 1.10 to 1.28) and compared with oral contraceptives users (aPR=1.14, 95% CI 1.05 to 1.24). Associations were stronger in low-Human Development Index (HDI) countries, especially among younger women (15–19 years), but were not significant in high-HDI countries. Country-level heterogeneity was observed.

Conclusions. LARC use is associated with reduced condom use and higher self-reported STI prevalence, particularly among younger women and in lower HDI developing countries. These findings support integrating STI prevention into LARC services and promoting dual-method use to prevent both unintended pregnancies and STIs.

36. *BMJ Glob Health* 2026;11(8):e023196

Preferences for characteristics of contraceptive methods: a large, multi-country discrete choice experiment

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Background. Nearly half of global pregnancies are unintended. Contraceptive use is preference-sensitive, including concerns about convenience, privacy and side effects (eg, irregular bleeding, weight gain). We conducted a multi-country study examining women's preferences for attributes of current and potential future modern hormonal contraceptives using a discrete choice experiment (DCE).

Methods. Between April and October 2022, we recruited nationally representative samples of women of reproductive age from seven countries (Burkina Faso, Nigeria, Ethiopia, Kenya, Zambia, Pakistan and the USA) using multi-stage random cluster sampling from national census enumeration areas. The DCE comprised six attributes of hormonal contraceptives: format (ie, mode of administration: injection, implant, etc), dosing interval, provider-administration versus self-administration, effect on menstruation, effect on weight and time from discontinuation until return to fertility. Mixed logit models were fitted separately by country to estimate the relative preference weights (β) for each attribute level.

Results. Across 20 068 participants, format was the strongest driver of preferences. Injectables were most preferred in Kenya ($\beta=0.44$, 95% CI 0.25 to 0.63), Pakistan ($\beta=0.55$, 95% CI 0.29 to 0.81), Ethiopia ($\beta=0.64$, 95% CI 0.38 to 0.90) and Zambia ($\beta=0.39$, 95% CI 0.20 to 0.58). Oral pills were most preferred in the USA ($\beta=0.78$, 95% CI 0.58 to 0.98), Burkina Faso ($\beta=0.43$, 95% CI 0.27 to 0.59) and Nigeria ($\beta=0.55$, 95% CI 0.40 to 0.70). Intrauterine devices and vaginal rings were less preferred in all countries. Menstrual bleeding changes and dosing interval were secondary drivers, with longer-acting methods modestly preferred and ongoing irregular bleeding modestly non-preferred. Avoiding weight gain was significantly preferred in several countries, most strongly in Pakistan ($\beta=0.56$, 95% CI 0.44 to 0.67) and the USA ($\beta=0.42$, 95% CI 0.31 to 0.53).

Conclusions. In this large, multi-country study, reproductive-age participants expressed strong, heterogeneous preferences for contraceptive format, and in some settings, avoiding weight gain side effects. These findings can support preference-aligned contraceptive product development.

37. *BMJ Glob Health* 2026;11(8):e024479

Scaling pleasure-based sexual and reproductive health: an impact and economic modelling study in 99 low- and middle-income countries

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Introduction. Pleasure is a key reason why people have sex. Yet many sexual and reproductive health (SRH) programmes do not consider the fundamental role of pleasure, focusing primarily on the prevention of pregnancy and sexually transmitted infections. Moreover, there is limited policy-ready evidence on pleasure-based sexual and reproductive healthcare (PBSRH), including implementation guidance, costs, impacts and return on investment at scale.

Methods. We conducted semi-structured interviews with nine PBSRH providers to characterise the incremental activities required to implement PBSRH relative to conventional SRH. Using activity-based costing, we estimated the costs of integrating pleasure principles into existing SRH programmes for 15–24-year-olds in 99 low- and middle-income countries (LMICs) over 2026–2035. We focused on a narrow behavioural pathway - increased condom use - and projected its effects on (1) Unintended pregnancies, abortions, maternal and child mortality using methods consistent with Guttmacher's Adding it Up approach and (2) HIV outcomes using the Goals-Spectrum application. We undertook a

prospective, societal benefit-cost analysis to estimate global, regional and country-level return on investment.

Results. Eighteen incremental activities are commonly undertaken when integrating pleasure into SRH programmes. The estimated incremental cost of these activities for 15–24 year olds in LMICs is \$1.6 billion (95% CI \$1.1 to \$2.2) over 10 years. This is expected to lead to 30.7 million (95% CI 17.8 to 41.1) additional years of condom use, averting 4.3 million pregnancies (95% CI 2.1 to 6.7) and 2.1 million abortions (95% CI 1.1 to 3.4). PBSRH integration would avert 92 318 deaths by 2050 (95% CI 47 965 to 139 835), ~80% relating to women and children. The expected return on investment is \$22.9 (95% CI \$13.8 to \$37.6) in benefits per \$1 of incremental cost. The largest benefits and returns are in Sub-Saharan Africa and Latin America and the Caribbean.

Conclusion. PBSRH is a cost-effective and high-return intervention to support global SRHR and HIV/AIDS goals for young people in LMICs.

38. BMJ Glob Health 2026;11(9):e021719

Lives saved and financial risk protection from scaling up kangaroo mother care in India: an extended cost-effectiveness analysis

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Introduction. Kangaroo mother care (KMC) is a proven, low-cost intervention to reduce neonatal mortality, yet its coverage remains limited in most low- and middle-income countries (LMICs), including India. In this study, we examined the impact of scaling up KMC in India on distribution of health and financial outcomes using an extended cost-effectiveness analysis (ECEA) framework.

Methods. Building on primary data from a randomised controlled trial (RCT), we modelled the health and financial outcomes of scaling up KMC to 95% coverage nationally. We estimated lives saved, disability-adjusted life-years (DALYs) averted, out-of-pocket expenditure (OOPE) averted and cases of catastrophic healthcare expenditure prevented. Estimates were disaggregated by socioeconomic quintiles and geography. We used deterministic and probabilistic sensitivity analyses to assess the robustness of our findings.

Results. Scaling up KMC in India could save around 26 000 neonatal lives annually, avert approximately 1.6 million DALYs, reduce OOPE by around US\$13 million and prevent an estimated 57 000 households from experiencing catastrophic health expenditures. Three-fourths of the benefits would be concentrated in the lowest two socioeconomic quintiles. Six high-burden states, including Uttar Pradesh, Bihar and Madhya Pradesh, accounted for 90% of the health and financial gains. The incremental cost-effectiveness ratio ranged from 0.08 to 0.17 times gross domestic product per capita for India across different quintiles. Probabilistic sensitivity analysis showed scaling up KMC would be cost-effective in 97.8% of simulations.

Conclusion. Our findings suggest that scaling up KMC is cost-effective and can reduce health inequities, particularly benefiting the lowest socioeconomic groups and high-burden states.

Incorporating geographical disaggregation and using primary RCT data into ECEA enhance its utility for informing evidence-based, equity-focused health policies in LMICs.

39. Health Policy Watch 2026;Sept 15

When Harm Hides in Hospital: Messaging and the Medicalisation of Female Genital Mutilation
Nkansa F et al.

Despite documented declines in Female Genital Mutilation (FGM) rates across West Africa — including a July 2025 ECOWAS Court ruling that Sierra Leone's failure to protect girls constitutes torture — the practice is shifting shape rather than disappearing. It is moving into clinics and happening at younger ages. Globally, UNFPA estimates 230 million women and girls alive today have undergone FGM, with UNICEF finding roughly one in four (52 million) were cut by health personnel. In Guinea, where prevalence remains near 95%, about 15% of procedures are done by health workers; in Nigeria the figure is around 13%. In The Gambia, the average age of cutting has fallen from four years to just before two over three decades.

The authors argue medicalisation isn't simply evasion of prosecution (the belief is that a clinical face makes the practice harder to detect and prosecute). Communities frame FGM as a health measure in its own right, as preventative hygiene care — keeping girls "clean," curbing desire, preventing infection — so anti-FGM campaigns warning only about unsterile blades and dirt floors were heard as "do it safely," not "don't do it." Parents acted on the message, switching from traditional practitioners to clinicians while retaining the underlying belief.

Alarmed by this trend, WHO's 2025 guideline recommends professional codes expressly prohibiting health workers from performing FGM, training them as agents of prevention, and sensitive communication approaches to help them decline family requests. WHO has warned since 1997 that medicalisation normalises and legitimises the practice, lending the white coat's credibility to the idea that FGM is a health service. The authors note these tools are supply-side and leave the demand side unaddressed.

The article closes with five recommendations:

- Torture: Name the brutality — Lead with the damage of cutting itself, using the ECOWAS framing of FGM as torture, rather than dangers of unsafe conditions. A sterile scalpel changes nothing about non-consensual amputation of healthy tissue.
- It's the cutting, not the setting — No venue sanitises FGM. Trained hands working on anaesthetised children may remove more tissue than traditional cutters, worsening long-term sexual and reproductive outcomes.
- Professional misconduct — Licensing bodies should issue written directives making performing, assisting, referring or supervising FGM misconduct, with suspension, deregistration, licence loss and police referral, plus regional standards to prevent cross-border re-registration.
- Equip health workers as messengers — Families invite clinicians into the conversation campaigners couldn't enter. Train them to speak of harm rather than mitigable risk; a trial in Kenya, Guinea and Somalia showed patients of trained workers became significantly more opposed to FGM.
- Test the messaging — WHO concedes the effect of health-sector interventions on medicalisation is an open research gap. Funders should study how messages are metabolised and what alternatives satisfy belonging needs.

40. Lancet 2026;408(10549)

Postpartum Haemorrhage

In this issue a Series of three papers about Postpartum Haemorrhage

All papers in the Series are available at thelancet.com/series-do/postpartum-haemorrhage

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* Lancet 2026;408(10549):62-73

Postpartum haemorrhage: epidemiology, consequences, and missed opportunities

Coomarasamy A et al.

* Lancet 2026;408(10549):74-82

Prevention of postpartum haemorrhage: from evidence to implementation at scale

Gallo ID et al.

* Lancet 2026;408(10549):83-92

Diagnosis and treatment of postpartum haemorrhage: a race against time

Coomarasamy A et al.

41. Lancet 2026;408(10556):681-3

World Report

Obstetric violence in Egypt

Devi S.

(Abbreviated)

A controversial court case is bringing renewed attention to gender-based violence towards pregnant women in the country's health system.

The case of Omnia Sweidan, a former doctor who worked as a medical resident at a university hospital in Alexandria, and who was arrested on charges of spreading false news and “misusing” social media

and sentenced to a 6-month suspended prison sentence because of posting cases of violence, abuse and medical mistreatment at hospitals, has focused attention on the mistreatment of women by health-care providers in Egypt, and, in particular, obstetric violence. Obstetric violence is a pervasive but under-recognised form of gender-based violence affecting millions of women, defined as the physical and emotional abuse of pregnant people in health-care settings by medical practitioners and other staff. WHO instead uses the term “mistreatment of women” and says this can range from dismissal of pain to physical abuse and the performance of medical procedures without informed consent, including episiotomies or the use of Kristeller's manoeuvre, in which manual pressure is applied on a woman's upper belly to help push out the baby but can cause injury.

Worldwide, 54·5% of women experienced mistreatment and disrespect during childbirth, according to a review of 117 studies involving 37 countries published in *Reproductive Health*. Lack of data and few formal complaints registered at clinics and hospitals make it difficult to estimate the prevalence of obstetric violence and mistreatment in Egypt, but according to one study published in 2025, nearly half of women experienced disrespectful maternity care and more than half reported insufficient privacy, according to a survey of 622 women in a rural part of upper Egypt. Health-care professionals and human rights campaigners have been working on these challenges since long before the Sweidan case. However, they say progress is hampered by an under-funded health system that fails to properly train health workers and over-medicalisation, exposing patients to unnecessary procedures.

The inclusion of obstetric violence in Egyptian medical school training is the subject of current discussions between medical professional bodies and the government, Amr El Noury, Vice President of the Egyptian Society of Gynaecology and Obstetrics, told *The Lancet*. “The rough handling of patients and verbal violence isn’t covered in training and we are now talking about this”, he said.

The percentage of caesarean sections in Egypt rose from 52% in 2014 to 72% in 2021, according to the Egypt Family Health Survey. Egypt has the world's fourth-highest caesarean section rate after the Dominican Republic, Brazil, and Cyprus, according to WHO research published in *BMJ Global Health* in 2021. It found caesarean section accounts for more than one in five of all childbirths globally and WHO recommends a caesarean section rate of 10%–15%.

Egyptian doctors are accused of pushing women towards caesarean section births for their own convenience and to make more money, and of having a misplaced belief that caesarean section is always safer while failing to explain to women the potential complications.

Obstetric violence in Egypt often appears as over-medicalisation, such as caesarean section and also a controversial practice sometimes referred to as the daddy stitch that is often performed during episiotomies to tighten the vaginal opening in the belief it will please a woman's male partner.

In June, the Ministry of Health and Population in partnership with UN agencies launched the National Midwifery Programme, saying midwives could prevent 259 maternal deaths, 26 556 neonatal deaths, 11 408 child deaths, 13 629 stillbirths, and 860 000 unintended pregnancies between 2026 and 2030.

But women's health experts worry that without awareness and education campaigns, Egyptian women might not have trust and confidence in midwives, deterring them from seeking care.

Egypt's health budget for 2025–26 of about US\$4·9 billion is equivalent to just 1·1% of gross domestic product, well below the minimum 3% required under the constitution, according to Human Rights Watch.

The prevalence of female genital mutilation fell from 97% in 1995 to 85·6% in 2021 and medicalisation reached 83% in 2021, according to a study published last year in *Global Public Health*.

42. *Lancet Glob Health* 2026;Aug 13:104034

Drivers of adolescent pregnancy decline in five adolescent sexual and reproductive health and rights exemplar countries: a quantitative decomposition analysis

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Background: In 2023, there were 9·9 million births among adolescents aged 15–19 years in low-income and middle-income countries, with an estimated half of those births unintended. Cameroon, Ghana, Malawi, Nepal, and Rwanda stand out as exemplar countries experiencing some of the largest declines in adolescent fertility (ie, the demographic concept of livebirths per woman) globally between 2000 and 2023 relative to countries with similar socioeconomic change during this period. We aimed

to examine how these five countries reduced adolescent pregnancy by decomposing declines into key determinants.

Methods: Our analysis leveraged all Demographic and Health Surveys and Multiple Indicator Cluster Surveys available for the five countries between 2000 and 2023. We implemented an Oaxaca-Blinder decomposition analysis of pregnancy among adolescents aged 15-19 years, comparing the earliest and latest years of available data on adolescent pregnancy and influential factors thereof. We implemented an array of sensitivity analyses to assess the robustness of the results of our analysis to different population strata and model specifications.

Findings: The largest driver associated with decreases in adolescent pregnancy in all countries was a substantial decline in the adolescent marriage rate, which dropped by between 4.3 and 12.2 percentage points. The second largest factor was increased educational attainment among adolescents, with gains between 1.5 and 3.0 more years of education. Although unmet need for contraceptive use exhibited a statistically significant association with adolescent pregnancy, it was not attributed a large contribution as it did not change substantially during the period of focus.

Interpretation: These changes coincide with major policy developments surrounding adolescent marriage and education in the five countries: the legal age of marriage increased, and exemptions were removed to facilitate stronger enforcement of laws; policies making education free (or of low cost) and compulsory were also implemented. Underpinning the policy changes were broad shifts in underlying social norms on gender and other changes to the enabling environment for the policies to have their intended impact.

43. PLoS Med 2026;23(6):e1004936

Prevalence and epidemiological patterns of *Neisseria gonorrhoeae* infection in sub-Saharan Africa, 1964–2025: Systematic review, meta-analyses, and meta-regressions

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Background. *Neisseria gonorrhoeae* (NG) infection is a global health concern because of its morbidity and increasing antimicrobial resistance. Sub-Saharan Africa is believed to carry a disproportionately high burden of NG infection, but the epidemiology of NG infection in this region has not been comprehensively synthesized. This study systematically reviewed and analyzed NG prevalence in sub-Saharan Africa to characterize prevalence patterns and identify populations at risk.

Methods and findings. A systematic review was conducted and reported following PRISMA guidelines. Embase, PubMed, Scopus, and Web of Science were searched from inception to June 4, 2025. Eligible studies reported NG prevalence in sub-Saharan Africa. Random-effects meta-analyses generated pooled prevalence estimates, and random-effects meta-regression analyses identified associations and sources of heterogeneity.

Nine hundred fifty publications contributed 1,604 prevalence measures spanning 1964–2025. In the general population, pooled urogenital prevalence was 3.2% (95% confidence interval (CI): 2.9–3.5), with substantial between-study heterogeneity and a wide prediction interval, indicating considerable variation in prevalence across settings. Prevalence was high in key populations: among female sex workers, 11.5% (95% CI: 9.9–13.2) for urogenital and 2.0% (95% CI: 0.4–4.5) for anorectal infection; and among men who have sex with men, 2.8% (95% CI: 2.4–3.3) for urogenital, 8.3% (95% CI: 5.8–11.0) for anorectal, and 5.7% (95% CI: 3.6–8.3) for oropharyngeal infection. Symptomatic men exhibited high urogenital prevalence (51.5%; 95% CI: 47.5–55.5), and symptomatic women showed 9.0% (95% CI: 7.7–10.4). Among women with adverse pregnancy or birth outcomes, urogenital prevalence was 8.6% (95% CI: 5.3–12.6). Meta-regression analyses explained over half of the variability in prevalence, showing a long-term decline of 1% per year, a clear population type gradient, subregional differences, and decreasing prevalence with increasing age, but no variation by sex. These findings may be affected by variability in data availability across countries, anatomical sites, and population groups, as well as heterogeneity across included studies.

Conclusions. NG prevalence remains markedly high in this region but has declined over time. These findings highlight the need for strengthened surveillance, expanded prevention and diagnostic strategies, and continued monitoring of gonococcal antimicrobial resistance to support effective control efforts in sub-Saharan Africa.

Tuberculosis

44. Health Policy Watch 2026;August 27

New TB vaccines are moving closer. Is Africa ready?

Mule SM.

Kenyan MP and Global TB Caucus Vice-Chair Stephen Mutinda Mule warns that Africa risks repeating a familiar failure — watching scientific breakthroughs arrive while health systems scramble to catch up.

African scientists, institutions and communities are helping advance the development of new TB vaccines and are part of advancing new TB vaccine candidates, some of which could be the first new TB vaccines in over a century, offering protection to adolescents and adults. Yet there is a concern that governments are not preparing at the same pace as scientists and manufacturers, who are already building production capacity and supply chains before trial results are even known.

The core danger is the years lost between scientific success and real access when countries lack approval, financing, procurement and delivery plans. The remedy is straightforward but urgent: every nation should draft a national TB vaccine readiness plan now, without assuming any particular candidate will succeed. Because future vaccines may target adolescents and adults, childhood immunisation infrastructure alone will not suffice; TB programmes, HIV services, primary care, data systems and supply chains must all be assessed together, with communities engaged from the outset to build trust that cannot be manufactured weeks before rollout.

Crucially, readiness cannot stay inside health ministries. At the Cape Town meeting, leaders of parliamentary Health and Finance Committees from 14 African countries were deliberately convened together, since pricing, budgets and accountability determine whether science becomes public health impact. The article calls for early disclosure of costs and supply timelines by developers, and for finance ministries to plan funding without gutting other essential services.

Collective action is urgently needed: pooled procurement, shared demand forecasting and joint price negotiations, so wealthier nations do not secure early access while the hardest-hit wait. Global partners should support rather than duplicate national systems, but government leadership remains non-negotiable. The question is not whether to prepare, but whether Africa will act early enough.

Miscellaneous

45. PLoS Med 2026;23(8):e1005201

Estimates of global burden of snakebite: A literature review and geostatistical modelling study
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Background. Snake envenoming (SE) remains an important public health problem, disproportionately affecting impoverished rural communities in tropical and subtropical regions. Although previous attempts have been made to quantify the global burden of SE, accurate, up-to-date data remain scarce. Here we present a comprehensive re-evaluation of the global burden of snakebite, 17 years after our initial estimate.

Methods and findings. A new literature review was conducted on snakebites, SE and mortality published in any language, up to March 31, 2025, to update the knowledge accumulated since our first global burden estimate. Based on country- and region-level aggregated data, and hospital and community-based survey data, we modelled SE and mortality burden in relation to geographic location. Explanatory variables were selected to reflect the underlying social and natural environmental conditions. Low and high estimates of the global snakebite burden were calculated using geostatistical models that produced individual-country estimates, accounting for possible underreporting of data when appropriate.

We estimate that at least 2.1 million envenomings and 274,000 deaths occur globally each year due to snakebites, and our high estimates suggest up to 7 million envenomings and 513,000 deaths annually.

Low-income countries exhibit the highest incidence and mortality rates, with sub-Saharan Africa accounting for 45% of global envenomings and deaths, nearly three times the incidence observed in South Asia. These estimates suggest that previous burden estimates could substantially underestimate the scale of the problem.

The main limitations of this study are the scarcity and heterogeneity of empirical data in many countries and the reliance on modelling assumptions to estimate burden in settings with limited or no direct observations.

Conclusions. Snake envenoming is a significant cause of morbidity and mortality globally, with sub-Saharan Africa, South Asia, and Southeast Asia being the most severely affected regions. Further improvement in the quality of epidemiological data is required for more accurate estimates of the global burden, particularly in sub-Saharan Africa.