

An Occasional Rural Miscellany

October 2016

Welcome to the October edition of Rural Miscellany. I am keen to introduce a young colleague from Indonesia who has helped me with this month's Newsletter. Dr Dewanto Andoko is a crucial member of the RuralWONCA team. He is responsible for the website and social media. He has added a short profile of himself together with a profile of another extraordinary rural doctor working in Highland Papua. They are part of a new breed of committed young rural doctors, and we need to give them all our support.

You will also find a link to a regular newsletter developed across Africa by the African Young Doctor Organisation, AfriWON. This month's bulletin is dedicated to rural health and has contributions from a wide range of young doctors from Botswana, Kenya, Nigeria, Uganda and Tanzania.

Dewanto and I are keen to highlight other doctors working in rural areas around the world. Please contact us if you feel that you can share your experiences and innovations in future editions.

RuralWONCA is doing fantastic work on the big picture of international rural practice and health. News of their efforts rarely reach individual practitioners often working alone in challenging rural conditions. Our goal is to keep them informed, show appreciation for their work, make them feel good about themselves and remind them of their significant contributions. I also want to give them a platform to share their experiences and insights across the globe.

Dr Dewanto Andoko



Dr Dewanto Andoko is a Family Medicine Specialist from Indonesia, currently pursuing his PhD in Family Medicine at Khon Kaen University, Thailand, researching transferrable rural general practice training pathways for Indonesia. He serves as a RuralWONCA Council Member. He is working with colleagues around the develop the Rural Institute of Learning. His special contribution is to develop a rural palliative care module. He also co-manages social media communications for RuralWONCA and has responsibility for the website. w was born into a family of rural General Practice; his father served in the jungles of Central Kalimantan. He is passionate about building sustainable training pipelines and connecting rural primary care workers globally.

Call to Action: Get Involved with RuralWONCA

As part of RuralWONCA's communications team, s invites members, young doctors, and rural health practitioners to share their stories, local initiatives, and photos with the global rural health community. If you would like to feature your work on Rural WONCA's social media channels or newsletter, please reach out directly!

Oebelo 2018 by Dr. Dewanto Andoko



We had come to Oebelo, a village in East Kupang built by former East Timorese refugees, on a short medical mission. I expected the usual queues, blood pressure cuffs, complaints of

headache and joint pain. What I did not expect was an elderly woman answering my questions in fluent Portuguese.

Between us stood a younger relative, translating patiently, carrying two languages and two generations in a single sentence. I held the medical degree, the training, the confidence of having survived clinical rotations. In that village hall, I was also the one who understood the least.

That mission taught me something no textbook had reached: a community's health lives inside a language, a history, a set of memories that existed long before I arrived with a clipboard. You do not bring medicine into a village. You are let in, if you are lucky, and only after admitting how much you do not know.

Agustinus Rudolf Phyma, M.D **(“dr. Puji”)**



Dr. Puji graduated as a general practitioner from Universitas Kristen Duta Wacana (UKDW) in Yogyakarta in 2016. Raised as a city boy, his experience with rural life was limited. When he relocated to Highland Papua in 2018 under the Nusantara Sehat program, he had no intention of staying long.

His first posting there was Puskesmas Kuari. Food arrived once a month by supply truck. Solar panels ran the lights. He lived without internet for close to two years. He treated severe asthma without oxygen on hand and delivered babies inside honai huts.

In 2021 till present, He became chief executive officer of Puskesmas Kanggime. They rebuilt it from a wooden building with a handful of staff into a proper facility with a team of thirty,

eventually earning top-tier national accreditation. Kanggime district spans 308 square kilometres with a population of 10,313 people.

A Morning in Nunggawi

by dr. Puji

The hill behind us was still wet from the night's rain. Eight children ran ahead of me down the track, bare feet slapping mud, one boy in a hand-me-down Air Force shirt pulling out front of his cousins. I stopped laughing long enough to catch my breath, then kept running. Nine years into serving in Indonesia's remotest corners, one scene from my first two months in Nunggawi, Tolikara Regency, is still burned into my memory—nine figures on a mountain path in the early morning light, the doctor outnumbered nine to one.

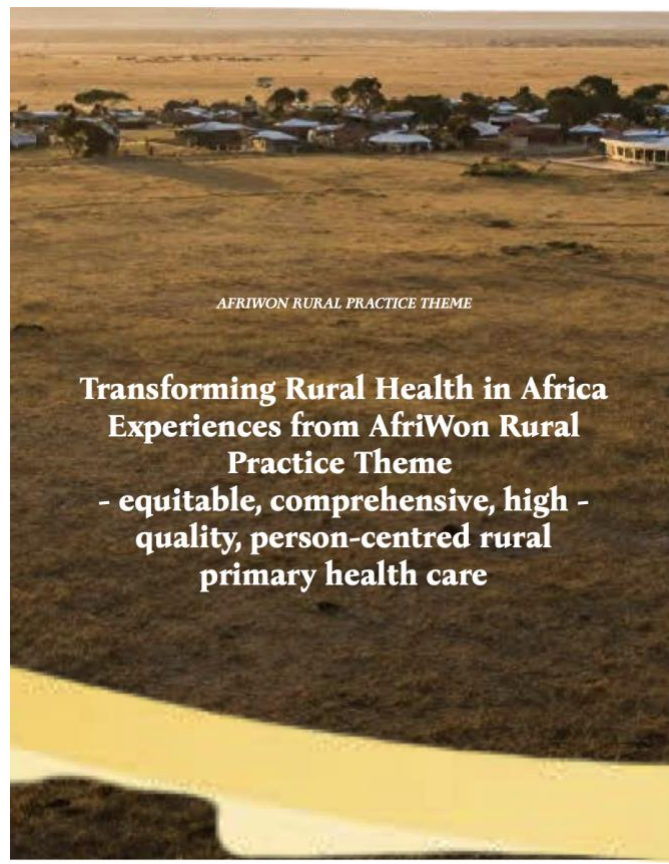


I came to this district to deliver vaccines and maintain a clinic roster. Somewhere along the way, the children claimed me. They would knock on my door before sunrise and wait outside the clinic, eventually pulling me out for a run before the day's work began—racing through the tall grass together until our legs gave out.

Their faces tell the rest. No fever there, no wasting, no cough dragging on for weeks. Mud on their knees, breath in their chests, legs that keep moving long after mine stop. A doctor in Papua's highlands spends most days treating what has gone wrong. This photograph holds the other half of the job: watching children get to be exactly what children are built to be.

A doctor in Papua's highlands spends most days treating what has gone wrong. This memory holds the other half of the job: watching children get to be exactly what children are built to be.

Transforming Rural Health in AfricaExperiences from AfriWon RuralPractice



Theme- equitable, comprehensive, high -quality, person-centred rural primary health care

The August 2026 AfriWON Renaissance newsletter, "Family Medicine Where It Matters Most: Communities, Continuity and Change," gathers rural practice stories from Botswana, Kenya, Nigeria, Uganda and Tanzania.

Edited by Dr Nantale Peace Atangwa (Editor in Chief) and Dr Thando Agape Dube (Co-editor).

Botswana: the launch of the Rakops Youth Service Centre in Boteti West and its work on teenage pregnancy and reproductive health.

Kenya: how Tenwek Hospital's apprenticeship model trains the next generation of rural family physicians.

Nigeria: Family Physicians and traditional leaders partnering to mobilise communities, drawing on Dr Adeleye Babarinsa's CHECK Medical Mission.

Uganda: Buliisa Health Centre IV's outreach model, bringing care to the homestead, with results on immunisation and facility deliveries.

Tanzania: a frontline reflection from Dr Murtaza Lamuwalla on continuity of care and cost barriers.

The edition also profiles the AfriWON Renaissance Rural Theme leads, **Dr Susan Wanjiku** and **Dr Emmanuel Addo Asante**.

https://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/youngDoctorsMovement/2026/Rural_AfriWON_news.pdf

Dr Nantale Atangwa Peace
Research Theme Lead and Editor in Chief Afriwon Newsletter



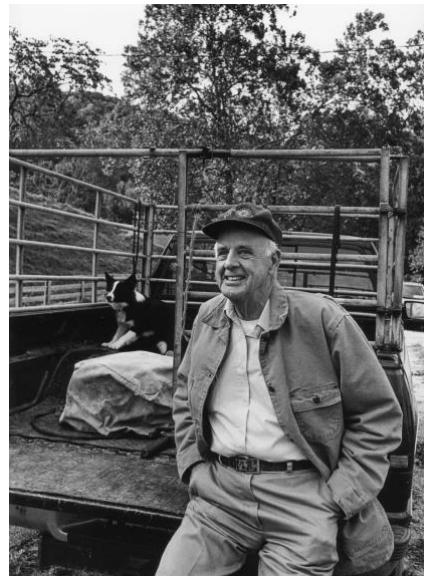
I currently work in a hard-to-reach area with an underserved population: Karamoja, a region often hit by long droughts and only two months of rain, where each season brings different challenges and culture affects the health of the sub-region.

When I became the AFRIWON theme lead for research and clinical audit, I realised members needed an avenue to amplify, advocate, and create an environment that would foster continued learning among young family physicians across the African continent.

As theme lead, responsible for organizing over nine research groups, with 80% of us working in rural settings, there was a lot to share, starting with our lived experiences in the form of stories. This would, in turn, lead to learning and support from one another.

Moving forward, we plan to have an online joint event on the 13th of December 2026, with eight panellists from different countries sharing their lived experiences. This event is organized by three AFRIWON teams, that is, research, rural, and image, to ensure inclusivity, despite working in rural areas.

Wendell Erdman Berry



Wendell Erdman Berry (August 5, 1934 – August 31, 2026) was an American novelist, poet, essayist, environmental activist, cultural critic and farmer. He was closely identified with rural Kentucky, Berry developed many of his agrarian themes in the early essays of *The Gift of Good Land* (1981) and *Unsettling of America* (1977). His attention to the culture and economy of rural communities is also found in the novels and stories of *Port William*, such as *A Place on Earth* (1967), *Jayber Crow* (2000), and *That Distant Land* (2004).

Berry was an elected member of the Fellowship of Southern Writers, a recipient of the National Humanities Medal, and delivered the Jefferson Lecture for 2012. He was also a 2013 Fellow of the American Academy of Arts and Sciences and, from 2014 to his death, a member of the American Academy of Arts and Letters. Berry was named the recipient of the 2013 Richard C Holbrooke Distinguished Award. On January 28, 2015, he became the first living writer to be inducted into the Kentucky Writers Hall of Fame.

Until his recent death, Wendell Berry lived in Port Royal, Kentucky near his birthplace, where he has maintained a farm for over 40 years. Mistrustful of technology, he held deep reverence for the land and is a staunch defender of agrarian values. He is the author of over 50 books of poetry, fiction, and essays. His poetry celebrates the holiness of life and everyday miracles often taken for granted.

The poems of Wendell Berry invite us to stop, to think, to see the world around us, and to savour what is good. Here are consoling verses of hope and of healing; short, simple meditations on love, death, friendship, memory and belonging; luminous hymns to the land, the cycles of nature and the seasons as they ebb and flow.

The Peace of Wild Things

When despair for the world grows in me
and I wake in the night at the least sound
in fear of what my life and my children's lives may be,
I go and lie down where the wood drake
rests in his beauty on the water, and the great heron feeds.
I come into the peace of wild things
who do not tax their lives with forethought
of grief. I come into the presence of still water.
And I feel above me the day-blind stars
waiting with their light. For a time
I rest in the grace of the world and am free.

What We Need Is Here

Horseback on Sunday morning,
harvest over, we taste persimmon
and wild grape, sharp sweet
of summer's end. In time's maze
over fall fields, we name names
that rest on graves. We open
a persimmon seed to find the tree
that stands in promise,
pale, in the seed's marrow.
Geese appear high over us,
pass, and the sky closes. Abandon,
as in love or sleep, holds
them to their way, clear
in the ancient faith: what we need
is here. And we pray, not
for new earth or heaven, but to be
quiet in heart, and in eye,
clear. What we need is here.

The Burial of the Old

The old, whose bodies encrust their lives,
die, and that is well.
They unhinder what has struggled in them.

The light, painfully loved, that narrowed
and darkened in their minds
becomes again the sky.

The young, who have looked on dying,
turn back to the world, grown strangely
alert to each other's bodies.

Basic Health Care Services **Rajasthan, India**

I would like to congratulate Dr Pravitra Mohan and his Team for what they have achieved

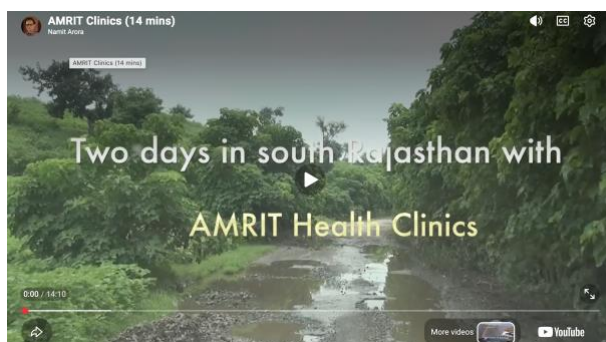


Basic Healthcare Services was registered as a not-for-profit trust in the year 2012 by a group of public health practitioners, academicians and development professionals, who shared the concern of poor healthcare to the marginalized communities. Aajeevika Bureau incubated BHS, helping it grow into an independently managed and governed organization, and continues to be a close associate.

From the beginning, BHS has been grounded in the principles of equity, health as a human right, and community participation. We aim to provide a responsive, empathetic primary health ‘circle of care’, that is rooted in the realities of the people we serve—especially migrants, tribal populations, and other underserved groups. We do this through a network of accessible primary healthcare and nutrition services, offering a continuum of preventive, promotive, and curative care that blends innovation in human resources and technology with community trust.

While our early focus was on maternal and child health, we soon recognized the need for a broader scope of care. Over time, our services expanded to include tuberculosis treatment, chronic respiratory diseases, and other non-communicable diseases. More recently, we have integrated mental health and physiotherapy into our model of care.

Video: Two days in South Rajasthan with AMRIT Health Clinics



<https://www.youtube.com/watch?v=8-kQjKMiBhA&t=8s>

Our Vision, Mission and Values

Vision: To enable marginalized and vulnerable communities to lead a healthy life with dignity.

Mission: To provide high quality and responsive primary healthcare for the last family in the communities BHS serves.

Our Core Values: A value is an inherent universal need, important to life and living, and which people strive to meet. BHS espouses and attempts to uphold values of:

- **Commitment:** A willingness to give your time and energy to something that you believe in.
- **Dignity:** The state of being worthy or honourable. The staff of BHS will at all times, through their action and behaviour, uphold the dignity of individuals and communities.
- **Equity:** Justness, fairness, and equality of rights and opportunities. Equity demands affirmative action towards the marginalized, disadvantaged and alienated. Such affirmative action will be reflected in BHS's vision, mission, norms, policies and practice.
- **Excellence:** Being extremely good at something.
- **Integrity:** Alignment in thought, word and action. It is also freedom from corruptive influence or motive. The staff of BHS will value commitments, not misappropriate, or knowingly misrepresent facts, and will maintain transparent and accountable systems and procedures.

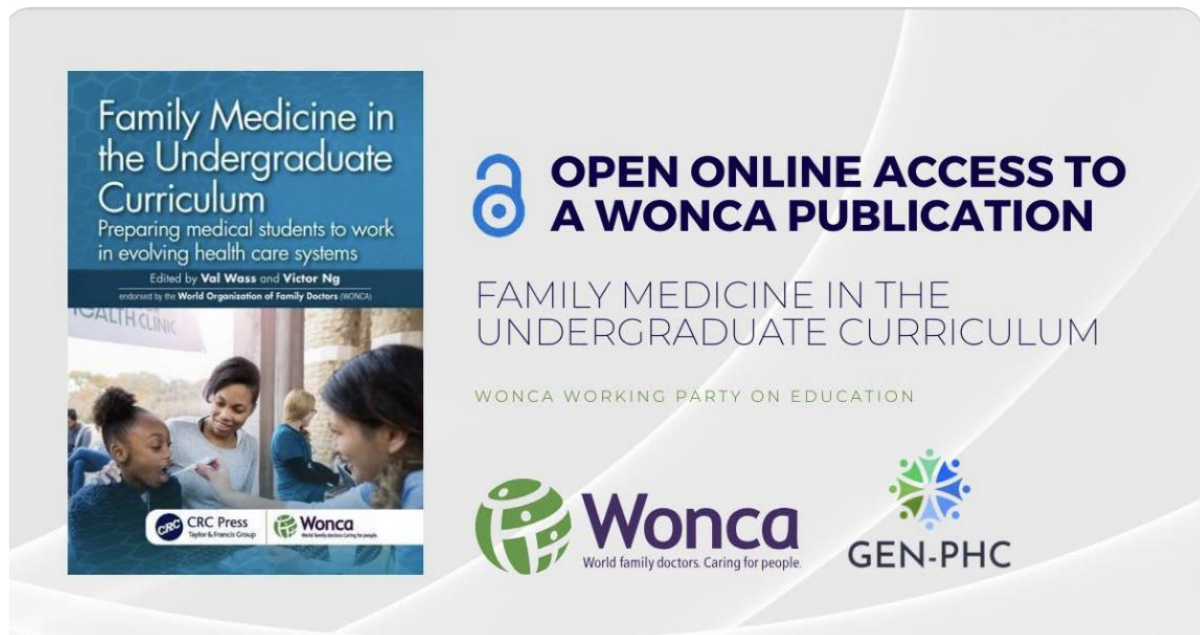
Basic HealthCare Service, Vidya Bhavan Rural Institute (VBRI), Badgoan Road, Udaipur - 313001

[0294-2453392](tel:0294-2453392)

info@bhs.org.in

Please read on: <https://www.bhs.org.in>

WONCA Publication: Family Medicine in the Undergraduate Curriculum



WONCA works to strengthen family medicine everywhere, and sharing our academic work openly is part of that. This book helps medical students get greater exposure to family medicine, especially in the places that need it most.

Read more: https://www.globalfamilydoctor.com/.../Open_access...

Nosey

Diagnostic Overview of Rural Medical Practice in Ibero-America



A Study to provide an initial, comprehensive assessment of the clinical, social, and technological realities faced by physicians working in rural and remote areas across Ibero-America

Presented by the Rural and Community Medicine Working Group of the Ibero-American Confederation of Family Medicine (CIMF)

Dear colleagues of the WONCA Working Party on Rural Practice:

Please accept our warm and fraternal greetings.

On behalf of the Rural and Community Medicine Working Group of the Ibero-American Confederation of Family Medicine (CIMF), we are pleased to share the results of a recent research initiative. This study was designed to provide an initial, comprehensive assessment of the clinical, social, and technological realities faced by physicians working in rural and remote areas across Ibero-America.

The study, which involved professionals from 17 countries in the region, examined key variables such as healthcare infrastructure, psychosocial well-being—specifically regarding workload and professional isolation—the adoption of digital tools (telemedicine and artificial intelligence), and the level of institutional integration among primary care teams.

The findings offer valuable insights for understanding priority needs regarding training, professional support, and workforce retention policies in the region's rural areas.

We cordially invite you to learn more about the report by viewing the following summary on YouTube:

Diagnostic Overview of Rural Medical Practice in Ibero-America:

<https://www.youtube.com/watch?v=WFy0lbZKmZ8>

Click settings and then English translations for those unable to speak Spanish

We also take this opportunity to reiterate our commitment to working together for the advancement of rural health.

Warm regards,

Dr. Juan Carlos Perozo

Coordinator, Rural and Community Medicine Working Group
Ibero-American Confederation of Family Medicine (CIMF)

En Español

Estimados/as colegas de la Grupo de Trabajo de WONCA Rural / WONCA Working Party on Rural Practice:

Reciban un cordial y fraterno saludo.

Desde el Grupo de Trabajo de Medicina Rural y Comunitaria de la Confederación Iberoamericana de Medicina Familiar (CIMF), nos complace compartir con ustedes los resultados de un reciente esfuerzo de investigación diseñado para obtener un primer diagnóstico integrador sobre la realidad asistencial, social y tecnológica que enfrentan nuestros médicos en los contextos rurales y remotos de Iberoamérica.

A través de esta indagación que contó con la participación de profesionales de 17 países de la región se exploraron variables clave relacionadas con la infraestructura sanitaria, el bienestar psicosocial frente a la sobrecarga y el aislamiento laboral, la adopción de herramientas digitales (telemedicina e inteligencia artificial) y el nivel de vinculación e integración institucional de los equipos del primer nivel de atención.

Los hallazgos resultantes ofrecen insumos valiosos para comprender las necesidades prioritarias de formación, acompañamiento profesional y políticas de retención laboral en el ámbito rural de nuestra región.

Los invitamos cordialmente a conocer los detalles de este informe a través del siguiente resumen disponible en YouTube:

Aproximación Diagnóstica a la Práctica Médica Rural en Iberoamérica:

<https://youtu.be/WFy0lbZKmZ8?si=O1G6nCatQIUavLzg>

Aprovechamos asimismo esta oportunidad para reiterar la intención de trabajar conjuntamente, en favor de la salud rural.

Reciban un abrazo fraterno.

Atentamente,

Dr. Juan Carlos Perozo

Coordinador del Grupo de Trabajo de Medicina Rural y Comunitaria
Confederación Iberoamericana de Medicina Familiar (CIMF)



Dr. Juan Carlos Perozo



A Global Call to Action from the international One Health* Community

World leaders are currently gathering in New York for the 81st UN General Assembly for discussions critical to the global health agenda. Today (25th September 2026), a **High-Level Meeting on Pandemic Prevention, Preparedness and Response** is taking place, aiming to adopt a new political declaration to guide strategies for preventing and addressing future pandemics and public health emergencies.

One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems. It recognizes the health of humans, domestic and wild animals, plants, and

the wider environment (including ecosystems) are closely linked and inter-dependent. The approach mobilizes multiple sectors, disciplines and communities at varying levels of society to work together to foster well-being and tackle threats to health and ecosystems, while addressing the collective need for clean water, energy and air, safe and nutritious food, taking action on climate changes and contributing to sustainable development. The One Health paradigm forges co-equal, all-inclusive collaborations between animal, plant, environmental and human health arenas, i.e. chemical, engineering and social scientists, dentists, nurses, agricultural/horticulturalists and food producers, wildlife and environmental health specialists and many other related disciplines that fall under its purview.

A ONE HEALTH CALL TO ACTION

We continue to urge world leaders, national governments, intergovernmental bodies, and relevant global conferences to meet the agreed targets of International Conventions for health, sustainability and equity; fund One Health research and implement actionable policies through a One Health lens; and, formally recognize that integrating human, animal, plant, and ecosystem health is vital to global health security, disease prevention, and resilience.

Beyond symbolic acknowledgement, we call on decision-makers to include One Health principles in national, regional, and inter-governmental negotiations, thereby translating these into concrete equitable and inclusive laws and regulations, cross-sectoral budgets, and binding commitments across all areas of health, health security, climate, animal, ecosystem, and environmental policy.

Support this Call to Action

Correspondence Received

A special thanks to for this note from **Sudeshni Naidoo** (Public Health Specialist), University of the Western Cape, Cape Town, South Africa.
Great to hear from another poetry lover.

“Dear John

I am specifically writing this to thank you for your most informative and comprehensive Miscellany that comes into my mailbox. You certainly do not have to worry about it not being appreciated it is fully packed with something for everyone! I must admit it sometimes takes me a good few days to go through the entire file ...all on account of the fact that at the end of each summary, you kindly put a link to source or the full manuscript ...I do not want to miss out on anything ...

BUT, THE best part for me is your obvious love of poetry ...I am CRAZY about poetry too and John Clare one of my all time favorite poets! So opening your email each month and re-reading "All nature has feeling" is always a pleasure ...

So, thank you for the effort you make to send us this Miscellany each mpth! I shall leave you with another of my favorite poets (Gerard Manley Hopkins) and his poem Pied Beauty”

Pied Beauty

By Gerard Manley Hopkins

Glory be to God for dappled things—
For skies of couple-colour as a brindled cow;
For rose-moles all in stipple upon trout that swim;
Fresh-firecoal chestnut-falls; finches’ wings;
Landscape plotted and pieced—fold, fallow, and plough;
And all trades, their gear and tackle and trim.

All things counter, original, spare, strange;
Whatever is fickle, freckled (who knows how?)
With swift, slow; sweet, sour; adazzle, dim;
He fathers-forth whose beauty is past change:
Praise Him.

Thanks also to Juan Barranco, a rural Family Doctor from Spain who commented on “A Fortunate Woman”

“On 27/08/2026 16:59, Juan Barranco wrote:

Dear John

Thank you for your efforts collecting all this evidence and information. A fortunate woman has become a "must read book" for my trainees, in part because it has a different and less ominous final than Dr Sassal's, and in part because it sets how important relationships are the ground for family medicine practice.

Kind regards and thank you again

Juan Barranco

Thanks Juan

Your email was much appreciated.

I agree about Sassall, who almost certainly was bipolar. The one important/crucial person left out of the book by John Berger was his wife who managed those dark moments. Sadly after her death, there was no one to stop him. Its still a great book.

Any contributions to further newsletter would be really welcome

John”

Conferences and Events



Africa HealthTECH Summit: Kigali Convention Centre:
30th September-1st October

The 2026 edition in Kigali marks a strategic inflection point for AHTS, positioning the Summit not only as Africa's leading digital health convening, but as a global platform accelerating the shift from care to wellness. As health systems confront rising NCDs, escalating costs, and fragmented delivery models, AHTS 2026 elevates the conversation from treatment-centric care to prevention-led, people-centred systems designed to operate at scale

Under the theme “**Wellness For All,**” AHTS @ 5 will focus on strengthening cross-border collaboration, advancing connected and home-based care, and aligning African health priorities with global digital health, innovation, and financing agendas.

<https://healthtechsummit.africa>



<https://forum.euripa.org/>

<https://www.euripa.org/>

15th EURIPA Rural Health Forum
CARTAGENA (SPAIN) | 1, 2 and 3 October 2026

"EMBRACING RURAL DIVERSITY"


Rural Café



Discovering Rural Medicine: Experiences, Challenges and Future Opportunities

Reflections from the EURIPA Rural Exchange

An informal and interactive space to share experiences, exchange ideas and connect with colleagues from across Europe.




Thursday
1 October 2026
18:15 – 19:15 (CET)


On-site
Cartagena, Spain


Online
(virtual access available)


Real experiences


Open conversation


New perspectives


A stronger EURIPA community

Join students, residents, young family doctors and experienced rural practitioners for a friendly discussion about rural careers, challenges, opportunities and the future of rural healthcare.



Good conversations build brighter futures ♥


Bring your coffee.
Bring your experience.
Be part of the conversation!





*Different places
Shared purpose*

WONCA WORLD CONFERENCE 2027



JOIN US TO GET THE LATEST INSIGHTS AT WONCA WORLD CONFERENCE 2027

Our global community of family doctors and primary care professionals is coming together for the landmark WONCA World Conference 2027, which will take place from 3–7 November 2027, in Cape Town, South Africa.

Prepare for five days full of updates and clinical tips to improve your practice, networking opportunities to meet colleagues from all over the world, sharing perspectives, and, of course, having fun! Together, we will dive into this year's essential theme: "The roles of the family doctor in the primary health care team".

Meet us at the crossroads of tradition and innovation, Cape Town. With its vibrant culture, excellent accessibility, and modern facilities, the city provides the ideal backdrop for our world-class global conference.

Let's improve global primary health care together!

3–7 November 2027, in Cape Town, South Africa.

<https://www.woncaworld2027.org>

The WONCA Eastern Mediterranean Region Conference



The WONCA Eastern Mediterranean Region Conference 2026 will bring together family doctors, primary care professionals, researchers, educators, trainees and health leaders in Cairo, Egypt, from **26-28 November 2026**.

Theme: *Solidarity in Primary Care: Bridging Innovation and Humanism for a Resilient Eastern Mediterranean.*

The conference is organised with the **Egyptian Family Medicine Association** and will provide a regional forum for sharing research, developing practical skills, building professional connections and discussing the future of family medicine and primary care.

For registration, submissions and the latest official updates, visit: woncaemr2026.org

Education, Webinars, Videos and Podcasts

The Lancet Voice

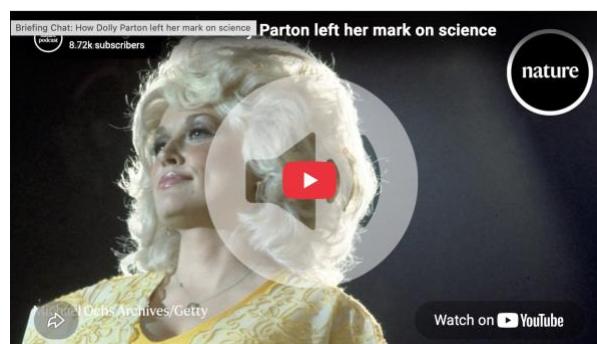
Social Prescribing in the Western Pacific Region the Western Pacific Region

Social prescribing is an approach that connects individuals to community support and services to improve health and well-being. The Series on social prescribing in the Western Pacific region features four papers from regional experts, highlighting available evidence on social prescribing models and offering perspectives on adapting these approaches to meet the region's diverse health needs. The Series also explores the impact of traditional arts and events on mental and social well-being, and proposes a stage-sensitive evaluation framework to guide the implementation and scaling of social prescribing in the region. The final paper presents a community-led social prescribing model from the Lao People's Democratic Republic.

<https://www.thelancet.com/video-do/social-prescribing-western-pacific-region>

Nature Podcasts

Briefing Chat: How Dolly Parton left her mark on science



Nature reporters discuss the country-music icon's advocacy for vaccines and public health — plus, promising trial results for an mRNA cancer therapy.

<https://www.nature.com/articles/d41586-026-02732-w>

New Scientist: Change Your Mind

How to Future-Proof Your Brain

In this episode of Change Your Mind, health journalists Helen Thomson and Cat de Lange explore the science of cognitive reserve, the brain's hidden resilience that can help delay the symptoms of dementia.

They talk to Professor Yaakov Stern, a leading researcher in the field, to uncover what cognitive reserve actually is, how it's measured and why some people stay mentally sharp despite significant brain changes. Along the way, they delve into surprising evidence on music, bilingualism, social life, exercise, and even hobbies like quilting and photography to ask how much effort we really need to put in to future-proof our brains.

<https://www.newscientist.com/podcasts/cognitive-reserve-how-to-future-proof-your-brain/>

BMJ Podcasts

The Doctor Podcast: Breaking barriers to care

A medical environment can be overwhelming for any patient, but to those who are neurodivergent, the sensory challenges involved can be enough to put them off obtaining the healthcare they need.

In recognition of the barriers to care faced by these patients, some doctors are attempting to change the way medical treatment in their workplaces are delivered in an effort to become more inclusive and effective.

Welcome to the sixth episode of The Doctor podcast, brought to you by the British Medical Association.

In this episode, Dr. Giles Armstrong and Dr. Sarah Davies discuss their efforts to make the NHS more accessible for autistic patients.

They share personal experiences, insights, and practical steps they have taken to improve healthcare, including enrolling their workplaces in a specialised award scheme provided by the National Autistic Society.

This episode builds on the feature article 'Sensory overload – making the NHS more accessible for autistic patients', by Tim Tonkin.

You don't need to have read the article to enjoy this episode but if you'd like to do so you can find it at: <https://thedoctor.bma.org.uk/articles/health-society/sensory-overload-making-the-nhs-more-accessible-for-autistic-patients/>

https://shows.acast.com/the-doctor/episodes/684fe2714ed3341b0f30bf98?utm_campaign=618597_27082026%20The%20Doctor%20Issue%20Promotion%20All%20UK%20Membership%20CMP-07120-L1P6Y&utm_medium=email&utm_source=The%20British%20Medical%20Association%20%28Comms%20Engagment%29&dm_i=7IPW,D9B9,19AQAX,1UNGH,1,0,0,0

NEJM Podcasts

Interview with Dhruv Khullar on concerns about displacement of clinicians by artificial intelligence and counterarguments based on economic theory.

Dhruv Khullar is an associate professor of population health sciences and of medicine at Weill Cornell Medical College. Stephen Morrissey, the interviewer, is the Executive Managing Editor of the Journal.

<https://www.nejm.org/doi/full/10.1056/NEJMp2607831>



Rural Road to Health Podcast

On the 27th of October, Rural Health Compass is hosting a Rural & Remote Patient Story day.

Melanie Costas, Andrew Moran & Donald Macgregor, will share their lived experience of being a patient in rural and remote areas of England and Scotland and reflect on what went well and where things could have been better.

This event is an opportunity to develop a better understanding of rural and remote patient journeys and participate in discussion about how we can better address rural health inequity and access to healthcare in the UK.

The target audience for this event are rural citizens, health and social care students and professionals, community & voluntary sector, local authorities, NHS organizations, public health professionals, and policy makers.

➡ Register to attend here: <https://www.eventbrite.com/e/rural-remote-patient-stories-registration-1995690518062>

🙏 Please share this event with others who might be interested.
Dr Veronika Rasic



New articles published in Rural and Remote Health

[10911 - North America - Rural healthcare providers' attitudes on climate change in the Northwestern US](#)

Climate change is recognized as an increasing threat to health, particularly in rural communities. This Original Research article reports on the analysis of a provider survey distributed in the northwest United States designed to identify health care provider attitudes on climate change and integration of these beliefs in patient care. Although the majority agreed climate change poses a risk to community health and indicated they had observed

associated adverse outcomes in their community, less than one-third felt comfortable counseling their patients on climate change related health impacts

9949 - Australasia - Consumer-driven approach to determining health research priorities: what matters most to people living in rural Australia?

Engaging consumers in research prioritisation ensures that emerging research questions remain grounded in real-world experience and are perceived as relevant to policy and practice. However, people from rural areas have often been left out of consumer and community involvement initiatives in health research. This Original Research study identifies consumer priorities for rural health research in Australia and describes the process and learnings of a novel approach to promoting involvement of rural consumers in health research.

10648 - Africa - Improving surgical care in rural South Africa: exploring collaboration between Indigenous and formal health sectors

In South Africa, individuals commonly seek care across both Indigenous and formal healthcare systems, reflecting a pluralistic approach to health-seeking, particularly in rural areas where access to formal medical services is limited. Many people with surgical conditions are reluctant to seek care in the formal sector due to barriers such as cost, transportation, language, and lack of trust. Since Indigenous knowledge healers are trusted members of the community, they could play a role in improving surgical care. This Original Research study identifies community-prioritized surgical conditions and explores Indigenous and formal health stakeholder buy-in to collaborative approaches to care.

10850 - Africa - The history of disability and rehabilitation in rural South Africa: hidden rural disability and the power of collaboration

Globally, more than 1.3 billion people experience significant disability, with the highest unmet rehabilitation needs found in rural and resource-constrained settings. In South Africa, disability prevalence remains underestimated, particularly in rural areas where under-reporting, limited access to services, and social stigma persist. This Rural Health History article examines the historical evolution of disability and rehabilitation in rural South Africa through a qualitative document review of archival materials, exploring policy development, service evolution, and system-level change over time.

10701 - Latin America - Perceived consequences of megadrought on wellbeing and the role of health care: narratives from rural communities in Elqui Province, Chile

Climate change is recognized as one of the most complex and persistent challenges for global public health, and drought, an extreme weather event that is increasing in frequency as a result of climate change, is one of the most geographically widespread natural hazards worldwide. Evidence remains limited on how rural communities experience the health consequences of prolonged drought and how they perceive the role of health care in responding to this crisis. Chile has experienced several major droughts, including a megadrought that has persisted in central Chile since 2010. This Original Research article describes the perceived consequences of drought and examines the role of health care from the perspectives of members of two rural communities in Chile.

10149 - Australasia - Adapting to context: supervisors' views on professionalism and professional identity development in regional, rural and remote settings

Although much has been written about how students develop professionalism and professional identity, less is known about the role and perspectives of clinical supervisors, the relationships that connect or disconnect them from the communities and cultures in which they work, and how these contexts influence students as they develop professionally. This qualitative Original Research study, undertaken in the Northern Territory, Australia, reports on the key challenges and benefits of clinical placements in unique settings, and factors that impact student development and professional identity.

Papers from other journals

The lancet Editorial: Health is political: setting an African agenda for the right to health

When I (TM) began my mandate as the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the world was already in crisis, as it often is. The COVID-19 pandemic was beginning in earnest, yet it had not created the crisis - in many ways it had simply exposed it. For many communities across the African continent, the pandemic served as another chapter in a much longer history rooted in deprivation, extraction, colonialism, racialized hierarchies, gendered violence, and sociopolitical abandonment both internally and from the rest of the world. It revealed, with painful clarity, that we cannot reduce the right to health to metrics such as the number of people who are able to access essential health services or receive a certain vaccine, how low maternal mortality has fallen, or the increases in life expectancy in numerical terms. These are undoubtedly essential measures to track, but they are not the whole measure of what justice is and what it entails.

From the outset of my mandate, I chose to centre substantive equality, anti-racism, and anti-colonial frameworks into our understanding of why the right to health remains unrealised for so many. This was not always welcomed. There is still a tendency, even within global health and human rights spaces, to treat the right to health as though it is a technical matter assessing the number of operational facilities, the availability of medicines and healthcare workers or SDG targets. But as we know, health is political - it is tied to, funded by, and impacts political decisions. Whether a person reaches a health facility or trauma center, whether that facility has water, electricity, anaesthesia, surgical supplies, a midwife, or a respectful clinician, and whether the patient is believed, dismissed, detained, shamed, or healed depends largely on power (and thereby politics) and how it is used. The right to health is about services and systems, but it is also about land, labour, housing, food, water, information, freedom from violence, and access to the social conditions that make a life of dignity possible.

To set an agenda for the right to health on the African continent, we must be comfortable naming historical and contemporary processes and how they impact health utilization and outcomes. If our desire is to be truly effective, colonialism, apartheid, slavery, and the continuation of exploitative and extractive forms of capitalist enterprises are not to be treated as abstract and historical events which can be acknowledged and paid lip service to but then removed from discussions on health policy. These processes have undeniably and systematically contributed to the health system we see present across many parts of Africa

today, be it the inequitable distribution of healthcare networks, the underdevelopment of rural health infrastructure, the dependence on imported technologies, the reliance on foreign healthcare workers, or even the precarity of financial public goods available to people. There is often a focus on short-term stopgap measures as opposed to seeking genuine flourishing. For example, during the COVID-19 pandemic many African countries were expected to negotiate for vaccines, access to diagnostic tools, and personal protective equipment and this was often from a dependent-status footing.

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Nature: The super El Niño is already wreaking havoc: here's what's in store The extreme weather of this year's mega El Niño could look different from past events.

The waters off the coast of Peru are normally one of the most productive fisheries in the world, each year producing millions of tonnes of anchovies to be used for fertilizer and animal feed. But in late August, the government cancelled the anchovy season early: the El Niño event gaining strength in the tropical Pacific Ocean has increased ocean temperatures and sent full-grown anchovies in search of food to deeper, colder waters, ruining the catch. That is just one example of how this year's monster El Niño is causing disruptions globally. Forecasts for the months ahead suggest that the impacts will be felt in many locations normally associated with El Niño's influence, says Deepti Singh, a climate scientist at Washington State University in Vancouver. That includes drought in areas around the equator, Central America and the western Pacific Ocean, as well as extreme rainfall in the horn of Africa, western United States and the Pacific coast of South America. But this El Niño is forecast to reach unprecedented strength. That, combined with the influence of global warming, could mean that the effects of this event look different from the strong El Niños of the past. "You change the patterns and the weather reacts," says Eran Vos, a climate scientist at Bar-Ilan University in Ramat Gan, Israel.

El Niños occur when sea-surface temperatures in the tropical Pacific Ocean become abnormally warm. This affects air temperatures in the atmosphere above the region, shaping wind and weather patterns across the globe.

Not all El Niños have the same influence on weather. El Niños caused by warm ocean temperatures in the central Pacific behave differently to ones formed in the eastern Pacific. And weather patterns during strong El Niño events are different from those caused by moderate ones. "El Niños come in flavours, like ice creams," says Jérôme Vialard at the Research Institute for Development in Marseille, France.

This event is the first strong El Niño with an eastern Pacific flavour since the late 1990s, says Vos. That means that there's not a lot of precedent for how it will influence weather when combined with almost three decades of global warming.

There are a few other aspects that make this year unique. The El Niño has strengthened earlier than it did during previous strong events, such as the ones that occurred in 1997 and 2015. Some forecasts suggest that this El Niño could become the [strongest one in centuries](#), combining with background global warming to raise average temperatures in 2027 to record levels.

https://www.nature.com/articles/d41586-026-02826-5?utm_source=Live+Audience&utm_campaign=f52eb8ad54-nature-briefing-daily-20260914&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet Editorial: A new normal?

In 2003 a record-breaking heatwave across Europe was estimated to have caused upwards of 70,000 excess deaths. Early attribution analysis indicated that the heat was made roughly

twice as likely due to anthropogenic climate heating and the authors also tentatively forecast that similarly hot summers could become commonplace by the [2040s](#).

Fast forward to today and Europe has experienced heatwaves in 2019, 2021, 2022, and 2025, many of which set regional heat records. True to form then in summer 2026 Europe is once again gripped by a prolonged heatwave. Attribution analysis focusing on the hottest June days and nights suggests that such conditions are – as a result of anthropogenic climate heating – tens to hundreds of times more likely in 2026 than back in 2003 and would have been virtually impossible [50 years ago](#).

In addition to the direct health effects indicated by for example excess mortality and hospital admissions statistics heat can have profound impacts on ecosystems, agriculture, built infrastructure, services and daily life. Notably wildfires are having a particularly intense season across Europe, facilitated by low rainfall and intense heat. These conditions are also affecting crop yields, water resources, aquatic ecosystems, energy grids, and transport networks, to name just a few. All of this is bound to exacerbate the ongoing cost of living crisis.

During extreme weather events media commentators frequently look for geographical analogues, implicitly or explicitly suggesting that because similar conditions might be commonplace in some parts of the world, then human societies can readily cope with these conditions anywhere and everywhere. While this does indicate something about the potential of human adaptability and ingenuity, it fails to recognise that societies do not just pop into existence. Rather they develop in a local and regional context. Communities rely on a mixture of traditions, social norms, technologies and trade relationships which are adapted to the range of conditions they have experienced. In the last 10,000 years or so – before anthropogenic climate change – climatic conditions have been relatively stable, making it possible to make reasonably simple assumptions of what to expect based on past experiences. In other words, it has been relatively easy to become adapted to the range of typical conditions experienced in a given place. Occasional extremes may be outside the normal societal coping mechanisms but if they are sufficiently infrequent these too can be weathered. Climate heating makes this situation dynamic so past occurrences become much less reliable indicators of what communities need to be adapted to. In the case of extreme heat in Europe, conditions that could previously be treated as rare events are increasingly commonplace and therefore require adaptations to minimise their impacts. So far, such adaptation has been slow and inadequate to the task. Furthermore, these changes are not now static. The UK is not now like the Mediterranean for example. We are all in a dynamic situation where conditions are changing and will continue to change until greenhouse gas concentrations stabilise and the earth system reaches some new climatic equilibrium.

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NEJM: Artificial Intelligence and the Future of the Clinical Workforce

Concerns about technology disrupting the work of clinicians have existed for decades, but they have intensified in recent years amid the growing sophistication of artificial intelligence (AI) tools and their rapid adoption in health care. AI has increasingly outperformed clinicians on complex clinical tasks, and the federal government recently announced an initiative to develop agents that can autonomously provide care to patients.[1](#)

Some experts have predicted that AI will take over clinical tasks to such an extent that there will be fewer employment opportunities for clinicians, especially in specialties such as radiology, pathology, psychiatry, and primary care. Counterarguments often emphasize technological, regulatory, and humanistic factors: it is possible, for example, that AI agents won't be as effective in the real world as they have been in benchmarking studies, that

regulatory requirements will slow the implementation of AI tools or limit their applications, and that patients will continue to highly value empathic, relational care. Although each of these considerations has merit, economic theory and history offer distinct and possibly more structural reasons to believe that in the long run, adoption of AI agents — even models capable of performing some forms of cognitive work — could lead to an expansion, rather than a contraction, of the clinical workforce.

Health care has long been subject to a phenomenon known as “cost disease,” whereby wages in labor-intensive sectors of the economy increase in parallel with wages in sectors that experience greater efficiency gains, such as manufacturing and technology.² Service industries cannot easily automate tasks or increase productivity, but employers must still increase wages over time, since new workers can choose to enter other sectors and existing workers can move between sectors. This phenomenon partly explains why the cost of health care and education has risen dramatically while the cost of clothing, computers, refrigerators, and televisions has fallen. Some commentators have argued that the key to ameliorating health care’s cost disease is transforming services delivered by clinicians into software-based goods.³ Employing a string quartet to play music (a service) is costly and limited by the availability of talented musicians, but digital recordings (a good) are ubiquitous and inexpensive.³ It is possible that AI will drive a similar transition in health care. For example, AI agents might eventually provide urgent or behavioral health care that was previously delivered by humans.

There are, however, at least three reasons to believe that AI won’t reduce the need for clinical labor. The first is the Jevons paradox, whereby technological advances that enhance the efficiency with which a resource is used can lead to an increase — rather than a decrease — in use of that resource. This concept was introduced by 19th-century economist William Stanley Jevons, who observed that the introduction of steam engines that burned less coal than previous models didn’t lead to a reduction in coal consumption; instead, it led to higher demand for steam engines and greater use of coal. Versions of the Jevons paradox have been demonstrated for lighting, air travel, and computing. In health care, technological advances that made procedures such as cataract surgery and joint replacement more efficient by reducing the amount of clinician effort necessary to perform them, shortening recovery periods, and improving safety enabled more patients to undergo those procedures. Decreases in the cost of genetic testing and magnetic resonance imaging have coincided with growing use of these technologies within and outside conventional medicine. There are more radiologists working in the United States today than there were a decade ago, and radiologists have higher average incomes and larger workloads than they did in the past.⁴

<https://www.nejm.org/doi/full/10.1056/NEJMp2607831?query=TOC>

The Lancet: The intersection of conflict, displacement, health, and human rights in Africa

The International Committee of the Red Cross recently reported that 40% of global conflict is taking place in Africa, and there are currently more than 50 armed conflict situations. Approximately 23 million people are forcibly displaced in eastern and southern Africa, and just over 16 million in western and central Africa. The impact of conflict and forced displacement on health systems, and consequently the health and [human rights](#) of these populations, is well [documented](#). Although only certain countries within the continent are affected, we cannot consider the health of our region without considering conflict, and the resultant displacement of populations. As a journal serving the African region, The Lancet Regional Health – Africa is committed to keeping these issues on the agenda. Accordingly, in

our September issue, we bring together nine pieces on these topics to draw attention to the intersection of conflict, displacement, health, gender, racism, and human rights in Africa. The Perspectives piece in this issue from Mofokeng and colleagues provides a critical framing—that health is political, and it is a human right that is owed to all Africans. The lead author brings her lived experience to highlight the political imperatives for transforming the right to health “from an aspiration to a lived reality.” Unfortunately, this shift needs to take place within the context of a global decline in [human rights](#).

On the intersection of health and conflict, the effects of armed conflict on HIV treatment in Ethiopia are documented by Kebede and colleagues, who conducted a time-series analysis of patient outcomes. They highlighted sustained disruptions to HIV care continuity that persisted beyond the conflict period. Duagani and colleagues report the findings of a longitudinal study on the mental health burden of cumulative trauma in the eastern Democratic Republic of the Congo. They highlight the urgency of integrating mental health support in humanitarian settings and bolstering psychological support for those experiencing trauma in these contexts. In their Comment, Hassan and colleagues discuss how conflict in Sudan has undermined the HIV care cascade, particularly for women who experience intimate partner violence.

Further illustrating the gendered dimension of conflict, as well as the vulnerability of children, Maroyi and colleagues documented pelvic-perineal injuries amongst child and adolescent survivors of sexual abuse in conflict-affected settings in the Democratic Republic of the Congo. Chirwa and colleagues report on trends in child homicide in South Africa – the most severe form of violence against children. Although South Africa is not currently experiencing armed conflict, its history of violence as a result of colonialism and apartheid have contributed to unacceptable levels of [violence](#) against women and children.

[https://www.thelancet.com/journals/lanaf/article/PIIS3050-5011\(26\)00132-X/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/lanaf/article/PIIS3050-5011(26)00132-X/fulltext?dgcid=raven_jbs_etoc_email)

The Annals of Family Medicine: Influence of Physician Behaviors on How Patients Interpret Normal Test Results

Reassuring patients that nothing serious is wrong is one of the most common interventions in family medicine. However, medical reassurance can sometimes fail, and it is not yet clear what role the doctor’s behavior plays in this regard. We tested the preregistered hypothesis that a doctor’s warmth and competence significantly and independently influence patients’ responses to normal results from diagnostic testing.

We used an online convenience sample reporting medium somatic symptom burden (N = 349, mean age 29.9 years, 79% female) and completed an experimental analog study. After presentation of a symptom vignette, participants watched a videotaped medical report in which a doctor provided the results of diagnostic tests, stating that no abnormality had been identified. Whereas the diagnostic information was always the same, the doctor’s behavior differed in terms of warmth (high vs low) and competence (high vs low).

Participants rated the likelihood of a serious disease significantly lower if the doctor showed high warmth and high competence. Further results showed that high warmth and competence also led to improvements in other outcomes, such as a lower desire to seek another doctor’s opinion or additional tests. A mediation analysis indicated that the effects of warmth and competence were modulated by the extent to which participants cognitively (de)valued diagnostic information.

For patients, diagnostic information does not speak for itself; the doctor’s behavior critically determines how they integrate such information. Showing high warmth and competence can help patients put trust in them and update their illness beliefs accordingly.

<https://www.annfammed.org/content/early/2026/08/21/afm.250671>

Lancet Editorial: Protecting against genetic discrimination requires more than a law

On Oct 8, 2026, Australia will ban life insurance companies nationwide from collecting genetic testing results when reviewing applications. The bill has been [widely welcomed](#) by stakeholders, including the Australian Medical Association, the Council of Australian Life Insurers, and the Australian Human Rights Commission. For the many who have hesitated to take a genetic test or participate in genomic research for fear of being refused insurance because of the results, the new law is a significant win against genetic discrimination.

Genetic testing used to be offered mainly to symptomatic patients for diagnostic purposes. However, as the costs of genetic testing have fallen, its use has become increasingly popular among healthy individuals and those with a family history who wish to proactively understand their own underlying risk of diseases for prevention. Common direct-to-consumer tests can identify carriers of recessive conditions such as cystic fibrosis before starting a family, BRCA1/2 gene mutations that increase the risk of developing breast and ovarian cancers, and provide pharmacogenomic information that guides the choice of medication for optimal absorption and metabolism. As these results are closely tied to health conditions, many people fear the information could backfire in the form of [genetic discrimination](#) (ie, the unfair treatment of individuals because of their genetic make-up), such as the risk of a genetic disorder. A [population-based study](#) reported that when told how genetic testing might affect insurance underwriting, people were 50% less likely to proceed with testing. On the contrary, a Japanese survey revealed that insurers were worried about actuarial fairness and “[adverse selection](#)”, by which people with hidden health issues exploit information gaps to withhold their details when taking out insurance, which eventually drives up premiums for all policy holders.

From a medical ethics perspective, the answer to this dilemma is straightforward: no one should be forced to choose between prioritising their health and financial security. This is particularly unfair when the genetic information used can be less predictive than we assume. For example, the reliability of a genomic risk-prediction tool in an Asian population increases when it has been [externally validated](#) in the region, as gene variants might be Asian-specific but most existing genetic data have been derived from populations of European ancestry. Although monogenic disorders strongly determine whether a disease develops, most allelic variants only marginally contribute to overall risk. Even with the development of [polygenic risk scores](#), they should be used together with traditional risk factors to give accurate risk projections, as managing lifestyle factors is shown to attenuate the associations. Genetic testing is therefore meant to direct individuals at higher risk towards more intensive prevention programmes for risk mitigation, rather than assigning them a permanent label. Banning genetic discrimination in the Western Pacific is not simple, partly because insurance systems are heterogeneous across the region. A community-rated system charges everyone the same base premium for the same product, whereas some jurisdictions, such as Hong Kong, typically adopt a risk-rated approach that adjusts premiums according to granular, individual-level risk factors. This raises a question: does the practice of risk adjustment based on health-related information contribute to discrimination? Governments in these jurisdictions should therefore clarify in law how genetic data are classified to distinguish between general health disclosure and sensitive personal details. In [Singapore](#), a partial ban has been implemented to exempt Huntington's disease and BRCA1/2 findings, which still discourages testing as no one knows beforehand whether they would fall into an exempted category.

[https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065\(26\)00179-3/fulltext](https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(26)00179-3/fulltext)

Science: Fauci speaks out about the pandemic, global health—and his own record **Largely silent for the past year, the beleaguered former NIAID chief defends himself in friendly forum**

Once the media's go-to scientist for all infectious disease stories, Anthony Fauci has largely avoided the spotlight over the past year—attracting the most press attention for repeatedly invoking the Fifth Amendment at a Senate [hearing](#) in July. But today he sat down for a nearly 2-hour interview with Lawrence Gostin, an expert in global health policy at Georgetown University, which hired Fauci in 2023 shortly after he left his longtime role as head of the U.S. National Institute of Allergy and Infectious Diseases (NIAID). Although the conversation, which was webcast, largely avoided politics, Fauci did address some hot-button issues surrounding the COVID-19 pandemic, vaccination, and global health.

Fauci never mentioned President Donald Trump or Senator Rand Paul (R-KY), two of his loudest critics, but he defended his actions during the pandemic. "I'm not sure we would change much" about the public health response, he said, contending there's "corporate selective amnesia" about how dire the situation was in the first part of 2020. "What you see going on right now is all blame game," he said. "That is not a constructive way to figure out how you can do better next time."

Fauci has taken a good deal of heat for schools and businesses closing down, recommendations about masking and vaccination, social distancing measures, and the origin of the pandemic itself. "I'm the bad guy," he joked. "I created the virus. I shut the schools. You know, I did everything, I did everything. Throw away the key." (Paul indeed has argued that Fauci should be prosecuted for his pandemic actions, but shortly before leaving office, then-President Joe Biden issued him a preemptive pardon.)

Fauci stressed that he did not set policy; that was up to governors, mayors, and teachers' unions. He told Gostin he wanted schools to reopen more quickly than they did, and he contested the claim that social distancing measures—such as the "30 days to slow the spread" invoked by the first Trump administration—were lockdowns. "We didn't lock anything down," he said. "Were you locked in your house? I wasn't locked in my house. In China, you were."

Fauci's critics have also charged him with covering up what they believe was the origin of the pandemic: a leak of SARS-CoV-2, the virus that causes COVID-19, from a laboratory in Wuhan, China, that received some funding from NIAID. Fauci said he has not ruled out a lab leak. "I keep a completely open mind," he said, "but I'm a scientist, and I go by data." A half-dozen papers in high-profile journals by "highly qualified evolutionary virologists" support the alternative theory, that the virus naturally jumped into humans from animals. "The people who say it definitively came from a lab leak, I'm sorry, but there's nothing in the data that backs that statement," he said.

https://www.science.org/content/article/fauci-speaks-out-about-pandemic-global-health-and-his-own-record?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=quotable&et rid=1169729274&et_cid=6061883

The lancet: Wildfire smoke and health: current evidence, mechanisms, and future challenges

In the era of climate change, numerous regions worldwide are facing a surge in both the frequency and unprecedented scale of wildfires. Exposure to wildfire smoke poses substantial risks to health, especially for vulnerable populations. Although previous studies have shed light on health effects of wildfire smoke, crucial research gaps persist, including long-term health effects, interactions with pre-existing health conditions, and health disparities. Closing these gaps is vital to enhancing the ability to safeguard public health during wildfire events

and to formulate effective strategies for prevention, mitigation, and response. This Review synthesises global evidence on the trends, health effects, and physical and chemical characteristics of wildfire smoke, exploring potential biological mechanisms and challenges in health risk assessment. Acknowledging the global impact of wildfires and their health effects is essential for mitigating environmental, social, and economic challenges. Safeguarding public health requires an interdisciplinary approach to comprehensively address the public health burden from wildfires. This integrated strategy is essential to systematically assess and mitigate the substantial public health burden posed by wildfires, as well as promoting resilience and sustainable solutions for affected communities.

In an era where the global threat of wildfires grows larger than ever before, the world is facing an unprecedented scale and intensity of fires in forests, grasslands, and peatlands (hereafter called wildfires). Globally, annual fire weather seasons lengthened by 14 days per year (a 27% increase) and the frequency of extreme fire weather rose by 10 days per year (a 54% increase) from 1979 to 2019.¹ Global warming will amplify the health burden and inequity caused by wildfire smoke. According to a 2025 study, carbon emissions from fires are projected to increase by 23% from the 2010–14 to the 2095–99 period, with related premature deaths rising to roughly six-times current levels.²

Forest regions globally have experienced substantial large-scale wildfires, exemplified by events such as the 2018 Californian wildfires, the 2019–20 Australian wildfires, the 2021 Russian wildfires, and the 2023 wildfires in Canada, Rhodes (Greece), and Hawaii (USA). These intense fires released harmful air pollutants, disturbed ecosystems, destroyed crucial infrastructure, and caused widespread damage, including the destruction of homes.

Particularly the most recent wildfires in Los Angeles (CA, USA), which killed at least 29 people, destroyed thousands of buildings, and forced tens of thousands to evacuate. The largest blaze, in Pacific Palisades, burned over 23 000 acres, making it the most destructive fire in the city's history. The negative health effects included social upheaval, mental distress, physical injuries from the destructive nature of fires, and a rise in morbidity and mortality linked to fire smoke exposure.³ However, beyond the immediate visible impacts, the toll on public health remains an underappreciated facet of the wildfire crisis.⁴

Understanding the health effects of wildfire smoke is imperative, given the dynamic nature of these infernos and their far-reaching impacts on air quality and human well-being; it is essential for safeguarding public health, planning emergency responses, and facilitating the development of more effective fire mitigation policies, but the research is still in its infancy. This Review synthesises the available evidence on the global health impacts of wildfire smoke, delving into historical trends and future projections under different climate change scenarios. It explores the agency-specific and organisation-specific effects that ultimately shape public health outcomes. The discussion extends to the major challenges in assessing health risks and understanding the underlying pathophysiological responses to wildfire smoke.

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Nature: Revealed: inside the US military's plan to tap huge sums from the NIH
An agreement paves the way for hundreds of millions of dollars' worth of projects to be transferred from the NIH's institute for infectious diseases to the Department of Defense.

Update: After this story was published, the US Department of Defense responded to Nature's request for comment with a statement confirming that the department has signed a research agreement with the National Institutes of Health. The agreement will allow "for strategic

collaboration on a project-by-project basis,” the statement said, adding that any assertion that the agreement was made in secret “is false.”

The [US National Institutes of Health](#) (NIH) is seeking to redirect research projects worth hundreds of millions of dollars from its infectious-diseases institute to military biodefence programmes at the US Department of Defense (DOD), according to two NIH employees. They confirmed to Nature that the NIH and the DOD, also called the Department of War, have signed an agreement for the arrangement. The NIH is now identifying projects it would transfer to the DOD and aims to complete the agreement by the end of September, when the fiscal year ends and some funds expire, according to a third NIH employee who is a senior official at the agency. (The employees spoke on the condition of anonymity because they are not authorized to speak to the press.)

An NIH spokesperson says, “This partnership will only take place on a project-by-project basis, and all research will be within the scope of NIH’s mission. There is no blanket transfer of funds”.

The senior NIH official said the new arrangement would untangle civilian public-health initiatives from defence priorities. “We’re trying to get research that’s more Department of War-related back to Department of War,” the official said. “When the public hears that NIAID funds biodefence, they think we’re developing bioweapons, and we’re trying to get out of that business.”

Federal law does allow agreements between US agencies to share funding in some circumstances, says Samuel Bagenstos, who until December 2024 was the top lawyer for the NIH’s parent agency, the Department of Health and Human Services. But “what’s not appropriate or legal is saying, ‘Look, DOD needs money, NIH has money, we’re going to take money and send it to the DOD,’” he says. If the administration is using NIH resources to cover military budget shortfalls, “that would be illegal, because that would be using funding not to serve the purposes of NIH, but to serve the purposes of DOD.”

The agreement would establish a pathway to move funding out of the NIH’s National Institute of Allergy and Infectious Diseases (NIAID), the country’s premier infectious-disease research institute, to support defence initiatives and will last 10 years, according to the three sources. The full agreement has not yet been finalized, the sources say.

[https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568\(26\)00095-4/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(26)00095-4/fulltext?dgcid=raven_jbs_aip_email)

Academia Global and Public Health: Community perspectives on early childhood mental health in Lesotho: symptoms, adversity, and resources

Early childhood is a formative time that can establish the foundation for a successful life.

Unaddressed adversities, however, can lead to mental health challenges. In Lesotho, little is known about factors affecting mental health in early childhood, preventing the development or effective use of resources to support children in need.

This study used a constructivist qualitative methodology to explore, through a series of 25 focus groups and four interviews, the perspectives of health professionals, mental health professionals, and community members (n = 218) related to signs and symptoms of mental health challenges, adversities, and resources to support mental health in early childhood.

Findings suggest an awareness of common signs and symptoms that a child may be struggling, but also a lack of knowledge of mental health and child development that may result in stigma. Adversities and resources related to the mental health of young children are identified.

Recommendations based on these findings are paired with evidence-based models of early childhood development to suggest a framework for improving early childhood mental health care and development in Lesotho. This study suggests a need for future research and greater support systems to help young children who are struggling and their families.

<https://www.academia.edu/3071-0324/2/2/10.20935/AcadPHealth8263>

The lancet: Public health in a fracturing world: the erosion of the international rules-based order

One of the greatest threats to public health today is not any single disease, environmental hazard, or conflict, but the erosion of the international rules-based order that enables countries to cooperate in addressing shared risks. Over the past decade, public health has faced increasingly interconnected challenges, including climate change, conflict, pollution, emerging infectious diseases, food and water insecurity, mass displacement, and misinformation. These threats are amplified by fragile governance, growing inequality, and declining trust in institutions. Public health depends fundamentally on international cooperation. Surveillance systems, outbreak reporting, vaccine supply chains, environmental regulation, and climate adaptation all require shared rules, transparency, and trust between states. As these mechanisms weaken, risks become harder to manage and their effects more unequal. Public health should adapt by strengthening collaborative infrastructure, treating misinformation as a major health threat, investing in shared preparedness, and engaging more actively with trade, finance, climate, and security policies. Rebuilding effective international cooperation is essential to protecting health in an increasingly fragmented world.

Introduction

The tenth anniversary of The Lancet Public Health comes at a moment of profound uncertainty for public health worldwide. The past decade has been defined not by a single defining crisis but by a convergence of forces that have reshaped the conditions under which public health is practised. There have been increases in the scale and severity of extreme weather events, conflicts, environmental damage, mass displacement, and outbreaks of new and old infectious diseases. Meanwhile, ability to respond is threatened by attacks on institutions and expertise, affecting universities, government agencies, and international bodies, thereby eroding trust in these organisations.¹ While these challenges have been recognised, less fully acknowledged is the extent to which they are being shaped and amplified by a deeper transformation in the global political environment, the erosion of the rules-based international order.

These dynamics were already visible when The Lancet Public Health was launched.² The UK's decision to leave the EU rapidly gave rise to workforce shortages and scientific marginalisation;³ the election of US President Donald Trump signalled a retreat from multilateral climate and health cooperation;⁴ and the Zika outbreak exposed how fragile preparedness remained even for foreseeable threats.⁵

This erosion of rules-based international order has become one of the most substantial threats to public health in the 21st century. It is not simply the context within which other risks unfold, but a factor that magnifies the scale, persistence, and inequitable distribution of these risks. In a world where collective action is weakening, public health risks exceed, more than ever, the capacity of individual states to manage them alone. Understanding how this erosion affects public health, and how public health policy should adapt, is now an urgent task.

[https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(26\)00164-7/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(26)00164-7/fulltext?dgcid=raven_jbs_aip_email)

Frontiers in Public Health: Availability and Accessibility of Primary Care for the Remote, Rural, and Poor Population of Indonesia

Adopting Universal Health Coverage for implementation of a national health insurance system [Jaminan Kesehatan Nasional (JKN)/Badan Penyelenggara Jaminan Sosial or the Indonesian National Social Health Insurance Scheme (BPJS)] targets the 255 million population of Indonesia. The availability, accessibility, and acceptance of healthcare services are the most important challenges during implementation. Referral behavior and the utilization of primary care structures for underserved (rural/remote regions) populations are key guiding elements. In this study, we provided the first assessment of BPJS implementation and its resulting implications for healthcare delivery based on the entire insurance dataset for the initial period of implementation, specifically focusing on poor and remote populations. Remote regions cover 27.8% of districts/municipalities. The distribution of the poor population and PBI members were highly correlated ($r^2 > 0.8$; $p < 0.001$). Three clusters of provinces [remote high-poor ($N = 13$), remote low-poor ($N = 15$), non-remote ($N = 5$)] were identified. A discrimination analysis enabled the $>82\%$ correct cluster classification of infrastructure and human resources of health (HRH)-related factors. Standardized HRH (nurses and general practitioners [GP]) availability showed significant differences between clusters ($p < 0.01$), whereas the availability of hospital beds was weakly correlated. The usage of PHC was ~ 2 -fold of AHC, while non-PBI members utilized AHC 4- to 5-fold more frequently than PBI members. Referral indices ($r^2 = 0.94$; $p < 0.001$) for PBI, non-PBI, and AHC utilization rates ($r^2 = 0.53$; $p < 0.001$) were highly correlated. Human resources of health availability were intensively related to the extent of the remote population but not the numbers of the poor population. The access points of PHC were mainly used by the poor population and in remote regions, whereas other population groups (non-PBI and non-Remote) preferred direct access to AHC. Guiding referral and the utilization of primary care will be key success factors for the effective and efficient usage of available healthcare infrastructures and the achievement of universal health coverage in Indonesia. The short-term development of JKN was recommended, with a focus on guiding referral behavior, especially in remote regions and for non-PBI members.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8491579/>

Nature: Chinese companies doubled down on science after US tech restrictions

Affected Chinese companies adjusted their sources of knowledge to stay competitive.

Chinese firms that were restricted from accessing specific technologies created in the United States increased their use of science publications to boost innovation, according to an analysis of patent citations and scientific publications¹ in Science today.

Researchers examined how Chinese firms adjusted their ways of accessing knowledge after the US government put them on an Entity List. The list prevents those on it from licensing certain materials and engaging with joint research and development projects. The US government says that the Entity List is designed to safeguard national security: It began putting large Chinese firms on the list in 2018 when the China–US geopolitical relationship became tense.

After their inclusion on the list, Chinese firms produced more patents that cited scientific publications than did companies similar to them that had not been sanctioned. They also published more scientific articles than did unsanctioned companies, the article says.

The finding is notable because it shows the “unintended consequences” of US export controls, says Cong Cao, a researcher of innovation policy at the University of Nottingham Ningbo China.

“Whether or not one supports technology controls, it is important to recognize that they can come with costs,” adds Dinsha Mistree, a political economist at Stanford University in California.

Although Chinese firms boosted their engagement with science after restrictions were introduced, Kenneth Huang, a researcher of innovation and technology management at the National University of Singapore, says the authors cannot be sure that a Chinese firm being placed on the Entity List actually caused this shift or whether other factors were at play. Other studies have assessed the impact of US sanctions on Chinese innovation. But the latest analysis “uses some of the best data, as well as rigorous methods for such an analysis”, says Mistree.

To show the effect of US sanctions on Chinese innovation, the authors of the latest analysis used data sets spanning 2010–22 from several sources, including the China National Intellectual Property Administration (CNIPA) — which is China’s patent and trademark office — the article-indexing platform Web of Science and the China Stock Market and Accounting Research Database.

https://www.nature.com/articles/d41586-026-02946-y?utm_source=Live+Audience&utm_campaign=243f0c5b23-nature-briefing-daily-20260917_COPY_01&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Results for Development: Translating an ambitious vision into realistic health system progress: Insights from a global convening

Health systems reform is often characterized by sweeping transformation agendas that entail large financing commitments. Political rhetoric is often unrealistic. Operationalizing these visions is highly complex. And raising enough resources to meet ambitious expectations can be difficult. But even more challenging are fragmented governance structures, weak implementation capacity, existing limitations to workforce and health infrastructure, and political disruptions. How can a health system planner — who wants to support realistic progress towards universal health coverage — navigate this landscape?

At a recent global convening on [realistic health system design and planning](#), policymakers, researchers, and implementers from countries including Argentina, Bangladesh, Estonia, Ghana, and Nigeria reflected on what it takes to successfully implement reforms under constraints. Their experiences revealed an important lesson. Successful reform is rarely about waiting for perfect conditions or large influxes of funding. Instead, it is about deliberately redesigning incentives, institutions, and implementation strategies to make steady progress despite constraints — strategically prioritizing existing resources while incrementally building toward a long-term vision.

One success factor is starting small, with a targeted, prioritized reform. Rather than attempting sweeping primary health care (PHC) transformation all at once, Nigeria demonstrated the value of prioritizing high-impact interventions that addressed the most critical system bottlenecks. Nigeria’s Basic Healthcare Provision Fund (BHCPF) focused on two things: improving governance and coordination within the health system, and improving the flow of funds to PHC facilities. To do this, Nigeria introduced PHC agencies at federal and state levels with clear coordination mechanisms and set aside 1% of government revenues for PHC. They also allowed funds to flow directly to PHC facilities through the new agencies and the National Health Insurance Authority. Over time, the BHCPF has expanded to include more facilities, and funding has been used by state health insurance agencies to provide access to a defined benefit package to low-income citizens.

<https://r4d.org/blog/translating-an-ambitious-vision-into-realistic-health-system-progress/>

The Lancet: Climate change and medication safety in older adults: an overlooked priority for healthy ageing

Climate change and population ageing are converging global trends that pose profound challenges for health systems. Older adults are disproportionately vulnerable to climate-related hazards because of physiological ageing, multimorbidity, frailty, cognitive impairment, functional limitations, and polypharmacy. Yet, although the direct health effects of climate change are increasingly recognised, its implications for medication safety remain largely overlooked. The ability of older adults to access, store, manage, and safely use medicines can be compromised by extreme heat, disrupted infrastructure, displacement, power failure, interrupted health care, and pharmaceutical supply-chain disruption.^{1–3} We argue that medication safety should be recognised as a core component of climate adaptation and healthy ageing.^{2,3} Climate change is emerging as a threat multiplier that amplifies medication-related vulnerabilities among older adults. Existing climate-health frameworks largely focus on heat-related mortality, infectious diseases, food insecurity, and disaster preparedness, with medication access, quality, adherence, therapeutic effectiveness, adverse drug events, and treatment outcomes being largely overlooked.^{4,5}

Heat-related medication harm represents a clear example of this emerging problem. Ageing is associated with impaired perspiration, reduced thirst perception, diminished cardiovascular responsiveness, and decreased thermoregulatory capacity, thereby increasing susceptibility to heat exposure and medication-related harm. Extreme heat can increase the risk of adverse drug events through dehydration, electrolyte imbalance, impaired thermoregulation, and pharmacokinetic alterations. Several commonly prescribed medicines, such as diuretics, anticholinergics, antidepressants, antipsychotics, and renin–angiotensin system inhibitors, can exacerbate heat-related vulnerability.^{6,7} A large study of older Medicare beneficiaries found that heatwaves increased the incidence of heat-related hospitalisations from 21% (95% CI 7–38) to 33% (95% CI 14–55), whereas the use of several commonly prescribed medication classes was independently associated with increased risk of hospitalisation during the summer months.⁷

As per a 2021 [report](#) by the International Centre for Integrated Mountain Development, climate-related disasters also interrupt medication access; seasonal floods, cyclones, wildfires, glacial lake outburst floods, landslides, storms, and extreme weather events frequently disrupt transportation corridors, interrupt pharmaceutical supply chains, and isolate vulnerable communities from essential health-care services. The uninterrupted treatment of chronic diseases and other long-term conditions is essential for many older adults. Even short interruptions in medication access might precipitate serious complications. Medication shortages following Hurricane Maria in Puerto Rico showed how pharmaceutical manufacturing disruptions can cascade through health systems.⁸ Analyses from 2023 and 2025 have highlighted the vulnerability of medicine supply chains to climate-related disruptions and called for greater attention to pharmaceutical resilience within climate adaptation planning.^{4,9} These concerns are particularly relevant in low-income and middle-income countries (LMICs), where climate vulnerability often coincides with inadequate health-system resources. Direct evidence on resulting medication-related harm remains scarce, highlighting an important research and surveillance gap.³

Compromise of medication quality and storage due to climate change represents another important but overlooked threat. Many medicines should be stored within specific temperature and humidity ranges. Rising temperatures, humidity, and power disruptions can compromise the pharmaceutical stability of medicines during their storage and transportation. Vaccines, insulin, biologics, blood products, and other temperature-sensitive therapeutics require reliable cold-chain systems, which might become increasingly vulnerable to extreme weather events.⁴ Climate-related degradation of medicines might reduce their therapeutic effectiveness and increase the risk of treatment failure. Moreover, evidence from 2025 studies has emphasised the need for climate-responsive pharmaceutical systems and greater

investment in heat-stable medicines, especially in LMICs where electricity supplies and storage infrastructure might be unreliable.[4,10](#)
[https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568\(26\)00095-4/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(26)00095-4/fulltext?dgcid=raven_jbs_aip_email)

Frontiers in Public Health: Editorial: Effective Strategies to Develop Rural Health Workforce in Low and Middle-Income Countries (LMICs)

Around the world, rural communities are facing similar challenges related to accessing the healthcare that they need. These challenges are most noticeable in low- and middle-income countries (LMICs) where the highest proportion of people lives in rural and remote under-resourced communities. The best way to access affordable care in these areas is to focus on building enough skilled health workers in these communities. This relies on LMICs rural communities adopting “grow your own” approaches, involving training local health workers to the scope of skills needed in the community and fostering their connection to the community through support, mentoring and good working conditions ([O'Sullivan et al.](#)). The steps involved in “grow your own” strategies are called “rural pathways” and the World Health Organization recommends that rural pathways are critical as part of a suite of strategies to improve health workforce retention ([1, 2](#)). For rural LMICs, investing in rural-based training for health workers, adds to the progress toward health, social, and economic progress in line with the Sustainable Development Goals ([3](#)). This is because this investment can dramatically lift local educational opportunities and increase access to jobs in locations where they are most needed ([4](#)).

However, despite the rich evidence from high income countries, there is a shortage of published evidence about rural pathways strategies in LMICs settings ([1, 2](#)). This special call was an attempt to foster exemplars of these, as a means of promoting cross-learning and reflection about the unique LMICs rural context. By sharing information about rural pathways, it is possible for effective approaches in one community to be adopted and scaled up elsewhere, for improving rural workforce capacity.

With this background in mind, this special call brings together a collection of examples of education and training strategies, tools, and resources, from LMICs of different world regions. We are pleased to have attracted a diverse representation of rural pathways strategies fit to a wide range of LMICs rural contexts as we know that every region has unique experiences to share.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8212967/>

Frontiers in Public Health: Keys to Expanding the Rural Healthcare Workforce in Kyrgyzstan

This study assessed Kyrgyzstan's progress with developing its rural primary care workforce and prioritized next steps to build on its current momentum. Kyrgyzstan has improved rural health care since 1997 through the implementation of family medicine, retraining of rural doctors and nurses, and other efforts. Attrition, emigration, urbanization, and population growth are threatening these hard-won advances. In response, Kyrgyzstan is now educating family medicine residents at rural sites and improving salaries. This study explores other steps to strengthen its rural health care, especially its rural generalists.

This was an observational study using a two-phase survey process. To access the current status of Kyrgyzstan's rural health care system, we surveyed key stakeholders within that system using a draft version of the new World Health Organization Rural Pathways Checklist. To prioritize next steps, we asked rural FM residents to rank the relative importance of 31 possible future actions to support Kyrgyzstan's rural primary care workers.

Doctors and nurses involved in teaching rural health workers identified that Kyrgyzstan has made good progress with rural professional support and upskilling of existing health workers through education. They saw the least progress with selection of health workers and monitoring. The rural family medicine residents' top ten suggestions for rural recruitment and retention all involved improving working conditions (providing housing, internet, basic medical equipment, protected time off, better salaries, and more respect) and improving clinic efficiency (switching clinic scheduling from walk-in based to appointment based, optimizing the roles of clinical team members, and decreasing low-value clinic visits).

The WHO Rural Pathways Checklist helped to evaluate Kyrgyzstan's current efforts to promote rural primary care. The priorities listed above from the next generation of potential rural family doctors could help guide future steps to promote rural health in Kyrgyzstan and the Former Soviet Union.

<https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2020.00447/full>

British Medical Association: Doctor Magazine: Behind the mask

Most of us have moments of self-doubt – but what happens when those feelings overwhelm you? Doctors tell Seren Boyd about their experiences with impostor syndrome – and how they have tried to overcome it

As with Inspector Clouseau's guard Cato in *The Pink Panther*, it sneaks up on you when you least expect it.

'You're a fraud and you're about to be found out. Who are you to play doctor?'

If you've ever experienced impostor syndrome, the self-doubt that ambushes at the worst moments, you're not alone.

Everyone from Sir Jonathan Van-Tam to Albert Einstein, and [62 per cent of health workers globally](#), have felt it. Up to 92 per cent of [orthopaedic surgeons in the UK](#) say they sometimes feel like a fake.

'I've been told that anyone who doesn't feel like an impostor is likely to be a sociopath,' says consultant spinal surgeon Iona Collins, who is also BMA Cymru Wales' council chair.

Medicine's high stakes – and high IQs strongly associated with perfectionism – make it the perfect breeding ground for impostor syndrome.

Yet, while it's normal to feel like a fraud, impostorism can become crushing and [tip people into burnout](#), or worse. 'Fake it till you make it' can only make things worse.

So, what is fuelling impostor syndrome and what can be done to contain it?

I would be lying if I said I didn't feel it every day, two or three times every day,' says Aditya Roy, an academic foundation year two doctor at Bangor University.

Self-doubt started early, when he was applying to study medicine. 'You're standing at the gates of what is a very intellectual profession and you haven't even got A-levels under your belt,' he says.

Impostorism has tracked Dr Roy throughout his training, launching its worst assaults in clinical settings. 'At medical school you see a problem and you fix it,' he says. 'But in real life, it's never straightforward: there's always extra steps that someone five years my senior wouldn't have a problem with. So, you start to think: what would someone else do in this situation and why can't I do it now?'

He mentions the Dunning-Kruger effect – the tendency of people with low ability in a specific area to overestimate their ability and that of high performers to focus on their knowledge gaps. Medical exams' propensity for including 'very niche' topics doesn't help, says Dr Roy.

'You obviously forget those topics when you start work but then you feel if I did the exam now, I wouldn't pass it. Ninety per cent of the time you're going to be OK because you know enough but there is always that uncertainty and sometimes it takes over. Those are bad days.'

The bad days get worse when more senior colleagues find ways to remind resident doctors of their relative ignorance, for reasons Dr Roy chooses to ascribe to stress and systemic pressures. 'There are individuals that will adopt the mentality that "I suffered so you will suffer as well",' he says.

https://thedoctor.bma.org.uk/articles/doctors-wellbeing/behind-the-mask/?utm_campaign=618597_27082026%20The%20Doctor%20Issue%20Promotion%20All%20UK%20Membership%20CMP-07120-L1P6Y&utm_medium=email&utm_source=The%20British%20Medical%20Association%20%28Comms%20Engagment%29&dm_i=7IPW,D9B9,19AQAX,1UNGD,1,0,0,0

The Lancet: A call to humanity in the wake of Nepal's massive Himalayan flash flood

On Aug 26, 2026, glacial lake outburst floods affecting Rasuwa, Nuwakot, and Dhading districts in Nepal swept away entire communities, killing 1204 people (as established by recovery of deceased bodies and body parts), with around 4216 people reported missing (as of Sept 2, 2026).¹ Global media reported this catastrophic disaster as a Himalayan tsunami.² Nestled in the Himalayas, Nepal faces an ongoing climate threat and is further vulnerable due to settlements along riverbanks. There are thousands of glacial lakes storing meltwater, and their number is increasing as global temperatures rise, making them akin to ticking time bombs.³ The risk of outburst floods will intensify with phenomena such as El Niño; modern eastern Pacific El Niño–Southern Oscillation variability is 36·5% stronger than in the preindustrial period.⁴ We can only expect more occurrences of similar or worse events across alpine regions globally.

Nepal has been exemplary in forest conservation and biodiversity protection. Despite this stewardship and a much smaller carbon footprint than that of high-income countries,⁵ the country faces disproportionate climate risk. The mountainous geography creates vulnerability to glacial lake outburst flooding, a hazard intensified by global warming. We, as public health professionals, feel the consequences of the flash flood were enormous, and the country was not immediately prepared to respond. This tragedy reflects deeper injustice. Nepal, a country with 0·05% of the world's carbon emissions in 2024, bears the catastrophic consequences of a climate crisis largely driven by high-income countries.^{5,6}

Mitigating these consequences requires urgent and coordinated global action. Progress towards low-carbon development pathways is essential to curb future emissions while strengthening climate resilience. In vulnerable regions, early warning systems should be established alongside effective emergency response capacity. Environmentally sustainable development alternatives are urgently needed.⁷ This Himalayan flash flood demands more than aid and sympathy; it calls for long-term, durable solutions rather than short-term fixes. This catastrophe requires recognition of climate justice as a moral imperative and a reconfiguration of global responsibility. Nepal and other vulnerable nations need not only emergency support but also equitable climate finance, technology transfer, and a sustainable development model that does not sacrifice low-income countries for the prosperity of high-income countries. We call on the global community to act now through emissions reduction in alignment with climate justice; active surveillance and early warning systems in glacier-fed regions; rapid disaster response coordination through the formation of a global alliance on the climate crisis, engaging affected people and families; and increased financing for adaptation and mitigation through the establishment of an emergency global fund for climate crisis assistance.

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(26\)01810-6/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)01810-6/fulltext?dgcid=raven_jbs_aip_email)

Nature: The Moderna cancer vaccine offers hope — now we must speed up personalized therapies: A positive trial holds promise for treating people with cancer. More research is needed to get effective vaccines to the clinic.

The announcement on 19 August that people with melanoma who received a personalized vaccine lived longer without a cancer recurrence than those who didn't have the vaccine is a sensation for the field. The results from pharmaceutical companies Merck, in Rahway, New Jersey, and Moderna, which is headquartered in Cambridge, Massachusetts, also [made a big splash](#) among researchers and people with cancer more widely.

What makes the findings so exciting and important is that they came from a large, late-stage phase III trial — a double-blind, placebo-controlled test involving more than 1,100 participants. It comes after a successful phase II trial in 2024, with just 157 participants ([J. S. Weber et al. Lancet 403, 632–644; 2024](#)). This latest study gives greater confidence that the vaccine, called intismeran, works, and brings it a step closer to gaining regulatory approval. If intismeran is approved, it will become the first cancer vaccine available for people with melanoma and only the second therapeutic cancer vaccine, following the US Food and Drug Administration's approval in 2010 of sipuleucel-T for advanced prostate cancer.

And the implications are wider. Because all cancers involve mutations in a cell's DNA, personalized cancer vaccines, which target mutations that are specific to a tumour, could have broad applicability across cancers. Several phase II and phase III trials testing intismeran in people with melanoma, lung cancer, bladder cancer and kidney cancer are ongoing. And previous clinical trials testing other personalized vaccines have also had encouraging results. The promise that cancer vaccines could soon be in use will lead to renewed interest and investment, accelerating discovery and advancing the field. The concept is attractive, being analogous to vaccination against infectious diseases. And there are ample opportunities to enhance cancer-vaccine efficacy further.

Such vaccines work by delivering tumour antigens to a person's body. These antigens are often small pieces of protein on cancer cells. They act like flags, helping the immune system to recognize that something is wrong and to respond by eradicating the cells.

https://www.nature.com/articles/d41586-026-02680-5?utm_source=Live+Audience&utm_campaign=d2c8c448f7-nature-briefing-daily-20260901&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Strengthening participatory migration health research in a changing political environment

Across Europe, rising anti-migrant sentiment is reshaping migration governance and public discourse. Rather than recognised as a potential for development and a matter of human rights, migration is increasingly framed as a security issue.¹ This shift is reflected in restrictive migration policies, the criminalisation of migrants and organisations supporting them, and the growing use of health systems as instruments of migration control.^{1–4} These developments hinder migrants' access to healthcare, while declining support for civil society organisations (CSOs) and migration health research undermines participatory and cross-sector migration health research.³

To address these challenges, the Network for Research on Migration and Health (NeRMiH), a complementary initiative supporting existing migration health networks^{5,6} through dialogue and knowledge exchange, convened an international roundtable in May 2026, bringing together migrant communities, CSOs, and academia. The discussions identified three interconnected barriers and highlighted four priorities.

The first barrier is a fragmented research ecosystem. Researchers, CSOs, migrant communities, and policymakers often operate in separate systems with different priorities, timelines, and institutional logics, limiting collaboration and knowledge co-production.

Academic research produces evidence too slowly to inform rapidly changing policy contexts, by which time policy windows may already have closed. Although CSOs play a bridging role by connecting community knowledge with research, policy, and practice, this work remains under-resourced and under-recognised.

Second, institutional structures and research funding do not recognise lived experience as a legitimate form of knowledge. Migrants frequently remain sources of data or consultation rather than equal partners in shaping research agendas, implementation, governance, data interpretation, and evidence use. Initiatives such as the Migrant Health Community Research Network face funding and institutional barriers.⁷ Excluding migrant communities risks reproducing evidence gaps and leaving their realities structurally underrepresented, particularly for those experiencing intersecting structural vulnerabilities based on residence status, age, disability, race/ethnicity, socio-economic position, housing, and immigration detention.

Third, meaningful CSO participation remains inadequately supported by institutional structures and research funding. CSOs' contributions often involve invisible labour, including recruitment, translation, trust-building, contextual interpretation, advocacy, safeguarding, and emotional support, that is seldom recognised through funding, authorship, institutional credit, or decision-making power. Consequently, CSOs lack the protected time and resources needed to engage meaningfully in research collaboration.

Addressing these barriers requires changes in how participatory and cross-sector migration health research is organised, conducted, and supported. First, research should move beyond project-based collaboration towards long-term partnerships among researchers, migrant communities, CSOs, and policymakers, recognising CSOs' role in connecting community knowledge with research, policy, and practice. Funders should incentivise such collaborations, while researchers should acknowledge them in publications. These partnerships should co-produce timely, relevant evidence from agenda-setting to policy and practice, as demonstrated by the National Health Advisors programme of Doctors of the World UK, which embeds people with lived experience of migration as equal partners in health policy, advocacy, and practice.⁸

[https://www.thelancet.com/journals/lanep/article/PIIS2666-7762\(26\)00215-2/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/lanep/article/PIIS2666-7762(26)00215-2/fulltext?dgcid=raven_jbs_etoc_email)

European Medical Journal: Reading for pleasure boosts memory, empathy and mental health

READING for pleasure boosts memory, empathy and mental health, according to new comprehensive research.

With reading levels among adolescents and children at their lowest recorded levels and the number of people reading recreationally steadily declining, giving way to online activities like social media, scientists have found that regularly enjoying a book had repeatedly been shown to have many substantial and tangible cognitive benefits.

In this latest review of a body of evidence from years of study into the relationship between literacy and brain health, researchers at the University of Cambridge confirm that reading can improve health and wellbeing at any age – regardless of reading material.

Professor Barbara Sahakian and her team drew on subjective surveys and objective studies using longitudinal, neuroimaging, and behavioural methods, examining evidence for the protective factors of reading for pleasure on [mental health](#) and cognition.¹

They found a range of results, highlighting consistent findings that link reading engagement with improved brain and mental health, better cognitive performance, and reduced risk of cognitive decline.

Survey data, including self-submitted questionnaires, showed that reading was associated with reduced stress, greater empathy, reduced feelings of loneliness and enhanced wellbeing. Reading emerged as the most popular method for stress relief, with around two in five adults (38%) reporting that they turn to a good book as their favourite way to relax. Further research showed that reading just 20 minutes of fiction literature can reduce stress levels by 20% whilst boosting concentration and problem-solving skills.

Longitudinal cohort studies carried out over longer periods with more participants, showed that people who took part in cognitively stimulating activities, namely reading, had a lower risk of developing dementia and had, on average, slower cognitive decline – including those with lower educational attainment.

One study, for example, found that out of 500 adults aged 55 years and older, individuals who frequently engaged in activities including reading were significantly less likely to develop cognitive impairment over a five-year follow-up period.

Another found that reading material such as newspapers, magazines and books was associated with a 33% reduction in the risk of Alzheimer's disease.

<https://www.emjreviews.com/general-healthcare/news/reading-for-pleasure-boosts-mental-health-and-cognitive-function/>

The Lancet: The US opioid epidemic at a turning point

After more than a decade of rising mortality, the USA is experiencing an unexpected and encouraging decline in drug overdose deaths. According to provisional estimates from the US Centers for Disease Control and Prevention, approximately 70 000 people died from drug overdoses in 2025—nearly 14% fewer than in 2024, marking the third consecutive annual decline, from a high of almost 108 000 in 2022.^{1,2} The reduction in overdose deaths has been widespread, as nearly every state in the country reported fewer overdose deaths in 2025 compared with the previous year.¹ This trend represents progress towards reversing the deadliest drug epidemic in American history. It also presents an important scientific challenge: understanding why overdose deaths are falling and how those gains can be sustained.

The answer is unlikely to be simple. Emerging evidence suggests that recent declines in mortality could be driven in part by the declining potency of illicit fentanyl,³ which constitutes a larger share of the illicit opioid supply in the USA than in any other country.⁴ Between 2023 and 2024, fentanyl-related deaths fell by 36·5% while non-fentanyl-involved deaths declined by 5·3%.⁵ That evidence suggests that overdoses are becoming less lethal even if opioid use and overdose incidence have not declined to the same extent.^{1,5} Nevertheless, changes in the drug supply are unlikely to explain the magnitude of the decline on their own. Expanded access to medications for opioid use disorder (OUD), greater naloxone availability, and broader implementation of harm reduction services over the past decade have almost certainly contributed. These strategies have consistently been shown to reduce overdose mortality and are essential to sustaining recent progress.⁶ It should be a priority to disentangle the relative contributions of each of these factors in order to better understand what has worked, and how that can inform future policy.

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(26\)01610-7/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)01610-7/fulltext?dgcid=raven_jbs_aip_email)

Nature: UN finally admits global warming will shoot past 1.5 °C climate limit Earth will breach a long-standing target before the end of the decade, report says.

The goal of [limiting global warming to 1.5 °C](#) to avoid the most dangerous consequences of climate change is officially dead. According to a report¹ released today by the United

Nations Environment Programme (UNEP), the best the planet can hope for on its current emissions trajectory is warming of about 1.8 °C above pre-industrial levels this century. “Obviously, yes, we have climate procrastinated,” Inger Andersen, UNEP’s executive director, said during a briefing on 1 September. “And obviously, yes ... when we started UNFCCC [the United Nations Framework Convention on Climate Change], we knew what action had to be taken. And we have not taken it at the speed that we could have.”

The nearly 200 countries that signed the Paris climate accord in 2015 agreed to cut greenhouse-gas emissions fast enough to keep the rise in global average temperatures well below 2 °C relative to the pre-industrial average, with an ambitious goal of limiting the rise to 1.5 °C. Beyond that 1.5 °C threshold, the risks of triggering [dangerous tipping points in the climate system](#) grow more acute², and rise with every tenth of a degree of warming, according to the UN’s Intergovernmental Panel on Climate Change (IPCC).

https://www.nature.com/articles/d41586-026-02753-5?utm_source=Live+Audience&utm_campaign=9803e5de03-nature-briefing-daily-20260902&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Addressing the needs of older people in Venezuela: beyond the earthquakes and humanitarian health crisis

Venezuela’s protracted humanitarian crisis has produced a decades-long mass exodus of more than 8 million people, primarily younger generations, leaving older people (ie, those aged 60 years and older) behind.¹ Deteriorating living conditions have posed a progressively worsening threat to life and health for older adults remaining in Venezuela. Overlaid upon this precarious context, on June 24, 2026, twin earthquakes—a magnitude 7.2 foreshock followed seconds later by a magnitude 7.5 mainshock—devastated Venezuela’s most populous north-central corridor, with severe damage extending to La Guaira and the nation’s capital, Caracas.² By late July 2026, the death toll exceeded 5500, with over 16 000 people injured and thousands missing,³ while much of the rubble from 190 collapsed structures remained unexcavated.⁴ Among earthquake survivors, an estimated 250 000 older adults required humanitarian support.⁵

The disproportionate impact of earthquakes on older adults has exemplified compounded vulnerability. Although Venezuela has not had gains in life expectancy throughout the 2000s, the number of older people—4.3 million (56% female)—represents a rising proportion of the population. This accelerated demographic ageing primarily reflects the loss of younger people to emigration. With 51 older people for every 100 children younger than 15 years, population ageing has modified the structure of demographic dependency.⁶ Care for older adults in Latin America traditionally relies on family, but the departure of younger adults has sharply depleted the caregiver generation, leaving grandparents behind (abuelos dejados atrás). Currently, 35% of Venezuelan households have either one or two older people, with many living alone and at an elevated risk for social isolation, neglect, abandonment, and functional decline.⁶

Predating the earthquakes, hallmarks of Venezuela’s ongoing humanitarian emergency included extended economic hardship, hyperinflation, and constriction of public services. For older people, these conditions translated into smaller pensions, reliance on unpredictable remittances sent from family members abroad, and widespread poverty. Food insecurity has led to pervasive malnutrition, especially among older adults, with many subsisting on two meals a day.

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**Science: Can cells genetically engineered in the body fight autoimmune diseases?
New approach that induces patients to make their own CAR-T cells could be faster and cheaper than existing methods**

Researchers have high hopes that genetically engineered immune cells known as chimeric antigen receptor (CAR)-T cells can treat and even cure autoimmune diseases such as lupus and multiple sclerosis by slaying the errant immune cells driving the conditions. But the current methods for producing CAR-T cells, in which the cells are generated in a lab and then infused into patients, are slow and expensive, and the treatment itself can be dangerous. A new clinical trial may point to a better way.

Reporting today in The New England Journal of Medicine, researchers say they have [induced patients to generate their own CAR-T cells](#). The treatment, which involves dosing people with a virus that genetically alters some of their T cells, didn't cause severe side effects in the 16 patients tested and showed early signs that it restored their immune systems to normal. "This is a step forward" for this approach, says rheumatologist Georg Schett of University Hospital Erlangen, who wasn't connected to the research. "It's a clear go signal for a further study."

The standard procedure for making CAR-T cells starts when patients provide copious amounts of their own T cells. The cells are shipped to a specialized facility, where they are infected with a harmless virus whose genome carries DNA coding for a cell surface protein known as a CAR. The virus inserts this genetic material into the genome of the T cells, causing them to produce the CAR.

When the modified T cells are returned to the patient's bloodstream, the CAR directs them to attack body cells that carry specific proteins on their surface. Five of the approved CAR-T varieties, for example, target CD19, a protein on other immune cells known as B cells.

The approach has already notched successes in treating blood cancers. For instance, the cells have received approval for treating B cell acute lymphoblastic leukemia and large B cell lymphoma, two cancers in which B cell numbers explode. Certain B cells also drive autoimmune conditions by producing antibodies that attack the body's own tissues. In hopes of replicating the experience with cancer, researchers have launched several dozen clinical trials to test the cells for [autoimmune diseases](#) such as myasthenia gravis and lupus.

https://www.science.org/content/article/can-cells-genetically-engineered-body-fight-autoimmune-diseases?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=etcetera&et rid=1169729274&et cid=6059907

The Lancet: Attributing climate-related health burdens in Southeast Asia: a scoping review

Attributing health outcomes to climate-related exposures is essential for informing adaptive policy, yet Southeast Asia, one of the world's most climate-vulnerable regions, remains critically underrepresented in attribution research. To address this gap, we conducted a scoping review of studies linking climate exposures to health burdens in the region. Although growing evidence demonstrates substantial health impacts from air pollution, heat, and extreme weather, the regional research landscape remains critically imbalanced, marked by neglect of other major hazards—including floods, droughts, extreme rainfall, storms and sea-level rise—and substantial methodological fragmentation. From 5294 records screened, 77 studies met our inclusion criteria. The evidence is dominated by air pollution research, the focus of 70% of studies and linked to up to 31% of all-cause mortality and an estimated

296,000 annual deaths from wildfire smoke during El Niño events. Heat, the second most studied exposure, was associated with up to 8.61% of mortality in Bangkok. In contrast, extreme events such as heatwaves, floods and storms were least frequently investigated. These findings reveal a critical misalignment between regional climate risks and current research focus. Standardized attribution frameworks are urgently needed to support integrated climate-health modeling and guide equitable, evidence-based adaptation across Southeast Asia.

The health impacts of climate change are increasingly evident globally. Rising temperatures are contributing to a higher frequency and intensity of extreme weather events, deteriorating air quality, and a cascade of associated health risks.^{1–9} Although epidemiological methods have long been used to quantify disease burdens from environmental exposures, the systematic integration of these approaches within the formal framework of climate attribution science remains methodologically and regionally uneven.¹⁰

Attribution studies, which estimate the likelihood of climate-related events under anthropogenic versus natural conditions, have become crucial tools for understanding the role of human-induced climate change.^{11,12} When linked with epidemiological data, these methods allow for the estimation of the burden of disease directly attributable to climate change. Such health attribution studies are essential for informing equitable adaptation strategies and have become central to global discussions around climate-related loss and damages, particularly since the 27th United Nations Climate Change Conference (COP27).¹³ However, the current climate–health attribution literature is characterized by a pronounced geographical imbalance. Low- and middle-income countries (LMICs) remain substantially underrepresented, despite bearing a disproportionate burden of climate-sensitive health risks.¹⁴ Analysis of publications indexed in Web of Science indicates that Southeast Asia accounts for only approximately 4.5% of global climate–health research output based on author affiliations, despite comprising around 8.5% of the global population (approximately 680 million people). This disparity underscores a marked underrepresentation of the region in the evidence base. The imbalance is particularly concerning given that populations in Southeast Asia are exposed to multiple, compounding climate-related hazards, including rising temperatures, high humidity, worsening air pollution, and an increasing frequency of extreme weather events.¹⁵ These environmental risks intersect with a triple disease burden—comprising communicable diseases, non-communicable conditions, and climate change challenges—which exacerbates regional health vulnerabilities.¹⁶ Despite these factors, there is a profound lack of systematic quantification of the health outcomes attributable to climate-related exposures in Southeast Asia.

This underrepresentation is also evident in the global evidence base used to derive exposure–response functions for climate–health burden estimation. Recent systematic reviews of long-term particulate matter exposure and mortality in the Asia–Pacific region identified cohort evidence from Australia, mainland China, Hong Kong, Taiwan, South Korea, and Japan, but no cohort studies from Southeast Asian countries.^{17,18} Similarly, global reviews of long-term particulate matter exposure and mortality remain dominated by studies from North America and Europe, with the comparatively small Asian evidence base largely originating from East Asia.¹⁹ This imbalance has direct methodological implications for attribution research, because widely used pooled exposure–response functions, including the Global Exposure Mortality Model, are derived from cohort data with limited Asian and effectively no Southeast Asian population representation.¹⁸ Importantly, this evidence gap is not uniform across all climate-sensitive health outcomes: meta-analyses of temperature-sensitive infectious diseases, such as dengue, include a larger contribution from Southeast Asian and other low- and middle-income settings.²⁰ The underrepresentation is therefore exposure- and

outcome-specific, and is most pronounced in the temperature- and air-pollution-mortality literature that currently forms a central basis for climate–health attribution estimates.

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Nature: AI models are being used to track zoonotic diseases. Will they prevent the next pandemic?: Spread of diseases between humans and animals is an issue around the world. But AI models can be used to monitor their progress.

Bwindi Impenetrable National Park in southwestern Uganda is famous for the endangered mountain gorillas that inhabit its lush, misty highlands. It's also home to around 120 other species of mammal, 350 types of bird and hundreds of plant varieties — and, on its borders, people and livestock. That's a recipe for what epidemiologists call spillover, the transfer of pathogens between species.

In 2003, the non-profit organization Conservation Through Public Health (CTPH) in Entebbe, Uganda, began work to protect the gorillas (*Gorilla beringei beringei*) from diseases, such as scabies, that were traced to their human neighbours. The team uses a holistic One Health approach that balances the needs of people with the health of the animals and the ecosystems that surround them. Typically, the process has been reactive: responding to outbreaks as they emerge, says Ssali Ronald Ogwal, a public-health specialist at the CTPH. But the organization is now shifting towards a more proactive, disease-prevention approach — thanks, in part, to artificial intelligence.

As part of a three-year collaboration that ended in March 2026 with public-health initiative NESTLER, a joint project between the European Union and African nations, Ogwal collected samples from cattle and poultry around Bwindi. He sent the specimens to a laboratory in Entebbe to be tested for diseases such as brucellosis and Rift Valley fever, both of which can infect people. After sharing the results with the relevant local communities, the team combined the data with the CTPH's routine gorilla-monitoring records and passed the information on to colleagues at NESTLER. There, the data are being used to train predictive AI models, which are designed to be early-warning systems for disease outbreaks that can affect people, livestock and gorillas.

Many infectious diseases that affect humans are zoonotic — that is, they originate in other animals. This includes such scourges as SARS-CoV-2, the virus that caused the COVID-19 pandemic, and [ebolaviruses](#), which are thought to have originated in fruit bats of the Pteropodidae family. Humans can catch ebolaviruses directly from bats' bodily fluids, or by way of animals that have come into contact with infected bats.

Agriculture, climate shifts and land-use changes such as deforestation have increased contact between people and wildlife, making spillover events more likely to occur. At the same time, globalization and geopolitics enable diseases to be spread more quickly between humans. As the COVID-19 pandemic so powerfully demonstrated, spillover events can have profound impacts, affecting physical and mental health, livelihoods and education around the world. For researchers such as Ogwal, AI — in combination with practical measures such as regulating wildlife trading — offers a powerful technology for managing zoonotic diseases and reducing the risk of spillover, possibly even preventing outbreaks in the first place. At least, that's the theory: AI tools are still limited and are not yet widely used in infectious-disease epidemiology. But the continuing boom in machine-learning techniques is beginning to change that.

https://www.nature.com/articles/d41586-026-02684-1?utm_source=Live+Audience&utm_campaign=d2c8c448f7-nature-briefing-daily-20260901&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: The impact of the women's medical education ban in Afghanistan on service coverage and maternal and neonatal mortality: a modelling study

Globally, Afghanistan has one of the highest maternal and neonatal mortality rates, with an estimated maternal mortality ratio (MMR) of 620 deaths per 100 000 live births in 2020 and a neonatal mortality rate (NMR) of 24 per 1000 live births in 2023.¹ Although these figures reflect improvements from previous decades, they remain well above Eastern Mediterranean region averages, underscoring barriers in access to maternal, newborn, and child health services.¹

Afghanistan has made remarkable progress in addressing its high maternal and neonatal mortality rates between 2001 and 2021. Recent restrictions banning midwifery and nursing education for women risk reversing these gains. Using scenario-based modelling, this study examined the potential long-term impact of the ban on service coverage and mortality.

In this modelling study, we developed four scenarios reflecting slow versus fast attrition among women nurses and midwives and the possibility of male substitution and simulated projected changes in care seeking for six services accessed by women and children.

Projections were from 2022 to 2035. Baseline data were collected from the 2023 Human Resources for Health Situational Assessment. We used a mathematical model that estimated care seeking as a function of health worker density and the proportion of women providers, accounting for varying levels of gender sensitivity to male substitution for each service as assessed by provincial-level Afghan health workers through a subjective expert elicitation exercise. Mortality outcomes were estimated using the Lives Saved Tool.

Our model projected decline in women's workforce entry, resulting in reduced service utilisation. We projected relative reductions in women's care seeking for maternal and reproductive health to 50–55% of current levels under the best-case scenarios to as low as 33–35% of current levels under the worst-case scenarios. These reductions translate into significant increases in the maternal mortality ratio, ranging from 29% under the best scenario to 41% under the worst scenario. Child health services would also suffer, but with greater substitutability of male providers to a lesser degree, with projected declines in care seeking to 76–80% under the best-case scenario and to 56–59% under the worst-case scenario. The resulting increase in child mortality rates could range between 10% and 16% and in neonatal mortality rates between 12% and 17%.

These findings represent scenario-based projections rather than forecasts and are highly dependent on assumptions regarding workforce attrition and substitution. Nonetheless, they show that the ban on women's medical education in Afghanistan will severely restrict women not only from providing health care but from accessing it as well. The policy threatens to reverse hard-won gains in maternal and child survival, with women's health and life chances disproportionately affected. Sustained advocacy and interventions are therefore urgently needed.

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C&EN: Toxins from freshwater algae blooms can go airborne

Each August, Lake Erie's fishermen develop a cough. Residents who live along the body of water, one of the Great Lakes situated between the US and Canada, feel their asthma kick up. Some have such trouble breathing that they end up in the hospital.

The suspected culprit: the harmful algal blooms that turn the lake into a noxious green soup every summer. A combination of nutrient-rich runoff (such as nitrogen and pollution), warm temperatures, and lots of sunlight supercharges the lake's algal growth.

Toxic particles from these blooms, scientists are discovering, [can also go airborne](#)—and likely into people's lungs (Environ. Sci. Technol. 2018, DOI: acs.est.7b03609).

“What happens in the water doesn’t stay in the water,” says [Greg Dick](#), a microbial biologist at the University of Michigan working to understand the public health threat posed by these transported toxins.

It’s a pervasive problem. About half of people worldwide [live close to a freshwater system](#) (PLOS One 2011, DOI: 10.1371/journal.pone.0020578), and blooms have occurred in every state and on every continent except Antarctica. In addition, [warming temperatures caused by climate change](#) are increasing the risk of both marine and freshwater blooms (Env. Sci. Technol. 2017, DOI: 10.1021/acs.est.7b01498).

Freshwater bloom research has largely centered on the common cyanobacteria *Microcystis* and their toxins, microcystins. In the 1990s, a bloom contaminated the water at a dialysis clinic in Brazil, and dozens of patients [died from microcystin poisoning](#) (Br. Med. J. 1996, DOI: 10.1136/bmj.312.7040.1183b). People who ingest the contaminated water can experience liver damage or neurological problems.

<https://cen.acs.org/biological-chemistry/toxicology/toxins-freshwater-algae-blooms-airborne/104/web/2026/08?et rid=1169729274&et cid=6055480>

The Lancet: Phone-based screening versus home-based screening after tuberculosis in India (TB Aftermath): a multicentre, open-label, randomised, controlled, non-inferiority trial

In 2024, an estimated 10·7 million people developed tuberculosis and 1·23 million people died from the disease.¹ To find and treat tuberculosis earlier, WHO recommends systematically screening household contacts of people with tuberculosis disease. This screening intervention is usually implemented shortly after the index patient is diagnosed.² However, contacts remain at increased risk for tuberculosis even after the index patient completes treatment.³ Additionally, the household member who survived tuberculosis is at risk for both endogenous reactivation (relapse) and exogenous reinfection.⁴ Both forms of recurrent tuberculosis are associated with poor outcomes.^{5,6} Household contacts have the highest risk of progressing to tuberculosis disease within the first 2 years of their initial exposure,^{3,7–9} and this risk is increased when re-exposed to a recurrent case.

Tuberculosis survivors and their household contacts are at increased risk for tuberculosis even after treatment completion; however, effective strategies for post-tuberculosis screening remain untested. We aimed to assess whether phone-based screening is non-inferior to home-based screening for tuberculosis after treatment completion in India.

In this multicentre, open-label, randomised, controlled, non-inferiority trial, we enrolled tuberculosis survivors (aged >18 years) within 60 days of completing treatment for any form of tuberculosis from six public clinics in Maharashtra, India. Household contacts were enumerated at baseline (all ages). Survivors were randomly assigned (1:1) to receive phone-based or home-based symptom screening at 6 months and 12 months. The trial was powered to identify a difference in the tuberculosis detection rate per 100 person-years among survivors and contacts together (primary outcome), comparing screening groups during the 12 months after survivor treatment completion. We conducted an intention-to-treat analysis with a rate difference non-inferiority margin of 1·70 per 100 person-years based on the upper bound of the 95% CI. We adjusted for household-level clustering of tuberculosis by fitting a multilevel Poisson model. We also conducted a subgroup analysis of detection rates among survivors and contacts separately. This study is registered with [ClinicalTrials.gov](#), NCT04333485 and is completed.

We enrolled 1076 tuberculosis survivors (537 in the phone-based screening group and 539 in the home-based screening group) and enumerated 3309 contacts (1638 in the phone-based screening group and 1671 in the home-based screening group) between Jan 21, 2021, and Sept 4, 2023. In the 12-month post-treatment period, tuberculosis was detected in 75 (7%)

tuberculosis survivors and 30 (1%) contacts: 41 events in the phone-based screening group (rate 1·19 [95% CI 0·82–1·71]) compared with 64 events in the home-based screening group (1·92 [1·37–2·45]). Non-inferiority was reached (rate difference 0·73 [95% CI 0·05–1·41]). Among tuberculosis survivors, the recurrence detection rate was 4·36 (95% CI 2·87–6·34) in the phone-based screening group compared with 8·00 (5·90–10·60) in the home-based screening group ($p=0·01$). Among contacts, the tuberculosis detection rate was 0·61 (95% CI 0·32–1·07) in the phone-based screening group compared with 0·70 (0·39–1·20) in the home-based screening group ($p=0·70$).

Risk of tuberculosis remains high for households with a tuberculosis survivor. For detecting tuberculosis among survivors and their household contacts together, phone-based screening was non-inferior to home-based screening. For survivors, the recurrence detection rate was higher in the home-based screening group. Countries with a high burden of recurrence should consider home-based screening among tuberculosis survivors.

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Nature: Canada recruits dozens of US scholars — including several science stars US funding uncertainty was a key factor for several of the researchers heading to Canada. Observers predict more will follow.

As Canada and the United States battle over tariffs, Canada has notched a victory for its scientific workforce. On 27 August, the government [announced that Canadian universities had recruited](#) 64 researchers from around the world as part of a campaign to attract foreign talent — and that 48 of them were moving from the United States.

The goal of the initiative is to “pursue ambitious research in fields critical to Canada’s prosperity, sovereignty, health and resilience”, the announcement said. The incoming scientists will receive a total of 500 million Canadian dollars (about US\$360 million) in funding for eight years as part of the Eddie Goldenberg Research Chairs of Canada and Canada Impact+ Emerging Leaders programme, the centrepiece of a broader effort to attract foreign talent launched in December.

Canada is just one of [a number of nations vying to attract foreign talent](#). Many spy an opportunity in particular to poach researchers from the United States as the administration of US President Donald Trump attempts to [cut funds for research grants](#) and [exert control over US universities](#). Earlier this year, [France recruited 41 researchers based in the United States](#) through its Choose France for Science programme, and Nobel-prize-winning chemist Omar Yaghi [retired from the University of California, Berkeley](#), and took a full-time position at Tsinghua University in Beijing, China.

US funding uncertainty was a key decision-making factor for several of the researchers who were successful in applying to Canada’s programme. Phillip Zamore, who is chair of the RNA Therapeutics Institute at the University of Massachusetts Chan Medical School in Worcester, is moving to McGill University in Montreal. One of his research grants from the US National Institutes of Health (NIH) was left without a funding decision for 18 months — an unusually long time. “I had to shrink my lab,” he says. Some people left, and he couldn’t replace them, he says, because “I didn’t know if I’d have the money”. Zamore will receive one of the highest levels of funding from the Canadian programme: US\$1.1 million annually.

https://www.nature.com/articles/d41586-026-02743-7?utm_source=Live+Audience&utm_campaign=daaefd5c41-nature-briefing-daily-20260903&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: The 2025 small island developing states report of the Lancet Countdown on health and climate change: building resilience in the face of rising heat

Small island developing states (SIDS) are particularly vulnerable to climate change, and people living in SIDS continue to bear the brunt of its manifestations, including sea-level rise, droughts, floods, and extreme weather events. The vulnerability of SIDS stems from their size, remoteness, geographical locations, and small economies. Collectively, SIDS produce less than 1% of the global greenhouse gas emissions, yet climate change presents an existential threat to them. In this report, we shed light on the disproportionate impact of climate change on SIDS and progress towards achieving the goals of the Paris Agreement by presenting the findings of specific indicators at the climate change–health nexus in SIDS. In this second iteration of the SIDS report, we present the findings of 28 indicators from five thematic areas: health hazards, exposures, and impacts; adaptation, planning, and resilience for health; mitigation actions and health co-benefits; economics and finance; and public and political engagement in health and climate change. The report is compiled by 30 authors from 25 institutions. General statements about SIDS were only made for indicators with data coverage of at least 70%, with the number of SIDS with available indicator data explicitly stated when this threshold was not met. The 2025 report includes a dedicated chapter on financing with a deep dive into international climate financing for SIDS.

Health hazards, exposures, and impacts

Extreme heat remains a major concern for SIDS. There is overwhelming evidence of the danger extreme heat poses to sustaining health, lives, and livelihoods, with negative effects along numerous clinical pathways. During the 2015–24 period, infants (≤ 1 -year old) were exposed to seven times the number of heatwave days than during the 2000–09 baseline period. During this period, their exposure increased from an average of 2.4 days per year per infant to 15.8. For the same comparison period, adults aged 65 years and older (older adults) faced five times more exposure than the baseline (average of 3.0 days per person per year to 15.9). Infants and older adults are clinically vulnerable to extreme heat; this substantial increase highlights the need for increased attention to the ramifications of exposure to extreme heat and investment in nature-based cooling systems.

SIDS have some of the highest rates of premature mortality due to non-communicable diseases, with more than 30% of all deaths occurring due to them. Consequently, Ministries of Health have advocated for the adoption of a healthy lifestyle built on the pillars of healthy diets and physical activity. The increase in ambient temperature since 2010 has made performing even light outdoor exercise difficult. Compared with the 1990–99 period, in 2024, SIDS were exposed to a record average of 41% more hours per year during which ambient heat posed moderate risk of heat stress when undertaking light outdoor exercise.

An estimated 4.4 billion potential work hours were lost due to heat in 2024, which was another record high. The potential loss in labour capacity in 2024 was twice as much as the annual average hours potentially lost over the 1991–2000 period. The associated loss in potential earnings has implications for the lives and livelihoods of outdoor workers and their families, and for the productivity of SIDS. The loss in earnings from heat-related reduction in labour capacity in 2024 was estimated at 1.27% of SIDS' gross domestic product; this estimate was higher than the global gross domestic product estimate of 0.99%.

On average, more than 40 million people in SIDS were exposed to daily concentrations of particulate matter with a diameter of less than 10 μm (PM₁₀) higher than the WHO guideline (2019–23). The exposure was driven by sand and dust storms, such as the Saharan dust events over the Caribbean. Poor air quality is associated with a cascade of health conditions, including asthma, chronic obstructive pulmonary disease, stroke, and cardiovascular disease. Dust warning systems are in place in the Caribbean; however, further research is required to assess the effectiveness of these early warning systems in evoking appropriate responses.

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Science: Why are human births so difficult? Male babies—not just upright walking—may be to blame

Analysis of 140 species suggests the risks of sons are offset by evolutionary advantages

One of the biggest downsides of upright walking in humans is the so-called obstetrical dilemma. Babies born with big brains—and thus big heads—must fit through a relatively narrow pelvis shaped for bipedal locomotion. These clashing demands, it's been suggested, have made human births especially grueling compared with other mammals.

But recent studies have questioned the simplicity of this explanation—and whether the phenomenon is even unique to humans. Reporting this month in *The Anatomical Record*, researchers add another wrinkle to the obstetrical dilemma: fetal sex.

Reviewing birth data for 140 species, the authors argue [sons are more difficult to birth than daughters](#) for many mammals, including humans and our ancient ancestors. This added risk may be offset by an evolutionary reward: Bigger male babies grow into bigger male adults, who tend to have more grandbabies, meaning more of that mother's genes are passed down. “Natural selection doesn't care if it's easy. It cares if it works,” says Anna Warrener, an anthropologist at the University of Colorado Denver who was not involved with the study. Still, she says the authors may be overinterpreting their finding.

Every day, about [700 people die giving birth around](#) the world. A leading cause is obstructed labor, often due to the baby's head exceeding the size of the birth canal. Even successful births require fetal acrobatics to navigate the narrow path from womb to world: Babies typically enter the pelvis sideways, twist, and rotate as they emerge.

Anthropologists have long assumed such perilous births evolved through a tug-of-war between two demands: large brains and upright walking, which favors a pelvis that's crunched front to back.

https://www.science.org/content/article/why-are-human-births-so-difficult-male-babies-not-just-upright-walking-may-be-blame?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=distillation&et rid=1169729274&et cid=6063826

The lancet: Climate change and animal infectious diseases: a systematic review of emerging evidence

Climate change is increasingly recognised as a major driver of infectious disease dynamics, yet its impact on animal health remains understudied compared with its impact on human populations. This systematic review aimed to assess the effects of climate variability and change on the epidemiology of animal infectious diseases, focusing on measurable changes in disease incidence, prevalence, mortality, and geographical distribution. We searched PubMed and CAB Abstracts for studies published between Jan 1, 1970, and Dec 31, 2024, and identified 33 eligible studies that assessed associations between climatic factors and observed disease outcomes in animal populations. The evidence base has grown over the past decade but remains geographically and taxonomically imbalanced. Most (24 [73%] of 33) studies reported positive associations between climatic variables and increased disease risk, expanded geographical ranges, or higher prevalence. Vector-mediated mechanisms were consistently proposed as underlying drivers (25 [76%] of 33). Domestic species were the most frequently studied hosts (18 [55%] of 33), whereas wildlife hosts were under-represented (11 [33%] of 33). Four studies (12%) included mixed host populations. 6200 studies identified by our search were excluded because they relied solely on environmental suitability indices, vector abundance models, or synthetic epidemiological outcomes, highlighting a persistent scarcity of longitudinal empirical disease data linked to long-term changes in weather and climate. Although modelling approaches are valuable for risk

projection, the poor availability of longitudinal epidemiological data constrains validation and attribution. Overall, the available evidence suggests that climate variability and change are reshaping animal infectious disease epidemiology, with important implications for animal health, food security, and zoonotic risk. However, important gaps in our understanding of these dynamics remain. Bridging these gaps, strengthening climate-aware surveillance, expanding data accessibility, and integrating animal health into One Health strategies will be essential to address emerging health risks.

Climate change has emerged as one of the most pressing global challenges of the 21st century, with implications for ecosystems, economies, and public health.^{1,2} Among its numerous consequences, climate change substantially affects the epidemiology of infectious diseases in both human and animal populations. Changes in temperature, precipitation patterns, and the frequency of extreme weather events can alter disease transmission dynamics through various mechanisms, including enhanced pathogen proliferation in vectors and geographical range shifts in vectors and human and animal reservoirs.³

[https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(26\)00097-5/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00097-5/fulltext?dgcid=raven_jbs_aip_email)

John Wynn-Jones

Past Chair RuralWONCA and EURIPA