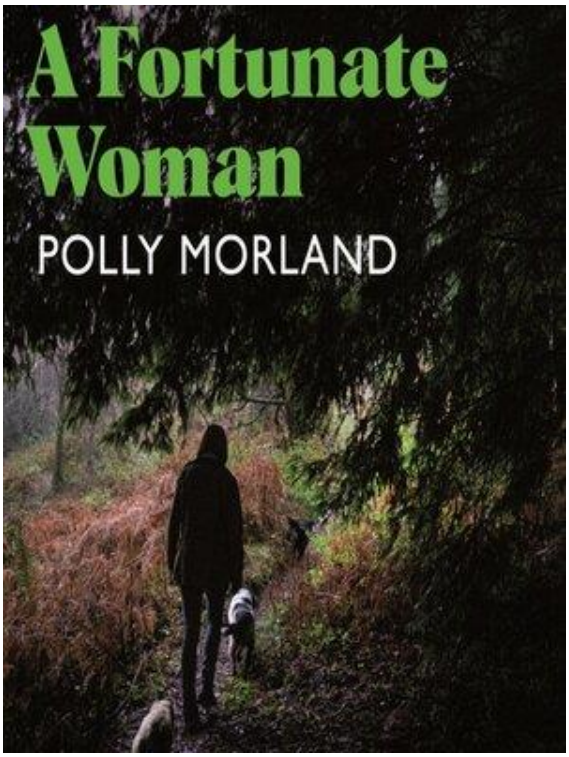
An Occasional Rural Miscellany

September 2016

A Fortunate Woman



I should have read this look a while ago, but I am so glad that I have done at last. I suppose that as a lifelong fan of John Berger's "A Fortunate Man", I felt that this book could only have been a cheap copy of the original. It certainly was not and it brings John Berger's seminal work into the 21st Century.

It is unashamedly a plea for the importance of maintaining continuity of care at all costs. It highlights the importance of patient & community centred care but more so, it must remain the model for rural practice.

Some may say that this type of practice is cosy and unrealistic in modern medicine. My colleagues who are still working tell me of the mountain of demand and the exhausting workload that now epitomises what general practice has become.

Polly Morland takes us through the impact of the Covid 19 Pandemic on a small rural practice, its staff and its community. There is no doubt that following the pandemic, general practice has become the sickest element within our health service. She tells us that *"General practice faces a choice between a personal or an impersonal future"* and *that "the pandemic brought general practice to a critical fork in the road: whether to move forward into a future*

of impersonal, automated, and fragmented care, or to fight for and protect the quiet, relational, human-centered medicine that lies at the heart of healing."

In this remote community, when the wider world seemed to be closing down and systems were buckling under strain, the local surgery remained an anchor. It was a place where people knew that, despite the chaos, someone was still keeping watch over them."

Polly Morland is an award-winning documentary maker, journalist and author. She came upon Berger's book by chance whilst clearing out her mother's house in the summer of 2020. She was so moved by the book that she sought out the doctor now working in Dr John Sassall's practice (from A Fortunate man) in the river valley. A Fortunate Woman owes a great deal to its predecessor in regard to its approach and structure. It's exact setting is never explicitly named.
Morland is intrigued by this small rural practice and the doctor who becomes the main character.

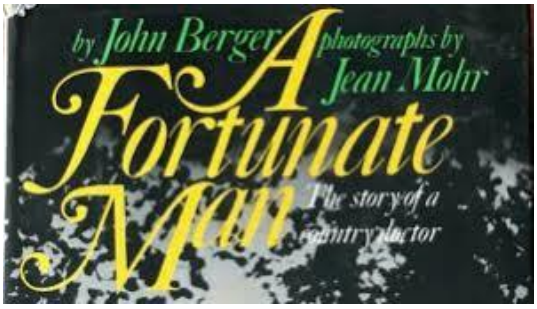
She describes the importance of continuity *""A relationship over time fosters familiarity, empathy, understanding, a two-way sense of responsibility, all core ingredients of trust; and this trust then encourages disclosure, improves communication, saves time; which in turn cultivates cooperation and empowerment, reduces anxiety and mistakes, improves the execution of tasks undertaken together... it all sounds like good common sense."*

On the Danger of 'Transactional Medicine "she says *"We have, it seems, forgotten to expect, or even to want, a doctor who knows our stories. That experience of a doctor-patient relationship that's more than transactional is slipping from collective memory. And if it's something you have never known, why on earth would you cherish it, or fight for it?"*

Morland contrasts the immersive, grounded nature of rural practice with the "conveyor-belt culture" of large acute hospitals, emphasizing how rural generalism allows a clinician to stay connected to context, community, and landscape.

Please take the time to read this book and also read 'A Fortunate man" (if you haven't done so before).

I finish with a quote from John Berger in "A Fortunate Man"
"Sometimes a landscape seems to be less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place. For Those who, with the inhabitants, are behind the curtain, landmarks are no longer geographic but also biographical and personal."
Many of you who has worked in small rural communities will understand this!



Dr Sassall on his rounds from a Fortunate Man

The Valley

Poems about Doctors

The Country Doctor
By Will Carleton

There's a gathering in the village, that has never been outdone
Since the soldiers took their muskets to the war of '61,
And a lot of lumber wagons near the church upon the hill,
And a crowd of country people, Sunday dressed and very still.
Now each window is preempted by a dozen heads or more,
Now the spacious pews are crowded from the pulpit to the door;
For with coverlet of blackness on his portly figure spread,
Lies the grim old country doctor, in a massive oaken bed,
Lies the fierce old country doctor,
Lies the kind old country doctor,

Whom the populace considered with a mingled love and dread.
Maybe half the congregation, now of great or little worth,
Found this watcher waiting for them, when they came upon the earth;
This undecorated soldier, of a hard, unequal strife,
Fought in many stubborn battles with the foes that sought their life.
In the nighttime or the daytime, he would rally brave and well,
Though the summer lark was fifing or the frozen lances fell;
Knowing, if he won the battle, they would praise their Maker's name,
Knowing, if he lost the battle, then the doctor was to blame.
'Twas the brave old virtuous doctor,
'Twas the good old faulty doctor,

'Twas the faithful country doctor-fighting stoutly all the same.

When so many pined in sickness he had stood so strongly by,
Half the people felt a notion that the doctor couldn't die;
They must slowly learn the lesson how to live from day to day,
And have somehow lost their bearings-now this landmark is away.
But perhaps it still is better that his busy life is done;
He has seen old views and patients disappearing, one by one;
He has learned that Death is master both of science and of art;
He has done his duty fairly and has acted out his part.

And the strong old country doctor,
And the weak old country doctor

Country Doctors

By CJ Dennis

The quiet country doctors
  Of many a country town,
Whose lives are spent to service bent,
  With scant hope of renown --
Those sturdy country doctors,
  That walk the healer's way,
At beck and call of one and all
  That pain be smoothed away.

Those patient country doctors,
  That journey day and night
By country roads to far abodes
  To ease some sufferer's plight;
Thro' fire and flood and tempest
  They make their pilgrimage
To bring release and healing peace,
  The comforters of age.

Those modern country doctors,
  They do not advertise;
Surcease they bring for suffering
  And hope to pain-filled eyes.
These be their ends to be man's friends,
  And so they shape and plan,
Divorced from greed to serve man's need,
  And give their lives to man.

Those quiet country doctors,
  Unsung, unknown to fame,
Refusing none what may be done
  In skilful healing's name --
Philosophers, friends, mentors,
  Thro' pain and death and birth,
And who shall say that such as they
  Are not salt of the earth?

Peggy and George

By Judith Wozniak

Before I can put my bag down.
a cup of tea is pressed into my hands,
biscuits topple in a puddled saucer.

I've come back to check on George,
listen to the tug and heave of his breath
eased since yesterday. Peggy hovers

making her curious clicking noises
with her mouth. Her loose dentures
oscillate to their own rhythm.

She peers up, squeezes her face.
I'm not wearing the Rimmel lipstick
she gave me, she worries I'm too pale.

They have shrunk over time
to fit into their sheltered home,
squashed together with their trinkets.

She has hardly left the house for years.
Once to visit George in hospital
and for their golden wedding buffet

at the Red Lion. Stooped together
like brackets, Peggy fidgeting
with the clasp of her best necklace.

Guests of honour, the district nurse,
unrecognisable, loosened from her tight bun,
and me with my sunset orange lips.

The Heart Block Poem

Undefined Poet

(The Heart Block Poem' is a short, four-line poem that was written in order to help medical students and medical professionals remember the degrees of heart blocks.)

If the R is far from the P, then it must be a First Degree
If PR gets longer then a QRS drop, then it must be a Type I Wenckebach
If PR stays normal and QRS quits, then it must be a Type II Mobitz
If the R's & P's don't agree, prepare to pace that 3rd degree!

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WHO launches global research priorities on climate, health and migration

WHO Health and Migration, in collaboration with WHO Climate Change, Energy and Air Quality, launched the Global research prioritization and action plan on health, migration and displacement in the context of climate change during a virtual webinar on 22 July 2026, bringing together more than 300 participants from over 75 countries to advance evidence and action on one of the most pressing and under-researched global health challenges of our time.

Addressing critical evidence gaps

Despite growing recognition of the climate–migration–health nexus, significant evidence gaps remain regarding how mobility in the context of climate change affects health, well-being and access to care. Climate change is increasingly recognized as contributing to the drivers of migration and displacement, disproportionately affecting populations already facing vulnerabilities and limited adaptive capacity, while influencing health risks and access to services throughout the migration journey.

“Closing research gaps is a matter of equity. To achieve universal health coverage, strengthen climate resilience and advance health equity, migrant and displaced populations must not be an afterthought, they must be part of the solution from the beginning,” said Dr Santino Severoni, head of WHO Health and Migration.

The Global Research Prioritization Exercise (GRPE), the first thematic deep dive under WHO’s Global research agenda on health, migration and displacement, was developed to address these challenges and support WHO’s commitment to generating robust, policy-relevant evidence for equitable and migration-inclusive health systems. The exercise followed a structured, participatory approach, including a scoping review, stakeholder mapping, technical consultations and an online prioritization survey, engaging 59 experts from academia, policy and practice across disciplines, sectors and regions.

Key findings

The GRPE identified priority research areas across three core themes – social determinants of health, universal health coverage and emergencies – alongside two cross-cutting areas: health outcomes and data, policy and interventions. It also produced a global action roadmap to guide future research, policy and practice. Key priorities identified include addressing social inequities and vulnerabilities, strengthening access to health systems and services, improving preparedness and resilience to climate-related emergencies, enhancing migration-sensitive

data systems, and generating evidence on mental health, maternal and child health, chronic diseases, and the long-term impacts of climate-related mobility.
“Climate change is already affecting the health and mobility of populations around the world. Strengthening the evidence base is essential to inform effective policies and ensure that those most affected are protected through climate-resilient and equitable health systems,” said Dr Diarmid Campbell-Lendrum, Head of WHO Climate Change, Energy and Air Quality.

Translating research priorities into policy and practice

The launch reinforced a shared commitment to strengthen interdisciplinary collaboration and ensure that research informs policy and practice. Discussions highlighted the need to break down silos across climate, health and migration sectors, strengthen migration-sensitive data systems, promote participatory and community-centred research, and translate evidence into practical policies and interventions that respond to the realities of affected populations. Participants also underscored the importance of sustained partnerships and stronger links between research, policy and implementation.
Through the GRPE, WHO reaffirmed its commitment to supporting Member States and partners in translating research priorities into action. By embedding the roadmap within regional and national agendas, fostering partnerships, strengthening capacity and advancing policy-relevant research, WHO aims to ensure that evidence informs decision-making and contributes to more resilient, migrant-inclusive health systems. The GRPE provides a foundation for turning knowledge into measurable impact and advancing health equity for migrant and displaced populations in a changing climate.
https://www.who.int/news/item/05-08-2026-who-launches-global-research-priorities-on-climate--health-and-migration

What Would Most Help Women Physicians

Reflections from the WONCA South Asia Community

*By **Dr Sarah Rashid,***
Young Doctor Representative, Working Party on Women and Family Medicine (South Asia Region),
*and Dr **Hina Jawaid**,*
Chair, Working Party on Women and Family Medicine

The WONCA Working Party on Women and Family Medicine continues to focus on empowering female family physicians and helping them address work-life balance. The combination of long working hours and home responsibilities can be exhausting. Peer support and practical solutions offered through professional networks can help members manage stressful situations and support their professional growth. Despite busy schedules, our women's working party members across the globe contribute in many ways to day to day learning and health, through monthly educational webinars, short case scenarios, medical quizzes and multiple choice questions.

In that same spirit, earlier in July a discussion took place within our South Asia community. Our Young Doctor representative, Dr Sarah Rashid, opened a conversation in the WONCA South Asia WhatsApp group, which brings together members from seven countries: Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. The prompt was a simple one:
Which ground-level actions would make the most impact on women physicians and women's health in family medicine and general practice?
What follows are the themes that emerged, offered as reflections from the community.

What came up:

Advocacy for policy change

The strongest theme by some distance was advocacy for policy change, specifically parental leave, safe working hours and pay equity, as a way of reducing burnout among women family physicians. This echoes the wider evidence base. Published literature notes that, compared with other specialties, the rate of burnout is disproportionately high among family physicians [1].

Community health screening

Another strong theme was a clear appetite for preventive, community-facing work, particularly community health screening camps for conditions such as high blood pressure, diabetes and cervical and breast cancer. Members expressed a wish to shift from reactive towards proactive care, with prevention seen as central to better community health outcomes.

Peer support and wellbeing

Peer support and burnout and wellbeing groups also featured prominently, reflecting how members think about managing occupational stress and exhaustion together rather than alone.

Mentorship

Mentorship, pairing senior GPs with early-career women physicians, drew interest as a route through the pressures of primary care, though it was raised by fewer members. It is an area worth exploring further. Feedback from members on their own past experiences could help

identify the barriers, and a peer mentoring programme for postgraduates in primary care may be worth considering.

Research, outreach and rural service

Other ideas raised included local research on women in family medicine, school and college health education outreach, and social media campaigns for health literacy. Training community health workers in underserved areas was raised too, though it prompted less discussion than other themes. That may reflect a familiar challenge: a 2017 study in Pakistan reported that doctors were reluctant to serve in rural areas because of limited infrastructure and the effect on social and family life [2]. The value of this kind of work was nonetheless clear from members' own experiences. One member described spending several years running a low-resource primary care initiative that was well received by her community, a reminder of the individual effort that so often sits behind service improvement in underserved settings.

Key reflections

- Advocacy for policy change, including parental leave, safe working hours and pay equity, is a clear priority for female family physicians.
- There is real interest in expanding screening for non-communicable diseases among women.
- Individual efforts to improve care in rural areas are valued, but more work is needed to understand the barriers to training community health workers in underserved settings.
- The group itself is a community where female family physicians can find peer support, share experience across borders, and learn from one another.

Beyond the ideas themselves, the exercise gave members a moment to reflect on the direction of the working party's work and on how WONCA as a whole can continue its stated mission of promoting equity through the equitable treatment, inclusion and meaningful advancement of all groups of people, particularly women and girls, in the context of all health care and other societal initiatives. Conversations like this one, among colleagues across seven countries, are a small but practical part of how that mission is carried forward.

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WONCA Featured Doctor: Prof Roger Strasser
Founding Chair, Rural WONCA

Professor Roger Strasser receives his Rural WONCA Fellowship from Chair Dr Pratyush Kumar at the Rural WONCA Assembly in Wellington.

At the Rural WONCA Assembly in Wellington, Aotearoa New Zealand, the first ever Rural WONCA Fellowships were awarded to the five past chairs of the WONCA Working Party on Rural Practice. Among them was Professor Roger Strasser, the founding chair, who led the group from 1992 to 2004 and helped bring it into being at the WONCA World Conference in Vancouver that year.

Presented by current Chair Dr Pratyush Kumar, the fellowships honoured more than three decades of leadership, service and vision. We spoke with Professor Strasser during the conference to talk about the movement's beginnings, how rural practice has changed, and where he sees it going.

You were there at the start. How did the Working Party come about?

In 1992 I attended the WONCA World Conference in Vancouver. I had just been appointed as the first professor of rural health in Australia, and there were a lot of rural practitioners at that meeting with real energy about them. I connected with a rural doctor from South Africa, realised there were many of us in the same position, and called an ad hoc lunchtime meeting. Around 70 doctors from around the world came together, and that was the beginning of the Working Party on Rural Practice, which WONCA recognised that same year.

What struck us was how much we had in common. There were obvious differences between our countries, our systems and our contexts, but there was a genuine sense of shared experience and shared purpose. Out of that came a clear recognition: when you are talking about rural health, access is the issue, everywhere. Resources concentrate in the cities,

distances and communications are always a challenge, and there is never enough health workforce. That is true of rural health right around the world.

The first World Rural Health Conference followed in China in 1996. Thirty years on, how has the movement changed?

That first conference was actually called the International Conference on Rural Medicine. We have moved a long way beyond a focus on medicine alone. Rural practice, rural generalism, is about all of the health professions working together as a team. This is the 21st of these conferences, and here in Wellington we have something like 950 participants from more than 36 countries. The sense of excitement and camaraderie is exactly what it was three decades ago, but the scope is far wider.

You have advocated for rural health through decades of technological change. How do you see technology's role?

Technology has been part of this from the beginning, and in a very practical way. In 1987, two developments gave the rural health movement in Australia its foundation. The first was the audio teleconference, which let rural practitioners stay in their own communities and their own practices while still connecting and working together as a group. The second was the fax machine, which meant we could develop documents between us. That is how the Working Party did something unusual for its time. Rather than meeting only in person, we held audio conferences between conferences and drafted policy together, so that by the WONCA conference in Hong Kong in 1995 we could present a draft policy on training for rural practice. At the first world rural conference in China, two colleagues came to demonstrate this newfangled thing called the internet. They brought it on discs, because they could not be sure a telephone line out of the venue would connect to anything.

The upside has grown over time. In Australia, the first satellite continuing education for remote practitioners came through satellite television. Given the national passion for sport, the dishes were often in pubs, so the broadcasts went out on a Sunday morning and practitioners had to go to the pub to watch. It probably caused some conversation in the community about what the doctor, the nurse and the pharmacist were doing at the pub on a Sunday morning. Today it is very different. In British Columbia in Canada, for example, there is a real-time virtual support system where hospital specialists make themselves available, essentially on call, to a rural nurse, community health worker or doctor who needs them. That kind of support is possible now with the internet, and it is exciting to see the potential to keep people cared for in their own home, family and community.

But there are minuses too. The one we warned about in our policy, first developed in 1997, is this: technological enthusiasts go to policymakers and governments and promote computers and communication technology as a substitute for having real people providing care in rural and remote communities. That is the danger. Technology should support rural practitioners who are there and who stay. It cannot replace them.

Read more of the interview
https://www.globalfamilydoctor.com/member/WoncaPeople/STRASSERProfRoger.aspx

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New Journal: Microbiome and One Health

Microbiome and One Health is a peer-reviewed journal dedicated to publishing original research that elucidates the critical role of microbiomes colonizing humans, animals, plants, and the environment. The journal especially emphasis on providing an interdisciplinary forum that integrates …

Aims & Scope

Microbiome and One Health is a peer-reviewed journal dedicated to publishing original research that elucidates the critical role of microbiomes colonizing humans, animals, plants, and the environment. The journal especially emphasis on providing an interdisciplinary forum that integrates microbiology with veterinary science, medicine, agriculture, and environmental science to advance the One Health paradigm.

We welcome original research articles, reviews, short communications, and perspectives. The scope includes, but is not limited to, the following themes:

1. Zoonotic Diseases and Pathogen Transmission
2. Antimicrobial Resistance (AMR)
3. Microbiome Interactions and Cross-Species Transmission
4. Environmental Microbiomes
5. Gut microbiota and human health
6. Interactios of Plant Growth-Promoting Rhizobacteria
7. Food Safety and Security
8. Climate Change and Planetary Health

Reproducible methods or protocols in microbiome research, and interventional strategies in global public health are also welcome.

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A Renewed Responsibility to Serve

Congratulations to Rural Doctor Sankha Randenikumara who re-elected uncontested as Honorary Secretary of the College of General Practitioners of Sri Lanka for a second term.

"Soon after returning from the UK, I accepted the invitation of our President, Dr Pushpa Weerasinghe, to be nominated for the position of Honorary Secretary. What followed has been a remarkable year of learning, collaboration and change.

Over the past year, our Council has worked to make the College more receptive, approachable and responsive. We have also worked to streamline our processes, introducing appropriate protocols and systems so that our work can progress in a more structured, consistent and sustainable manner.

I am immensely grateful to our President, Dr **Pushpa Weerasinghe**, Vice President Dr Chandana Atapattu, and Senior Past President Dr **Eugene Corea**, for their guidance, and to all members of the Council and the College who have supported and contributed to this journey. My heartfelt thanks to my dear wife, **Nirodha Jayawickrema**, for her patience, understanding and unwavering support, especially when work has taken me away from family time.

As we begin another year, we look forward to creating more opportunities for our members and associates, strengthening General Practice and Family Medicine in Sri Lanka, and further advancing the role of the College."

And we continue to hold an ambitious dream close to our hearts:

A GP-led primary care system in Sri Lanka, where every person can access continuous, comprehensive and person-centred care in the communities where they live, contributing to universal health coverage.

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

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15th EURIPA Rural Health Forum

1– 3 October 2026 • Cartagena, Spain

https://forum.euripa.org/

https://www.euripa.org/

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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

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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 .

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Education, Webinars, Videos and Podcasts

Videos

One Health Video: ONE HEALTH Listenmi News - Bay-C
(Great music video!!)

Bay-C, bass vocalist from platinum-selling dancehall/reggae quartet, TOK, in partnership with UWI's One Health One Caribbean One Love Project produced a ListenMi Feature on One Health. Bay – C is One Health's Celebrity Patron, ideator of ListenMi News and is a Caribbean pioneer in 'edu-tainment.' "One Health" is a term coined to express the joint effort of different disciplines to improve the health of humans, other living beings, and the environment. Professionals from fields, such as, environmental science, veterinary medicine, human medicine and agricultural science, work together to implement One Health solutions in the built and natural environment. The One Health One Caribbean One Love Project is funded by the ACP/EU and supported by IICA SPS Project. It works regionally on the BIG health issues affecting the Caribbean region such as Antimicrobial resistance, water issues and emerging diseases.
https://www.youtube.com/watch?v=0mL29J_J_bk

The Lancet Voice

What is "AI psychosis"?

What's the truth behind media reports of people experiencing "AI psychosis" after interacting with chatbots? Editors Niall Boyce and Miriam Sabin are joined by psychiatrist Matthew Nour of Oxford University and Microsoft AI to separate fact from fiction, and understand more about the ways in which artificial intelligence might affect human mental health.
https://www.thelancet.com/audio-do/ai-psychosis

How will the AI change the NHS?

Can an algorithm decide who sees a doctor first — and what happens when it gets the call wrong?
The NHS is rolling out AI triage tools and ambient scribes across general practice, promising to shorten waiting lists and free up clinician time. In this episode of The Lancet Voice, host Niall Boyce and Chloe Wilson, senior editor at The Lancet, cast a questioning eye over the initiative.
Chloe raises concerns about AI triage — including the risk of downgrading seemingly innocuous but important symptoms — and questions whether AI in health care is adding efficiency, or simply cutting costs. The hosts also examine ambient scribes in the consulting room, discussing how AI scribes may change clinical practice, or even deskill physicians. The issue isn't whether AI can help the NHS — it's whether we're asking it to do the right things, and if we are implementing it in the right way.
https://www.thelancet.com/audio-do/ai-change-nhs

Science Podcast

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

First up on the podcast, we continue our coverage of the fallout from cuts to the U.S. Agency for International Development (USAID), this time focusing on how one of the largest recipients of aid is coping 18 months later. Contributing Correspondent Catherine Offord talks about her trip to Malawi and the efforts to strengthen their health infrastructure in the wake of funding shocks.
Next on the show, Collin Cherubim, Ph.D. candidate in the Earth and Planetary Sciences Department at Harvard University, discusses what it means to find helium escaping from the atmosphere of a rocky planet in the habitable zone of a nearby red dwarf.
https://www.science.org/content/podcast/health-care-malawi-after-usaid-s-end-and-rocky-exoplanet-atmosphere

How childhood environments shape the brain, and how susceptible is the Atlantic Ocean's current to climate change?

First up on the podcast, producer Kevin McLean talks with Staff Writer Paul Voosen about the latest on the Atlantic Meridional Overturning Circulation, or AMOC. Researchers have long been concerned that global warming could cause a collapse in the AMOC, which would trigger dramatic cooling in Northern Europe. But recent data and models suggest the AMOC may be more resilient than previously thought.
Next on the show, Scott Marek, assistant professor in the Mallinckrodt Institute of Radiology at Washington University School of Medicine, talks with host Sarah Crespi about brainwide association studies (BWAS) for childhood brain development. BWAS measure structure and function across many brains and look for correlations between these measures and behavior, disease, and environment. In this work, Marek and colleagues focus on how socioeconomic

factors—captured by zip code—are strongly correlated with certain brain differences in more than 4000 children ages 9.5 to 11. The work also suggests lack of sleep and excess screen time could mediate the influence of socioeconomic conditions on differences in brain structure and function.
https://www.science.org/content/podcast/how-childhood-environments-shape-brain-and-how-susceptible-atlantic-ocean-s-current

Did meat or fruit give people big brains, and protecting bison diversity using ancient DNA

First up on the podcast, Deputy News Editor Michael Price discusses the history of the North American bison population, its decline, and resurrection—and links to Indigenous cultures. He's joined by University of California, Santa Cruz evolutionary molecular biologist Beth Shapiro and Greg Wilson, a wildlife ecologist with Parks Canada. They talk about their Science paper on the genetic diversity of modern bison after near extermination during European colonization. Shapiro and Wilson also explain how these findings can be used to inform conservation efforts.
Next on the show, Jennie Brand-Miller, professor emeritus in the School of Life and Environmental Sciences and Charles Perkins Centre at the University of Sydney, joins host Sarah Crespi to talk about what our ancient ancestors were eating and a big question—was hunting key to evolving big brains? Brand-Miller argues instead that fruit was the key factor in the expansion of hominin brains. She points to the high sugar demands of large brains, about 100 to 120 grams per day, and how this level of sugar intake was likely only achievable by consuming things such as fruit and honey before our ancestors' mastery of cooking and fire.
https://www.science.org/content/podcast/did-meat-or-fruit-give-people-big-brains-and-protecting-bison-diversity-using-ancient?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=podcast&et_rid=1169729274&et_cid=6034222

Nature Podcasts

Medical records could be revealed by AI training-data vulnerability

Identification risks are more severe for underrepresented groups in the training data — plus, evidence that the Universe is more uneven than assumed.
https://www.nature.com/articles/d41586-026-02032-3

The probiotic bacteria engineered to treat diabetes

Genetically modified bacteria lower high blood-sugar in animal trials — plus, how to watch a solar eclipse safely.
https://www.nature.com/articles/d41586-026-02521-5?utm_source=Live+Audience&utm_campaign=718b66bdaa-nature-briefing-weekly-20260814&utm_medium=email&utm_term=0_-33f35e09ea-50521540

BMJ Podcasts

Social Media literally changed my brain chemistry
Does your digital footprint represent you personally, or are you perceived as a doctor while you doomscroll? Can you ever be sure that *all views are your own* ? Are you an avatar representing medicine or a private citizen?
Zaynah Khan sits down with Dr Jonny Guckian, together with panellists Kayode and Korianne, to discuss whether medics have a duty of care on social media. They share storytimes of social media horror stories for medics, lessons learnt (sometimes the hard way), and how medics can ethically use social media without the fear of getting struck off!
https://open.spotify.com/show/7A92ZIPYK3OTIhNjV3sF8d?si=FCQ-DkXjQ92pLjisgHMuUg&nd=1&dlsi=e1a640a0006943ee

Are doctors afraid of death

In this week's podcast - the Sensitivity of Patient Questionnaires: If you've ever asked a patient to fill out a Patient Health Questionnaire (like the PHQ-9) to assess their mental health and wondered exactly how much of a change it can actually detect, new research just published on bmj.com sets out to answer that question. We're joined by Brett Thombs, Professor in the department of Psychiatry at McGill University
Also this week, Are Doctors Scared of Death? BMJ Careers Editor Abi Rimmer sits down in the studio with Richard Coker, Emeritus Professor of Public Health at LSHTM. Drawing from his early days as an HIV doctor during the onset of the AIDS epidemic, and later with infectious disease outbreaks in South East Asia. Professor Coker discusses the profound experiences of the end of his patients lives that shaped his new book, Timor Mortis: How We Live with Death.
https://open.spotify.com/episode/0cOJiggSWokUU3aDvaq6jS

NEJM Podcasts

Interview with Jean Nachega on the importance of investment in equitable partnerships, community trust, and local scientific leadership for outbreak preparedness.
Jean Nachega is a professor of infectious diseases and the director of the Biomedical Research Institute at Stellenbosch University and an associate professor at the University of Pittsburgh School of Public Health. Stephen Morrissey, the interviewer, is the Executive Managing Editor of the Journal.
https://www.nejm.org/doi/full/10.1056/NEJMp2607819?query=TOC&cid=DM2460205_NEJM_Non_Subscriber&bid=-665386371

Intention to Treat> The Race equation.
The Race Equation, we confront how assumptions about race are embedded into medicine and continue to harm Black patients. Each week, we tell the stories of patients, clinicians, and trainees, and the struggle to change these unscientific practices. From diagnostic algorithms to clinical guidelines, the series explores how these practices took hold, why they endure, and what it will take to replace them with more equitable approaches to care. Listen to The Race Equation and follow “Intention to Treat” on Apple Podcasts or wherever you get your podcasts.
https://store.nejm.org/signup/nejm/intention-to-treat?query=TOC&utm_source=nejmetoc&utm_medium=ad&utm_campaign=ITT2026

Rural Road to Health Podcast

Podcast: Project SETU Foundation Trust

Dr Roshni Jhan Ganguly, a family doctor and founder of Project SETU foundation trust. About 70% of India's population lives in villages where access to primary health care services may not be easily accessible. Project SETU was created to be the bridge that connects urban physicians with rural health care and communties. We talk about Project SETU and its mission. Available 10th August 2026.
https://theruralroadtohealth.blog/podcast/

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New articles published in Rural and Remote Health

10231 - Australasia - Medical students' attitudes towards rural practice post-rural placement: a 10-year national survey

The maldistribution of the medical workforce is a global phenomenon, and rural physician retention is a critical barrier to achieving universal health coverage. While there are several international strategies, many high-income countries (including Australia, Canada and the US), have invested heavily in regionalised medical education to foster 'rural intent' early in the professional pipeline. Evidence from systematic reviews and longitudinal cohort studies indicates that rural career intent during medical training is strongly associated with subsequent rural practice. This Original Research study assesses the rural intent of medical students by examining the prevalence of negative and positive feelings associated with their Rural Clinical School placement, as well as associations with demographic characteristics and placement experiences.

11269 - Asia - Professional identity and rural workforce commitment among regional quota medical students in Japan: a qualitative study

In response to the shortage of healthcare professionals in rural areas in Japan, medical schools across the country have implemented the *Chiiki-Waku* (regional quota) system, which selects students based on their intention to work in rural health care, often offering scholarships in exchange for a service obligation in specific regions after graduation. Despite the system's potential, current educational approaches often fail to adequately address the unique expectations, concerns, and aspirations of *Chiiki-Waku* students, which presents a significant challenge in translating the goals of the *Chiiki-Waku* system into successful, long-term outcomes for rural health care. This Original Research article explores how *Chiiki-Waku* students' learning experiences, educational support, and relationships with educators and peers shape their professional identity formation and anticipated commitment to rural practice.

10491 - Europe - Can rural exposure to general practice influence career aspirations? A study with former participants of the 'Excellent Project', Germany

In Germany, the shortage of rural GPs and the aging population, with older people requiring increasing amounts of medical care, is creating considerable strain on the healthcare system. In addition, the average age of GPs in Germany is climbing steadily. To encourage young doctors into general practice, especially in rural areas, GPs in the rural region of the Bavarian Forest launched the 'Excellent Project', which provides medical students with a structured internship program in a rural general practice, combining intensive one-on-one supervision by experienced GPs with an accompanying teaching program. This Original Research study investigates the impact of The Excellent Project.

10695 - North America - The role of rurality on self-reported sleep and cognition in middle-aged and older adults: a preliminary study

Cognitive impairment is linked with poor sleep health (eg sleep duration, sleep efficiency, daytime sleepiness) and is more prevalent in rural areas. However, despite independent associations of rurality and sleep with cognitive function in aging adults, their interactive association is unclear. This Original Research study examines whether rurality (non-rural v rural) moderates the associations between self-reported sleep and cognition (including working memory, executive functioning, spatial attentional orienting, and processing speed) in aging adults in the US.

9978 - Europe - A qualitative analysis of colon capsule endoscopy using a novel GP-led, home-delivered service model in the Western Isles, Scotland

Colorectal cancer is the third-most common cancer diagnosis and the second-most common cause of cancer death worldwide. As access to cancer investigations like colonoscopies are a significant barrier identified by rural primary healthcare providers, novel approaches like colon capsule endoscopy (CCE) – in which a camera is digested and travels through the gut transmitting images to a data recorder for review and diagnosis before elimination – are required to meet the needs of rural and remote populations. This Original Research study examines the experiences and perspectives of staff involved in an innovative CCE service in Scotland.

Papers from other journals

Nature: A harmonised framework for assessing geographic healthcare access across the rural-urban continuum

Equitable access to healthcare is essential for sustainable development, yet spatial inequalities are often assessed using inconsistent definitions for classifying the rural-urban continuum. We aimed to develop a harmonised framework to assess geographic healthcare access across the rural–urban continuum using comparable metrics. We apply this framework to Nigeria and Zambia as contrasting case studies, reflecting differences in population size, settlement patterns, and levels of urbanisation.

We combined high-resolution population data with geolocated healthcare facilities and modelled travel times to the nearest facility using walking and motorised transport scenarios at 1-km resolution. Settlement types were classified using the Degree of Urbanisation method, a globally standardised approach that categorises areas into cities, towns and semi-dense areas, and rural areas based on population density and settlement size. We analysed travel-time distributions and relative accessibility using a comparative metric across settlement types.

Here we show that 90% of the population in Nigeria and 80% in Zambia can reach any healthcare facility within 15 minutes by motorised transport, compared with 60% and 54%, respectively, on foot. For hospitals, only 61% (Nigeria) and 47% (Zambia) are within 15 minutes by motorised transport, and 8% in Nigeria by walking. In Nigeria, 45% of the population remain more than 120 minutes from hospitals on foot, compared with 54% in Zambia. Across both countries, cities generally have better access, but substantial overlap exists, with some urban populations (defined as the share of population living in cities, towns and semi-dense areas) experiencing travel times comparable to and even worse than rural populations. Uncertainty arises from assumptions in travel speeds and input datasets, but relative patterns are consistent across scenarios.

These findings indicate that geographic healthcare inequalities extend beyond a simple rural–urban divide and include underserved populations within cities, towns and semi-dense areas. A harmonised framework based on consistent settlement definitions can support more comparable and policy-relevant assessments of healthcare access across countries and inform targeted infrastructure and service planning.
https://www.nature.com/articles/s44528-026-00017-2

The Lancet Planetary Health: Planetary Health Research Digest.

Urban forests

In 2007, the global urban population overtook the rural population for the first time, and by 2050, an estimated 70% of people will live in cities. This demographic shift reinforces the importance of urban forests, particularly in the context of climate change, where they support adaptation and mitigation by buffering weather extremes, sequestering carbon, and lowering energy demand for cooling. In a newly published Essay, Manuel Esperon-Rodriguez (Bangor University, UK) and colleagues describe four urgent policy priorities for safeguarding and enhancing urban forests.

To secure their long-term benefits, the authors argue that, first, urban forests must receive recognition, investment, and maintenance as essential living infrastructure. Second, access to greenspaces must be equitable across all communities. Third, urban forests must be integrated into climate and biodiversity governance frameworks. Lastly, the authors call for evidence-based management and continuous learning to be utilised to strengthen future resilience. By reframing urban forests as essential living infrastructure embedded in legal, financial, and planning frameworks, the researchers assert that cities can become cooler, healthier, more biodiverse, and socially just.

Passive cooling

As global temperatures continue to rise and heatwaves become more frequent, cooling technologies will become increasingly important. While mechanical air conditioning is effective, it is energy intensive and has environmental impacts, with mounting challenges for electricity grids during hot periods. Matthaios Santamouris (University of New South Wales, NSW, Australia) and Konstantina Vasilakopoulou, therefore, discuss advances in passive cooling technologies, which reduce the thermal load of buildings and urban spaces by reducing heat gains and dissipating excess heat, in their new Review.

Focusing on smart solar control; ventilation; and radiative, evaporative and hybrid dissipation systems, the authors highlight that each technology has benefits and trade-offs. Ventilative, radiative, and evaporative cooling technologies are low-energy, but their effectiveness depends on climate, timing and air quality. Meanwhile, solar control improves thermal comfort but requires regular maintenance or comes with design constraints. Although passive cooling techniques are restricted by several factors, including scalability, Santamouris and Vasilakopoulou emphasise that policies to encourage the uptake of these technologies are needed, particularly where access to affordable cooling is limited.

The cooling gap

Global energy demand for space cooling tripled between 1990 and 2016, driven partly by climate change and the growing frequency of extreme heat events. While air conditioning is one of the most widespread and effective cooling strategies, it is also energy intensive and therefore unaffordable for many people—epitomising the cooling gap. Aiming to shed more light on this matter, Constance Crassier (Netherlands Environmental Assessment Agency, The Netherlands) and colleagues explore the evolution of the residential space cooling gap and energy demand for cooling through 2100.

Disaggregating data by region, income group, and urban or rural populations, the authors estimate that, despite socio-economic development, at least 3·4 billion people will remain in

the cooling gap by 2100, compared with 3·6 billion today. Those affected will predominantly reside in Central and South America, Africa, and South Asia, with intra-regional inequality increasing in most places, and the poorest populations increasingly impacted in nearly all regions. Overall, the study highlights that socio-economic development alone will not close the cooling gap—targeted adaptation efforts are needed alongside it.

Plastic beaches

Around 460 million metric tonnes of plastic are produced annually worldwide, and, by 2060, the total accumulation of plastic in the ocean is projected to reach 145 million metric tonnes. Given that this undermines the health of marine ecosystems and threatens food security, plastic pollution represents a major global environmental challenge. To help develop targeted interventions, Max Richard Kelly (University of Plymouth, UK) and colleagues assess which specific plastic products are the primary culprits behind ocean litter.

Drawing on 5,300 marine litter shoreline surveys spanning seven continents, nine ocean systems, 13 regional seas, and 112 nations, the authors find that food and beverage plastics dominate shoreline debris globally, ranking among the top three most abundant item types in 93% of included nations. This was followed by plastic bags, cigarettes, fishing and shipping gear, and expanded polystyrene foam. By identifying the most prevalent items across national and regional scales, this research redirects attention toward sector-specific interventions and upstream strategies to reduce production.

https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00101-4/fulltext?dgcid=raven_jbs_aip_email

Nature: Dolly Parton dies aged 80 — researchers celebrate her contributions to science

The country singer was an advocate for vaccines, public health, literacy and marginalized communities.

Legendary country musician Dolly Parton has died at the age of 80 after “a brief battle with cancer”, her representatives said in a statement on Tuesday.

Parton, who was born into a poor farming family in Locust Ridge, Tennessee, in 1946, became a singer and performer during her early childhood, and earned ten competitive Grammy Awards during her career.

But she also left a mark on science, public health and education. She donated to medical centres, vaccine research and disaster relief. One of the most famous animals in science was named after her: Dolly the sheep, the first mammal cloned from an adult cell.

Scientists around the world paid tribute to Parton following the news of her death.

“Dolly provided the soundtrack for my PhD, and is gratefully acknowledged in my thesis as a key contributor! She was the very best of us: we should all strive to be more like Dolly (rhinestones and all),” Catherine Heymans, an astronomer at the University of Edinburgh, UK, told Nature by e-mail.

“Today is a sad day as we mourn an exceptional artist, a true champion of kindness, and ambassador of science and public health,” wrote Tedros Ghebreyesus, director-general of the World Health Organization, on the social-media platform X.

Others reflected on how Parton wielded her fame for good. “Few celebrities use their influence to support science so meaningfully,” wrote Gaurav Kansagara, a cell biologist at the Institute for Stem Cell Science and Regenerative Medicine in Bangalore, India, on Bluesky, another social-media site.

Here are five ways that Dolly Parton contributed to science.

Research funder

One of Parton’s longest-lasting influences on science is her part in creating one of the major vaccines against SARS-CoV-2, the virus that causes COVID-19. In March 2020, Parton gave

US$1 million to Vanderbilt University Medical Center (VUMC), in Nashville, Tennessee, which created the Dolly Parton COVID-19 Research Fund.
According to Mark Denison, a Vanderbilt paediatrician and infectious-disease researcher, the money helped to fund the "critical" early stages of research into a then-experimental mRNA vaccine eventually produced by Moderna, a biotechnology firm based in Cambridge, Massachusetts. The fund is acknowledged in the first published report of a phase I trial of the vaccine, which appeared in the New England Journal of Medicine in July 20201.
At least 37 research papers credit the Dolly Parton COVID-19 Research Fund with support, according to a Nature analysis of the Dimensions database (part of Digital Science, a firm operated by the Holtzbrinck Publishing Group, which has a share in Nature's publisher, Springer Nature).
https://www.nature.com/articles/d41586-026-02676-1?utm_source=Live+Audience&utm_campaign=283d7151c4-nature-briefing-daily-20260826&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Experience reports: Confluences between arts, healths, environment, listening and communications: the experience of the Ilha dos Abraços Project in the quilombola territory of Ilha de Maré
This experience report proposed to build collectively with the quilombola community of Ilha de Maré, Brazil; a text-territory-denouncement about environmental necropolitics and community resistance. The Ilha dos Abraços project, part of the Planett&Ar umbrella project, worked on popular surveillance through an artistic residency with a transdisciplinary group to create a memory map and graffiti panels that culminated in the creation of a research group with the community that is also the author of this article. The residency took place in 2022 with workshops on comics, graffiti, and planetary health. There is a need to know how to tread into the territory, to enter a community and the local oral tradition, which is done also through listening and, as proposed here, "listen-action". It also reflects on the island's invisibility in face of pollution and public authorities, and how art transgresses this silencing.
https://www.scielo.br/j/icse/a/tr8k3rFnDYBYsgxKpSvwB3x/?lang=en
Science: A boost for chemical vaccination against malaria
Malaria is one of the world's most devastating infectious diseases, causing an estimated >600,000 deaths yearly, particularly in children up to 5 years old. Two vaccines that became available in the past few years partially protect children against infection with Plasmodium, the malaria parasite. However, a need remains to increase vaccine efficacy and expand it to other groups of people at risk (1). Plasmodium sporozoites infect the mammalian host's liver without causing malaria symptoms, before developing into symptomatic mature merozoites that infect red blood cells. Whole-sporozoite vaccines use sporozoites that have been irradiated or genetically modified before immunization to arrest their liver development or drugs that act on liver- or early-blood-stage parasites to prevent the onset of symptomatic blood-stage infection. On page 683 of this issue, Steel et al. (2) report using drugs that target the plasmepsin IX and X (PMIX/X) proteins of Plasmodiumsporozoites to induce protective immunity against malaria in mice.
https://www.science.org/doi/10.1126/science.aek0196?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=distillation&et_rid=1169729274&et_cid=6041833

Microbiome and One Health: From micro to macro: The key to solving human health challenges
Humanity now faces unprecedented and multifaceted health challenges, including the recurrent emergence of infectious diseases, the escalating burden of chronic non-

communicable diseases, the worsening crisis of antibiotic resistance, and the far-reaching health impacts of climate change. These challenges are not isolated; rather, they are deeply interconnected and mutually reinforcing, rendering traditional single-discipline and siloed approaches insufficient. In this context, the convergence of microbiome science and the One Health concept provides a novel, systemic scientific paradigm. The launch of the journal Microbiome and One Health responds directly to this urgent need. Its core missions are to promote interdisciplinary integration, stimulate intellectual innovation, and advance holistic research that bridges the microbiome with the health of humans, animals, and the environment.

Microecology investigates the patterns of emergence, development, and decline of microorganisms within humans and other organisms in microenvironments. It has been demonstrated that microecology plays a significant role in health maintenance, disease prevention, and treatment across humans, animals, and plants.1

The human body is a "superorganism" composed of human cells and trillions of microorganisms.2 Microbial communities residing in the gut, respiratory tract, skin, reproductive tract, and other niches are not only involved in host metabolism and immune regulation but also exert broad influences through pathways such as the gut-organ axis. Within the systematic framework of the gut-organ axis, the regulatory role of the microbiome extends far beyond the digestive system, reaching multiple distal organs. Axes such as the gut-brain, gut-lung, gut-liver, and gut-skin axes have been successively established, through which the gut microbiota affects physiological processes—including pulmonary immunity, liver metabolism, skin barrier function, and bone homeostasis—via metabolites, immune-regulatory molecules, and neural signals.3, 4, 5 These findings further underscore the central role of microecology in systemic physiological integration and disease networks. In recent years, advances in technologies such as metagenomics, proteomics, and metabolomics have deepened our understanding of the structure and function of microecological systems. Research indicates that microecological dysbiosis is closely associated with the development of conditions such as obesity, diabetes, inflammatory bowel disease, autoimmune disorders, and even mental illnesses.6, 7

https://www.sciencedirect.com/science/article/pii/S3117633X26000011

Nature: A 'super' El Niño could transform the Amazon. Is the world's biggest rainforest doomed?: The Amazon rainforest might be closer to a tipping point than scientists thought. Some fear that droughts and fire could nudge it into irreversible decline.

El Niño is back with a vengeance. A mammoth patch of warm water is growing in the equatorial Pacific Ocean, and the US National Oceanic and Atmospheric Administration is giving four-in-five odds that the disruptive climate phenomenon will turn into a "very strong" event by the end of the year. Some forecasters say this El Niño is on track to become the strongest in at least 150 years.For the Amazon rainforest, the timing could hardly be worse.

El Niño events, which happen roughly once every two to seven years, upset weather patterns around the globe. For the Amazon basin, they typically trigger severe droughts. The most recent El Niño, which formed in June 2023 and had dissipated by June 2024, hit the rainforest especially hard by drying out large sections1, shrinking major rivers to historic lows2 and helping to fuel the worst fire season in more than two decades3 (see 'Tree troubles'). Some researchers suggest that the developing El Niño, coming on top of warming and drying caused by climate change, might push the rainforest past its 'tipping point' — shorthand for the threshold at which a runaway cascade of drying, tree death and wildfire would begin to spread irreversibly across the Amazon basin. If that were to happen, rainforest

would give way to savannah and degraded woodland over decades, potentially releasing an amount of carbon equivalent to several years of global emissions and dramatically reducing rainfall across South America and beyond4.
The impacts of the current El Niño might not be as severe as the gloomiest forecasts suggest; much depends on how strong it becomes, and how much of the forest burns. But the Amazon is entering this test in a weakened state, and some researchers who know it well are uneasy. "If this next El Niño really is as strong as we think it will be, it might result in things like huge wildfires in the Amazon, spreading across areas that were unimaginable before," says Bernardo Flores, a specialist in Amazon resilience at the Juruá Institute in Manaus, Brazil. "We will see how much of the forest might die from it."
https://www.nature.com/articles/d41586-026-02449-w?utm_source=Live+Audience&utm_campaign=9e7926dce0-nature-briefing-anthropocene-20260821&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Beyond survival: malaria-associated acute kidney injury
In this issue of The Lancet Global Health, Kagan A Mellencamp and colleagues report that children who survive severe malaria complicated by acute kidney injury (AKI) have three times the risk of major adverse kidney events, four times the risk for mortality 2 years after discharge, and an elevated likelihood of subsequent chronic kidney disease (CKD).1 Their findings shift attention from the immediate question of survival to the longer term question of kidney health after survival. This reframing is timely. Malaria caused an estimated 263 million cases and 597 000 deaths globally in 2023, with the WHO African region accounting for 94% of malaria-related deaths; children younger than 5 years accounted for more than three-fourths of these deaths.2
For decades, the paediatric severe-malaria agenda has appropriately prioritised a single urgent outcome: survival through acute illness. That priority remains unquestionable. However, the new findings presented by Mellencamp and colleagues challenge the assumption that malaria-associated AKI is typically transient after fever resolves and serum creatinine levels improve. This distinction is important because AKI in severe malaria is common, frequently community acquired, and often under-recognised, particularly when non-standard definitions, isolated creatinine measurements, or inadequate urine-output monitoring are used.3,4
The biological rationale for persistent kidney vulnerability is compelling. Severe Plasmodium falciparum malaria can damage the kidney through haemolysis, systemic inflammation, endothelial dysfunction, microvascular sequestration, haemodynamic instability, and nephrotoxic exposures during a period of physiological vulnerability.5 Apparent clinical recovery, reflected by normalisation of serum creatinine concentrations, might therefore not equate to structural recovery. Because serum creatinine is an imperfect and late marker of nephron injury, children might leave a hospital with acute kidney damage that manifests later as hypertension, proteinuria, reduced estimated glomerular filtration rate, CKD, or premature death.6,7
The findings presented by Mellencamp and colleagues should also prompt reconsideration of what constitutes a complete severe-malaria outcome. Parasite clearance, survival to discharge, and neurological recovery remain crucial endpoints, but they are insufficient if children subsequently enter an unrecognised trajectory from AKI to acute kidney disease (AKD) and CKD. Previous data from prospective studies in Uganda showed that AKI affects a substantial proportion of children with severe malaria, AKD might be detectable after discharge, and mortality after discharge is higher among survivors with unresolved kidney disease.4 Longer term follow-up strengthens the case that kidney outcomes should be integrated into severe-malaria survivorship.

https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00169-5/fulltext?dgcid=raven_jbs_aip_email

Nature: Moderna cancer vaccine stops melanoma returning: what's next for personalized treatments?

Promising trial results suggest cancer vaccines work and could be used to target other tumours.

A personalized mRNA vaccine for melanoma reduced the risk of the cancer returning in a phase III clinical trial, the companies behind the trial announced this week. The vaccine — which relies on the same mRNA technology used to develop COVID-19 shots — is the first mRNA-based cancer treatment to show success in a late-stage trial.

"It's incredibly exciting," says Seth Cheetham, an mRNA scientist at the University of Queensland in Brisbane, Australia. "This is the first really large-scale trial" to release data for a personalized mRNA cancer vaccine. The results put it a step closer to regulatory approval for wider use and could bolster the whole field, he adds. Marco Gerlinger, a medical oncologist at St Bartholomew's Hospital in London, says the study provides proof of principle that personalized cancer vaccines work. "This is important as they can be designed against many different cancer types," adds Gerlinger, who is a principal investigator on a trial for a cancer vaccine being developed by BioNTech in Mainz, Germany.

The study could have implications beyond the field of cancer, too, says Sam Barrell, the chief executive of medical research charity LifeArc, in London. It will help to build confidence in more-tailored approaches to treatments for rare conditions that are often driven by unique genetic mutations, she adds.

How does the vaccine work?: The vaccine, called intismeran, doesn't prevent a person from developing cancer in the first place, rather it seeks to prevent it from recurring.

The study enrolled around 1,100 people with advanced melanoma that had been completely surgically removed. They received either the vaccine combined with an immunotherapy drug called pembrolizumab, which is used to treat the cancer, or they received pembrolizumab alone. The vaccine's developers Merck, in Rahway, New Jersey, and Moderna, which is headquartered in Cambridge, Massachusetts, announced on Wednesday that people on the combined treatment survived for longer without recurrence than did those who received only pembrolizumab. The companies said that they plan to present more-detailed data at an upcoming medical conference.

https://www.nature.com/articles/d41586-026-02612-3?utm_source=Live+Audience&utm_campaign=3600bd2098-nature-briefing-daily-20260821&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Domain-specific physical activity levels and risk of dementia: a systematic review and meta-analysis

Associations between physical activity and distinct health outcomes vary by domain (eg, leisure-time, occupational, household, or commuting); however, comparable evidence on dementia risk remains scarce. We aimed to examine the associations between domain-specific physical activity and risk of all-cause dementia, Alzheimer's disease, and vascular dementia.

In this systematic review and meta-analysis, we systematically searched PubMed, CINAHL, Scopus, PsycINFO, SPORTDiscus, and Web of Science for cohort and case–control studies published between Jan 1, 2021, and May 2, 2026. We also included studies from a previous systematic review (from database inception to Oct 21, 2021) with the same search strategy and eligibility criteria. Eligible studies included adults aged 20 years or older with cognitive function assessed at baseline, physical activity measures, and at least 1 year of follow-up.

Studies were appraised with the Rayyan web-based platform and summary data (relative risk [RR] and 95% CI) were extracted by up to six independent reviewers. Outcomes were all-cause dementia, Alzheimer's disease, and vascular dementia, analysed by multilevel random-effects meta-analyses. Study quality was assessed with an adapted scale. This study is registered with PROSPERO (CRD420251010899).
Among 6270 identified records, 17 studies were eligible for inclusion. Combined with 57 studies in the previous systematic review, we included 74 studies totalling 4 227 297 participants (2 230 046 [52·8%] female and 1 997 251 [47·2%] male; median age 67·3 years [IQR 56·5–74·1]). 40 (54%) studies were of moderate or high quality and 69 (93%) were conducted in high-income countries. Over a median follow-up of 10·0 years (IQR 5·1–21·3), high physical activity levels were associated with reduced risks of all-cause dementia (n=146 effect sizes; RR 0·80 [95% CI 0·75–0·86]; I2=97·4%), Alzheimer's disease (n=59; 0·79 [0·70–0·90]; I2=91·3%), and vascular dementia (n=21; 0·71 [0·58–0·87]; I2=77·5%); however, associations varied by domain. Leisure-time (k=20 studies; n=33 effect sizes; RR 0·76 [95% CI 0·65–0·88]; I2=96·6%) and household (k=1; 0·85 [0·74–0·98]) physical activity were associated with a reduced risk of all-cause dementia. By contrast, occupational (k=5; 1·20 [1·01–1·42]; I2=85·6%) and commuting (k=2; 1·10 [1·03–1·18]; I2=0·0%) physical activity were associated with an increased risk. Dose–response meta-analyses showed non-linear inverse associations for leisure-time and occupational activity. Certainty of evidence ranged from very low to low across domains.
Interpretation
The association between physical activity and dementia risk might be domain-specific. Public health strategies for the prevention of dementia should address equitable access to safe spaces for exercise, adequate leisure time, and mitigation strategies in occupational settings.
https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(26)00142-8/fulltext?et_rid=1169729274&et_cid=6044025

IMPAKTER: Ebola's New Warning: The Bundibugyo Outbreak Shows the World Is Not Prepared
The 2026 Bundibugyo Ebola outbreak in eastern Democratic Republic of the Congo (DRC) is no longer a regional health emergency. In a matter of weeks, this virus has spread faster than national and international systems can contain, crossing into Uganda and threatening, once again, to destabilize a region already strained by conflict, displacement, and climate-driven ecological change.
For global policymakers, the lesson is not simply that Ebola remains dangerous. It is that the world's outbreak-response architecture — built after the catastrophic 2014–2016 West Africa epidemic — is now buckling under the weight of new pressures.
Bundibugyo Ebola, first identified during an outbreak in Uganda's Bundibugyo District in 2007, has historically been the "quiet cousin" of the more infamous Zaire strain. Compared with the scale of the current outbreak, previous Bundibugyo Ebola outbreaks were relatively small: the 2007 outbreak in Uganda recorded 149 cases and 55 deaths, a case-fatality rate of about 37%, while the 2012 outbreak in the Democratic Republic of the Congo recorded 56 cases and 29 deaths, a case-fatality rate of about 52%. But as of early August, the 2026 Bundibugyo Ebola outbreak has already surpassed both, with 3,874 confirmed cases and 1,751 deaths, according to data provided by the DRC.
This is in line with a report from WHO issued a week earlier (July 30, 2026), noting that "the outbreak is now the largest Ebola outbreak ever reported in the Democratic Republic of the Congo," with 3,605 confirmed cases and 1,587 deaths. While the case-fatality ratio, at ~45%, appears lower than the lethal Zaire strain, it is nevertheless exceptionally high for the Bundibugyo species, whose historical average hovered around 30–35%.

https://impakter.com/new-ebola-outbreak-shows-the-world-is-not-prepared/

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

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.

https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00135-X/fulltext?dgcid=raven_jbs_aip_email

Nature: Too hot to sleep? How heatwaves at night affect our health:As climate change ramps up, scientists must urgently understand how night-time heat makes it harder for our bodies to rest and recover.

Global warming isn't just about heat during the day. Nights are also getting hotter1–3. In May, Delhi recorded an overnight minimum temperature of 32.4 °C, and other parts of India remained 3–5 °C above normal after dark. As Western Europe experienced its hottest June on record, France registered a record overnight low of 22 °C, and East Saxony, Germany, sweltered at a historic 29.4 °C. In July, record night-time warmth exceeding 27 °C added to the mugginess of cities on the US Gulf and Atlantic coasts.

Heat affects people's sleep (see 'Global sleep deficit'). Two-thirds of respondents to a UK survey said they struggled to sleep during the June heatwave, with almost half losing at least three hours of sleep each night (see go.nature.com/5rcv6y). An analysis of more than 1,300

cities found that, during 2020–25, each resident lost nearly 56 hours of sleep, on average, each year owing to night-time heat4.
The consequences go beyond lost sleep. Across 28 East Asian cities, intense heatwaves at night were associated with a 3% increase in deaths (excluding those from injuries and other external causes)3. In Hong Kong, long, hot nights — around 30 °C for 12 hours — were linked to a 3.1% rise in emergency hospital admissions, reaching 5.3% among older and poorer people2.
But scientists don't fully understand how hot nights affect health and sleep. To get the full picture, measuring temperatures alone is insufficient; people's physiological responses to heat must also be studied. Here's what is needed to better understand the link and manage night-time heat.
https://www.nature.com/articles/d41586-026-02532-2?utm_source=Live+Audience&utm_campaign=9e7926dce0-nature-briefing-anthropocene-20260821&utm_medium=email&utm_term=0_-33f35e09ea-50521540

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.
Demographic, economic, and healthcare infrastructure information was obtained from public resources. Data about the JKN membership structure, performance information, and reimbursement were provided by the BPJS national head office. For analysis, an ANOVA was used to compare reimbursement indexes for primary healthcare (PHC) and advanced healthcare (AHC). The usage of primary care resources was analyzed by comparing clustered provinces and utilization indices differentiating poor [Penerima Bantuan Iur (PBI) membership] and non-poor populations (non-PBI). Factorial and canonical discrimination analyses were applied to identify the determinants of PHC structures.
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 theachievement 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://www.academia.edu/73698859/Availability_and_Accessibility_of_Primary_Care_for_the_Remote_Rural_and_Poor_Population_of_Indonesia?email_work_card=title

Human Resources for Health: A scoping review of training and deployment policies for human resources for health for maternal, newborn, and child health in rural Africa
Most African countries are facing a human resources for health (HRH) crisis, lacking the required workforce to deliver basic health care, including care for mothers and children. This is especially acute in rural areas and has limited countries' abilities to meet maternal, newborn, and child health (MNCH) targets outlined by Millennium Development Goals 4 and 5. To address the HRH challenges, evidence-based deployment and training policies are required. However, the resources available to country-level policy makers to create such policies are limited. To inform future HRH planning, a scoping review was conducted to identify the type, extent, and quality of evidence that exists on HRH policies for rural MNCH in Africa.
Fourteen electronic health and health education databases were searched for peer-reviewed papers specific to training and deployment policies for doctors, nurses, and midwives for rural MNCH in African countries with English, Portuguese, or French as official languages. Non-peer reviewed literature and policy documents were also identified through systematic searches of selected international organizations and government websites. Documents were included based on pre-determined criteria.
There was an overall paucity of information on training and deployment policies for HRH for MNCH in rural Africa; 37 articles met the inclusion criteria. Of these, the majority of primary research studies employed a variety of qualitative and quantitative methods. Doctors, nurses, and midwives were equally represented in the selected policy literature. Policies focusing exclusively on training or deployment were limited; most documents focused on both training and deployment or were broader with embedded implications for the management of HRH or MNCH. Relevant government websites varied in functionality and in the availability of policy documents.
The lack of available documentation and an apparent bias towards HRH research in developed areas suggest a need for strengthened capacity for HRH policy research in Africa. This will result in enhanced potential for evidence uptake into policy. Enhanced alignment between policy-makers' information needs and the independent research agenda could further assist knowledge development and uptake. The results of this scoping review informed an in-depth analysis of relevant policies in a sub-set of African countries.
https://www.academia.edu/17722359/A_scoping_review_of_training_and_deployment_policies_for_human_resources_for_health_for_maternal_newborn_and_child_health_in_rural_Africa?email_work_card=thumbnail

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.academia.edu/97438984/Keys_to_Expanding_the_Rural_Healthcare_Workforce_in_Kyrgyzstan?email_work_card=abstract-read-more

Nature: Trump wants MMR vaccine split up: the science behind why it's a bad idea
Numerous studies have shown that separating childhood jabs will delay protection and increase costs for families.
Researchers are worried that an executive order signed by US President Donald Trump earlier this week will have negative consequences for children's health across the country — and are laying out the scientific evidence that backs up their concerns.
The 10 August order calls for children to be vaccinated against fewer diseases than they currently are, and it recommends that combination shots, starting with the one for measles, mumps and rubella — commonly known as the MMR vaccine — be split into individual jabs that are spread out over time.
The order is "not in any sense grounded in science", says Paul Offit, a viral immunologist and director of the Vaccine Education Center at the Children's Hospital of Philadelphia in Pennsylvania.
Trump's authority to change the schedules that physicians use to vaccinate children is limited, because these schedules are typically set by US state health officials.
But Nature spoke to paediatric vaccine specialists to learn what the effects of delaying kids' vaccines — or even recommending a delay — could be.
What does the science say about splitting up vaccines?
When he signed the executive order, Trump justified the change by stating that combined vaccines contain a dangerous amount of fluid. A vaccination is "the size of a bottle of soda", he said. But Offit says there is no evidence to support this claim. One dose of a childhood vaccine such as the MMR shot contains roughly one-tenth of a teaspoon (about half a millilitre) of fluid, he adds, which is a far cry from the "vats" that Trump said they contain.
Previous research1,2 has shown that combined vaccines against multiple diseases can increase population-level immunity and decrease health-care costs, because families can visit the clinic fewer times to receive fewer shots, says Mark Jit, a health economist at New York

University. For example, the proportion of people vaccinated against diphtheria, tetanus, pertussis and a bacterial infection called haemophilus influenzae type b increased by 8% in Belgium after the country introduced a jab that combined all four shots into one3.
https://www.nature.com/articles/d41586-026-02515-3?utm_source=Live+Audience&utm_campaign=07bdbe7ad7-nature-briefing-daily-20260813&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Academia Medicine and Health: The destruction of healthcare in armed conflict: policy implications and accountability

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

Armed conflict harms population health in ways that extend far beyond battlefield mortality. Among its most destructive impacts is the strategic destruction of healthcare infrastructure: hospitals and governance systems are damaged or rendered non-functional; health workers are killed or displaced due to insecurity; medical supply chains collapse; and water and sanitation systems are disrupted or destroyed [1]. These processes exacerbate otherwise manageable health conditions into large-scale morbidity and mortality [2]. Indeed, across contemporary conflicts, attacks on healthcare have rendered large proportions of facilities non-functional, disrupted essential services, and eroded access to care, transforming preventable illness into intergenerational challenges [3–17]. Table 1summarises the extent of health facility destruction across selected conflicts, demonstrating that these losses reflect a structural pattern rather than isolated anomalies.
https://www.academia.edu/3070-3530/3/2/10.20935/AcadMedHealth8372

NEJM: Who Will Care for America? Immigration Policy and the Coming Health Workforce Crisis

Since taking the oath of office on January 20, 2025, President Donald Trump and his administration have unleashed a torrent of executive actions as part of an “America First” agenda. Central among these are policies to facilitate mass deportation, including the rescission of the Department of Homeland Security’s guidance on “sensitive areas” — an Obama-era rule that prohibited Immigration and Customs Enforcement (ICE) agents from arresting people in houses of worship, schools, and university campuses, along with hospitals, clinics, and other health care settings. With these restrictions lifted, ICE raids have since escalated in both frequency and intensity nationwide, even as U.S.–Mexico border crossings dropped to historic lows.

But what happens when immigrants who work in the U.S. health care system are forced to leave? Just 4 days after the inauguration, 25 undocumented Filipino direct care workers were

arrested in an ICE raid at a senior care facility in Chicago; at least 8 have since been deported.1Weeks later, Dr. Rasha Alawieh, assistant professor of medicine at Brown University, was denied reentry after a return flight from Lebanon. Despite a court order barring removal without due process, Alawieh had her H-1B visa revoked and was deported on March 14.2 Alawieh was one of only three transplant nephrologists in Rhode Island, and her forced departure left a critical gap in a highly technical specialty, further limiting access to lifesaving care for patients with end-stage kidney disease.

As physicians, we have witnessed firsthand the harms that such policies pose to patients and health care workers alike. In one case we know of, an older patient with metastatic cancer fell at home and lay on the floor for days before being found by a family member; he died shortly after being admitted to a local hospital. Though it's uncertain whether he would have lived had he been found sooner, his home health aide had stopped coming to work for fear of deportation.

Such tragedies illustrate the dangers that the current political climate pose to immigrants (whether documented or undocumented) who interact with the U.S. health care system. As the federal government seeks to curb immigration of all forms, immigrant health care workers and their patients will inevitably find themselves caught in the dragnet, which will have serious consequences for the system at large. The United States has already been grappling with severe health care worker shortages, which are projected to worsen over the next few years. According to the Bureau of Health Workforce, the physician shortage is expected to increase from 12% (124,180 physicians) in 2027 to 16% (187,130 physicians) in 2037. Among primary care physicians, the projected gap is even wider — growing from 18% (50,100) to 27% (87,150) in that time frame.

https://www.nejm.org/doi/full/10.1056/NEJMp2504949

Nature: The baffling science of SSRIs: how do they really work?

The world's most popular antidepressant drugs are under fire. But are they really harder to quit than heroin?

Every year, millions of people start taking a drug with therapeutic effects that can't be fully explained, for a condition that can't be objectively diagnosed with a laboratory test. Selective serotonin reuptake inhibitors, or SSRIs, are among the most prescribed medications in the world. Yet, even after decades of use, scientists are still untangling the biological changes that SSRIs trigger in the brain and body.

"We fundamentally don't know how they work," says Maurizio Fava, a psychiatrist at Massachusetts General Hospital in Boston.

That uncertainty collided with politics earlier this year when, speaking at a wellness summit focused on mental health, US Secretary of Health Robert F. Kennedy Jr argued that the drugs are greatly overused and have withdrawal risks that are on a par with heroin. His claims prompted an outcry from some scientists and clinicians, who warned that Kennedy had overstated the concern, potentially scaring people away from life-saving treatment. But others said he had identified a real problem, even if clumsily. "This is a major public-health issue," says Mark Horowitz, a psychiatrist at Adelaide University in Australia. "I hope the messenger's controversialness doesn't kill the message."

The divide reflects how much remains unresolved with regards to SSRIs. Researchers are still piecing together a complicated picture of the drugs' therapeutic actions, involving neural circuits and their connecting synapses, gene expression, inflammation, stress hormones and psychological expectation. None yet offers a complete explanation. And the chain of biological changes that ultimately relieves symptoms can look very different from one person to the next. "There's not one route to depression," says Catherine Harmer, a cognitive neuroscientist at the University of Oxford, UK.

But many scientists say the field is entering a more revealing era, as new tools begin to connect symptoms to biological processes. “We’re at an inflection point,” says Mark Rapaport, a psychiatrist at Stanford University in California and president of the American Psychiatric Association. He likens it to cancer research in the 1990s, when advances in molecular biology and basic science were leading to the development of the first targeted therapies.

Even many people who are critical of Kennedy’s claims acknowledge that SSRI withdrawal can be a substantial issue for some people. With an estimated one in six adults in the United States taking an antidepressant, even a small proportion experiencing serious problems while discontinuing the drugs amounts to a large public-health concern. “It’s a real phenomenon,” says Fava.

Before scientists can explain fully why withdrawal symptoms occur — or how best to prevent or treat them — they need to finish answering more basic questions: what is happening in the brain when someone is depressed? And what, exactly, are SSRIs doing to change it?

https://www.nature.com/articles/d41586-026-02570-w?utm_source=Live+Audience&utm_campaign=283d7151c4-nature-briefing-daily-20260826&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Medical Education: Empirical evidence for symbiotic medical education: a comparative analysis of community and tertiary-based programmes

Flinders University has developed the Parallel Rural Community Curriculum (PRCC), a full year clinical curriculum based in rural general practice in South Australia. The examination performance of students on this course has been shown to be higher than that of their tertiary hospital-based peers.

To compare the learning experiences of students in the community-based programme with those of students in the tertiary hospital in order to explain these improved academic outcomes.

A case study was undertaken, using an interpretivist perspective, with 3 structured interviews carried out over 2 academic years with each of 6 students from the community-based programme and 16 students from the tertiary hospital. The taped interviews were transcribed and analysed thematically using NUD*IST software.

The community-based programme was successful in immersing the students in the clinical environment in a meaningful way. Four key themes were found in the data. These represented clear differences between the experiences of the community-based and hospital-based students. These differences involved: the value that students perceived they were given by supervising doctors and their patients; the extent to which the student’s presence realised a synergy between the work of the university and the health service; opportunities for students to meet the aspirations of both the community and government policy, and opportunities for students to learn how professional expectations can mesh with their own personal values.

This study has provided empirical evidence for the importance of the concept of symbiosis in understanding quality in medical education.

https://www.academia.edu/2086825/Empirical_evidence_for_symbiotic_medical_education_a_comparative_analysis_of_community_and_tertiary_based_programmes?email_work_card=view-paper

Nature: Ocean temperatures set to break all-time record: what’s next?

High sea surface temperatures are expected to weaken ocean carbon sinks and damage coral reefs. The world’s oceans are on the brink of setting an all-time heat record, reaching

temperatures that could roil marine ecosystems and sap the ocean's ability to take up carbon dioxide from the air.
"It just spells trouble for the planet," says Kristina Dahl, a climate scientist at Climate Central, a non-profit organization in Princeton, New Jersey.
Sea surface temperatures — boosted by human-caused climate change and a powerful El Niño event gaining strength in the Pacific Ocean — have already broken monthly records for the past two months, according to the European Commission's Copernicus Climate Change Service. In July, the average sea surface temperature outside the Arctic and Antarctic oceans was 20.96 °C, surpassing the previous July record set in 2023 by 0.07 °C, the agency reported. That followed a record hot June (see 'Hot water').

This leaves the oceans about to become hotter than they've been at any other point on record: average sea surface temperatures are currently hovering just a few hundredths of a degree below the current record from March 2024. Given that temperatures tend to rise for months after the emergence of an El Niño, this record will almost certainly be broken this year. "It's just a case of when," says Samantha Burgess, a climate scientist and Copernicus' deputy director in Reading, UK.
Much of the anomalous heat comes from a warm band of water across the tropical Pacific that marks the El Niño climate pattern, which forecasts suggest could become the strongest on record. But El Niño isn't the whole story. Wide areas of the northern Pacific and Atlantic, as well as much of the Mediterranean Sea, are notably hotter than the average temperature from the three decades before 2020.
An analysis tool developed by Climate Central shows that human-caused climate change made the high temperatures in many parts of the ocean dozens of times more likely.
"Basically, everywhere on Earth, we're having above-normal temperatures in the ocean," says Dahl.
https://www.nature.com/articles/d41586-026-02496-3?utm_source=Live+Audience&utm_campaign=07bdbe7ad7-nature-briefing-daily-20260813&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Impact of the Strengthening Teamwork and Respect (STAR) intervention on organisational learning culture and person-centred maternity care in rural South Africa: an uncontrolled before-and-after implementation study
Respectful maternity care is essential for quality maternal and newborn health services. Interventions to promote respectful care often focus on training, overlooking organisational culture underpinning disrespectful behaviour. This study aimed to evaluate the implementation and effects of the Strengthening Teamwork and Respect (STAR) intervention on organisational learning culture and person-centred maternity care (PCMC).
This implementation research used an uncontrolled before-and-after design with continuous process evaluation in nine district hospitals in KwaZulu-Natal, South Africa. Surveys with postpartum women (baseline n = 893; endline n = 918) and maternity staff (baseline n = 104; endline n = 102) assessed changes in PCMC using the validated PCMC scale and organisational learning culture using the Dimensions of Learning Organisations Questionnaire (DLOQ). Descriptive statistics and Wilcoxon-Rank Sum test explored changes in the DLOQ. PCMC scores were modelled using mixed-effects linear regression including interaction terms with time period (pre-vs post) to examine variation across key predictors. Five of seven DLOQ dimensions improved, particularly amongst attendees of STAR learning sessions. Mean re-scaled PCMC scores increased from 61.5/100 to 65.7/100 post-intervention ($p < 0.0001$), with significant improvements in communication and autonomy (53.5/100–59.4/100; $p < 0.0001$) and supportive care (57.5/100–63.0/100; $p < 0.0001$). Mixed-effects

analysis showed an overall increase of 4.56 percentage points. Women in the lowest socio-economic status group and those with fewer antenatal care visits experienced the largest gains.
Modest improvements in organisational learning culture and PCMC were observed following STAR implementation, with larger gains among disadvantaged women. While causal attribution is limited, the findings suggest that participatory approaches targeting organisational culture may support more equitable and respectful maternity care in resource constrained settings.
https://www.thelancet.com/journals/lanafr/article/PIIS3050-5011(26)00051-9/fulltext?dgcid=raven_jbs_etoc_feature_lanafr

Scientific American: Major COVID study that fueled vaccine skepticism retracted over 'misinformation'
This study was originally published in 2024 and was criticized as being misleading by other scientists at the time
A controversial 2024 study that some vaccine skeptics used to argue that millions of people likely died as a result of COVID vaccines has been retracted over misinformation and issues with the research.
The article was originally published in the BMJ Public Health in May 2024. It analyzed data from 47 Western countries and concluded that there had been more than three million excess deaths between 2020 and 2022, a statistic known as excess mortality.
"Overall, the journal concludes that the discussion of causes of mortality is imbalanced, lacks rigour, and includes misinformation," the BMJ stated in the retraction notice.
The study did not specifically cite vaccines and lockdown measure as the reasons for the deaths, but the authors noted that COVID vaccines that were deployed to save lives also appeared to be responsible for a large number of "suspected adverse events." At the time of publication, the findings were taken by some prominent vaccine skeptics and critics of governmental pandemic responses—including several Republican lawmakers in the U.S.—as proof that the science and policies around COVID were flawed or even nefarious.
The results also immediately garnered skepticism in the weeks following publication. A month after the study appeared in the journal, the BMJ began an investigation into its quality, as did the Netherland's Princess Máxima Center, a pediatric hospital, where three of the paper's four co-authors then worked. One of them, corresponding author and now independent researcher Saskia Mostert, testified before a U.S. congressional subcommittee about the report's findings in June 2026.
https://www.scientificamerican.com/article/major-covid-study-that-fueled-vaccine-skepticism-retracted-over-misinformation/?fbclid=IwY2xjawTumlVwZG9mAWV4dG4DYWVtAjEwAHNydGMGYXBwX2lkEDIyMjAzOTE3ODgyMDA4OTIAAR4E3O4i7jtLpUtyLGRQsM9Jp7qhIomWs43bi7P0ibmnQOcK2Z-4cD2RTrq9_A_aem_l8lr5spIrz2RepHplB6y3w

The Lancet Editorial: Breastfeeding in Africa: mothers need enabling environments beyond education
Breastfeeding is one of the most cost-effective interventions for improving child survival. Child benefitsof breastfeeding include protection against infectious diseases, and improvement of long-term cognitive and educational outcomes. Although education campaigns have increased early initiation across Africa, with seven in ten newborns breastfed within the first hour of life as recommended by WHO, sustaining exclusive breastfeeding for the first six months and continued breastfeeding alongside complementary foods until two years of age and beyond remains a challenge. Marked heterogeneityexists between countries,

with exclusive breastfeeding rates ranging from approximately 80% in Burundi and Rwanda to just 25% in Guinea and 19% in Gabon. As the global community marks World Breastfeeding Week (Aug 1–7, 2026), the next step in closing this gap requires recognition of breastfeeding as a collective societal responsibility rather than one borne by mothers alone. Multiple system-level barriers continue to undermine exclusive and continued breastfeeding across Africa, slowing progress towards several Sustainable Development Goals (SDGs). Weak healthcare systems, including inadequate breastfeeding counselling, insufficient provider training, inconsistent implementation of the Baby-Friendly Hospital Initiative (BFHI), routine formula supplementation, and rising caesarean section rates without adequate pain management and lactation support, limit breastfeeding initiation and duration. These challenges are compounded by weak enforcement of maternity protection policies and the International Code of Marketing of Breast-milk Substitutes, aggressive commercial marketing of formula, and insufficient funding for breastfeeding support programmes. In Africa, where more than 80% of women work in the informal sector, limited maternity protection and the absence of breastfeeding-friendly workplaces present major barriers to continued breastfeeding. Persistent cultural misconceptions, inadequate family and community support, lingering concerns about HIV transmission despite updated guidance, socioeconomic and urban–rural inequities, and disruptions caused by conflict, displacement, and climate-related disasters further constrain breastfeeding practices.
https://www.thelancet.com/journals/lanafr/article/PIIS3050-5011(26)00101-X/fulltext?dgcid=raven_jbs_etoc_email

Indian Journal of Medical Research: The challenge of building rural health services

The challenge of building rural health services, State's responsibility in providing these and training paramedical personnel to carry out limited curative and preventive responsibilities were part of India's development thinking before and after independence.

The Sub-Committee on Health of the National Planning Committee of the Indian National Congress set up in 1938 the Gandhian Plan the Bombay Plan and the People's Plan of 1944 despite major differences in addressing the issue of economic growth and poverty, unanimously agreed on building rural health services.

The Bhore Committee Report called for an integrated 3-tier health infrastructure to provide basic services for the rural areas. Reviewing past achievements, the Mudaliar Committee Report in 1962 offered financial options for building health services. India's mixed economy attempted to accommodate a welfare policy that led to expansion of health service infrastructure, manpower and public sector drugs and instruments production units. The training of paramedics was a key activity through nursing, ANM and Basic Health Workers and Health Assistant's training schools. After the Third Plan this emphasis got diluted. Investments in health services continuously declined and urban hospital based services got priority over the rural 3-tier system proposed by Bhore Committee. To contain the emerging dissatisfaction in rural areas, the State introduced the Minimum Needs Programme in the Fifth Five Year Plan (1974) the Community Health Workers Scheme in 1979, and expanded and restructured primary health Centre network adding Community Health Centres in the Sixth Five year Plan (1981)

The acceptance of Alma Ata declaration of Comprehensive Primary Health Care in 1978 the National Rural Health Mission (NRHM) of 2005, training Accredited Social Health Activists (ASHAs) and now the proposal for a shorter training for rural practitioners, all were meant to strengthen rural infrastructure. The para-medics, however, remained neglected as a variety of male and female health workers were integrated into multi-purpose workers of both sexes in 1973 without much attention to

improving the number and quality of training schools. Instead of an effective integrated manpower, capable of responding to the needs of rural areas the State created an army of ASHAs with limited skills to apparently provide full coverage.
https://www.academia.edu/56627086/The_challenge_of_building_rural_health_services?email_work_card=view-paper

The Lancet: Biodiversity: actions lagging behind aspirations

In 2022 governments entered into a ground-breaking multinational agreement to halt and reverse biodiversity loss globally: the Kunming-Montreal Global Biodiversity Framework. The agreement was precipitated by a recognition that nature is declining at the fastest rate seen in human history, with one million plant and animal species facing extinction in the coming decades, driven by human conversion and over-exploitation of land and sea, by climate change, pollution, and the spread of invasive species. Biodiversity has arguably received less policy attention than issues like climate change, but healthy, functioning, and biodiverse ecosystems are foundational to human wellbeing and prosperity, as well as to the health and resilience of the planet as a whole.

The Kunming-Montreal Framework is a high-level roadmap for its 195 signatory countries that set transformative goals to restore and even expand biodiverse ecosystems by 2050, to achieve a balanced relationship with nature where its value is properly recognised and sustainably used, and to share the benefits of biological resources fairly and collaboratively. Ambitious targets for the year 2030 were agreed, the headline targets being the so-called "30x30" ie, to restore at least 30% of degraded terrestrial and marine ecosystems and to place at least 30% of land, waters, and seas in conservation areas. Now, at the halfway point to those 2030 targets, a first draft report on progress in implementing the framework has been published for open peer review.

The overarching message of the draft progress report is that commitments and implementation are falling well short of the framework's 2030 ambitions. While most countries have set national targets, collectively their proposals do not yet meet the framework's goals. On the target of restoring 30% of degraded ecosystems by 2030, for example, a majority of countries have set some sort of target in their national plans, but less than half have explicitly linked restoration with boosting ecosystem biodiversity, functioning or integrity. Collectively, countries reported 193 million hectares of land under restoration in 2025, but this represents only a modest amount of the degraded land globally. On the target of placing 30% of ecosystem areas into conservation zones by 2030, coverage did increase several percentage points up to around 20% for aquatic and terrestrial ecosystems, but that is substantially less than the 30% target and only 100 countries actually provided quantitative data on this metric. Again, while most countries committed to the basic aim of increasing the coverage of protected areas, far fewer incorporated the wider recommendations from the framework, like prioritising particularly important ecosystems or a representative range, considering broader landscape and seascape integrity, or ensuring equitable governance of protected areas.

Implementation is a key shortcoming at this halfway point to the 2030 targets. On the positive side, the availability of funding, knowledge, and other resources for implementation have all increased, but these remain insufficient to meet the scale of transformation needed. As ever, inadequate funding for biodiversity projects is a major constraint, especially for lower income countries. So far, few countries have followed the framework's recommendations to boost spending on biodiversity, such as through phasing out subsidies harmful to biodiversity and replacing them with biodiversity-positive incentives or looking at novel mechanisms to secure private funding for biodiversity projects. Despite the scarcity of funding, from a research community perspective there remains great scope for increasing

resource and technical knowledge sharing through collaboration in fields such as environmental monitoring or data analytics, especially through partnerships between higher-income and lower-income countries.
https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00070-7/fulltext?dgcid=raven_jbs_etoc_email

NEJM: The Inequality–Pandemic Cycle — Rethinking Preparedness
We are in a new era of pandemics. Over past millennia, millions of people died from infectious diseases, with few tools for stopping deadly pathogens. Today, we have science that previous generations would have considered miraculous — Nobel Prize–winning vaccines, precision antiretrovirals, genomic surveillance systems that can sequence a new pathogen within hours. Yet major outbreaks have become more frequent: Ebola, severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), mpox, and more. The largest outbreaks have killed tens of millions of people — at least 44 million have died of AIDS, and 15 million to 18 million died during Covid-19's first 2 years.1
The dominant model of pandemic preparedness has focused on technical capacities: stronger laboratories and surveillance, more effective vaccines and medicines, faster emergency response. Yet in real-life pandemics, some of the most "prepared" countries have mounted the most ineffectual responses. Among the officials and experts charged with stopping pandemics, the current understanding of what drives pandemic risk for the world is proving to be insufficient. The missing element, we believe, is inequality.
This era of pandemics has also been an era of high and increasing economic inequality. Since the 1980s, when AIDS first became pandemic, the world has grown many times wealthier, but the distribution of wealth and income within countries has grown more unequal (see figure). The very wealthiest sliver of people now control several times more wealth than the less wealthy half of humanity. Today, more than 90% of the world's population lives in countries with economic inequality levels considered to be high according to global standards.2 Gaps among countries have narrowed, but global inequality remains stark: average per capita national income in the United States is about 15 times that in Africa. These economic inequalities intersect with, and reinforce, inequalities along lines of race, ethnic group, gender, and sexual orientation.
The co-occurrence of increasing pandemic frequency and increasing inequality is not coincidental — it reflects a self-reinforcing cycle: inequality makes outbreaks more likely to become pandemics, then drives their severity and duration, while pandemics deepen inequality, making future outbreaks harder to control and fueling the next cycle.
https://www.nejm.org/doi/full/10.1056/NEJMp2607839?query=TOC

The Lancet: Treatment utilisation for Aboriginal and Torres Strait Islander people diagnosed with prostate cancer in Australia: a population-based study
Prostate cancer is the most common cancer diagnosed in Aboriginal and Torres Strait Islander men. Surgery and radiotherapy are curative options, with equivalent survival but different side effects and financial costs. We aim to determine the uptake of surgery and/or radiotherapy for prostate cancer by Aboriginal and Torres Strait Islander people within New South Wales (NSW).
This was an individualised patient linked-data study which used the NSW Cancer Registry (2009–2018), NSW Admitted Patient Data Collection, Outpatient Radiation Oncology Data and Register of Births, Deaths and Marriages. Fine-Gray Competing Risk models were used to estimate cause-specific hazards for time to radiotherapy and time to prostatectomy with a competing risk of death.

There were 59,621 people diagnosed with prostate cancer; 1061 (1.8%) were Aboriginal and Torres Strait Islander people. The median follow-up time was 6.3 years. A total of 22,946 (41.4%) patients received a prostatectomy; in Aboriginal and Torres Strait Islander people, it was lower at 362 (36.6%) patients. A total of 17,196 (31.0%) received external beam radiation therapy and for Aboriginal and Torres Strait Islander people, 349 (35.3%) received radiotherapy. In univariate analysis, Aboriginal and Torres Strait Islander people were less likely to receive a radical prostatectomy (HR 0.9, $p < 0.05$) than the rest of the population. However this association was lost when adjusting for possession of private insurance and comorbidities. Aboriginal and Torres Strait Islander people were more likely to receive radiotherapy on multivariable analysis (HR 1.2, $p = 0.001$).
Aboriginal and Torres Strait Islander people are more likely to receive radiotherapy but less likely to receive surgery than the rest of the NSW population, with socio-economic factors associated with the treatment received. It is imperative there is equitable and affordable access to treatment options for Aboriginal and Torres Strait Islander people.
https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(26)00135-5/fulltext?dgcid=raven_jbs_aip_email

The Permanente Journal: The Impact of Digital Health Solutions on Bridging the Health Care Gap in Rural Areas: A Scoping Review

Digital health tools can improve health care access and outcomes for individuals with limited access to health care, particularly those residing in rural areas. This scoping review examines the existing literature on using digital tools in patients with limited access to health care in rural areas. It assesses their effectiveness in improving health outcomes. The review adopts a comprehensive search strategy to identify relevant studies from electronic databases, and the selected studies are analyzed descriptively. The findings highlight the advantages and barriers of digital health interventions in rural populations. The advantages include increased access to health care practitioners through teleconsultations, improved health care outcomes through remote monitoring, better disease management through mobile health applications and wearable devices, and enhanced access to specialized care and preventive programs. However, limited internet connectivity and a lack of familiarity with digital tools are barriers that must be addressed to ensure equitable access to digital health interventions in rural areas. Overall, digital tools improve health outcomes for individuals with limited health care access in rural areas.

Digital health encompasses the utilization of technology, including digital devices, software, and communication tools, to enhance health and health care delivery.[1,2] Its applications range from monitoring and managing health to diagnosing and treating diseases and supporting health care practitioners and patients.[3–6] Various digital tools and services fall under the umbrella of digital health, such as mHealth, telehealth, electronic health records (EHRs), health IT, wearable devices, and remote monitoring systems. The primary goal of digital health is to enhance the efficiency, quality, and accessibility of health care services, empowering individuals to take an active role in managing their health and well-being.[7,8]

Health determinants comprise the conditions that influence an individual's health. These determinants can stem from biological, environmental, behavioral, and socioeconomic factors; access to health care; and cultural beliefs.[9] They can impact a patient's well-being positively or negatively.[10] Access to health care is a crucial determinant of health that substantially affects the outcomes of individuals and populations. Therefore, insufficient access to health care services can result in delayed or missed diagnoses, inadequate treatment, and poorer health outcomes.[11,12] Furthermore, individuals without access to health care may miss out on preventive care, such as immunizations and cancer screenings, leading to the

development of chronic diseases that are more challenging and expensive to treat in the long run.13–15
https://www.thepermanentejournal.org/doi/10.7812/TPP/23.134

The Lancet: Radical, transformative, or decolonial? A systematic review of The Lancet Planetary Health's progress on embracing Indigenous Peoples' knowledge systems
All life on earth is affected by the intensifying impacts of climate change, biodiversity loss, and pollution. Planetary health science is emerging as a crucial framework to address the health of the planet and its inhabitants. Indigenous Peoples' knowledge systems have evolved over millennia and are grounded in principles such as interconnectedness of all living things. As a discipline, the tenets of planetary health draw upon Indigenous science and approaches; however, the extent of ethical engagement has not been examined. We conducted a systematic review of all articles published in The Lancet Planetary Health up to October 2025, to assess the recognition and integration of Indigenous knowledge systems. 1137 of 1172 articles reviewed contained no Indigenous research features or perspectives. Although the number of articles engaging with Indigenous knowledge systems has increased over time, these publications are predominantly commentaries, with relatively few original research articles. The Lancet Planetary Health was launched with the aim of informing a "radical civilisational transformation". Based on the findings of this systematic review, we suggest that decolonising planetary health science should be integrated into this civilisational transformation.
The relevance of planetary health science is increasing as the trifecta of climate change, biodiversity loss, and pollution escalate. As the challenges of these issues are felt by all life on earth, the concept of planetary health is emerging as a crucial framework to address the health of the planet and its inhabitants.1 The concept underpinning the emerging discipline of planetary health—that the health of humans, the environment, and all living things are interconnected—is not new; it has been central to Indigenous knowledge systems and ways of life for millennia.2–5 Indigenous Peoples constitute approximately 5% of the global population, care for approximately 20% of the earth's surface, and protect nearly 80% of the world's remaining biodiversity.6,7 This evidence shows that Indigenous Peoples are subject-matter experts and global leaders in what is now termed planetary health science, with continuing, deep-rooted, holistic understandings of health and wellbeing and the interconnections among all living matter and the land, water, and air on which they depend.5,8,9
https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00049-5/fulltext?dgcid=raven_jbs_aip_email

Australian Journal of Rural Health: Rural Health Pro—A Digital Platform Connecting Rural People, Organisations, and Communities
Rural areas face persistent health disparities exacerbated by workforce shortages and the geographical isolation of health professionals. Innovative approaches are needed to mitigate professional isolation and enhance access to continuous professional development. This paper explores how health professionals perceive and utilise Rural Health Pro, analysing its potential to support professional needs, enhance capability, and improve workforce retention. To explore rural health professionals' experiences and perceptions of the Rural Health Pro focusing on its functionality, support for professional needs, enhancement of capability, and contribution to workforce retention.
A qualitative study utilising thematic analysis of semi-structured interviews with 12 allied health professionals working in rural practice, examining their experiences and perceptions of

the utility of the Rural Health Pro platform. They are independent of the Rural Doctors Network.
Participants reported that the Rural Health Pro platform supported their capability through professional development, peer connectivity, reducing feelings of professional isolation, and leadership development. Challenges included the need for more structured support in mentoring and professional development.
Rural Health Pro facilitates resource sharing, knowledge exchange, and access to professional connectivity, enabling rural health professionals to access relevant information and support. While it enhanced users' sense of capability and reduced professional isolation, further evidence is needed to evaluate its broader impact on workforce retention and quality of care in rural health.
Challenges in providing health care in rural areas have been directly linked to poor health outcomes in rural areas [1, 2, 3]. A major contributor to these health disparities is that those living in rural and remote areas experience health workforce shortages despite having a greater need for health practitioners with broader scopes of practice [1, 4, 5]. The challenges associated with attracting and retaining healthcare professionals in rural areas are multifaceted and impacted by personal, organisational, social, and spatial factors [6, 7].
https://pmc.ncbi.nlm.nih.gov/articles/PMC12135139/

Science: COVID-19 can wake up dormant viruses in the body, large study confirms
Virus reactivations by SARS-CoV-2 could worsen initial symptoms and increase risk of Long Covid
Early in the COVID-19 pandemic, scientists noticed that a SARS-CoV-2 infection can “wake up” other, dormant viruses already present in the body. A study out today in Nature extends those and subsequent observations, documenting viral reactivation for a cohort of more than 1000 patientshospitalized with COVID-19 before mid-2021.
The findings provide a detailed picture of the hidden viruses that become active at different points of a SARS-CoV-2 infection, and link reactivation of some of them to more severe COVID-19 and to lingering symptoms, such as fatigue, that are the hallmark of Long Covid. Although the study can’t prove virus reactivation causes these outcomes, it has impressed some SARS-CoV-2 researchers. “The scale of the endeavor and the range of human viruses they’ve looked at” makes this the most comprehensive data set yet on viral reactivation in COVID-19, says Danny Altmann, an immunologist at Imperial College London who was not involved in the work. The findings, which were partially described in a preprint in late 2024, include data on viruses previously overlooked in COVID-19 patients, he adds.
The human body is usually efficient at clearing viruses. But some, such as the Epstein-Barr virus (EBV), a herpesvirus that causes mononucleosis, stick around quietly in pockets of cells called reservoirs, until certain illnesses or other stressors unleash them. In COVID-19 patients, scientists have documented numerous instances of reactivation of EBV and other herpesviruses, including cytomegalovirus (CMV), which causes flulike symptoms in some people.
https://www.science.org/content/article/covid-19-can-wake-dormant-viruses-body-large-study-confirms?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=distillation&et_rid=1169729274&et_cid=6034222

Nature: Despite global turmoil, Gen Z researchers are not giving up: Four researchers born after 1997 describe how they stay motivated and cultivate resilience during difficult times.

Geopolitical unrest, rising costs of living, research funding cuts and a widespread sense of decreasing trust in sciencehave put early-career scientists everywhere on edge. World events have added to the uncertain job security of up-and-coming researchers and graduate students, many of whom face defining choices that will shape their career trajectories. Among them are Generation Z scholars: those born after 1997 who are now in their 20s and in the scientific workplace.

Nature's Careers team asked four Gen Z researchers why they joined the scientific ranks and what motivates them to stay. Here, they describe the lessons they have learnt and the strategies they use to stay positive and move forwards in the face of hard circumstances and anxiety-inducing current affairs worldwide.

TATIANA UAMAN SVETIKOVA: Seek a good research environment

I am involved in two physics research projects. The first focuses on non-linear terahertz effects in quantum materials. In simple terms, I study what happens when materials that have unusual quantum properties are exposed to intense, ultrafast far-infrared pulses of light. This work can contribute to ultrafast electronic devices, terahertz emitters and detectors and technologies in future wireless communication systems, including 6G. The second project, DiaQNOS, uses magnetic detection for medical purposes, such as monitoring brain activity during surgery. My speciality is condensed-matter physics, but I joined DiaQNOS to use my programming skills and to help with data processing.

I definitely want to stay in academia and research: there's pleasure in studying something at the edge of what is known and in thinking that your work can help to move that boundary, even if just a little. But during my bachelor's and master's degrees in Moscow, I thought I would not be able to pursue an academic career because it was extremely difficult to treat science as a full-time profession while earning enough to cover basic living expenses, particularly rent and food in such an expensive city. I came to Dresden in Germany to pursue my doctoral degree, because it was a way to stay in science.

https://www.nature.com/articles/d41586-026-02453-0?utm_source=Live+Audience&utm_campaign=9cc7d0018f-nature-briefing-daily-20260810&utm_medium=email&utm_term=0_-33f35e09ea-50521540

International Journal of Innovative and Advanced Studies: Research and National Rural Health Mission With Special Emphasis On Asha Workers

Medical profession is one of the oldest profession of the world and is the most humanitarian one. There is no better service than to serve the suffering, wounded and the sick. Inherent in the concept of any profession is a code of conduct, containing the basic ethics that underline the moral values that govern professional practice & is aimed at upholding its dignity. Medical ethics the values at the heart of the practitioner-client relationship. In the recent times, professionals are developing a tendency to forget that the self regulation which is at the heart of their profession is a privilege in return for an implicit contract with society to provide good competent and accountable service to the public. It must always kept in mind that doctors are the noble profession and aim must be to serve humanity otherwise this dignified profession will lose its true worth. There has been mushrooming of hospitals after liberalization introduced in India in 1991 with the raising off import restrictions new and advanced medical gadgets and Hi-tech computerized equipments have become part and parcel of modern hospitals.

National Rural Health Mission or NRHM as it could be established on the basis of its mission documents was a Government of India intervention to correct the public health sector of the country. It was launched in April 2005 and had continued until March 2012. In fact Government of India had adopted a time bound and mission oriented approach to correct the public health situation in the country (MOHFW 2005). However it was all the probability

that it would further continue during the 12th plan period starting from April 1, 2012. It was found that National Rural Health Mission was a combination of several programs including population stabilization, disease control, nutrition, water & sanitation, improvement of workforce, infrastructure, and logistics. Therefore it could say that National Rural Health Mission was like a sunshade or a podium under which several health and development programs were implemented however the main focus was towards providing financial and know how assistance to states to eliminate the gaps existing in terms of work force, infrastructure, and logistics. In addition it further took in hand health determinants especially nutrition to an extent. For all such diversified approaches National Rural Health Mission had to establish wide spread sectoral and intersectoral convergences, public private partnerships, forging alliances with developmental partners and outsourcing of some key supportive and medical services. It could be further evident from the NRHM framework of implementation (MOHFW 2005) that National Rural Health Mission had recognized the need to make optimal use of the non-governmental sector to strengthen public health systems to increase access to medical care for the poor.
https://www.academia.edu/121684902/National_Rural_Health_Mission_With_Special_Emphasis_On_Asha_Workers?email_work_card=view-paper

NEJM: Ebola at 50 — Lessons for Outbreak Response and Preparedness
Fifty years after the first recognized Ebola outbreaks in central Africa, the ongoing Bundibugyo virus disease outbreak in the Democratic Republic of Congo (DRC) and Uganda serves as a stark reminder that critical gaps in epidemic preparedness remain.1,2Immediate priorities include rapid detection, clinical care, infection prevention and control, contact tracing, safe and dignified burial practices, community engagement, and evaluation of candidate vaccines and therapeutics. Yet the outbreak also raises a broader question: Has the global health community learned all the lessons from Ebola's history, or does it continue to reproduce patterns in which African risk, knowledge, biologic samples, and frontline expertise are indispensable, while scientific recognition, leadership, equitable partnerships, and the benefits of innovation remain unevenly distributed?
The current outbreak highlights enduring lessons from Ebola's history, which has been shaped as much by scientific recognition, community trust, research governance, sample ownership, and equity as by virology and outbreak control. The history of Ebola is still often narrated through the lens of laboratory discovery in Europe and North America, but this narrative is incomplete. A more accurate account begins with partnerships among clinicians, nurses, public health workers, affected communities, national investigators, and international laboratories, and ultimately between responders and the populations they serve.
The first recognized Ebola outbreaks occurred in 1976 in Yambuku, Zaire (now the DRC), and in Sudan.3 The earliest stages of discovery played out not in high-containment laboratories but in African hospitals and communities, where clinicians, public health workers, and affected communities saw an unfamiliar and lethal disease and initiated investigations. One of us (J.-J.M.-T.) was then a young Congolese physician and microbiologist who was involved in these stages, contributing to the field investigation and specimen collection that laid the foundation for identifying a previously unknown pathogen.3 A clinical specimen collected in Kinshasa from a patient linked to the Yambuku outbreak was subsequently analyzed at the Institute of Tropical Medicine in Antwerp, Belgium, where one of us (P.P.), then a young microbiologist, and colleagues isolated and visualized a Marburg-like virus by electron microscopy. A few days later, investigators at the U.S. Centers for Disease Control and Prevention in Atlanta confirmed that the virus was distinct from Marburg virus, establishing the existence of a previously unrecognized filovirus.3

As this history makes clear, Ebola discovery entailed a sequence of interconnected scientific and public health contributions. Clinical recognition, field investigation, specimen collection, laboratory characterization, and outbreak control were all integral to the process. The discovery of Ebola virus was therefore a collective achievement of frontline health care workers, affected communities, national scientists and institutions, and international scientific collaborators. Recognition of this pathway leads to a more accurate historical account and reinforces an important lesson for preparedness: the same questions that shaped Ebola's past — who leads research, who governs samples and data, who receives scientific credit, who benefits from innovation, and who is trusted by affected communities — continue to influence outbreak responses today.
https://www.nejm.org/doi/full/10.1056/NEJMp2607819?query=TOC&cid=DM2460205_NEJM_Non_Subscriber&bid=-665386371

University of Exeter (UK): Hub improves healthcare access for farmers and rural communities

Hundreds of farmers and people who live in rural areas are getting easier access to healthcare thanks to a market health hub.
The University of Exeter has been working in partnership with Cornwall Partnership NHS Foundation Trust and not-for-profit social enterprise Imagine If to deliver the Market Health Hub in Holsworthy.
Since its launch in 2023, over 700 people have used the service. To date 100 people have required blood pressure referrals and just under 30 have required a diabetic referral.
Rachel Williams is a consultant respiratory practitioner for Cornwall Partnership NHS Foundation Trust and said: "It's about meeting farmers where they are – in spaces they know and trust.
"Rural and coastal communities face unique challenges in accessing services. Our aim is to improve health and wellbeing through a sustainable farming health hub."
The average UK farmer is 60 years old, and 40 per cent are over 65. Almost half work more than 81 hours a week. With such demanding schedules, healthcare often falls to the bottom of the list of priorities.
Mental health is a major concern. A 2024 survey found that 91 per cent of farmers believe poor mental health is the biggest hidden problem in farming. The Office for National Statistics reported that in 2023, 88 men working in agriculture died by suicide.
The hub gives farmers and their families the opportunity to receive health advice and support without leaving their community and runs every Wednesday at Holsworthy livestock market.
A nurse, a community navigator, and a healthcare assistant staff the hub and services include health checks, advice such as stopping smoking, and diabetes and pain management.
There are plans for drop-in clinics focusing on chronic disease management such as asthma and COPD, vaccination clinics, holistic wellbeing, and long-term pain support.
The University of Exeter are evaluating the project. Gemma Brailey is the research lead and said: "The hub is a testament to what can be achieved when research is co-produced with the people it is designed to serve.
"At the University of Exeter, we are leading the evaluation of this work to understand its impact and ensure that decisions about future investment and wider roll-out are grounded in robust evidence and lived experience."
https://news.exeter.ac.uk/faculty-of-health-and-life-sciences/hub-improves-healthcare-access-for-farmers-and-rural-communities/

Academia Medicine & Health: Armed conflict and cholera outbreaks: a narrative review of epidemiology, challenges, and responses

Background: Cholera remains a significant global public health threat, with its burden disproportionately affecting regions experiencing humanitarian crises. Armed conflict, through the disruption of infrastructure and governance, creates ideal conditions for cholera transmission. This narrative review synthesizes evidence on the epidemiological patterns, underlying challenges, and response strategies of cholera outbreaks in conflict settings. **Methods:** A systematic search was conducted across PubMed, WHO IRIS, EM-DAT, ReliefWeb, and Google Scholar for studies published from 1990 to the present. Studies were included if they discussed cholera outbreaks in the context of armed conflict, detailed epidemiological patterns, or described outbreak responses. A six-step thematic analysis was employed to identify and synthesize key themes from the included literature. **Results:** Thirty-six studies were included. The analysis identified six interrelated themes: (1) the breakdown of public health infrastructure; (2) acute vulnerabilities in refugee and internally displaced person (IDP) camps due to overcrowding and poor WASH (Water, Sanitation, and Hygiene); (3) the role of political instability and the weaponization of health infrastructure; (4) critical delays in surveillance and response; (5) the influence of environmental factors; and (6) the challenges of coordinating interventions. Findings from countries like Yemen, Sudan, and Syria demonstrate that conflict is a primary catalyst for outbreaks, leading to recurrent epidemic waves and protracting crises. Response efforts are often hampered by aid obstruction, politicization, and a reactive focus on case management over prevention. **Conclusions:** Cholera outbreaks in conflict zones are not incidental but are direct and predictable consequences of war. Effective control requires an integrated approach that combines rapid deployment of oral cholera vaccines (OCVs) with sustainable WASH interventions. However, long-term solutions depend on rebuilding infrastructure, ensuring neutral humanitarian access, and strengthening local health systems. Ultimately, addressing cholera in conflict is as much a political challenge as a public health one, necessitating greater accountability and adherence to international humanitarian law.
https://www.academia.edu/3070-3530/3/1/10.20935/AcadMedHealth8124

The News Mill: Smart primary health centre improves healthcare access in Gujarat village

A Smart Primary Health Centre (PHC) in Pandhara village, located in Gujarat's Gandhinagar district, is enhancing rural healthcare by offering free medical services, advanced diagnostic facilities and technology-enabled care closer to residents.

The PHC is equipped with solar-powered infrastructure, modern laboratories, digital health records and improved healthcare facilities, which have expanded access to quality medical services in the area.

Medical Officer Dr Chetanaben Patel explained that tuberculosis patients receive free nutrition kits under the government's Nikshay Mitra initiative, and mothers delivering at the PHC are given newborn care kits. She said, "Patients diagnosed with tuberculosis receive a free nutrition kit through the government's Nikshay Mitra initiative. Mothers who deliver at our health centre also receive a free newborn care kit for their babies. All our work is carried out through a computerised system, and the government has provided excellent healthcare facilities here. Our doctors and the entire medical staff are dedicated to serving patients, and the public is very satisfied with the quality of care they receive."

The PHC prioritises maternal and child healthcare through digital monitoring, facilitating safe deliveries, timely immunisation and better health outcomes. Villagers can consult specialists via the e-Sanjeevani Telemedicine portal, minimising the need to travel to district hospitals for medical advice.

Beneficiaries have noted that free medicines and treatment at the centre have greatly reduced healthcare and transportation expenses. Patient Hittal Patel stated, “The government hospital is very good, and I come here for my treatment. All the medicines are provided free of cost. The doctors and medical staff take good care of us, and we receive proper treatment. I am satisfied with the services provided at this government hospital.”
https://thenewsmill.com/2026/08/smart-primary-health-centre-improves-healthcare-access-in-gujarat-village/

Nature: China is changing the shape of global health. The terms are still up for negotiation
Health-care partnerships can provide other nations with cheap diagnostics, medicines and more — but global institutions should help to ensure that they also strengthen local capacity and preserve sovereignty.
China is making waves in global health care. The country’s biotechnology companies are producing medicines at a speed and cost that has drawn interest from the world’s largest pharmaceutical groups. They manufacture drugs and medical equipment used across the world. And the national health-care system is testing digital models that connect appointments, test results, follow-up care and more on a scale few other countries have attempted.
There has been much discussion on what these trends mean for the United States and Europe, but this overlooks an equally significant issue: China’s growing number of health-care partnerships with low- and middle-income countries (LMICs).
Governments across parts of Africa, Asia and Latin America are facing expanding populations and disease burdens, which are putting huge strain on fragmented health-care systems. Their nations urgently need medicines, diagnostics, manufacturing capacity and workable care models — all of which China can deploy affordably, quickly and at scale. During the COVID-19 pandemic, Chinese companies supplied vaccines to Indonesia and Mexico. Chinese firms have since begun to finance medical equipment in Kenya and Côte d’Ivoire, pharmaceutical and vaccine production in Zambia and digital-health solutions across the world.
These partnerships differ from old models of multilateral aid, budgets for which are dwindling worldwide. Other nations, notably the United States, are moving towards bilateral partnerships, but China has been making these agreements for longer, and is doing so on a bigger scale. And because many of China’s health products were developed while the country was facing pressures similar to those that LMICs contend with — shortages of specialists, regional inequality, tight budgets — they appeal to countries that cannot copy the expensive, hospital-heavy systems of richer nations.
https://www.nature.com/articles/d41586-026-02622-1?utm_source=Live+Audience&utm_campaign=707a46fad9-nature-briefing-daily-20260825&utm_medium=email&utm_term=0_-33f35e09ea-5052154

RFI: Violence against healthcare workers in DRC hampers Ebola response
Healthcare workers in the Democratic Republic of Congo have been coming under attack, the United Nations and Red Cross have warned, hampering efforts to stem the spread of the Ebola virus, which is spreading 'exponentially'.
More than 260 healthcare workers have been attacked in the past six months and eight have been killed, warned United Nations Ebola coordinator Julien Harneis.
"Fear translates into angry young men who start throwing stones at their object of fear, the ambulance," he said on Friday from the northeastern city of Bunia.
He described incidents in which ambulances have been burned and health facilities attacked.

The attacks are "obviously terrifying because people are already risking their lives to deal with Ebola," Harneis said, noting that about 160 healthcare workers have themselves fallen ill with Ebola and 43 have died.
The Red Cross reported 11 incidents against its volunteers in the DRC, nine of whom have been injured, while some ambulances and equipment damaged and destroyed in attacks.
The latest incident was last Wednesday in Beni, in North Kivu province, where three volunteers were assaulted and equipment destroyed.
Two other volunteers had been injured the previous day in Haut-Uélé while attempting to carry out burial, and a convoy of the Ugandan Red Cross in Aru, in Ituri, on 17 August was attacked, injuring several members and three ambulances were hit with stones and vandalised.
https://www.rfi.fr/en/africa/20260824-violence-against-healthcare-workers-in-drc-hampers-ebola-response

Qualitive Research in Health: Mechanisms for Advancing Universal Health Coverage in Kenya: a qualitative study
Universal Health Coverage (UHC) is a cornerstone of Sustainable Development Goal 3, yet its implementation in Africa shows mixed results. This study explores mechanisms driving UHC progress in Kenya.
Realist interviews were conducted with 44 key informants across Kenya's health ecosystem, including government officials, private sector representatives, insurance agency members, and community and faith-based organizations. The study was guided by initial program theories from a realist synthesis of UHC in Africa, that identified political commitment and community engagement as critical mechanisms for successful UHC reforms. Through realist interviews, this study tested and refined these initial theories.
Four interconnected mechanisms emerged as key drivers of UHC in Kenya: political commitment, community engagement, intersectoral collaboration, governance and accountability. Political commitment drives legislative reforms, resource allocation, and structural developments, while community engagement fosters co-ownership, accountability, and tailored healthcare solutions. Intersectoral collaboration leverages diverse resources and expertise to improve access to quality health care, while effective governance and accountability structures ensure resource efficiency and responsiveness to community needs.
This study confirms political commitment, community engagement, intersectoral collaboration, governance and accountability as critical enablers of UHC in Kenya. Our findings emphasize the need for inclusion of marginalized voices in UHC discussions, shifting from centralized community engagement forums to more inclusive, outreach-oriented approaches, sustained political will, coupled with the education of leaders, and active private sector involvement. By refining UHC program theory through iterative stakeholder engagement, this research offers context-specific insights for Kenya and other countries facing similar challenges.
https://www.sciencedirect.com/science/article/pii/S2667321526001630

The Lancet: Planetary Health Research Digest
Repressing Action
Many governments are perceived to have taken insufficient action to prevent climate breakdown. Consequently, climate activists have escalated their protest tactics to become more disruptive—eg, roadblocks and occupying public buildings—in order to demand adequate change. In response, numerous governments in historically open civil societies have increasingly used repressive tactics on disruptive but non-violent protests. In their new study,

Sunniva Davies-Rommetveit (University of St Andrews, UK) and colleagues investigate whether this repression inhibits or galvanises climate activism.
Using survey data from 1375 Extinction Rebellion UK mailing list subscribers, the authors find that lived experience of repression positively predicts non-normative action intentions and shows a positive indirect predictive effect on non-normative action through reduced fear. Meanwhile, they find that anticipated repression has no direct effect for normative or non-normative collective action, but it does show positive indirect predictive effects on both action types. Overall, this study suggests that protest repression has a predominantly galvanising effect on climate activism, and policy makers should reconsider their current approach as criminalisation may result in more extreme actions.

Greenwashing agriculture

Animal agriculture is responsible for at least 16·5% of global greenhouse gas emissions, with animal-based food production accounting for 57% of total food system emissions. In response to these disproportionate environmental impacts, many major animal agriculture companies have increasingly published sustainability commitments to offset public concerns. Seeking to test their credibility, Maya Bach (University of Miami, FL, USA) and colleagues examine environmental claims made by 33 of the world's largest meat and dairy companies and assess whether they constitute greenwashing.
The authors identify 1233 environmental claims on the sustainability reports and websites of the 33 companies. According to the authors, 1213 (98%) claims could be classified as containing indicators of greenwashing, with 467 (38%) claims consisting of forward-looking projections with no clear implementation plan. Furthermore, companies only provided supporting evidence for 356 (29%) of their claims, with only three claims across the entire dataset providing citations to peer-reviewed literature. The authors assert that these companies may be using greenwashing tactics to delay meaningful climate action in the same manner that fossil fuel companies have for decades.

Diurnal wildfire trends

The intensity and frequency of wildfires have more than doubled over the past two decades, largely due to climate change. While recent research has advanced our understanding of annual, seasonal, and daily fire activity, the dynamics shaping diurnal (ie, the 24-hour day-night cycle) burning patterns have received far less attention. To shed light on intraday wildfire trends, Kaiwei Luo (University of Alberta, AB, Canada) and colleagues modelled hourly burning probability and reconstructed historical potential burning hours from 1975 to 2024 across North America using machine learning.
Through an analysis of hourly satellite data of 8993 large wildfires (burning >200 hectares) from 2017–2023, the authors find that annual potential burning hours increased by 36% between 1975 and 2024. Additionally, extreme fire days (burning for 12 hours or more) increased by 81–233% in the most fire-prone biomes. The authors attribute these trends to a climate-driven weakening of the diurnal weather cycle. Furthermore, they suggest the window for successful early wildfire containment is narrowing, and that firefighting strategies built around the assumption of overnight suppression are becoming increasingly inadequate.

Private solution trap

Climate change is a global issue that requires collective action to be addressed. However, problems with collective action often emerge when individual incentives and group interests are misaligned. For this very reason, a private solution trap is emerging in the case of climate change. Instead of contributing toward public solutions such as global warming mitigation, many actors are investing in so-called private solutions, such as local adaptation. Consequently, collectively optimal public solutions are not being provided, and existing inequalities are being exacerbated.

To assess the impacts of this private solution trap, Eugene Malthouse (University of Nottingham, UK) and colleagues investigate its influence over a collective action game featuring private and public solutions and wealth inequality determined by luck or merit. With participants from 34 countries, the authors find that wealth inequality increases as participants with high endowments consistently adopt private solutions regardless of the origin of wealth. This shift towards private solutions ultimately undermines the provision of collectively optimal public solutions, which highlights the challenge faced by those seeking to implement unified global solutions for climate change.
https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00062-8/fulltext?dgcid=raven_jbs_etoc_email

Nature: How smallpox reached the Americas: first genomic evidence points to Europeans
Viral sequences from Chilean mummies confirm the disease was introduced from Europe.
More than 400 years ago, two people living in modern-day Chile died while infected with the smallpox virus. Viral DNA found in their mummified remains has now yielded genetic evidence of when the disease arrived in the Americas.
The findings, published on 30 July in Science1, confirm that Orthopoxvirus variola — the virus that causes smallpox — arrived in the Americas from Europe. The study adds to a small but growing body of evidence that the smallpox virus lost genes as it adapted to human hosts, a mechanism that related viruses, such as the one that causes mpox, might also be using today.
"We don't know anything about the recent history of viruses," says Terry Jones, a computational virologist at Charité — University Medicine Berlin. Studies such as this provide a rare snapshot into a pathogen's past, he says.
Smallpox was one of the deadliest diseases in the world. The virus killed an estimated 300 million people in the twentieth century alone. Historical records suggest that its introduction into the Americas was similarly catastrophic, killing millions of people across two continents. However, viruses don't leave much archaeological evidence. So far, there are only two examples of smallpox DNA from before the twentieth century: a set of sequences from seventh-century Viking remains, and a single sequence from a seventeenth-century Lithuanian mummy.
What limited genetic evidence researchers do have suggests that smallpox has undergone intense evolution over the centuries. The seventh-century virus genome is much larger and contains more active genes than do twentieth-century smallpox strains.
https://www.nature.com/articles/d41586-026-02366-y?utm_source=Live+Audience&utm_campaign=b447af0858-nature-briefing-daily-20260731&utm_medium=email&utm_term=0_-33f35e09ea-50521540

NEJM: Doctor's Dirty Little Secret — The Cost of Silence
The vomiting may be messy, I thought, scanning the Tylenol in the drugstore aisle, quietly calculating its lethal dose. I heard the wail of an ambulance siren. My shift was about to start. I returned the bottle neatly to the shelf, pulled on my white coat, and slipped back into my familiar role as an emergency physician. No one would suspect that for the past month I'd been plotting my death. Death felt like the only way to let go of the fear and exhaustion that was swallowing me whole.
"You know we don't lock people up just for having suicidal thoughts anymore, right?" The on-call emergency psychiatrist's tone, though comforting, was edged with frustration. She understood that my reluctance to speak openly was rooted in outdated taboos related to mental health.

“Most of us have had thoughts of suicide at some time in our careers,” she said plainly. “It’s an occupational hazard — like a needlestick or missing your kid’s recital.”
With those matter-of-fact words, she named the doctor’s dirty little secret: we are human. But we believe this admission could cost us everything. That curbside consult saved my life. For the first time in a long while, I didn’t feel alone.
I’d been an emergency doctor for nearly half my life, running on a steady drip of cortisol. By my 40s, my body struggled to keep pace with the demands of the job. Constant stress blunted progesterone’s soothing effects and intensified perimenopause. The demands were relentless. Twelve-hour shifts that often bled into 14, spent wading through a department thick with noise, irritation, unease, and grief. Moving quickly from a scraped knee to a traumatic cardiac arrest, and from the run-of-the-mill runny nose to a 3-year-old’s near-drowning, while alarms blared, phones rang, and someone always demanded more. I was responsible for everyone and everything all at once — crisis, illness, intoxication, and circumstance colliding, each person having been carried to me by whatever fear or fate had gripped them. I absorbed the frequent interruptions along with the urgency and blame, until the weight of it all settled as a constant heaviness in my chest — the kind that comes from knowing there will be no relief, no silence, and no margin of error, only the next patient, and the next. Eventually, like an old clunker that’s missed too many oil changes, my engine sputtered. My body began shaking as I slid deeper into a hole.
I’d always worn grit like a badge of honor. The less I slept and the more patients I could see, the better a doctor — and martyr — I believed myself to be. From the moment I’d decided to go to medical school, it felt like I’d jumped onto one of those old playground spinners that you run alongside, leap onto…and instantly regret. At first, the momentum felt like purpose: study harder, work longer, sacrifice now for the chance to help more people later. But it never slowed, and grit only accelerated the spin. I clung on white-knuckled as the world blurred around me, too scared to let go. Grit told me I could handle it and that everyone else was spinning, too. But then came a quiet, terrifying thought: maybe the only way off was to let go entirely.
I was deep in burnout.
https://www.nejm.org/doi/full/10.1056/NEJMp2515506?query=TOC&cid=DM2460205_NEJM_Non_Subscriber&bid=-665386371

The Lancet: The overlooked role of local frontline health workers in the Bundibugyo Ebola response

The Bundibugyo Ebola outbreak, declared in May, 2026,[1] is still spreading throughout Ituri Province in the Democratic Republic of the Congo. Several operational challenges indicate that response governance might not be fully integrating local frontline health workers (FHWs).
In Ituri, a province encompassing 36 health zones and over 1027 health facilities, the provincial health manager issued a directive[2,3] to systematically bypass primary care and refer all suspected cases to just six centralised Ebola treatment centres. Yet local primary care personnel frequently serve as the initial point of contact for suspected patients and community notifications. Similarly, local FHWs often serve as the most trusted interface between affected communities and the health system. Unlike emergency response teams sent during epidemics, these individuals have long-standing relationships with local people, having provided routine care before the outbreak and anticipating continuing to provide treatment after the outbreak ends. Their position in communities puts them in a unique position to facilitate risk communication, encourage timely reporting of suspected cases, and build trust in response actions.[4]

Despite a wealth of international resources and experience, FHWs across Ituri continue to report shortages of personal protective equipment, infection prevention supplies, and operational support. From our experience in frontline clinical practice in Bunia, the capital city of Ituri and the current epicentre of the outbreak, these deficiencies have had real practical implications. As a result, several hospitals have been unwilling to treat patients with febrile or diarrhoeal illnesses or have scaled back services because of fears of workplace exposure.

This situation is concerning given the continuous community spread of the disease due to the delayed declaration of the epidemic and community mistrust.[5] Although community-based health workers are important for outbreak detection and containment, they face considerable diagnostic uncertainty, as malaria, typhoid fever, and other endemic parasitic infections might mimic Bundibugyo virus disease. Consequently, to mitigate dangers associated with unexplained fevers, shortages of personal protective equipment, and insufficient quick testing, local care providers might over-refer the number of suspected patients directed to emergency units, which are already operating at almost full capacity. This epidemiological–clinical vicious circle might be the weakness of the response process.

https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00198-1/fulltext?dgcid=raven_jbs_aip_email

Science: An "unhinged obsession" Under fire from Republican senators, Fauci takes the Fifth at COVID-19 hearing

Former top NIH official says Senator Rand Paul is trying to imprison him because of an "unhinged obsession"

The latest showdown between Senator Rand Paul (R–KY) and Anthony Fauci ended up as a one-sided affair this morning when the former federal scientist invoked his Fifth Amendment right against self-incrimination in declining to testify over his role in the COVID-19 pandemic. After a brief opening statement, he then sat in a packed Senate hearing room for nearly 3 hours without answering any questions, including familiar and new accusations from Paul and other Republicans that he helped create the pandemic or even profited from it. During the hearing, Paul threatened Fauci with "repercussions" for his refusal to respond to questions. But the politician may be limited in his options as it takes a full Senate vote to hold a witness in contempt and Republicans may not have enough votes on their own to pass such a resolution.

Noting that he had testified before or briefed Congress more than 200 times in his long career, including during the pandemic, Fauci said in his opening statement before the Senate Committee on Homeland Security & Governmental Affairs chaired by Paul that the senator has an "unhinged obsession with me." Fauci, who directed the National Institute of Allergy and Infectious Diseases (NIAID) for 38 years, also said he had concluded Paul's "sole reason" for subpoenaing him to testify "is to get me to say something, anything, that could vindicate his repeated public pledges that I end up, in his words, 'behind bars.'"

https://www.science.org/content/article/under-fire-republican-senators-fauci-takes-fifth-covid-19-hearing?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=etcetera&et_rid=1169729274&et_cid=6027221

The Lancet: Health inequities faced by sex workers

Stark health inequities persist for sex workers globally—particularly in the areas of mental health, sexual and reproductive health, and harm reduction. To inform this Series paper we reviewed epidemiological studies published over the past decade to describe the burden of key health outcomes among sex workers and associated factors contributing to these

disparities. Within the mental health literature, we estimate at least one in four and as many as four in five sex workers experience depression. Within sexual and reproductive health literature, at least one in three sex workers are estimated to experience an unmet need for contraception. Using a Health Equity framework, we contextualise evidence gaps related to these health areas across multiple levels of influence (eg, systems of power, relationships and networks, physiological pathways, and individual factors) and offer recommendations to advance an agenda of health equity for sex workers in future research and programmes. Priority programme and policies include upholding the autonomy and dignity of sex worker communities, ensuring the inclusion of gender diverse populations in research, addressing structural determinants of health, and fostering meaningful community engagement and collaboration.

A substantial body of evidence has shown that sex workers (people aged 18 years or older of any gender who receive money, goods, or reward in exchange for consensual sexual services) either regularly or occasionally globally face disproportionate inequities in HIV and other sexually transmitted infections (STIs),[1,2] as well as violence and other human rights violations.[3] Much of this research has focused explicitly on sexual health, with outcomes largely centred on the prevention and treatment cascades for HIV and other STIs, including incidence, prevalence, testing, and suboptimal access to and outcomes of antiretroviral therapy.[4,5] However, sex workers represent a population with far broader health needs that have received comparably less attention—for example, few previous syntheses have attended to other areas of mental health, sexual and reproductive health (SRH) and rights, and harm reduction beyond the implications for HIV and other STIs.[6]

The health inequities faced by sex workers are deeply rooted in interconnected social and structural factors such as the explicit criminalisation of sex work (comprising either the buying or selling of sex, or both), stigma and discrimination, social injustices, and policies and practices that foster violations of sex workers' health and human rights. For example, a systematic review and meta-analysis documented that in settings where sex work was criminalised, women had 40% increased likelihood of reporting increased HIV and STI risk exposures, such as condomless sex, as well as twice the likelihood of experiencing physical or sexual violence compared with sex workers in settings with less repressive policing and criminalisation practices.[7] Other reviews have reported a disproportionately high burden of self-managed (thus higher-risk) abortion among sex workers, especially in more restrictive legal environments.[8] Additional literature has focused on the burden of comorbid mental health conditions—namely depression, anxiety, post-traumatic stress disorder (PTSD), and suicidal ideation—among sex workers globally.[9] Further, consistent evidence shows that stigma and discrimination, often acting synergistically with criminalisation and other repressive laws, policies, and practices, restrict sex workers' access to life-saving health services and exacerbate health inequities.[10,11] However, across these reviews, there has been relatively little exploration of how these widespread inequities challenge broader achievement of health equity among sex workers.

https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(25)00307-X/fulltext?dgcid=raven_jbs_aip_email

NEJM: The Paradox of Medical Aid in Dying

Legislative support for medical aid in dying (MAID) in the United States is growing. In the past year alone, three states — Delaware, Illinois, and New York — have legalized the practice, bringing the number of permissive jurisdictions up to 14 (13 states plus the District of Columbia). Nearly one third of the U.S. population now lives in a jurisdiction in which MAID is legal, permitting authorized clinicians to prescribe lethal medication for terminally ill patients, provided that certain regulatory requirements are met (e.g., the patient is an adult

with a survival prognosis of 6 months or less, is mentally competent, can self-administer medication, and, in some jurisdictions, is a state resident and has waited for a prescribed period). And yet, despite this significant growth, there is a paradox at the heart of MAID: whatever reasons people may have for supporting it, its expansion hinges on its rarity.
One of the key ethical arguments driving MAID legalization in the United States rests on the assumption that it will remain a rare event. If it is working correctly, its proponents maintain, it will be used infrequently. In U.S. jurisdictions with the longest history of MAID, utilization rates are exceptionally low. In Oregon, which authorized MAID in 1997, a total of 400 deaths were recorded under the Oregon Death with Dignity Act (DWDA) in 2025, accounting for an estimated 1% of total deaths in Oregon that year.1 Despite steady growth in utilization since 1997, the Oregon data have persuaded many lawmakers in other states that legalization will not lead to a "slippery slope" of abuse in which vulnerable patients are coerced to use MAID — a key concern of opponents.2 The crux of MAID's utilization paradox lies in the fact that its popularity with legislators partially rests on its unpopularity in practice.
Given these low utilization rates, what can the drive toward expanded access to MAID tell us about cultural aspirations for death and dying in the United States today? A desire for greater control at the end of life is central to the pursuit of MAID. MAID allows terminally ill patients to control the timing and circumstances of their death, as well as the kinds of symptoms they are willing to live with and the types of suffering they hope to forgo. By enabling patients to plan the timing and place of their death and who will accompany them, it also invites control over the personal meanings of death. From this perspective, death becomes an experience that one actively choreographs, rather than an event that one resists or endures.
https://www.nejm.org/doi/full/10.1056/NEJMp2606019?query=TOC

The Conversation: Cholera still kills thousands each year – in places without clean water, it's far from history
Many Americans have heard about cholera only from "The Oregon Trail," the retro computer game in which players try to get their 1830s pioneers to the Oregon Territory. If your wagon train comes down with this highly contagious bacterial infection, the pioneers could die from diarrhea and dehydration before they get out of Nebraska.
In the 21st century, the U.S. records fewer than 20 cholera cases per year, nearly all of them in travelers who were infected abroad.
While cholera has nearly disappeared from wealthy countries, it remains one of the world's deadliest waterborne diseases in places where clean water and basic healthcare are unreliable. The latest reminder came in the summer of 2026 in Sudan, where a long conflict has devastated hospitals and water systems, allowing cholera to spread rapidly.
As an epidemiology professor, I teach the story of John Snow, the London physician who traced an 1854 cholera outbreak to the contaminated Broad Street public water pump. His work not only helped establish modern epidemiology, it also illustrates a lesson that remains true today: Cholera spreads wherever safe water fails.
Cholera has surged over the past five years: Reported cases rose about 175%, from 223,370 in 2021, to 614,828 in 2025. In fact, 2025 was the deadliest year for the disease in more than a decade, with almost 7,600 deaths across 33 countries. Over that period, there was an average of about 481,000 cases a year globally.
But the true burden is likely far higher, because many countries with the largest outbreaks lack the laboratory and surveillance systems needed to detect and report every case. The World Health Organization estimates the real figure is closer to 1.3 million to 4 million cases and 21,000 to 143,000 deaths each year.

https://theconversation.com/cholera-still-kills-thousands-each-year-in-places-without-clean-water-its-far-from-history-288170?utm_source=Live+Audience&utm_campaign=ab8567a05f-nature-briefing-daily-20260729&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: July 2026 floods in Chattogram, Bangladesh: an escalating emergency

Since July 5, 2026, exceptionally heavy monsoon rainfall, runoff from surrounding hills, high tides, and embankment failures have caused flash floods, prolonged waterlogging, and landslides across southeastern Bangladesh. By July 11, at least 44 people had died across seven affected districts.1Chattogram District alone had recorded 11 deaths, 12 injuries, approximately 759 530 people affected, and 188 648 marooned families.1 Of the 44 deaths, 43 occurred across five districts within Chattogram Division, highlighting the concentration of this emergency in the southeast.1

The consequences extend far beyond the immediate mortality. In Satkania, a sub-district of Chattogram District, breaches along the Sangu and Dolu river systems inundated most Union Parishads, submerged the Upazila Health Complex and other government facilities, and isolated hundreds of thousands of residents.2 Floodwaters entered homes throughout Lohagara, Banshkhali, Chandanaish, and neighbouring sub-districts of Chattogram District; mud houses collapsed, road access was cut off, and electricity and mobile communications failed.2 Although no comprehensive housing-loss assessment has yet been released, the scale of household inundation and displacement indicates that the final number of damaged homes is likely to be substantial.

The floods have also inflicted a major livelihood and food-security shock. Preliminary assessments indicate that 15 911 ha of cropland in Chattogram District were damaged, including Aush paddy, Aman seedbeds, and summer vegetables.3 Fish, shrimp, and fry were washed out of 9933 ponds and farms, resulting in estimated fisheries losses of BDT 91·42 crore.3 Livestock losses across Chattogram Division were estimated at BDT 27·18 crore, and more than 241 km of road in southern Chattogram were damaged.4 These figures remain incomplete because many affected locations are inaccessible and field-level assessments are continuing.

The deterioration of water, sanitation, and hygiene conditions presents the most immediate secondary health threat. Floodwater can contaminate drinking-water sources with human waste, agricultural runoff, household chemicals, and animal remains. Crowded shelters with insufficient toilets, safe water, menstrual-hygiene facilities, and waste disposal could facilitate acute diarrhoeal disease, skin and eye infections, and respiratory illness. Standing water can subsequently increase mosquito breeding, whereas damaged roads and interrupted communications can delay access to emergency obstetric care, childhood treatment, routine immunisation, and medicines for diabetes, hypertension, and other chronic conditions. WHO identifies waterborne and vector-borne disease, injury, chemical exposure, disrupted health services, food insecurity, and unsafe shelter as important medium-term consequences of flooding.5

The destruction of crops, fish farms, livestock, homes, and household possessions is also likely to deepen malnutrition and psychological distress. Families that rely on daily labour, subsistence agriculture, or aquaculture can lose both current income and the assets required for future recovery. Children, pregnant people, older adults, people with disabilities, displaced households, and residents of landslide-prone informal settlements require additional protection. Evidence from previous floods shows that displacement, financial insecurity, housing damage, and uncertainty about recurrence can precipitate or prolong anxiety, depression, sleep disturbance, and post-traumatic stress.6 Mental health and

psychosocial support should therefore be incorporated into relief services rather than postponed until physical reconstruction begins.
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)01477-7/fulltext?dgcid=raven_jbs_aip_email

Nature: When physicians and AI work together, who is accountable? How to lay out medical liability

A staging system based on how big a role AI has in patient care can help to identify who is responsible in cases in which care fails.

Artificial intelligence is fast becoming embedded in hospitals and healthcare clinics. Yet, with the benefits of AI tools come fresh patient-safety risks — and questions about who is responsible when things go wrong.

Conventionally, responsibilities in health care are clearly delineated. Clinicians must provide a set standard of treatment. Institutions must organize safe treatment processes. Manufacturers must deliver non-defective medical devices. Regulators and bodies involved with licensing and credentials can intervene if any of these parties fall short of expected standards. And courts can assess which party is liable if patients are harmed.

An incoming wave of medical AI tools is set to blur these lines.

Current AI tools are being used mainly as assistants, backed up by human checks, much as with other medical devices. For instance, when AI models trigger an alert that a patient is at risk of sepsis, a clinician must review and confirm the physiological rationale before any treatment.

But in the next few years, AI-driven clinical tools are expected to advance from synthesizing data to acting on it, with less and less human input. They will make diagnoses, devise treatment plans and make patient-management decisions that clinicians play little or no part in. Whereas the outputs of many existing tools are understandable — sepsis models, for instance, work by combining defined physiological variables according to a transparent formula1 — more-advanced tools can involve black-box deep-learning processes. Clinicians will no longer be able to fully follow the tools' reasoning, even for algorithms that provide some explanations for their judgements2.

Such tools land between accountability rules. Their black-box reasoning makes it hard to determine when they are defective. And when decisions are made jointly by humans and an opaque AI model, it becomes difficult to assess responsibility when people are harmed while receiving health care. Existing medical-liability frameworks do not address this crossover point3.

https://www.nature.com/articles/d41586-026-02315-9?utm_source=Live+Audience&utm_campaign=dbc243c82e-nature-briefing-daily-20260728&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Sudan virus disease in humans

In 2025, Uganda had Africa's ninth outbreak of disease caused by Sudan virus (SUDV), a filovirus similar to Ebola virus (EBOV) that causes severe febrile disease in humans. In this Review, we summarise the evidence on the epidemiology, natural history, and immunology of Sudan virus disease (SVD) from outbreaks since 1976. Following an incubation period averaging about 1 week, SVD typically presents with an influenza-like illness followed by a severe diarrhoeal disease, often accompanied by cardiorespiratory symptoms and dehydration. Clinical findings can include kidney and liver injury, acute inflammation, and coagulopathy. Severe cases can progress rapidly to shock, multiorgan failure, and death. The pooled case-fatality rate until 2022 was 49% (95% CI 39–58), although a lower case-fatality rate of 29% was recorded during the 2025 outbreak. The virus is detectable in blood from

symptom onset, peaking during acute illness. Transmission occurs mainly through close contact with acutely symptomatic individuals and their body fluids, driving household and nosocomial spread. Early T-cell responses and SUDV-specific antibodies might be important for survival, and suppressed immunity and uncontrolled inflammation might predict fatal outcomes. Survivors present durable humoral and cellular immunity for up to 15 years after infection. Although outbreaks to date offer valuable insights into SVD, substantial evidence gaps and limitations exist. Future outbreak preparedness should include prospective planning for high-quality research that can be rapidly implemented to address key evidence gaps. Strengthening these data, together with advancing the development and evaluation of vaccines and therapeutics, will be essential for timely and effective outbreak response.
On Jan 30, 2025, Uganda declared an outbreak of disease caused by Sudan virus (SUDV, species Orthoebolavirus sudanense),1 one of four orthoebolaviruses pathogenic to humans, alongside Ebola virus (EBOV), Bundibugyo virus (BDBV), and Taï Forest virus (TAFV). Phylogenetic relationships between filoviruses have been described previously.2 The 2025 SUDV disease (SVD) outbreak was the sixth in Uganda and ninth in sub-Saharan Africa.1,3,4
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(26)00072-0/fulltext?dgcid=raven_jbs_etoc_email

Science: Major highway of the human nervous system gets a complete road map
First comprehensive map of the vagus nerve may point to more precise stimulation therapies
The vagus nerve snakes through the human body like an elaborate highway system, transmitting signals from the brain to the heart, lungs, and gastrointestinal system and back. But despite its critical role in regulating breathing, heart rate, and digestion, researchers have long struggled to map its anatomical structure—until now.
Scientists have created the first comprehensive map of the human vagus nerve, tracing thousands of individual nerve fibers stretching from the lower brain stem to all major organs. The map—announced last week and detailed in a data set released earlier this year—might help scientists and doctors more precisely stimulate the nerve as a potential treatment for conditions such as epilepsy, stroke, and inflammatory diseases.
Some existing therapies stimulate the vagus nerve with electrodes implanted in the chest or neck sending signals that can suppress seizure activity in the brain, for example, or blunt pain. But the vagus nerve is a staggeringly intricate network: After forking into a main left and right branch, it shoots out finer branches made up of fascicles—small bundles of nerve fibers—that project to organs throughout the body. That complexity makes it hard to isolate and target specific nerve fibers or to understand the effects of stimulating at a given point.
“We place an electrode on the vagus nerve, and things happen. But why do these things happen in this certain way?” asks Stavros Zanos, the physician-scientist at the Feinstein Institutes for Medical Research who led the mapping project. “We just had no idea, and we looked at the literature, and it just wasn’t there.”
To build a comprehensive map of the nerve structures, Zanos and his colleagues analyzed 30 sets of left and right vagus nerves dissected from 30 human cadavers.
The dissected nerves underwent ultrasound imaging to capture basic anatomy. Then the team used a form of x-ray imaging called micro-CT to trace the paths of nerve fibers at the microscopic scale. Finally, at an even finer scale, the researchers made thousands of thin cross-sectional slices of the nerves and exposed them to antibodies that bound to specific proteins, staining them different colors. This process highlighted fibers that carry specific neurotransmitters—providing insight into individual fibers’ functions and the organs with which they communicate.

https://www.science.org/content/article/major-highway-human-nervous-system-gets-complete-road-map?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=distillation&et_rid=1169729274&et_cid=6030877

The Lancet: Oncology and emergency care collapse in the West Bank

The health-care system in the occupied Palestinian territory is undergoing a silent, catastrophic collapse, pushing regional public hospitals to the brink of total structural failure. As an emergency medicine and oncology physician at Dura Governmental Hospital, West Bank—a crucial secondary-care hub—I witness daily the devastating erosion of our capacity to deliver basic, life-saving medical care. Prolonged fiscal blockades, severe restrictions on movement, and the economic isolation of the Palestinian health sector have culminated in an unprecedented shortage of essential medicines and crucial medical infrastructure.1

The crisis is most acute in oncology and specialised care units. Public hospitals across the West Bank (including Dura Governmental Hospital) are experiencing chronic depletions of more than 50% of essential chemotherapeutic agents and targeted therapies.1,2 Patients with cancer, who already face immense logistical barriers in securing medical referrals and travel permits to specialised centres outside the West Bank, are now left without local treatment alternatives.3 At Dura Governmental Hospital, our oncology ward is overwhelmed, operating with severely constrained resources and with an absolute deficit of advanced diagnostic equipment.4 Similarly, the management of end-stage renal disease has reached a critical bottleneck due to the erratic supply of dialysis consumables and solutions, directly jeopardising the lives of thousands of patients.

Emergency departments are equally compromised. The emergency and critical-care referral networks we attempt to maintain are paralysed by regional communication disruptions and the inability to safely transport patients who are critically ill across fragmented territories. Emergency medical services are forced to operate under severe triage conditions without the necessary medical reserves.5

International humanitarian interventions, while valuable, remain reactive stopgaps rather than sustainable systemic solutions. Multiple organisations, including WHO and Médecins Sans Frontières, have repeatedly warned of the systemic degradation of Palestinian health-care infrastructure.6–8However, without a strategic, internationally backed funding campaign to establish permanent, self-sufficient specialised facilities—eg, a dedicated oncology building at Dura Governmental Hospital—and a guaranteed, unhindered supply chain for essential medicines, mortality rates from treatable non-communicable diseases will inevitably surge. The international medical community cannot remain silent while an entire health-care system dies. Strategic, immediate intervention is an absolute ethical and clinical imperative to safeguard the fundamental human right to health for millions.

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)01415-7/fulltext?dgcid=raven_jbs_aip_email

Science: As a weekly anti-HIV pill nears the market, vaccine research faces new hurdles
Trial failed of supposedly potent antibodies that the leading vaccine candidates aim to trigger

Powerful anti-HIV drugs took another step forward at the 26th International AIDS Conference, held here last week. Among the most exciting findings were studies showing one pill a week could be enough to keep HIV under control in people living with the virus—a significant improvement over the current once-a-day regimen. But vaccine development, which has struggled even as treatments advance, faced new questions as a study highlighted the limits of unusually powerful antibodies that the leading vaccine candidates aim to trigger.

The meeting itself was a shadow of its former self. Some 7300 delegates attended, about one-third the number who came to the conference in its heyday between 2002 and ’12. World leaders and celebrities were absent. That partly reflected success: By reducing new infections and deaths, science has made HIV a less urgent topic than it used to be.

But the sparser attendance was also due to the steep cuts in funding by the United States. Its foreign assistance for HIV/AIDS dropped from $8.3 billion in 2024 to $6.2 billion in 2025, a 25% cut, according to a report released at the conference by KFF and the Joint United Nations Programme on HIV/AIDS (UNAIDS). “People are not able to travel or pay for registrations because they don’t have grants,” says Beatriz Grinsztejn, an infectious disease specialist at the Oswaldo Cruz Foundation who chaired the meeting. A study by the nonprofit amfAR showed that in the wake of the cuts, 46 countries closed some 1700 sites that deliver HIV services, with prevention efforts taking the biggest hit. “The scientists have delivered,” said Winnie Byanyima, head of UNAIDS. “The politicians need to step up.”

The cuts have contributed to the slow rollout of lenacapavir pre-exposure prophylaxis (LEN PrEP), an injectable drug that can keep HIV at bay for 6 months. (Protesters at the meeting decried the slow start and criticized LEN PrEP’s manufacturer, Gilead Sciences, for excluding Latin America from a deal that makes the drug available at low cost to 120 countries.) But injectable LEN PrEP is occasionally used as an HIV treatment, as well. Now, Gilead has joined forces with Merck, producer of islatravir, to test a pill combining the two drugs. Two trials presented at the meeting—one of which was published in the 29 July issue of The New England Journal of Medicine(NEJM)—showed the combination can hamper viral replication for 1 week. Gilead and Merck plan to submit the data to regulatory agencies for approval.

https://www.science.org/content/article/weekly-anti-hiv-pill-nears-market-vaccine-research-faces-new-hurdles?utm_source=sfmc&utm_medium=email&utm_campaign=ScienceAdviser&utm_content=etcetera&et_rid=1169729274&et_cid=6032005

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