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Editorial

Over the past few months, extreme weather events, disease outbreaks, and infodemic management have collectively challenged health professionals in their daily practice. Reports of record-breaking high temperatures during the summer months, torrential rainfall in Africa, Asia, and Europe, and projections of the most active hurricane season on record demonstrate the observable impacts of climate change on the delicate balance within our planet's ecosystems. The emergence of disease outbreaks, such as mpox, oropouche virus, and highly pathogenic avian influenza virus, has helped drive global discourse about health system preparedness and response, as well as the evaluation of national action plans for pandemic preparedness (including reducing risk of potential zoonotic transmission). The rapid spread of misinformation and disinformation hinders the delivery of accurate health recommendations with patients, families, and communities, as well as the opportunity to build public trust and rapport.

To address this global burden, WMA leaders underscored the urgent need for global solidarity as a means to quickly respond to climate change adaptation and mitigation efforts, support the negotiations of the Pandemic Agreement, improve global health workforce training, and streamline public health messaging. As the impacts of anthropogenic phenomena on the aquatic, atmospheric, and terrestrial ecosystems cannot be overlooked, alterations or loss of natural biodiversity and animal habitats, chemical and plastic pollution, and the introduction of non-native species remain significant threats to humanity. Hence, the question remains: How can global health professionals leverage their expertise, develop robust One Health collaborations to address these endemic and emerging health risks, and fortify medical education and training across our countries?

As global leaders attend the 79th session of the UN General Assembly from 20-30 September 2024, which consists of High-Level Meetings on the Summit of the Future, General Debate, Sea-Level Rise, Antimicrobial Resistance (AMR), and Elimination of Nuclear Weapons, they share the urgent message for international cooperation and collaboration to combat diverse global crises and conflicts that affect public health and environmental sustainability. Over these next months, additional key global meetings will highlight innovative strategies to accelerate progress to achieving the Sustainable Development Goals, including the Group on Earth Observations (GEO) Symposium and Regional Meetings (Africa, Americas, Asia-Oceania, Europe), World One Health Congress, and the UN/WHO Regional Conference on Space Technology for Advancing Global Health. These timely events – together with reports from leading agencies like the multi-agency's *United in Science 2024* – support knowledge exchange, propel interactive debates, and allow for expanded networks for collaborative climate action.

The Finish Medical Association invites WMA members and relevant guests to attend the WMA General Assembly in Helsinki, Finland, from 16-19 October 2024. At this event, WMA members can offer their perspectives to scholarly debates on timely global health and medical ethics topics and build connections with other NMAs. As WMA members have participated in several regional expert meetings on the WMA Declaration of Helsinki revisions in Johannesburg, Munich, and Washington, DC, they can articulate any final comments for the overall consensus and subsequent consideration for adoption.

In this issue, Dr. Otmar Kloiber shared his perspectives on WMA activities as well as his leadership achievements over his tenure as WMA Secretary General. Ms. Marr, Dr. Julia Tainijoki, Dr. Caline Mattar, Dr. Lesley Ogilvie, and Mr. Ashrit Challa offer a high-level summary of the roundtable discussion on AMR ahead of the UN High-Level Meeting on AMR in September 2024. Dr. Mike Kalmus Eliasz, Dr. Yassen Tcholakov, Dr. Maria Inês Francisco Viva, Dr. Marie-Claire Wangari, and Dr. Wenzhen (Jen) Zuo presented reflections on the UN High-Level Meeting on Pandemic, Prevention, Preparedness, and Response in September 2023. Dr. Jeazul Ponce Hernández, Dr. Francisco Franco Pêgo, Dr. Flora Wendel, Dr. Marie-Claire Wangari, and Dr. Balkiss Abdelmoula described the Junior Doctors Network (JDN)'s participation in the World Health Summit 2023. Dr. Marie-Claire Wangari, Dr. Deena Mariyam, Dr. Lekha Rathod, and the WMA-JDN Working Group on WHO Activities examined JDN perspectives on barriers and solutions to the equitable access of global health opportunities. Finally, Ms. Tabasom Fayaz described pharmaceutical policy in Afghanistan.

WMA members are inspirational leaders who contribute their clinical and surgical expertise in daily practice and at national and international meetings. As they are acutely aware of challenges facing medical education and training, ethics, and public health across their countries, we encourage them to prepare scientific analyses and commentaries for the *World Medical Journal*. In this issue, two remarkable articles from eight NMAs in Africa and Europe described leadership experiences, ongoing NMA activities, and perceived strengths and challenges in medical education. Dr. Johannes Steinhart, Dr. François Arnault, Dr. Philippe Cathala, Dr. Simon Kigondu, Dr. John Baptist Nkuranga, Dr. Mvuyisi Mzukwa, Dr. Tomás Cobo Castro, Dr. Sofia Rydgren Stale, and Dr. Herbert Luswata, representing the NMAs from Austria, France, Kenya, Rwanda, South Africa, Spain, and Sweden, respectively, expressed their valuable viewpoints for ongoing discourse. Also, WMA members representing 14 countries of the African, Americas, Eastern Mediterranean Region, and South-East Asian regions highlighted national policies and activities that promote patient safety practices related to World Patient Safety Day 2024.

We look forward to exciting discussions and networking opportunities at the WMA General Assembly in Helsinki!

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Interview with the WMA Secretary General

Otmar Kloiber

For this interview, Dr. Otmar Kloiber, the WMA Secretary General, shares his perspectives on WMA activities as well as his leadership achievements over his tenure with Dr. Helena Chapman, the WMJ Editor in Chief.

How would you describe your role as General Secretary, and how has the WMA evolved as an organisation over your WMA tenure?

As Secretary General, my role is to operationalize the aims of the WMA, promote the application and development of medical ethics, and advocate for better patient care and equity in order to protect human rights in healthcare. I joined the WMA after many countries, especially in central and eastern Europe, became democracies or at least less authoritarian, and old blocks of power had disappeared. The world was opening up politically, which helped significantly to increase our membership. Since that time, the WMA has become a more vibrant community, with more active engagement in global health activities and healthcare advocacy at all levels.

What do you consider to be the WMA's top three most important leadership achievements over the past decade?

First, we have made major changes in the WMA governance, which corrected the perception of the WMA as a club of wealthy countries. We now represent the largest portion of physicians globally. Second, we have engaged in addressing major global health challenges, such as social determinants of health, One Health, climate crisis, and research ethics. With the Declaration of Taipei, we have provided a blueprint for transferring our principles of research ethics into the research world of large databases and biobanks [1].

Finally, we have held global discussions to defend, develop, and update our core documents, including the Declaration of Geneva and the International Code of Medical Ethics [2,3]. We also needed to adapt to new developments in medicine and adopt a more modern language, while remaining true to our principles and traditions of caring, ethics, and science. This year, I am confident that we will finalise discussions on one of our key documents, and will complete the revision of the Declaration of Helsinki in October 2024.

How would you describe the observed impact of the WMA declarations, resolutions, and statements in the health sector? Please share two examples that you have observed during your WMA tenure.

During my WMA tenure, I have observed three specific examples with significant global impact. First, the Declaration of Helsinki, which is referenced in national and international law, has become the cornerstone of research ethics worldwide [4]. Second, in collaboration with regional and national physician organisations, we strongly advocate for our professional autonomy. Over time, we have witnessed that professional autonomy has been under attack from multiple stakeholders. Some governments and commercial entities have attempted to commoditise healthcare and subordinate medical decision-making to commercial interests, rather than serving the interests of patients or communities. Finally, we lead efforts to raise attention to human rights violations in individual or national cases, and although not always successful, we remain vigilant. Most recently, we participated in a movement that convinced the Parliament of Gambia to maintain the prohibition of female genital mutilation [5].

How does the WMA manage international discourse throughout the year, including contentious debates and disagreements that may arise on complex medical ethics topics? Please share two examples of how contentious debates were addressed during your WMA tenure.

There have always been, and probably always will be, divergent opinions on ethical questions, particularly concerning the beginning and end of human life. It is important to note that divergent views on medical ethics issues often exist within countries rather than just between countries. Over the past decades, our approach has been to engage in open and inclusive debate on these issues. Although a lengthy and resource-intensive process, we are convinced that this approach produces the

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best results. For example, we have discussed issues ranging from gamete donation, embryo transfer, and surrogate motherhood to abortion, physician-assisted suicide, and euthanasia. Although controversial topics, we were able to discuss them thoroughly and eventually address them through the development of WMA policies.

How can the WMA help support specific national challenges faced by national medical associations (NMAs), including medical education and training and health policy reform. Please share two examples of how the WMA has helped support NMAs during your WMA tenure.

When managing diverse national issues, the WMA acts at the request of our NMAs. If in a country there is no NMA in our membership, then the WMA may speak out independently. Over the past year, the WMA has supported several specific situations of significant concern. For example, the WMA supported the Indian Medical Association in their struggle against a government policy that grants traditional healers more rights to practise modern medicine and surgery without any relevant education and training. Similarly, the WMA joined the Korean Medical Association in their objection against the government's attempts to either satisfy a small group of voters or place pressure on Korean physicians by allowing practitioners of traditional Korean medicine to use western medical technologies without appropriate education [6]. The WMA has also supported Korean physicians in their protest against nearly doubling the number of medical students without first creating the necessary university resources [7].

However, if pressing concerns arise in several countries simultaneously, NMAs may be unaware that they are affected by issues, such as the commoditization of healthcare and the increasing loss of professional autonomy. For example, some governments are prohibiting their medical residents from seeking employment abroad, rather than offering decent working conditions. These actions that target professional groups represent civil conscription, and may qualify as forced labour and constitute a human rights violation.

Please describe three ongoing WMA initiatives that help address specific challenges facing the global medical community over the next five years.

By the nature of the WMA, most initiatives are focused on identifying pressing global challenges in medical ethics and collectively developing a relevant and timely policy to help guide NMAs in their advocacy, decision-making, and educational activities. Over the next five years, three specific focus areas include supporting pandemic preparedness, reducing risks of antimicrobial resistance (AMR), and combatting the climate crisis. To that extent, we have revised our policies on emergency preparedness and engaged actively with the World Health Organization on fostering action against AMR. We have also actively participated in the Conference of the Parties (commonly called COP) of the United Nations Framework Convention on Climate Change (UNFCCC), where we collectively advocate for more political action on climate adaptation and mitigation, noting the direct or indirect consequences on health and well-being.

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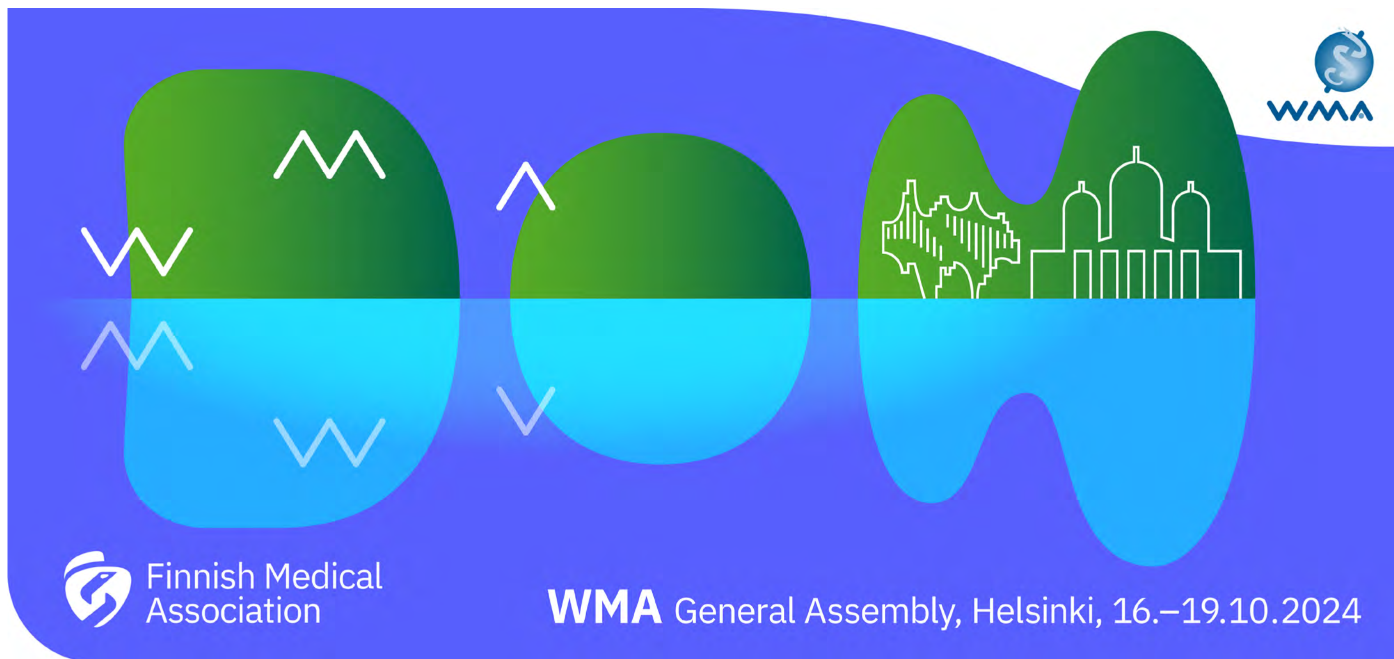
Invitation to the WMA General Assembly in Helsinki, October 2024



Dear Colleagues and Esteemed Members of the World Medical Association (WMA),

It is with great pleasure that we invite you to join us for the WMA General Assembly, which will be held in Helsinki, Finland, from 16-19 October 2024. This year's gathering will be particularly significant as we celebrate the 60th anniversary of the Declaration of Helsinki, a foundational document that has guided the ethical standards of medical research for the past six decades.

Theme: Equality in Healthcare

Our theme for this year – *Equality in Healthcare* – reflects one of the most urgent and pressing issues of our time. Despite tremendous advancements in medicine, disparities in healthcare access and quality continue to persist across populations, communities, and countries. This assembly will bring together thought leaders, healthcare professionals, and advocates from around the world to discuss how we can collectively work towards more equitable health systems, ensuring that everyone, regardless of race, gender, socioeconomic status or geography, receives the healthcare they need and deserve.

Celebrating 60 Years of the Declaration of Helsinki

The Declaration of Helsinki has stood as a pillar of ethical guidance in medical research for the past six decades, shaping the conduct of clinical trials and the protection of research participants worldwide. Its principles have become the cornerstone of ethical medical practice, ensuring that the rights, safety, and well-being of patients remain paramount in research efforts. This anniversary is timely to reflect on the Declaration's profound impact on global health, as well as renew our commitment to upholding its values in an ever-changing medical landscape. Helsinki, the birthplace of the Declaration of Helsinki, is a fitting location for this important dialogue. Over the course of the meeting, we will reflect on the progress made since the Declaration's adoption in 1964, as well as hear the results of a two-year renewal process and explore how we can apply its principles to the challenges of today – particularly in advocacy efforts for equal access to healthcare.

A Comprehensive Program

The event will serve as a vital platform for physicians to connect, share knowledge, and influence the future direction of medical ethics and medicine. It is comprised of the General Assembly proceedings as well as preceding meetings of the Statutory Committees and the Council. We encourage all WMA members to take part in this historic event. Your voice and your expertise are essential in shaping the future of global healthcare and ensuring that the principles of equality, dignity, and ethical responsibility remain at the core of our profession.

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The Host City and Association

We invite you to explore our beautiful capital and its surroundings. Helsinki is known for its blend of modern urban culture, history, architecture, design, and natural beauty. As saunas are a significant part of Finnish culture, Helsinki offers many opportunities to experience them, including on the way from the official meeting hotel to the conference centre in the harbour.

This will be the third WMA General Assembly that the Finnish Medical Association (FMA) has hosted. Established in 1910, the FMA is a professional organisation and trade union representing more than 90% of Finnish physicians. It plays a significant role in the development of the medical profession in Finland, advocating for the rights and interests of physicians and ensuring high standards in medical practice.

We are proud of this opportunity to host this event, and we will do our best to make your visit successful and memorable. Mark your calendars for 16-19 October 2024, and join us in Helsinki, as we celebrate 60 years of the Declaration of Helsinki and reaffirm our commitment to advancing equality in healthcare for all.

Warm regards,

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Report on the Roundtable Discussion on Antimicrobial Resistance – Looking Towards the UN High-Level Meeting on AMR and Beyond

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Julia Tainijoki

Caline Mattar

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Ashrit Challa

The World Medical Association (WMA) collaborated with the Global Antimicrobial Resistance (AMR) Research and Development (R&D) Hub to host a roundtable discussion on AMR on the sidelines of the 77th World Health Assembly in Geneva, Switzerland in May 2024. This event was held in preparation for and anticipation of the United Nations General Assembly (UNGA) High-Level Meeting (HLM) on AMR, which will take place on 26 September 2024, in New York. Invited participants represented a range of sectors and backgrounds and were brought together to discuss four key themes: Access and Innovation, Health Systems and Health Workforce Education, Stewardship, and One Health. This article aims to summarise the key messages and highlight perceived gaps in the Zero Draft of the UNGA HLM on AMR political declaration, as discussed during the roundtable.

Background on the AMR Situation

AMR is estimated to have been directly responsible for 1.3 million deaths globally in 2019, with approximately 4.95 million deaths associated with AMR in the same year [1]. In addition to mortality figures, AMR also results in significant economic burden, with the World Bank estimating that AMR could result in a 3.8% reduction in global gross domestic product (GDP) by 2050, amounting to a US $3.4 trillion loss each year [2]. AMR could push 24 million more people into extreme poverty by 2030 if left unchecked and reduce global life expectancy by 1.8 years by 2035 [2,3]. Moreover, the burden of AMR is unequal, with low- and middle-income countries (LMICs) disproportionately affected by drug-resistant infections. As LMICs often have the greatest unmet needs for diagnostics, therapeutics, and vaccines, AMR only widens these gaps in healthcare access and bolsters existing inequities.

In 2016, the first UNGA HLM on AMR stressed the urgency of action in the resultant political declaration [4]. In response, several initiatives were launched, and progress was well underway until the coronavirus disease 2019 (COVID-19) pandemic brought efforts to a standstill. Resources were diverted from AMR efforts, with surveillance and stewardship programs also falling by the wayside, resulting in increased global rates of AMR incidence [4]. Currently, we are at a critical junction in the aftermath of the COVID-19 pandemic, with another UNGA HLM on AMR rapidly approaching. While it is crucial that the resultant UNGA declaration reflects the necessary progress, much-needed political commitments, and defined monitoring targets, the implementation path post-UNGA remains challenging. Multiple avenues of collaboration and

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alignment among global actors are essential if we hope to accelerate progress at all levels and facets of the AMR challenge we face today.

Outcomes of Roundtable Discussions

This invitation-only roundtable event was convened to unite stakeholders in the AMR field to share expertise, explore synergies, and make recommendations for next steps. An overview of the discussions from the expert dialogue as well as the suggestions for strengthening the UNGA political declaration on AMR are provided below, with the aim of driving action against AMR at the highest political levels. Suggestions are categorised into four key thematic areas, which were the basis of our discussion subgroupings and were handpicked to ensure diversity in geographic representation, sector, and professional background among roundtable members.

Theme 1: Access and Innovation of AMR Diagnostics and Treatment

Recognising that the lack of new antimicrobials and rising resistance endangers vulnerable populations, necessitating urgent prioritisation and incentives for development and access, participants raised that the access and innovation sections of the Zero Draft of the political declaration required a clearer statement of intent and greater ambition. While including specific global research and development (R&D) targets in the declaration was thought to be challenging, they suggested that – at a minimum – a mechanism for establishing such targets in the future should be outlined. There was general consensus that this could involve a political mandate and commitment for the forthcoming Independent Panel on Evidence for Action against AMR to develop these targets. However, the role of this Panel and its relationship with the Quadripartite organisations would need to be clearly defined.

Participants also highlighted that the declaration should include specific wording on supporting existing global initiatives, acknowledging the progress that has been made on access and innovation since 2016. For example, this progress has included initiatives such as CARB-X (https://carb-x.org/), GARDP (https://gardp.org/), the Global AMR R&D Hub (https://globalamrhub.org/), and country-specific pull incentive pilots [5,6]. They highlighted the call to recognise the WHO pipeline analyses and priority lists as foundational to ongoing work in this area [7-9].

In the Zero Draft, participants commented that financing was largely siloed around National Action Plans (NAPs). The requirement to establish financing targets for new antibacterials and give greater considerations to the complexities of diagnostic funding from an R&D perspective was expressed, given that diagnostics often exceed the costs of antibiotics. They agreed on the importance of increased emphasis on push and pull incentives as sustainable strategies for long-term innovation and new economic models de-linked from revenues. Participants inquired about how to appropriately signal these next steps towards resource mobilisation through the G7 and G20. Furthermore, it was emphasised that most prescribed antibiotics today are generics, and the supply chain remains unstable due to manufacturer consolidation. The discussion ended with pragmatism, underscoring the urgency to plan for the replacement of life-saving antibiotics, as failing to do so would leave nothing to preserve their access in the future.

Theme 2: Health Systems and Health Workforce Education

Participants acknowledged that strong health systems and a well-resourced workforce are fundamental to combat AMR through prevention, diagnosis, treatment, and public education. The Zero Draft placed insufficient emphasis on education and training of medical professionals related to AMR. They agreed that there must be a greater emphasis on and investment in preparing the workforce for AMR, both within the language of the Zero Draft and through the strengthening or establishment of education frameworks. Participants stressed the importance of educating patient communities alongside medical professionals, including engaging patients in discussions about AMR and the development of NAPs. Participants believed that creating stronger systems for sharing information can propel health personnel and patient communities to spearhead government-level change in combat AMR.

Participants also expressed the need for greater levels of education during training, including significant investment into health infrastructure for all healthcare roles. They commented that physicians, dentists, nurses, and pharmacists tend to represent the majority workforce, often overlooking 'invisible personnel' in the health workforce, such as administrators, patient escorts, and cleaners. Improving education systems and enabling healthcare professionals to spend more time with patients were seen as essential steps to strengthen healthcare team collaborations in AMR initiatives. Furthermore, they shared their concern about the lack of investment in dissemination of available information including tools to enhance understanding of AMR.

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One suggestion was to include the terms "Investment" and "Patient Voice" in the Zero Draft to reflect the importance of these concepts.

Theme 3: Stewardship to Reduce the Burden of AMR

Discussions centred on the fact that antimicrobial stewardship (AMS) is essential to combat AMR, addressing overprescription, misuse, and educational gaps, while promoting global collaboration and policy reform within the health system. The political resolution should clearly define and outline the key components of AMS. Participants acknowledged that clear, accessible guidelines should extend beyond physicians to include nurses and community health educators, considering the disparities between high- and low-resource settings. A simplified set of guidelines was viewed as essential to ensure effective implementation of AMS principles at the community level, supported by meaningful surveillance data that reflect local resistance patterns. They highlighted that guidance on usage, especially for new antibiotics coming to the market, should be aligned with the implementation of an appropriate stewardship plan.

Participants stressed that access to essential antibiotics is foundational to successful stewardship and should be prioritised in the declaration's opening paragraphs. Without access, healthcare professionals face the difficult dilemma of balancing stewardship measures with patient health needs, as well as recognising direct links between human and animal health. They also emphasised that universal health coverage is a vital component of AMS, to ensure the effective implementation of diagnostics or infection prevention and control.

Building on this narrative, the participants hoped that the declaration would offer an opportunity to broaden the scope of AMS, advocating for a holistic, society-wide approach that includes stewardship at the community level, consideration of behavioural changes, and attention to commercial determinants. Civil society organisations and health professional associations can play a key role in this expanded approach to AMS. The discussions ended with the recognition that the draft declaration does not adequately recognise how women and children disproportionately bear the impacts of AMR, facing higher risks and challenges in accessing adequate treatments, such as paediatric formulations.

Theme 4: One Health Approach

Participants suggested that the term "One Health" be replaced with "intersectoral," "cross-sectoral" or "multisectoral" in the draft political declaration, as it may minimise any potential political setbacks or challenges associated with definitions of "One Health". Other participants commented that the term "One Health" could be used in the introduction or preamble and removed from the main text. This discourse was highlighted as the "One Health" term and concept are not yet well entrenched in some countries, with additional translation issues in other languages.

Participants also discussed how other relevant terms are defined and incorporated into the declaration. First, the term "animal" was found to be often poorly defined and oversimplified in the context of AMR. A need for antimicrobial use to be species- or sector-specific, potentially through the introduction of an animal-focused version of the WHO Access, Watch, Reserve (AWaRe) Classification was raised. This system would account for the varying impacts of different antibiotics and classes on AMR, emphasising the importance of appropriate use. Second, the term "integrated surveillance" was questioned due to the challenges in its implementation, noting that a more suitable approach might be mono-sectoral surveillance with integrated or coordinated analysis.

Some participants viewed the inclusion of global targets as polarising and a potential barrier to adoption of the resolution, recognising that targets should be evidence-based, inclusive, and appealing to politicians. They believed that such targets could be adapted by regions or countries and reevaluated over time. This conversation emphasised the necessity of true multisectoral collaboration, with participants raising that the Quadripartite organization's *One Health AMR Priority Research Agenda* had not been included in the declaration [10]. In the research arena, the benefits of considering the social and behavioural aspects of AMR and a greater focus on implementation research to improve the delivery of interventions was voiced. Overall, participants agreed that the "One Health" concept should be integrated into all aspects of AMR policy, not simply treated as a separate entity.

Key Messages and Recommendations

- The lack of new antimicrobials and rising resistance endangers vulnerable populations, necessitating urgent prioritisation and incentives for development and access.
- Urgent planning is needed to ensure adequate supply of generic antibiotics and address the consolidation of suppliers.

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- Strong health systems and a well-resourced workforce are essential to combat AMR through prevention, diagnosis, treatment, and public education.
- Education frameworks for healthcare professionals, patients, and communities at large should be more widely disseminated, and governments should ensure patient voices are included in NAP considerations.
- AMS is essential to combat AMR, addressing overprescription, misuse, and educational gaps while promoting global collaboration and policy reform.
- Ensuring access to essential antibiotics is the foundation for successful stewardship, as healthcare professionals face difficult choices between applying stewardship measures and safeguarding the health of their patients.
- A greater focus on behaviour change and implementation science would assist in improving the delivery of AMR interventions.

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Reflections on the Value of the UN High-Level Meeting on Pandemic, Prevention, Preparedness, and Response One Year Later

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In September 2023, Member States gathered at the United Nations (UN) High-Level Meeting on Pandemic Prevention Preparedness and Response (PPR) in New York, against the backdrop of the UN General Assembly [1]. The meeting was supposed to provide leadership at the 'highest level' to reset the system for PPR in the wake of the coronavirus disease 2019 (COVID-19) pandemic and was called for by the Independent Panel for Pandemic Preparedness and Response (IPPPR) and other parties [2]. Hence, it is worth reflecting on the impact of High-Level Meeting, as negotiations continue in Geneva to try and develop a pandemic agreement or convention following the extension of the International Negotiation Bureau (INB) (https://inb.who.int) at the World Health Assembly (WHA) in May 2024 and ahead of the UN General Assembly in September 2024.

In September 2023, members of the World Medical Association (WMA)'s Junior Doctors Network (JDN) collectively analysed all 114 statements delivered at the UN High-Level Meeting on PPR to understand Member State's stated priorities on PPR and the level of prioritisation within governments. JDN members subsequently agreed with the post-meeting consensus from academics and civil society, which concluded that this event was particularly underwhelming, in terms of keeping pandemic threats on the agenda of heads of government, delivering new policy commitments, and creating new accountability mechanisms [3].

The only tangible outcome of the political declaration was a future UN Secretary General's report and a subsequent meeting to take place in 2026 [4]. Two questions remain: What was the added value of having health negotiations in New York? To improve PPPR at the global level, would it have been better to invest efforts into 'real action' happening in Geneva-based processes or following discussions at the G7 or G20?

Participants

For a meeting labelled as 'High-Level,' the meeting surprisingly lacked the expected stature, especially when compared to representation at previous High-Level Meetings. Only 13 Heads of State and 16 Ministers of Foreign Affairs participated in this meeting. Over half of the representation were Ministers of Health, which somewhat diminishes the purpose of a High-Level Meeting outside of the World Health Organization (WHO). Notably, except for the President of the European Union Council, none of the Heads of State present represented G7, G20 or BRICS countries [5]. This potentially signifies that health is considered lower on the priority list of country leaders than during the COVID-19 pandemic. Notably,

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leaders from four (France, the United Kingdom, Russia, and China) of the five permanent members of the UN Security Council chose not to participate in the UN General Assembly at all [6]. The gender balance of representation also remained a cause of significant disappointment, whilst better than most WHAs: only one-third of representatives were women, despite the overwhelming evidence of the gendered impact of the recent pandemic [7].

Meeting Discussions

The High-Level Meeting was notable more for what was unsaid than said. Specific calls to action were scarce, with only a handful of countries (United Kingdom, Australia, Germany, Uganda, Sweden, Angola, Spain) making new commitments, often without clear financial pledges or reiterating previous promises from forums like the G7 or G20 [8]. Countries from the Global South vocalised their discontent over vaccine access during the COVID-19 pandemic, highlighting the need for stronger local manufacturing capabilities.

With simultaneous High-Level Meetings on Tuberculosis and Universal Health Coverage taking place on the same day, there was very limited integration with PPR with very few statements cross referencing the other meetings. There were nods by many Member States to incorporate a One Health approach, and some did allude to interlinkages between climate change, but references to upstream prevention were mostly missing from the discussion. Some Caribbean nations also reiterated reforms from previous debates, including a halt on debt repayments during pandemics.

Over half of the speakers supported amendments to the International Health Regulations (IHR) and progress for the INB, yet they did not articulate specific expectations for the negotiations in Geneva. During such negotiations, there was little to no mention of the High-Level Meeting, and it would be hard to link the updated IHR adopted in May 2024 to this process. Unfortunately, most statements focused on what national governments had done during the recent pandemic, rather than looking forward to the future. This was highlighted by the lack of engagement with the Global Health Threats Council as a proposed concrete outcome of the meeting, which was acknowledged by only one Member State. The definitive outcome was the decision to convene another High-Level Meeting on PPR in 2026 [4].

The Political Context

Holding a High-Level Meeting for health and shifting health discussions to New York seem less effective in galvanising global health actions than in previous years, leading to broad, lowest common denominator, non-specific political statements. Negotiators in New York in private will often cite a lack of competence and technical expertise on health topics, which is shown in the meeting's outcomes, especially noting a handover of decision-making to Geneva. The lack of relevance is also exemplified by how German delegates articulated their redlines on intellectual property in discussions around the Pandemic Accord much more clearly at the World Health Summit in Berlin in October 2023 than in New York in September 2023 [9].

On 18 September 2023, two days prior to the High-Level Meeting on PPR, the President of the UN General Assembly received a letter from seven countries (Belarus, Bolivia, Cuba, Eritrea, North Korea, Russia, Syria, Venezuela, Zimbabwe) opposing any attempt to formally adopt any draft outcome documents of four of the UN High-Level Meetings taking place in New York. This response prioritised meetings as an opportunity to push back against what they described as universal coercive measures (sanctions). Although the declaration was ultimately adopted by consensus in September 2023, widespread dissatisfaction remained. The frustrations included attaching reservations ranging from opposition to the inclusion of gender and intellectual property, matters to unilateral coercive measures, and process issues such as countries expressing that the voice of the Global South was ignored [10].

The meeting occurred against a backdrop of strained multilateralism and multiple competing crises such as inflation, conflict and climate change, for which global consensus remained elusive and exhausted needed political bandwidth. Concomitantly with the High-Level Meeting on PPPR, important meetings of the UN Security Council on Ukraine and a Climate Ambition Summit were also held with greater engagement by senior government leaders, reflective of the pandemic fatigue and how the world has moved on [11].

These events underscore the current complexities of international cooperation, particularly in health policy, and prompt critical questions about the future of multilateralism and the pursuit of global health goals in a fracturing world and distrust between the Global North and South. The adoption of the updated IHR in Geneva in May 2024, demonstrated that agreement can be achieved on contentious issues [12]. It remains to

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be seen whether the INB can reach a Pandemic Agreement finalised and overcome key issues on issues such as intellectual property, benefit sharing, and financing.

The Value of High-Level Meetings for Health

High-Level Meetings for health have historically had widely variable impacts, with the session on HIV/AIDS in 2001 standing out, contributing to a significant surge in financial commitments and subsequent reductions in HIV-related mortality rates. However, subsequent High-Level Meetings – Non-Communicable Diseases in 2011, Antimicrobial Resistance in 2018, Universal Health Coverage in 2019, and Tuberculosis in 2023 – have resulted in comparatively limited financial pledges, primarily raising the policy profile of these issues within the government and driving changes for interagency work within the UN [13]. This puts the effectiveness of High-Level Meetings for health issues into question, as decision-making increasingly shifts to smaller groups like the G7, G20, and BRICS. The preference of many leaders to attend the G20 over the UN General Assembly points towards a focus on smaller forums, as developing a consensus may be easier and quicker. Since the G7 and BRICS are comprised of countries with the largest economic, technological, and manufacturing capacities, there may be more ideological alignment in such forums, albeit lacking the universal legitimacy of UN global processes [14,15].

Despite the focus on smaller forums and increasing polarisation, universal actions are still essential to global health. It is crucial to remember the historical successes achieved even during tense periods (such as the Cold War), including smallpox eradication and the adoption of key UN conventions including the 1979 Convention on the Elimination of All Forms of Discrimination Against Women and the 1989 Convention on the Rights of the Child at the UN and last year the UN adopted a landmark, 'High Seas Treaty' [16-18].

For academics, activists, and policymakers alike, working to ensure the next opportunities to drive progress on health issues at the UN should still be embraced as possible avenues to galvanise action. We agree with the authors of this recent analysis on Non-Communicable Diseases High-Level Meetings: *"HLMs play an important role in galvanising high-level engagement from national leaders and serve as a vehicle for high-level advocacy… To make the most of these meetings, other sectors need to be activated, and health advocates should focus on the supporting elements that link international declarations to funding decisions and the implementation of policies and programmes that make a difference to people and families around the world"* [19].

In summary, the High-Level Meeting on PPR in 2024 did not contribute to a world better prepared to respond to pandemic threats. It failed due to an unfavourable political backdrop; a preference by negotiators and the WHO for pandemic discussions to remain primarily on the domain of Geneva and a visible absence of political leadership and attention. In 2024, the Antimicrobial Resistance High-Level Meeting and the UN Summit for the Future provide interesting opportunities to galvanise policy commitments on key health issues, if the lessons of this High-Level Meeting are heeded.

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Junior Doctors Network's Leadership at the World Health Summit 2023

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The World Health Summit (WHS) 2023, held from October 15-17, 2023, in Berlin, Germany (https://www.worldhealthsummit.org/), stands as one of the most significant conferences dedicated to global health. This prestigious event gathers a diverse array of stakeholders, including representatives from the scientific, political, private, and public sectors, to address pressing global health challenges. Unlike the World Health Assembly (WHA) and the World Health Organization (WHO) meetings, which have more rigid formats, the WHS offers a unique program structure. It features parallel sessions that not only encourage in-depth scientific discourse, but also provide ample networking opportunities and foster collaboration across different sectors and disciplines. This distinctive format allows participants to engage with a broader spectrum of ideas and initiatives, making the WHS a crucial platform for shaping the future of global health.

Under the theme, "A Defining Year for Global Health Action," the WHS 2023 program delved into eight critical topics that align closely with the mandates and priorities of the World Medical Association (WMA) and the Junior Doctors' Network (JDN). These agenda topics included: 1) learning lessons from the coronavirus disease 2019 (COVID-19) pandemic for future prevention efforts; 2) preparedness and response to address global crises; 3) emphasis on universal health coverage (UHC); 4) sustainable health for people and the planet; 5) G7/G20 measures to strengthen global health equity and security; 6) digital technologies for global health; 7) WHO's 75th anniversary; and 8) innovations to combat tuberculosis [1]. Attendees were able to reflect on the WHO's achievements over the past 75 years, while they recognised that universal health coverage serves as the cornerstone to global health equity and novel technology can help expand access to care and ultimately improve health outcomes. Notably, the launch of the global financing facility pledging event was a crucial moment for securing financial commitments to support global health initiatives.

The WHS 2023 YouTube channel (https://www.youtube.com/WorldHealthSummit) captured key discussions during the conference sessions, offering further insight into the decisions that will shape the global health landscape in the coming years. The JDN delegation gained insight on these pressing health topics and contributed to the dialogue, particularly in areas where junior doctors can lead and drive local and global change. Their active participation highlighted the crucial role young professionals play in

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developing innovative solutions for the future of healthcare. By learning updates on scientific and policy initiatives to address the current challenges in global health topics, junior doctors can identify ongoing projects, align their professional interests, and join leadership teams across their countries. This engagement can empower them to make meaningful contributions to the evolving landscape of global health, ensuring that their voices are integral to shaping the future.

JDN Participation

During the WHA in May 2023, the WHS organisers contacted the JDN leadership, as they had proposed an agenda that would highlight youth engagement at the WHS in October 2023. The WMA Secretariat agreed with these plans, and the JDN secured five placements to attend the WHS for the first time. Although it was challenging to attend the WHS immediately following the JDN Management Team term transition, an open call among the JDN Management Team and Working Groups Chairs resulted in a prompt assembly of three participants – Dr. Francisco Franco Pêgo (Portugal), Dr. Jeazul Ponce Hernández (Spain), and Dr. Flora Wendel (Germany). At the event, the JDN delegation networked with several health organisations to identify synergies and foster connections for future collaborations. They attended various scientific sessions on WMA primary topics and prioritised sessions that explored strategies for increasing the capacity of healthcare professionals globally, addressing workforce shortages, and ensuring that junior doctors are actively involved in policy-making and leadership roles.

Highlights on Health Workforce and Youth Engagement

This article will describe high-level highlights on four WHS sessions, including early career engagement, future of global health, global health research and policy, and UHC. It will also underscore the critical role of youth leadership and engagement in shaping the future of global health. These sessions provided a platform for the JDN delegation to actively contribute to discussions that were directly aligned with the JDN mission, where they could advocate for and empower early-career physicians on the global stage.

Youth Side Program: Hosted by the German Medical Students' Organization, the Youth Side Program is quickly becoming a central platform for empowering early-career professionals through targeted capacity-building, advocacy training, and representation. During the WHS, the program featured an intensive two-day capacity-building session complemented by two networking events. These activities provided essential updates on expanding youth engagement in both clinical and public health sectors as well as equipping participants with the skills and connections needed to drive meaningful change in their respective fields. Additionally, delegates emphasised the importance of professional networking and fostered meaningful youth participation within the WHS and the wider global health community.

Post the High-Level Meetings: Youth's Vision for the Future of Global Health: Organised by the International Federation of Medical Students' Associations (IFMSA) and the International Pharmaceutical Students' Federation (IPSF), this session was a cornerstone of the main program, dedicated to amplifying youth voices and ensuring their active involvement in shaping global health policies (https://www.youtube.com/watch?v=EopfaijotXs). The session specifically focused on sharing critical perspectives and the vision of youth

Photo 1. Dr. Jeazul Ponce Hernández, Dr. Francisco Franco Pêgo, and Dr. Flora Wendel (left to right) as the JDN delegation at the World Health Summit in May 2023. Credit: JDN

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in accelerating progress towards UHC and applying innovative technologies for global health security, which are central topics toward achieving health equity. Junior doctors and stakeholders met to brainstorm on timely solutions related to UHC and global health security as well as identify crucial action points following the High-Level Meetings during the United Nations General Assembly. The session offered an opportunity for delegates to reflect on the growing recognition within the WHS community that youth engagement is essential for building sustainable health solutions.

Research and Policy in Global Health (GLOHRA): The GLOHRA alliance, organised by the German Alliance for Global Health Research, is funded by the German Federal Ministries for Education, Research, and Economic Cooperation, dedicated to strengthening global health research in Germany. The session centred on tackling the complex challenges and opportunities in global health research and policy, with a strong emphasis on fostering South-South collaborations among academics, policymakers, and communities. It convened a diverse range of perspectives from researchers, public health institutes, and policymakers, addressing issues spanning from infectious diseases to health systems and implementation research. One key focus was on the importance of policy training for early career professionals and the pivotal role of national public health institutions in turning research into actionable policies. Delegates emphasised successful country-specific approaches and the necessity of critical enablers such as infrastructure and networks. They also highlighted steps on how government institutions can integrate lessons learned from previous programs as well as provide financial support for research opportunities.

A Promise Forgotten? Putting Universal Back into Health Coverage: The political will to promote UHC was widely debated, building upon the conference discussions on UHC-related topics and the Political Declaration adopted at the United Nations General Assembly in September 2023. Delegates made a call to join

Photo 2. Group photo of the youth attendees at the World Health Summit in May 2023. Credit: World Health Summit

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international efforts that promote primary health system development, highlighting the importance of health professionals working directly with affected populations and understanding community needs. To further emphasise the urgency of strengthening health systems globally, delegates also stressed the critical role of fostering community trust and ensuring equitable access to care, recognising that UHC cannot be truly achieved without addressing the unique challenges of vulnerable populations. Additionally, there was a strong appeal for sustained global solidarity and cooperation to guarantee that international commitments translate into tangible improvements in health outcomes for all.

Conclusion

As emerging leaders in global health, JDN members have a unique opportunity to collaborate and engage actively in future WHS events, thereby amplifying the voice of junior doctors on the global stage. By developing a strategic advocacy plan aligned with JDN priorities and the WMA's policy papers and position statements, JDN members can effectively articulate physicians' perspectives and secure prominent roles as speakers or trainers in scientific forums. Additionally, identifying and securing funding opportunities is crucial to ensure the sustainable participation of JDN members in upcoming WHS events, which is essential for advancing the agenda of meaningful youth involvement in global health. These efforts will not only strengthen JDN's presence at these global health meetings, but will also lay the groundwork for impactful participation in WHS 2024.

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Junior Doctors' Perspectives on Barriers and Solutions to Equitable Access to Global Health Opportunities

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Global health conferences and meetings are crucial for knowledge exchange and professional growth, but recent reports suggest that there is an underrepresentation of stakeholders from low- and middle-income countries (LMICs) due to neo-colonial patterns in global health [1]. Decolonizing global health, a concept that has recently gained traction, aims to remove all forms of supremacy within global health practice and create a future with no more pervasive remnants of colonisation [2,3]. In addition, with more than half of the world's population being under 30 years of age, increased youth representation at global health conferences is essential for the meaningful engagement of young people to accelerate progress toward the Sustainable Development Goals as well as contribute to timely policy and health decision-making [4]. The following article explores junior doctors' perspectives on barriers and solutions related to the equitable access to global health opportunities.

Existing Barriers

As junior doctors seek additional learning experiences at conferences, in order to complement their medical training, they can experience diverse challenges before, during, and after the conference. First, young people are often unaware of engagement opportunities with key stakeholders, have inadequate support and guidance from mentors and senior staff, and observe limited transparency and reporting from international organisations [5]. In fact, junior doctors may lack continuous mentorship when they first start on their global health journey. Second, understanding the pathways for attending meetings, including navigating the registration process, can be laborious due to bureaucratic and non-transparent procedures. Third, strict conference agendas may hinder speaking opportunities for young participants, who are often assigned an observer status and are limited to verbally sharing their perspectives. Fourth, most United Nations (UN) member states and World Medical Association (WMA) country delegations do not include or invite young people to form part of the meeting delegations [6]. Finally, junior doctors, who represent different languages and cultures, are constantly challenged when engaging with stakeholders, especially due to language and structural barriers [7].

Furthermore, financial and administrative barriers remain a significant hurdle for junior doctors to travel and contribute to global health meetings. Indeed, junior doctors' access to global health opportunities, including attending the World Health Assembly (WHA) sessions, is considerably impacted by logistical complexities, namely those associated with cross-border and international travel. This is especially relevant since many High-Level Meetings take place in New York City or Geneva, for which an entry visa is needed for participants from LMICs [8]. Visa procurement can be a costly and time-consuming endeavour, with no guarantee that complete documentation will be available in time for scheduled travel. [9,10].

Applying a gender representation lens, cultural, social, and institutional variables may also influence the unequal participation of male and female delegates at WHA sessions [11]. Between the 74-year span from 1948 to 2021, although more female delegates have attended WHA sessions, more males (83%) than females (30% at its peak in 2017-2018) have represented these delegations [11]. As women represent more than 70% of the

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health workforce, working across clinical and community settings, their collective leadership role in global health governance continues to be significantly overlooked.

Recommendations

Junior doctors have faced financial challenges, administrative complexities such as visa procedures, difficulties in taking time off from clinical responsibilities, and knowledge and language barrier gaps; nevertheless, these lived experiences have helped shape their commitment to continuous learning and professional development. The WMA Junior Doctors Network (JDN) Working Group on World Health Organization (WHO) Activities conducted an internal evaluation of JDN members' perspectives to better understand the specific challenges related to junior doctors' attendance at global health meetings. Between September 2022 and February 2023, Working Group members developed and shared a preliminary questionnaire with JDN and WMA members, reviewed the submitted responses, and developed a consensus on three potential recommendations to address existing challenges.

Recommendation 1: Incorporating and empowering youth representatives in conference delegations and offering financial and administrative support.

To increase youth representation in global health conferences, global health and youth organisations should offer junior doctors partial or complete funding to cover visa and travel costs, especially for participants living in LMICs or geographically distant from the meeting location [12]. WMA members can advocate for the establishment of a fundraising sub-committee to work with national member associations and disseminate timely funding opportunities, with priority given to candidates from LMICs. Also, the WHO and the WMA may be able to offer fast-track support for visa processing, including providing visa letters that confirm the selection of youth representatives and the key role that youth representatives play in ensuring meaningful conference engagement. Organising committees of scientific conferences, together with global organisations (including national medical associations), should provide ample time for attendees to navigate the visa application process.

WMA and JDN leaders can promote an open dialogue to better understand explicit barriers that hinder junior doctors' participation in global scientific events and subsequently develop novel approaches to empower their future contributions. For example, essential networking and professional development opportunities can help guide junior doctors in their training, including establishing a mentorship or buddy system that can match experienced doctors with junior doctors. Also, the promotion of equitable gender representation should remain on the forefront of global dialogue and conference proceedings toward ensuring equal participation in plenary and scientific sessions, interactive workshops, and other networking opportunities.

Recommendation 2: Supporting hybrid platforms and digitalisation of conference materials

With technological advancements, lessons learned during the coronavirus disease 2019 (COVID-19) pandemic, and the push for environmental sustainability, the world has embraced the digitalisation of conference materials, hybrid conferences, and live streaming. These adaptations have helped committees of scientific conferences use digitisation technology (e.g. mobile applications, interactive web applications) to facilitate the engagement of global audiences in major conferences. Since these applications have provided a platform to organise conference agendas (instead of printed booklets), hybridise conference sessions, and network with colleagues, junior doctors can effectively plan their conference agenda and travel logistics. As junior doctors attend these hybrid meetings and conferences, albeit lack of in-person engagement and networking opportunities, they can expand their international networks without the logistical conundrums of complicated travel processes including visa acquisition [9,10].

Mobile or web applications can support the session hybridisation, offering a space for junior doctors to contribute online and in-person, and hence increasing engagement in sessions by asking questions and sharing lived experiences. Taking into consideration the benefits of digital technologies, committees of scientific conferences should ensure that hybrid conferences are engaging for all attendees. Furthermore, junior doctors who represent their national medical associations or other organisations (like the WMA) can request guidance from authorities on specific expectations and deliverables, as a result of their participation in these external meetings.

Recommendation 3: Improving communication and dissemination of opportunities to junior doctors to represent their lived experiences at relevant conferences.

Communication efforts towards potential conference attendees, including junior doctors, should be diverse and incorporate various channels (e.g. emails, newsletters, social media, website updates). Since

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official communications and activities are conducted in diverse languages, junior doctors can help promote inclusivity and cultural exchange and even pursue language training as part of their continuing education [13,14]. As junior doctors may choose to participate in international events, like the WHO Simulation or pre-WHA workshops, they can also register for keynote lectures, roundtable discussions, skills-based courses, communication and diplomacy activities, and simulation exercises.

Conclusion

Junior doctors call upon local, regional, and global health organisations to develop strategies that enhance their access to global health opportunities integral to their professional growth. The current barriers, such as financial constraints, extensive administrative procedures, and lack of departmental approval, hinder their participation in international conferences, adding to the anxiety and strain experienced by these health professionals. As observed at previous WMA and WHA meetings and findings from the JDN internal evaluation, JDN members embody a strong desire to contribute to solutions that promote their inclusion in global health meetings. To address these challenges, it is essential to initiate an open dialogue within organisations (like WHO and WMA) that focuses on providing financial and administrative support, digitising conference registration processes, and enhancing communication about available global health opportunities. By implementing these strategies, we can move towards decolonizing global health and ensure equitable participation, thereby amplifying the voices of junior doctors from all backgrounds and fostering a more inclusive global health community.

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Pharmaceutical Policy in Afghanistan

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After 40 years of war and political unrest, the Afghan people are suffering from incalculably adverse medical complications that are worsened by extreme weather events (like drought), impacts of conflict (resulting in internally displaced populations), and attacks on healthcare facilities (increasing trauma cases). The country's low life expectancy of 63 years, coupled with the high annual infant mortality rate of 58 deaths per 1,000 live births, are clear indications of severe public health issues and a lack of adherence to medical regulations [1,2]. To make matters worse, citizens must contend with a healthcare system that lacks treatment options and funding, including limited assistance from international health organisations.

Although it is recognised that patients' medical concerns can be promptly addressed through evidence-based medical practices for diagnosis, treatment, and prevention, there is limited universal adherence to the healthcare system's regulations in Afghanistan's health facilities. Healthcare professionals in Afghanistan have highlighted that weak governance, lack of supply chain management, and corruption are giving rise to a thriving trade in altered medications coming from neighbouring countries and placing millions of people at risk [3]. As a result of this weak governance and corruption, illegal activities frequently occur in Afghanistan, including smuggling, importation, and alteration of medications for communicable and non-communicable diseases.

Afghanistan's National Health Policy 2015-2020 was adopted in 2015, highlighting five policy areas: governance, institutional development, public health, health services, and human resources [4]. According to this policy, the National Medicines and Health Regulatory Authority was strengthened and updated to help mitigate nationwide public health risks [5]. With the governmental transition in 2021, this national policy has not been updated to reflect pressing health issues.

The lack of evidence-based regulations existed even before the most recent government came to power; however, the isolation of the new government makes any external involvement impossible. Poor regulatory oversight has enabled illegal imports, impacting the quality of medication in Afghanistan. In a global self-benchmarking assessment, which was established to rate national healthcare systems on a scale of 1 (lowest) to 5 (highest), the World Health Organization (WHO) concluded that Afghanistan scored 2 for pharmacovigilance and 1 in quality control, inspection, and clinical trials in 2017 [5]. The scores from the benchmarking assessment are still extremely low running the national healthcare system.

In addition to poor regulatory authority, Afghanistan's Anti-Corruption Monitoring and Evaluation Committee noted that the trade in illegal imports thrives because of corruption, border issues, quality assessments, and poor governance [3]. The committee found that at least half of the country's pharmaceutical import market comprises illegally imported products. Although this illicit importation and smuggling could be reduced if rules and regulations were followed, the financial incentives have led to increased production, importation, and distribution of low-quality pharmaceuticals throughout the country. With an estimated 450 foreign pharmaceutical suppliers, of which 250-300 suppliers are in Pakistan, medications that are prohibited from being sold in Pakistan are frequently shipped to Afghanistan [3]. Prescription drugs (e.g. benzodiazepines, opioids) and heroin were the most reported drug types used among the Afghan population [6]. Although the healthcare system is unprepared to address drug dependence and addiction, developing solutions to manage altered medications and substance use will help reduce public accessibility.

As high-quality, safe, and effective medications are a pillar of the healthcare system, compromised medications can lead to a major collapse of its infrastructure. It can be challenging, however, to distinguish between legitimate and fraudulent pharmaceuticals, especially since labels and directions may not be in Dari (official language of Afghanistan). In addition, incompliance to regulations and guidelines can further complicate the scenario and lead to major public health adversities. This dilemma

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calls upon physicians and leading health organisations worldwide to help create a system that connects healthcare professionals to patients to ensure that correct medications are prescribed. Additional pressure on Afghan health leaders can help prioritise the purchase of medications imported from countries in the Eastern Mediterranean and European regions, which can reduce illegal importations. Robust efforts to strengthen the healthcare systems of low-income countries (like Afghanistan) can lead to the prioritisation and adherence to evidence-based clinical practices and regulations, and most importantly, improve patient health outcomes.

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African Health Leadership: A Physician's Perspective

Marie-Claire Wangari

The Coalition of African National Member Association (CANMA) came into inception in 2018, with the sole vision of uniting African National Member Associations (NMAs) to have one common voice in the advocacy and policy arena. Currently, the coalition is composed of 20 member countries including Kenya (interim chair), Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Lesotho, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Somalia, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

The Landscape of Health Leadership in Africa

Currently, the main issue plaguing African NMAs is the rise of physician migration out of the continent. From Nigeria's mass migration of citizens including health personnel termed "Japa" to Kenya's bilateral health professional exchange with Cuba and the United Kingdom, many nations have their physician-patient ratios plummeting due to volatile working conditions in their countries [1-3]. Physician migration in Africa is largely driven by the pursuit of better working conditions, higher salaries, and advanced training opportunities abroad, which are often limited in their home countries. Additionally, political instability, inadequate healthcare infrastructure, and limited career advancement prospects further contribute to this exodus ("brain drain"), which exacerbates healthcare challenges in already resource-strapped regions.

Despite the high number of emigrant physicians from the continent, efforts have been made to train more physicians in the continent's medical schools. In East Africa, universities have allowed cross-border training of undergraduate health professional students in Burundi, Ethiopia, Rwanda, Somalia, South Sudan, Tanzania, and Uganda [4]. Although this initiative is a start, more adaptive leadership and governance systems nationally and regionally are needed to bridge the low physician-patient ratio in the Africa region.

The Physician's Journey to Leadership

Traditional medical students take an average of six years of undergraduate training, where the first two years focus on pre-clinical sciences (e.g. human anatomy, medical physiology, biochemistry), followed by four years of clinical training in various clinical departments. After these six years of medical school, graduates proceed to complete a one- to two-year licensing internship year, as required by their country's Ministry of Health. After the internship is completed, physicians can practice as General Practitioners or proceed to a post-graduate specialisation that lasts between one to seven years, depending on the specialty requirements and modality of training [5]. In Kenya, medical students undergo six years of undergraduate training, followed by a mandatory one-year licensing internship under the Ministry of Health, and then they either select to pursue general practice or postgraduate training [6,7].

African physicians often seek valuable professional development and networking opportunities for knowledge exchange on best practices in health systems strengthening. Specifically, they have the opportunity to join and contribute as associate members to the various organisations, such as the CANMA at the regional level, Commonwealth Medical Association (CMA) at the sub-regional level, and World Medical Association (WMA) at the global level. Despite opportunities to join regional and global medical associations, few African physicians have held senior leadership positions in these organisations since their inception. Reflecting upon the historical timeline, the WMA and the Junior Doctors Network (JDN) have had less than 10 African physicians serve in senior WMA or JDN management leadership positions since 1947 and 2010, respectively. Given the rise in physician numbers from the African continent, specialist associations should provide more sensitisation on the importance of regional representation in global health leadership.

Future Directions in African Health Leadership

Looking to the future, empowering the next generation of African healthcare leaders is essential to address the continent's unique challenges. By fostering innovative approaches and inclusive leadership, African health systems can be strengthened to improve access

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and equity. As the global landscape evolves, African leaders can drive sustainable health solutions that meet the needs of their communities. The African region, given the potential for cross-cultural collaborations through various health associations and coalitions, has a bright future of producing future global health leaders through two specific actions.

Identifying emerging trends and promoting cross-border collaborations: The African continent serves as the cradle of primary healthcare, and with the rise of telemedicine, the region has a chance to pave the wave to new frontiers of medicine in implementation science and primary healthcare services. In conjunction with the national Ministries of Health's efforts, this is further amplified by the efforts of regional health bodies, such as the Africa Centre for Diseases and Control (Africa CDC)'s New Public Health Order for Africa and the World Health Organization Regional Office for Africa (WHO AFRO)'s multisectoral strategy to promote health and well-being [8,9]. These positive strides can help propel efforts to expedite the attainment of universal health coverage for African nations. Furthermore, by addressing complex national and regional challenges, African countries are pursuing stronger regional integration to reap the benefits of larger markets [10]. Through collaborative efforts, leaders can tackle issues such as infectious disease outbreaks, inadequate healthcare infrastructure, and health disparities more effectively and efficiently.

Supporting key mentorship opportunities for professional development: Direct mentorship and coaching in the health professions are pivotal towards supporting education and training and strengthening healthcare systems [11]. Mentoring specifically involves the informal conveyance of knowledge, social capital, and support, that recipients perceive to be pertinent to their work, career, and personal or professional development. During their formative academic training, health professional students can benefit from mentorship programs, which provide guidance, career development, and emotional support. Notably, it can ensure that new professionals are well-prepared to meet the complex challenges of modern healthcare systems. Despite these observed benefits of mentorship programs, however, many institutions in Sub-Saharan Africa have not fully embraced the inclusion into their programs [12]. By fostering a culture of mentorship, experienced leaders can share their knowledge, experiences, and insights across generations, which helps build a resilient and capable future workforce.

Conclusion

The article underscores that adaptive leadership, cross-border collaborations, and robust mentorship programs, can effectively address challenges and foster the next generation of healthcare leaders. Concerted efforts are needed to increase African representation in global health leadership and harness innovative approaches that can strengthen health systems across the continent. By bridging generational gaps and promoting knowledge transfer, mentorship programs can support a resilient healthcare workforce that can drive sustainable improvements in global health systems. Moreover, promoting cross-border collaborations is essential to leverage expertise to improve the quality of healthcare at the national and regional level. Now is the time for African healthcare leaders to unite, collaborate, and mentor, ensuring a brighter future for health to over 1.5 billion persons living on the continent.

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Interview with National Medical Associations' Leaders of the African Region

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Herbert Luswata

Mvuyisi Mzukwa

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Dr. Simon Kigondu, Dr. John Baptist Nkuranga, Dr. Mvuyisi Mzukwa, and Dr. Herbert Luswata, the Presidents of the national medical associations (NMAs) of Kenya, Rwanda, South Africa, and Uganda, respectively, join the interview with Dr. Helena Chapman, the WMJ Editor in Chief. They share their perspectives on their leadership experiences, ongoing NMA activities, strengths and existing challenges in medical education, and how the World Medical Association (WMA) can support NMA initiatives in the African region.

As you reflect upon your journey as NMA president, please describe one memorable experience, one challenge and how you resolved the challenge, and one hope for the future of medicine.

Kenya: The Kenya Medical Association (KMA) had the privilege and honour to host the World Medical Association (WMA)'s 223rd Council Session, which was held from 20-23 April 2023. Following many months of planning and preparation, the KMA welcomed guests from all over the world to the Ole Sereni Hotel, a scenic hotel overlooking the Nairobi National Park. WMA meetings were successfully conducted, and WMA members participated in the opening dinner at the Kenyatta International Conference Centre, one of Nairobi's iconic venues. They also had a fruitful tour to the Nairobi National Park that culminated in a dinner within the park at the club house.

At the same time, the KMA has experienced diverse challenges over the past few years, including widespread inflation, lawsuits related to large loan repayments, and financial challenges directly connected to reduction of pharma industry support. However, there is hope for a good future of medicine in Kenya. The number of medical schools has grown from two in 2000 to 13 in 2024, which has led to an increase in the numbers of trained doctors, specialists, and subspecialists and hence improve quality healthcare. One of the most important pillars of a healthcare system is adequate doctor-patient ratios.

Rwanda: One memorable experience was when the Rwanda Medical Association (RMA) hosted the successful 74th WMA General Assembly, which brought together leading medical professionals from around the world and fostered collaboration and knowledge exchange among more than 50 national medical associations. It was rewarding to showcase Rwanda's development and recovery progress 30 years after the genocide against the Tutsi as well as RMA's continued contributions to the global medical community. The experience left a lasting impression on organisers, and coupled with positive feedback from participants, RMA members gained confidence and built trust with the Ministry of Health and other participating government agencies.

When coronavirus disease 2019 (COVID-19) cases surged in Rwanda in early 2022, RMA members aimed to support the government response

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measures through the "Operation Save the Neighbour" initiative. They integrated doctors into home-based care teams, incorporated data with patients' and doctors' geolocations, and aligned this information with community health professionals who could visit, assess, and treat COVID-19 cases in their neighbourhood. Within two weeks, home-based visits had increased from 30% to 92%, with 82% of patients having regular oxygen monitoring from home, contributing to decreased mortality rates. This approach strengthened support and rapport among doctors, community health professionals, and patients, which has increased overall confidence in telemedicine consultations.

One significant challenge in Rwanda is the retention of doctors within the health workforce, primarily due to poor remuneration, incentives, and sometimes poor working environments. As this "brain drain" has increased demand for medical professionals in the country, the RMA is focusing on advocating for better compensation and working conditions for doctors, in efforts to promote the retention of a sustainable health workforce. RMA members actively engage policymakers, contribute to research initiatives that examine the driving factors of health workforce retention, and strengthen RMA membership services including establishing a career guidance program and fostering a supportive membership network.

South Africa: One recent memorable experience that highlighted the South African Medical Association (SAMA)'s influence occurred during the COVID-19 pandemic, namely the rollout of the vaccination programme. As the pandemic swept across South Africa, the SAMA played a crucial role in shaping the national response, demonstrating its leadership and advocacy capabilities in a time of crisis. The SAMA's commitment to improving access to life-saving medications showcased its dedication to public health and solidified its role as a key player in South African healthcare.

One significant challenge, however, was the health workforce shortage that was exacerbated by the emigration of medical professionals seeking employment and academic opportunities abroad. This "brain drain" left the public health sector understaffed and overburdened, affecting the quality of care provided to patients. Using a multi-faceted approach, the SAMA called upon the government, advocating for better working conditions, competitive salaries for healthcare professionals, and policies that would encourage current students to pursue the medical profession. Additionally, the SAMA launched initiatives to support and retain medical professionals within the country, including continuous professional development programmes and partnerships with international medical associations to foster exchange programmes that allowed for professional growth without permanent relocation. Through these efforts, the SAMA managed to stem the tide of emigration and helped to rebuild a robust health workforce.

Looking to the future, the SAMA hopes for a more equitable healthcare system where all South Africans have access to high-quality medical care, regardless of their socioeconomic status. This vision includes the integration of advanced medical technologies and innovations that can improve patient outcomes and streamline healthcare delivery. The SAMA envisions a future where preventative care is prioritised, reducing the burden of chronic diseases and ensuring that the healthcare system is sustainable. Moreover, the SAMA aspires to see a stronger emphasis on mental health services, recognising the critical role that mental well-being plays in overall health. By fostering a collaborative environment among healthcare professionals, policymakers, and communities, the SAMA aims to build a resilient healthcare system that can adapt to future challenges and continue to improve the health and well-being of all South Africans.

Uganda: As President of the Uganda Medical Association (UMA), I am honoured to have led our dedicated and resilient team through successful advocacy efforts to improve the welfare of health professionals in Uganda. As a result of negotiations and industrial action during December 2021, Ugandan health professionals achieved a salary increment of over 100%, and they are still advocating for adjustments concerning specialists' salaries. Collective advocacy has also led to policy developments that have resulted in new public service structures in the health sector, and the creation of doctor positions at the parish level (e.g. Health Center 111 in May 2024). These national achievements will help to address unemployment among junior doctors and improve access to quality health care services for the observed population growth of 24.2 million in 2000 to 47.25 million in 2014.

The UMA is leading efforts to explore two specific challenges for healthcare professionals in Uganda. First, the UMA's Human Resource survey conducted in January 2024, which aimed to examine human resource coverage and gaps, highlighted the 21-62% (average of 42%) human resource coverage and 58% human resource gap in public health facilities in Uganda. To address this gap, the Uganda government is been actively involved in negotiations to

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expand recruitment of healthcare professionals. In June 2024, the Uganda Ministry of Health indicated that they can only employ 38% of available healthcare professionals in the country, and that more strategies should be embraced to combat this unemployment challenge such as exporting health professional services to other countries and supporting training and recruitment for the private health sector.

Second, the Uganda government adopted a proposal to stop paying allowances to medical interns and introduce self-sponsored internships in May 2023, which was prompted by reduced external funding due to the controversial anti-homosexuality bill. However, the UMA believed that alternative solutions existed, such as increasing local funding and prioritising wages for these allowances, which consider the valuable contributions of medical interns to the health sector. UMA members vigorously advocated for the prioritisation of these allowances, and our efforts were met with initial resistance, leading to hospital crises based on delayed deployment and a lack of medical interns. The situation escalated to the point where Ugandan doctors considered launching a nationwide industrial strike in 2023. However, through persistent negotiations, the UMA and the health system successfully secured the deployment of medical interns (doctors, nurses, pharmacists) with a negotiated pay. This outcome demonstrates the UMA's commitment to fighting for the rights and welfare of health professionals, even in the face of adversity.

The future of medicine is promising in Uganda, with robust relationships between the government and healthcare professionals and good political will towards the improved welfare of healthcare professionals. The *Abuja Declaration*, which emphasises the need for 15% allocation of the health budget to the health sector, represents the most advanced health policy (including the national health insurance scheme) in the African region to date. Moving forward, the UMA hopes to advocate for expanding the current 8.2% allocation of the health budget in Uganda, to align with the recommended 15% allocation, and hence increase access of healthcare services to the public. Although an alternative financing model for the health sector was introduced to the Parliament of Uganda, the national health insurance scheme legislation was formulated in 2023, but not yet approved or adapted into the health sector.

How would you describe the current opportunities for NMA members to help influence health care policy-making activities in your country?

Kenya: First, the KMA has various thematic committees that focus on different aspects of healthcare. The thematic committees can develop policy position papers for the Association that are submitted to the Ministry of Health and other relevant health authorities for review and policy guidance. A case in point is the drafting of memoranda to the Parliament and Senate of Kenya on pressing issues including human resources for health and healthcare financing. Second, KMA members are frequently requested to serve as members of various Ministry of Health task forces and share their professional opinions on various thematic areas related to the taskforces. Third, since the KMA has representation in the Kenya Medical Practitioners and Dentists Council (KMPDC), members can help improve medical training and medical practice by contributing to the Council's mandate of regulating the medicine and dental training, practice, and licencing within healthcare institutions. Finally, the KMA serves as a member of the National Health Insurance Fund (NHIF) and proposed as a board member of the new Social Health Authority. The KMA's input is useful to help guide and oversee the management of healthcare financing in Kenya.

Rwanda: The opportunities for advancing healthcare are enormous, particularly in the context of ongoing advocacy efforts that influence key decision-making and policies. The COVID-19 pandemic has placed the role of healthcare professionals in the spotlight, underscoring their critical contributions to the healthcare system. In response to pressing society needs, Rwanda has initiated the 4x4 strategy, as a comprehensive plan designed to quadruple the number of healthcare professionals over the next four years and engage the health workforce to address unmet healthcare needs for citizens.

The threat of the health workforce loss (due to physician migration) has prompted a renewed commitment to consider the welfare of healthcare professionals, including concerted effort to enhance monetary incentives and improve working conditions. To address this challenge, the Rwanda Ministry of Health is taking significant strides towards building a resilient healthcare system that meets the needs of its population. Leaders have established policies and guidelines that foster collaborations with RMA members, to ensure that the voices of healthcare professionals are integrated into the development of policies and decision-making processes, which can foster a sense of ownership and commitment among the health workforce.

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South Africa: The SAMA views the current landscape as ripe with opportunities for its members to play a crucial role in shaping healthcare policy in South Africa. As a respected body representing medical professionals, SAMA members can advocate for meaningful change and engage in policymaking through various channels, including leveraging their clinical expertise through active participation in governmental advisory committees. By serving on these committees, members contribute to the development of health policies that are both practical and informed by real-world challenges and solutions.

Additionally, SAMA members can engage in public consultations and forums organised by the government and other stakeholders. These platforms allow medical professionals to voice their opinions, provide feedback on proposed policies, and suggest improvements. The Association regularly organises engagements, workshops, seminars, and conferences, where members can discuss pressing healthcare issues and formulate collective positions that the SAMA can present to policymakers. This collaborative approach ensures that the insights and expertise of a wide range of medical professionals are considered in the policy-making process. The SAMA also encourages its members to engage directly and build strong relationships with local communities and civil society organisations to better understand the health needs and concerns of the population. Through this grassroots engagement, SAMA members can advocate for inclusive and effective policies that address the specific health challenges faced by different communities.

Uganda: Currently, the UMA has a significant opportunity to shape the country's health policies. As a key stakeholder, UMA members are regularly consulted by the government to formulate and review health-related policies, as they are well-positioned with expertise and technical knowledge to influence policy changes that benefit the health sector and the Ugandan population. The Ugandan government values our inputs and recognises the importance of our contributions to national discourse. I am truly humbled and proud to lead the UMA, as an organisation that plays a vital role in shaping the future of healthcare in Uganda.

How do perceive the physician-patient relationship and rapport in the clinical setting in your country?

Kenya: Kenya leaders have recognised that physician-patient relationships vary within the public and private sectors. Public facilities are characterised by high client flow, high workload, and less than optimal human resources for health capacity. The physician-patient relationship and rapport tend to be short in order to minimise patient queues. Management is less influenced by patients, and treatment is often constrained by limited diagnostics and resources. On the other hand, private facilities are generally for-profit, and therefore physician-patient interactions tend to last longer with greater rapport, and patients are directly involved in diagnostics and various treatment modalities.

Rwanda: In Rwanda, the physician-patient relationship is generally characterised by high levels of trust and mutual respect, which fosters a positive rapport in clinical settings. This trust contributes to an overall sense of safety and confidence in the medical care received, with patients adhering to their physicians' recommendations. To support the relationship between healthcare professionals and patients, the Rwandan government created the Patient Rights Charters, which serves as a code of conduct with roles and responsibilities for both healthcare professionals and patients. It aims to ensure that patient care is delivered in a respectful and ethically sound manner, reinforcing the positive dynamics necessary in the physician-patient relationship.

It is evident that the physician-patient relationship is evolving towards a more collaborative and communicative model. However, significant imbalances remain, primarily due to patients' lack of awareness of their rights and available protections within the healthcare system. Many patients may not feel empowered to ask questions about their medical conditions, often relying on unreliable sources (e.g. friends, family members, social media), which can lead to misconceptions about medications and treatment. Additionally, the power dynamics in these relationships can hinder effective engagement, as many clinicians may feel that they have authority over patients' care. To improve this dynamic, it is crucial to educate patients about their rights and ensure that healthcare providers are trained on patients right and effective communication strategies, which can ultimately foster a culture of mutual understanding and respect as well as improve patient satisfaction and health outcomes.

South Africa: The physician-patient relationship and rapport in the clinical setting is fundamental to the delivery of quality healthcare. The SAMA recognises that this relationship is built on trust, communication, and mutual respect, which are essential for effective diagnosis, treatment, and patient satisfaction. In South Africa, where the healthcare landscape is diverse and often strained by

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resource limitations, maintaining a strong physician-patient rapport is crucial yet challenging. The SAMSA acknowledges the pressures faced by physicians, including high patient volumes and administrative burdens, which can strain these relationships. However, the Association advocates for a patient-centred approach that prioritises empathy, active listening, and cultural competence. By promoting continuous professional development and ethical practices, the SAMA strives to enhance the quality of interactions between physicians and patients, ensuring that every patient feels heard, respected, and cared for by physicians. This commitment is seen as a cornerstone for improving health outcomes and fostering a more humane and effective healthcare system in South Africa.

The physician-patient relationship is constantly evolving due to various factors, including technological advancements, increased access to online medical information, and the integration of artificial intelligence. As one notable example, the Health Professionals Council of South Africa's swiftly responded to the pandemic by allowing virtual consulting, resulting in a shift that fundamentally transformed the physician-patient relationship. Hence, it is essential to acknowledge and adapt to these changes to ensure the relationship remains effective and patient-centred.

Uganda: The physician-patient relationship in Uganda is built on a strong foundation of efficient communication, mutual respect, confidentiality, and empathy. Our healthcare professionals strive to provide excellent care, and the majority of patient interactions are positive and respectful. When instances of inappropriate conduct are observed, however, the UMA Ethics and Professionalism Committee and the Uganda Medical and Dental Practitioners Council promptly address the ethical and professional standards by discussing the incident and agreeing upon appropriate actions (including sanctions). As President of the UMA, I am committed to upholding the highest standards of medical practice and ensuring that our patients receive the care that they deserve.

How would you describe the anticipated challenges in medical education over the next decade in your country?

Kenya: The quality of medical education and training remains a challenge in Kenya. Medical schools are domiciled in universities that do not have university hospitals. Medical students and trainees complete their clinical rotations in hospitals that are not administratively linked to the university. Over the past few years, many public universities dependent on the exchequer, have had funding challenges from government. In efforts to increase their revenues, they have increased admissions of medical students to their programs even beyond their quality capacity. The Commission of University Education (CUE), which oversees university education, adopted a law that made the input of the KMPDC concerning medical training not mandatory. The KMA has observed that hospital programs have an excess number of medical students contrary to what the KMPDC would recommend as capacity for quality training. The trainees thus complete their clinical rotations with inadequate patient contact time, decreasing the quality of education and training. The KMA, through its representatives in the KMPDC and in Parliament, continues to advocate for mandatory input of the KMPDC on medical training in the CUE Act.

Rwanda: First, the RMA anticipates significant gaps in knowledge acquisition, as medical schools, teaching hospitals, and research centres are not rapidly evolving to meet the current and future public health challenges. With the rapidly evolving technology, we foresee shortages in incorporating essential training resources, including simulation lab resources, robotic, and other advanced training technologies, into medical education. Second, there is a growing concern about the shortage of medical school faculty in the basic sciences, as these positions are often less attractive for professionals to pursue advanced studies and such teaching careers. As a result, this continued shortage of qualified faculty could hinder the quality of medical education. Third, many trained professionals are migrating to middle- and high-income countries to seek improved work environment and incentives, which could result in a depletion of trained professionals within the country ("brain drain") and further exacerbate the health system challenges.

South Africa: Over the next decade, the SAMA anticipates several significant challenges in medical education, reflecting on broader issues within the healthcare system and the evolving landscape of medical practice. First, there is an urgent need to address the growing demand for healthcare professionals amid an ongoing shortage of medical educators and clinical training facilities. As the South African population increases and the burden of communicable and non-communicable diseases continues to rise, the strain on medical schools and academic hospitals will likely intensify. This shortage could hinder the ability to provide high-quality training and practical experience, which are crucial for preparing future physicians.

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Second, the integration of advanced technology and digital health solutions into the medical curriculum will require additional training for educators and students. While technological advancements offer significant potential to enhance medical education through simulation-based learning, telemedicine, and electronic health records, ensuring that both educators and students are proficient in these technologies will require substantial investment and adaptation. To incorporate these tools effectively, the SAMA foresees the need for comprehensive training programmes and updates to the curriculum, ensuring that graduates are well-equipped to navigate a technologically advanced healthcare environment.

Third, the SAMA recognises the necessity of adapting medical education to the evolving healthcare needs of the South African population, including a greater emphasis on primary care, preventative medicine, and chronic disease management. Medical education must therefore shift to produce physicians who are skilled in acute care, managing long-term health conditions, and promoting health and wellness. This shift will entail changes in the curriculum, as well as increased opportunities for students to gain experience in community health settings.

Additionally, efforts to increase diversity in the medical profession, especially from underrepresented and disadvantaged backgrounds, are essential to better reflect the population's demographics and effectively address health disparities. Some strategies may include providing financial support, developing mentorship programmes, and targeting recruitment efforts to ensure that the medical workforce is diverse and inclusive. As medical practice evolves, ethical and professional dilemmas faced by healthcare professionals are expected to become more prominent. If medical education places a stronger emphasis on bioethics, professional conduct, and legal aspects of medical practice, students will be prepared to navigate issues related to patient autonomy, informed consent, and ethical use of emerging medical technologies throughout their career path.

Finally, the demanding nature of medical education, coupled with the high levels of stress and burnout experienced by healthcare professionals, necessitates a proactive approach to supporting medical students' mental health and well-being. Some strategies include providing access to counselling services, promoting a healthy work-life balance, and fostering a supportive and inclusive educational environment.

Uganda: The medical education system in Uganda faces significant challenges, notably the inadequate supervision of medical students during graduate training and post-graduate internships and residency. This is largely attributed to the unregulated number of admissions to medical schools, which can compromise the quality of healthcare professionals in the future. As President of the UMA, I am concerned about the potential consequences of this observed trend and urge health leaders to address this issue promptly to ensure the production of competent and skilled healthcare professionals to support the Ugandan health system. Over the past few years, the UMA has been working collaboratively with the Ugandan government to develop an internship policy related to medical residents' training and secured financial compensation and good welfare.

From the medical education perspective, how has your NMA responded to the existing and emerging health challenges within your country?

Kenya: The KMA serves as a leading institution in Africa, maintaining robust health professional training. First, during the COVID-19 pandemic, the KMA partnered with the Ministry of Health and other leading health agencies to develop a curriculum for training the health workforce on infection prevention and control. Second, as the CUE Act clause restricts the consideration of the KMPDC's contributions to national discourse, the KMA has continued to advocate for the KMPDC's valuable input on institutional requirements related to medical education and training programs.

Rwanda: The RMA is actively advocating for increased incentives for medical doctors and improving working conditions of its members and other healthcare professionals. Since the beginning of this year, the RMA initiated an ambitious career guidance program to promote the good of the profession, inspire young professionals and create a support network. It is also working on a capacity building initiative to raise awareness on patient rights, medical ethics and ethical practices intended to promote professionalism among all cadres of medical doctors. The RMA is also partnering with the Ministry of Health on its ambitious 4X4 reform program to increase the number of health workforce and bridge the gap especially in rural areas and primary healthcare settings.

South Africa: The SAMA has pushed for a medical education that is comprehensive and reflective of the country's health landscape, as it recognises the urgent need to address the high burden of both

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communicable (HIV/AIDS, tuberculosis, emerging zoonoses) and non-communicable (diabetes, hypertension, mental health disorders) diseases. By ensuring that medical students receive extensive training in these critical areas, the SAMA is helping to equip future healthcare professionals with the knowledge and skills needed to effectively manage these health challenges. To keep pace with the digital transformation of healthcare, the SAMA supports the integration of modern technologies into medical education, including the adoption of simulation-based learning tools, telemedicine training, and the use of electronic health records in the curriculum. Additionally, the SAMA encourages practising physicians to pursue professional development opportunities to keep them updated on emerging technologies and innovative practices.

The SAMA places a strong emphasis on research and evidence-based practice as a cornerstone of medical education. By encouraging and supporting medical research initiatives, the SAMA aims to cultivate a culture of inquiry and continuous learning among medical students and professionals. As research can help generate local data and insights that are crucial for addressing South Africa's specific health challenges, the SAMA promotes the prompt dissemination of research findings through conferences, publications, and collaborations with international medical communities. Hence, South African healthcare can benefit from these global best practices and innovations. Furthermore, the SAMA has advocated for policies and programmes that promote equity and inclusion, such as providing scholarships and financial support to students from disadvantaged backgrounds, to increase diversity within the medical profession. The SAMA believes that a diverse health workforce is essential for delivering culturally competent care and reducing health disparities.

Uganda: I am proud to highlight that our contributions and advocacy efforts are aimed at maintaining high-quality medical trainings in Uganda and producing competent healthcare professionals who can provide high-quality care to our citizens. The proposals include: 1) adding a standardised national curriculum for all medical schools; 2) implementing a national entry exam and exit exam into medical schools; and 3) requiring that national medical councils effectively supervise medical students during their clinical training and post-graduate internships. Currently, the UMA is actively advocating for the finalisation of the internship policies and the development of postgraduate training regulations.

From your perspective and national experiences, how has the COVID-19 pandemic affected medical education in your country?

Kenya: During the COVID-19 pandemic, most medical education programs were virtual, which enabled faculty to continue teaching their course and their training for faculty and students. This virtual format worked well for theoretical subjects, even noting increased class attendance. Skills-based courses (including physical examinations with patients) and other soft skills (like building rapport with patients) that required physical contact, however, were limited by their nature of requiring physical contact, and hence affected the quality of learning.

Rwanda: Like other disciplines, medical education faced significant disruptions during the COVID-19 pandemic in Rwanda, as institutions were closed and medical students were confined in their homes. Although virtual learning platforms were used for alternative clinical training approaches, medical students' clerkships were disrupted due to restricted hospital access. The emergence of telehealth education platforms provided an opportunity to effectively adopt virtual education platforms, and to this date, a significant number of training courses continue to be delivered virtually. Although the pandemic hindered growth of the health workforce, it spurred innovation with medical students participating in COVID-19 research, adapting to new academic learning modalities (e.g. hybrid education models), gaining interest in digital health applications.

South Africa: The COVID-19 pandemic significantly disrupted medical education in South Africa, as traditional in-person lectures, hands-on clinical training, and practical assessments were abruptly halted due to lockdown and social distancing measures. It presented unprecedented challenges that forced educational institutions to adapt swiftly, and simultaneously accelerated the integration of digital tools and e-learning in medical education. To enable continuity in education, the SAMA supported the adoption of virtual classrooms, webinars, and online simulation tools to replace traditional teaching methods. As not all students had reliable internet access or suitable devices for online learning, recognised as the "digital divide", the SAMA advocated for solutions to these disparities, such as providing data subsidies and lending technological devices to students in need.

One of the most significant impacts of the pandemic on medical education was the disruption of clinical training. With hospitals overwhelmed by COVID-19 cases

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and the high risk of infection, many medical students faced reduced access to clinical rotations and hands-on patient care experiences. The SAMA recognised the critical importance of clinical training in developing competent physicians and worked with healthcare institutions to develop alternative training methods, such as virtual clinical rounds, telemedicine consultations, and simulated patient interactions.

The COVID-19 pandemic prompted a comprehensive evaluation of medical curricula and educational models, to better prepare academic programs for such disruptions and future doctors for public health crises. The SAMA advocated for the inclusion of public health emergency preparedness, epidemiology, and infectious disease management in medical education, in order to equip students with the knowledge and skills necessary to respond effectively to future pandemics or health emergencies. The pandemic also underscored the importance of research and collaboration in addressing global health crises. The SAMA supported efforts to involve medical students in research related to the pandemic, fostering a culture of inquiry and evidence-based practice. Collaborative projects, both within South Africa and internationally, provided valuable learning opportunities and contributed to the broader understanding of the virus and its impact on global health security.

Uganda: I can attest that the COVID-19 pandemic had a devastating impact on education (especially medical education) in Uganda. Some medical schools were forced to close, creating a significant gap in human resources, as many hospitals relied heavily on post-graduate medical residents for health service delivery. Although other medical schools remained opened, halting in-person academic lectures for over one year, the shift to virtual learning limited hands-on training and physical interactions with mentors and patients. The lack of practical experience and direct supervision compromised the quality of training, posing a significant risk to the competence of future healthcare professionals. As the health system recovers from the pandemic's impact on medical education and training in Uganda, UMA members are working tirelessly to mitigate its effects and ensure that our healthcare system emerges stronger and more resilient.

How does your NMA leadership implement the WMA policies in the organisation?

Kenya: As active member of the WMA, the KMA endeavours to have as many as possible of its leaders and members attend WMA activities like the Council Meetings, General Assemblies, and regional meetings. In this manner, KMA members can learn about WMA policies, provide input at meetings, and disseminate relevant policy guidance for implementation at the local and national levels.

Rwanda: RMA leadership actively advocates for the adoption and integration of some WMA policies into national health policies, by engaging with government bodies and stakeholders and submitting policy proposals. They participate in national health forums to ensure that relevant WMA policy statements and guidelines can inform their decision-making processes. The RMA works to influence health policies that align with international standards and ethical practices set by the WMA, ultimately aiming to improve healthcare quality, patients' rights protection, and patients' health outcomes. To build capacity within the medical community, RMA members focus on establishing leadership development programs and training initiatives, designed to equip members with the skills necessary for ethical leadership and advocacy. Mentorship programs pair experienced professionals with emerging leaders to guide their development, while workshops and seminars incorporate the topics of ethics, human rights, and professional conduct. This collaborative approach helps build a cohesive and informed medical community, aligned with WMA principles and committed to advancing healthcare standards.

South Africa: SAMA leadership actively integrates WMA policies into its strategic planning and operational activities. This process begins with a thorough review and contextualisation of WMA guidelines, to ensure that they align with South Africa's unique healthcare landscape and needs. SAMA's leadership disseminates these policies through official channels, including meetings, seminars, and training sessions, so that all members are aware of and understand the WMA's standards and recommendations. Additionally, the SAMA incorporates WMA policies into its advocacy efforts, as a framework to influence national healthcare legislation and policy development. The SAMA hopes to influence these principles as globally recognised best practices, thereby enhancing the quality and integrity of healthcare delivery in South Africa.

Uganda: The UMA has been represented at the WMA General Assemblies, and members actively participate in shaping WMA policies and resolutions that guide the global medical community. Notably, the UMA adopts relevant WMA policies and advocates for their integration

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into Ugandan health policies through our engagement with the Parliament of Uganda. Through this collaboration, we ensure that Uganda's health policies align with international best practices and standards, as we aim to improve the health system that benefits our patients and the community at large.

How can the WMA support the ongoing NMA activities in your country?

Kenya: As KMA leadership, we occasionally request that the WMA provide a statement on ongoing issues affecting the medical profession in Kenya to influence policy makers as well as help connect the KMA with potential resource partnerships. We request that the WMA continue this financial support as it is particularly important for junior doctors who may not have adequate resources to participate in WMA and Junior Doctors Network (JDN) activities. Second, as the WMA supports capacity building activities, the WMA could offer leadership courses to KMA leaders, which can help strengthen their advocacy skills in health leadership. Furthermore, the WMA could offer exchange programmes between the various national medical associations inside and outside of Africa, which could help improve knowledge sharing and foster collaborations within the medical profession.

Rwanda: The WMA can support the ongoing activities of the RMA in several key ways. First, the WMA can enhance the overall growth of the RMA by providing adaptable policy frameworks that expand capacity building through continuing professional development and strengthen its advocacy efforts. Second, by providing leadership support in medical education and research, the WMA can help improve the quality of medical training and research in Rwanda and equip healthcare professionals with essential skills needed to advance quality medical education and evidence-based practices. Third, the WMA can facilitate partnerships with Rwandan professional medical associations, by enhancing collaborative efforts that would positively impact healthcare systems in Rwanda. Finally, the WMA can serve as a resource for consultation, allowing RMA members to seek guidance on complex issues where they may lack expertise, thus benefiting from the broader WMA network and opportunities for knowledge exchange.

South Africa: By leveraging its global influence, the WMA can help amplify SAMA's voice to garner attention and resources from global health organisations and governments for pressing health challenges in South Africa. WMA leaders can offer expert guidance on policy development, helping the SAMA to craft and implement policies that align with international best practices and address local health needs. Also, the WMA can assist the SAMA by offering capacity-building programmes and training initiatives that can enhance SAMA members' knowledge and skills in medical ethics, leadership, public health, and research. This support is especially valuable in areas like emergency preparedness and response, where global expertise can significantly strengthen local capabilities. Still, the WMA can help secure funding for collaborative research projects, especially through international research grants and partnerships, which can generate data and insights on specific health issues.

The WMA can help advocate for increased resources and infrastructure support for South Africa's healthcare system from international donors and organisations, which can lead to improved healthcare facilities, better access to medical supplies, and enhanced support for public health initiatives, thereby strengthening the overall healthcare system in South Africa. Furthermore, with the recent Declaration of Helsinki African Regional meeting, WMA's support for SAMA's hosting has enabled the organisation to foster networking and collaboration opportunities with other national medical associations. By facilitating connections and partnerships, the WMA can help the SAMA share best practices, learn from other nation's experiences, and collaborate on global health initiatives. This network can enhance SAMA's ability to manage local health challenges while contributing to the global medical community.

Uganda: We are pleased to leverage our membership with the WMA and request guidance on how to obtain financial and asset support from international agencies for UMA initiatives. Currently, the UMA is launching a fundraising campaign to construct the headquarters building, which will serve as a hub for our activities. With the WMA's guidance, we hope to secure the necessary resources to complete this construction, which can enhance our capacity to advocate for the optimal welfare of healthcare professionals and high-quality healthcare in Uganda. The UMA has developed initiatives to explore working with international partners to expand healthcare collaborations – including the United Kingdom's National Health Services' Royal College of Physicians and Rwanda Ministry of Health – as well as promote opportunities for health professional services to be exported to other countries. We request the guidance

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of WMA on how to identify and facilitate reliable connections with other countries, as one strategy to address unemployment and underemployment among healthcare professionals in Uganda.

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Interview with National Medical Associations' Leaders of the European Region

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Dr. Johannes Steinhart, Dr. François Arnault, Dr. Tomás Cobo Castro, and Dr. Sofia Rydgren Stale, the Presidents of the national medical associations (NMAs) of Austria, France, Spain, and Sweden, respectively, as well as Dr. Philippe Cathala, Delegate for European and International Affairs of the NMA of France, join the interview with Dr. Helena Chapman, the WMJ Editor in Chief. They share their perspectives on their leadership experiences, ongoing NMA activities, strengths and existing challenges in medical education, and how the World Medical Association (WMA) can support NMA initiatives in the European region.

As you reflect upon your journey as NMA president, please describe one memorable experience, one challenge and how you resolved the challenge, and one hope for the future of medicine.

Austria: In 2023, Austria witnessed widespread negotiations on healthcare reform with political leaders, and a first draft gave rise to fears of negative consequences for the healthcare system. Only when the Austrian Medical Chamber (AMC) finally became involved, these negotiations took place in a constructive and purposeful atmosphere, and hence the involvement of the AMC prevented major healthcare dilemmas. These timely improvements were related to future patient care, such as eliminating end dates for the implementation of standardised nationwide contracts and committing resources to reduce administrative burden in health institutions.

France: There have been many significant moments in our French Medical Council (Conseil National de l'Ordre des Médecins, CNOM) activities, including the development of robust policies and the management of challenging negotiations on pressing health issues. Specifically, one memorable experience (highlighted by Dr. Philippe Cathala) is the implementation of our mentorship policy with junior doctors, as they are the future of medicine, and it is our collective responsibility to contribute to their medical training. To support this mentorship policy, an annual ceremony has been established in the local council, chaired by Dr. Philippe Cathala, where council members invite all junior doctors from the region and present them with the most symbolic tools of our profession: the stethoscope and code of ethics. We are very pleased that this initiative has inspired other doctors at all levels of training, and now several councils have followed in our footsteps.

Spain: One of the most memorable experiences during my term as president of the Spanish General Medical Council (CGCOM) was the

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approval of the new Code of Medical Ethics. This document, which is aligned with the WMA Code of Medical Ethics, is the result of years of work and multi-stakeholder consensus, and sets the ethical and professional principles that will guide medical practise in Spain. The approval ceremony, which was held in 2023, was a moment of pride and celebration for all persons involved. Upon signing the document, I remember that I felt a deep sense of responsibility and commitment to the values that the code represents. This achievement not only reinforced our commitment to medical ethics, but also enhanced public confidence in the medical profession. Over my tenure, one of the most significant challenges was the implementation of the Continuing Medical Education (CME) credits of the European Union of Medical Specialists (UEMS) in Spain and in Latin America, as it comprised of a formal agreement between CGCOM, the European Union of Medical Specialists (Union Européenne des Médecins Spécialistes, UEMS), and the Medical Confederation of Latin America and the Caribbean (Confederación Médica Latinoamericana y del Caribe, CONFEMEL). We envision a future where medicine will be more precise, less invasive, and more focused on prevention and personalised treatment, which will significantly improve patient quality of life and life expectancy.

Sweden: One memorable moment as the Swedish Medical Association (SMA) president was when I posted, *"I'm a physician, not a border-policeman,"* on social media, in response to the government starting an investigation to examine the possibility of demanding physicians and other employees in municipalities and regions to report undocumented migrants. Such an obligation to report undocumented migrants would be in opposition to the important ethical principle that care must be provided on the basis of clinical need alone, regardless of the care seeker´s legal status. It also goes against the International Code of Medical Ethics and threatens patient safety. As health professionals and as an NMA, it is important to speak out against any proposal that prevents us from fulfilling our duties. My post went viral in Sweden, and many physicians as well as representatives from other professions and employers raised their voices in support. I believe that this community response demonstrates the importance of our medical ethics, how strongly we feel about them, and how we can hopefully make a difference when we come together and use our collective voice on pressing health issues. At the same time, it offers an example of a challenge that we face and one approach to resolve the issue, by working together with our SMA members as well as organisations from different parts of the healthcare sector and society.

My hope for the future of medicine is that we will see a development towards a more equal healthcare and universal health coverage, where everyone can benefit from medical advances and take full advantage of new research findings. It is important that the trust in research and science remains high (and, where necessary, increases) in society and the general public, and specifically among patients, politicians, and decision makers. Healthcare needs to be governed by science and ensure strong professional autonomy for the best of all patients.

How would you describe the current opportunities for NMA members to help influence health care policy-making activities in your country?

Austria: The forementioned involvement of the AMC in the healthcare reform of 2023 shows the important role that the AMC plays in healthcare policy activities (including constructive cooperation with politicians and advocacy for healthcare improvement) that focus on patient care and the medical profession. As the professional organisation representing all Austrian doctors, the AMC is committed to positive developments in the Austrian healthcare system by implementing innovative approaches to offer the best possible medical care for patients. The AMC is comprised of various committees that collectively advocate for socially-oriented, modern healthcare that is accessible to the entire population through doctors working in public and private sectors.

France: The CNOM, established in 1945, is the only institution in France that unites all doctors, regardless of their status, practice mode or specialty. It was created by law and entrusted with several public service missions, defending the independence and honour of the medical profession throughout French society. Upon my election as president of the CNOM, I committed to strengthening our contacts and working relationships with all institutional partners, including public authorities, doctors' unions, health profession councils, patient associations, members of the French parliament, and elected officials from various regions.

As a key player in discussions on the evolution of the healthcare system, CNOM members actively contribute to numerous committees and serves as experts with ministries, regional health agencies, and French public health organisations (e.g. National Agency for the Safety of Medicines). As a leading speaker for public authorities, the Council provides opinions on health-related bills and decrees as well as conducts periodic surveys on pressing topics such as

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medical demographics, physician safety, and continuity of care.

Spain: Currently, we have a direct and collaborative relationship with the administrations of central and regional association in Spain. Following the coronavirus disease 2019 (COVID-19) health crisis, the CGCOM has led timely national efforts that continue to strengthen the medical profession, including forming the State Public Health Agency, developing and advocating for the approval of the emergency medicine specialty training, supporting an increased number of specialist training placements. As an organisation, we recognise that our members represent experts in their clinical and surgical specialties, who are frequently requested to provide input to help national discourse on pressing health issues. Upon each request, we are increasingly aware of our important role, working with leading stakeholders (like the government) in order to support health system resiliency.

Sweden: The SMA, a labour union and professions association, is a well-respected organisation in Sweden. Our representatives at local and national levels are elected by our members, and we encourage active participation by individual members. We work hard to prioritise the needs of physicians and patients as well as promote the continued positive development of Swedish healthcare. The SMA is often consulted as subject matter experts for national inquiries on healthcare issues, and we have recurring meetings with the Minister for Health Care. Although regional and state representatives vote on final decisions related to the adoption of healthcare policies, guidelines, and legislation, SMA members offer robust perspectives to such discourse that can help influence policy-making activities.

How do perceive the physician-patient relationship and rapport in the clinical setting in your country?

Austria: As doctors, our top priority is to be actively present for our patients, offering quality time for direct interactions to learn about their personal needs and concerns. Trust is the be-all and end-all in the relationship between doctors and their patients, and hence those who trust their doctor will also adhere more precisely to recommended treatment. Since doctors acknowledge that significant time is wasted on non-medical work such as documentation, the AMC has been a long-time advocate for reducing bureaucratic activities (e.g. writing discharge letters, personnel management) and expanding digital options such as a standardised information technology infrastructure (e.g. extramural and intramural areas), development of digital apps, and national documentation assistants that support electronic health records (elektronische Gesundheitsakte, ELGA).

France: The CNOM is the guarantor of the patient-doctor relationship in France, serving doctors in the interest of patients. We understand that today's doctors face several challenges in building a strong patient-doctor relationship, including limited time to conduct clinical responsibilities due to the burden of administrative tasks, working in large health teams, patients who are more informed and in control of their health, increasing technicalities of clinical practice, and the development and use of novel technologies (e.g. artificial intelligence). Some solutions to these challenges may include health professionals' training, improved team coordination and communication, and the responsible use of technologies in clinical practice. Since novel technologies cannot replace the individual medical consult, and must require the doctor's supervision, the CNOM is currently preparing an ethical and deontological framework for the use of these new tools.

Spain: The doctor-patient relationship is and will continue to be the basis of medical practice, and it is well safeguarded in Spain. This fundamental bond remains visibly strong among doctors in Spain, as evidence of their strong vocation and professionalism in medicine, albeit experiencing multiple challenges like infection control during the pandemic, hospital surges, and overburdened schedules. As the CGCOM is absolutely committed to protecting this doctor-patient relationship, we launched an initiative in 2016, to make the doctor-patient relationship part of the intangible heritage of humanity. Despite technological advancements, medicine must continue to revolve around this intimate and trusting relationship between the doctor and the patient.

Sweden: A good patient-physician relationship is necessary for optimal care. Of course, there are patients who are dissatisfied with their healthcare and their physician. Even threats and violence against health professionals occur, which is never acceptable and something that we must work hard to prevent. In general, though, I would say that the relationship between patients and physicians in Sweden is a positive one. With the continuous development of new treatments and the strengthened position of patients in healthcare, today´s patients often have high expectations of what healthcare can do for them. This can stimulate cooperation between patients and physicians as well as encourage patients to be more active participants in their care. At the same time, increased patients' expectations necessitate that physicians are well trained and given sufficient clinical

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time with patients to discuss the management plan in a respectful and sensitive manner that fosters understanding and trust.

How would you describe the anticipated challenges in medical education over the next decade in your country?

Austria: There is what has been referred to as an "unbalanced mobility" of students in the European Union (EU). Austria, in particular, has a disproportionate number of international medical students, who leave the country after having acquired their degree. Notably, most medical students in Austria come from Germany, as medical students seeking opportunities to study abroad. According to the German Minister of Health, however, the nation has trained an estimated 50,000 fewer doctors than the country will likely need for the next decade. Hence, the AMC supports reforms like the suggestion of the Austrian Minister of Education, Martin Polaschek, who proposed that EU member states should be required to provide a minimum quota of university placements, with states who meet or surpass their quotas being compensated by those states who are unable to meet these quotas.

Also, we need to ensure that young doctors in Austria choose to stay and work in the country. There are high demands internationally, particularly among Austria's neighbours (Germany and Switzerland), where a common language and geographic proximity present appealing alternatives for Austrian doctors. We have to stay competitive in the light of the global migration of health professionals, developing programs and incentives to encourage doctors to remain in Austria.

The medical profession has changed significantly over the past generations: 100-hour work weeks for example used to be common schedules in hospitals. Positions in the public healthcare sector were highly sought after amongst doctors, who would face stiff competition in the selection process. However, these job offerings have failed to keep up with the shift in priorities and expectations of younger generations who value flexibility in the workplace, seek a better work-life balance, and desire more time with their families as well as time to pursue interests outside of work. For this reason, part-time work models have risen in popularity. We cannot afford to ignore these professional changes in Austria and recognise that if contracts with social security providers and hospital administration do not offer more flexible and more attractive work conditions, fewer doctors will seek employment in the public healthcare system and the existing workforce gap will grow even larger.

France: In France, there are three major challenges that the health system will face over the next decade. First, junior doctors who complete their training do not often identify with the available types of medical practice. Young doctors who complete their training do not identify with the type of medical practice being offered to them. This is particularly evident in general practice within local communities, which should be at the core of healthcare for the population. The appeal of this specialised field is declining, and young doctors are increasingly inclined to choose salaried positions or roles that do not involve direct patient care, such as aesthetic medicine. This is where the real issue lies! It is pointless to significantly increase the number of medical students if we do not create a strong appeal for the care sector. Second, integration of artificial intelligence and telemedicine into training programs will require that teachers and students refine their skills of this rapidly changing discipline. Third, it is important to maintain rigorous and high-quality training standards to ensure patient safety. This is crucial, especially in the context of increasing international mobility among doctors.

Spain: As doctors, we recognise that there are enormous challenges in the field of medical education and training at national, regional, and international levels. First, limited time and incentives are offered to doctors to pursue regular continuing medical education, including updates on clinical guidelines for diagnosis, treatment, and prevention. For example, Spanish doctors may be granted five days to complete such important training, which can negatively influence the provision of high-quality healthcare services to patients and ultimately the health system as a whole. Second, it is important to harmonise medical training in Spain, Europe, and the world, ensuring that health professionals are well-trained with the knowledge and skills to treat patients. Hence, together with UEMS, we must promote a list of competencies that represents a benchmark for all countries, as well as guarantee that medical training has received the respective accreditation without any conflicts of interest.

Sweden: In 2021, the government of Sweden initiated fundamental changes to our system of medical education. Up until 2021, all doctors received a medical degree upon leaving the university (e.g. duration of 5.5 years), and after an 18-month internship, they could register as medical practitioners and start their speciality training. However, the average waiting time to start the

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internship has been 11 months after graduation, and this delay to educate new specialists (e.g. duration of five years) has exacerbated Sweden´s shortage of specialist doctors. Since 2021, the new system includes specific changes, where basic medical education (medical degree and license to practice medicine) is completed at the university in six years (e.g. addition of six months). Specialty training then follows and incorporates a new introductory training period (e.g. total duration of a minimum of 5.5 years). Eventually, the 18-month internship will be removed when the previous system has been phased out and replaced with the new system. During this transition period, we are closely monitoring (and working to remove any unnecessary delays) related to the implementation of the new system. Overall, these changes are timely for Sweden to better harmonise with our European neighbours' education systems.

From the medical education perspective, how has your NMA responded to the existing and emerging health challenges within your country?

Austria: Conducting an annual academic evaluation for training within hospital departments, the AMC analyses the current status and can therefore react quickly to incorporate any necessary modifications. For years, the AMC has advocated for a quality training, where senior-level doctors are assigned to each training program, and sufficient resources are available to allow time for teachers and trainees to complete their training and adopt an optimal work-life balance. If we can guarantee high-quality training, then we can guarantee that our patients will be cared for by highly trained doctors.

France: The CNOM proposes the implementation of innovative, modern, and simple solutions to bring more flexibility to expand healthcare services, meet patients' needs, and increase the attractiveness of the medical profession. After the COVID-19 pandemic, the CNOM launched the "Healing Tomorrow" ("Soigner demain" campaign) in 2021, offering several recommendations to national leaders on how to optimise medical education and training in France. Regarding academic coursework, national leaders can support the curriculum reform that emphasises infection control and prevention in the first year of studies, and medical ethics and CNOM missions in the second cycle of studies. Encourage second cycle medical study internships in public and private healthcare sectors, including outpatient settings. Promote internship placements in private clinics and hospitals, during the third cycle of medical studies, distributed across the coutry, regardless of specialty, to help students understand how professionalisation is closely aligned with local community needs Leaders can support doctors who wish to pursue part-time practice within their designated specialty field, as well as authorise the presence of value mixed and shared practice models without impairing social rights, regardless of status (e.g. hospital, salaried, private). In order to meet local community needs, national leaders can also offer physicians a five-year community placement, with significant salary, indemnity, contractual incentives, and retirement benefits. Finally, complementary topics (e.g. "One Health" concept, domestic and family violence) can be incorporated into reflections on the collective and social responsibility of doctors, economic and social implications of prescriptions, and critical analysis of emerging health threats.

Spain: Health leaders across Spain are leading efforts to identify and address health challenges with sustainable solutions that strengthen medical education and training as well as the health system. In 2022, the Government of Spain approved the *Decree 589/2022 (Real Decreto 589/2022)*, which sets the foundation for all stages of competence-based medical training, including coordinating annual exams for specialty training and establishing the role of professional organisations [1]. This regulation is pivotal as an important first step, and our CGCOM is enthusiastic to contribute to advancing this regulation and medical education and training in Spain and Europe.

Sweden: There is significant ongoing policy discussion regarding our changing demographics, such as how an ageing population will affect healthcare demands, a predicted future Sweden shares with many other countries. One key issue is to balance our physician workforce, especially since Sweden faces a nationwide shortage of specialist doctors. The current imbalance is partly due to the unnecessary delays for medical graduates to begin the internship, which is required to receive a license to practice and continue with their specialist training. Swedish healthcare should offer enough training positions and ensure sustainable working conditions for doctors, which will also help recruit the next generation of doctors. The SMA has published several reports with experiences of poor and unsustainable working conditions from our members, noting that almost one-third of junior doctors have considered leaving the medical profession. Moving forward, employers should act to improve these working conditions and offer fair compensation for all doctors.

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From your perspective and national experiences, how has the COVID-19 pandemic affected medical education in your country?

Austria: Due to the *2nd Covid-19 Act of 2020*, all deadlines in connection with medical education, training, and advanced education as well as medical practice were suspended for the duration of the COVID-19 pandemic. This action is in accordance with § 36 b par. 4 of the Austrian Medical Act 1998, namely for pandemic-related measures such as quarantine, leave of absence or childcare. In order to ensure the quality of training, the responsible attending physicians documented and assessed trainees' acquired knowledge, experience, and skills. Furthermore, faculty used digital teaching formats to teach coursework, resulting in a massive increase of online training courses, and many congresses were cancelled or postponed. All in all, I believe that everything possible was done, even during the pandemic, to offer junior doctors the best possible medical training.

France: During the COVID-19 pandemic, formal academic coursework could not be delivered via in-person format for several weeks. Students in clinical internships were focused primarily on prevention and care activities, and albeit increased workloads, they were fully committed to assisting their senior colleagues. The pandemic highlighted both the resilience and vulnerabilities of the medical education in France, emphasising the importance of adaptability, mental health awareness, and the integration of technology in training future healthcare professionals. The medical curriculum has incorporated an emphasis on public health, infectious diseases, and emergency preparedness topics, reflecting on the lessons learned during the pandemic.

Spain: Although the pandemic slowed (and halted) the development and adoption of regulations and legislation in medical education, we have uncovered positive aspects such as telemedicine advancements, greater training in digital skills, and even virtual learning. The CGCOM insists on the need for the measures to be directly coordinated so that training remains a prioritised pillar within the reformed Spanish health system. As medical professionals are the main asset of the health system, training is imperative to providing quality medical care. Although the pandemic slowed down such progress, we should collectively push forward and support advancements to medical education and training.

Sweden: The COVID-19 pandemic stressed one valuable lesson for the medical discipline to protect healthcare teams and patients in the case of any catastrophic situation (e.g. armed conflict, pandemic). Long-term planning within the healthcare system requires ample storage for medical supplies and medicine as well as regular training and continuous medical education for all healthcare personnel. My concern is that we are beginning to forget some of the lessons that we learned during the COVID-19 pandemic. However, in light of Sweden's recent entry into North Atlantic Treaty Organization (NATO) and its demands on preparedness, these issues continue to be highly relevant.

How does your NMA leadership implement the WMA policies in the organisation?

Austria: The AMC is fully committed to the WMA's commitment to providing people with the highest international standards in medical education, medical science, ethics, and healthcare. In addition to representing the common, professional, social, and economic interests of doctors working in Austria, the AMC's mission statement promotes socially orientated, modern healthcare by doctors in public and private practice that is accessible to the entire population. Our doctors are committed to a high standard of medical care, with a particular focus on ongoing quality management to increase patient safety.

France: Once WMA policies are adopted at the WMA General Assembly or Council Meeting, CNOM leaders disseminate the statements and recommendations within all levels of the CNOM. These policies offer valuable support and help reinforce our scientific positions at the national level. Prior to implementing these WMA policies within the CNOM, members carefully examine and analyse each of the WMA's proposals, initially within the CNOM's delegation for European and International Affairs (chaired by Dr. Philippe Cathala) and subsequently by members in section and session with all CNOM members.

Spain: As the WMA has adopted various initiatives, positions, and statements, our CGCOM members can use this information to broaden their knowledge and simultaneously adapt content to the context of the medical profession in Spain. Throughout my tenure as CGCOM president, designated delegates of different committees have prepared and shared reports with internal governing bodies, which can serve as a reference point for working groups or guiding documents for national health authorities. As the medical profession transcends frontiers, we must leverage our expertise and skills within national, regional, and international settings.

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Sweden: The SMA strives to actively participate in the WMA policy activities, noting that the WMA-adopted policies can be quite useful in our daily activities. Specifically, the SMA refers to WMA policies, especially the ones on ethical issues, when we contribute to interviews by the media, present at meetings, prepare scientific commentaries or articles, and discuss topics with SMA members. In fact, the WMA's core ethical policies, such as the International Code of Medical Ethics and the Declaration of Geneva, have inspired our own national code of medical ethics.

How can the WMA support the ongoing NMA activities in your country?

Austria: The fundamental framework and central guiding principle of our medical activities is to help patients, behind which all political and economic considerations take a back seat. The strong international co-operation within the WMA helps us to achieve these goals in Austria as well as internationally.

France: The WMA is an important organisation for the CNOM, and we are proud to be one of its founding members. Today, the WMA provides support by strongly reaffirming the role and place of physicians in the healthcare pathway, emphasising ethics in clinical research, and launching awareness campaigns on crucial public health issues such as vaccination, disease prevention, and mental health. Furthermore, it plays a major role by adopting guidelines and policies based on best practices in medical ethics. These actions are only made possible with the support of all NMAs and by strengthening dialogue with other organisations, such as CONFEMEL and the Conference of Medical Councils from French-speaking countries (la Conférence Francophone des Ordres des Médecins, CFOM).

Spain: In Spain, the WMA is highly respected as a leading international group of medical experts who advocate for high ethical standards in medical practise by adopting codes of ethics and organising ethics training activities. As the WMA General Assembly passes different emergency resolutions and declarations in any field, the CGCOM forwards these documents to legislators within the Congress of Deputies, Senate, Autonomous Communities, and the Ministry of Health, who in turn review and even post these documents on institutional websites. By providing this valuable support, the WMA can help strengthen the capacities of NMAs, improve the quality of medical care, and foster a collaborative environment for global medicine.

Sweden: The WMA plays an important role in developing and communicating international policies, especially in the area of medical ethics, as well as in speaking internationally against violations of medical ethics and health-related human rights. As a global organisation representing physicians from over 110 countries around the world, the WMA has a strong international voice. Its policies and statements regarding current events threatening physicians, healthcare systems, and human rights are often very helpful, offering a reference for our NMA when developing policies or addressing international events. Hence, we would like to encourage the WMA to continue its important work in these areas.

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WMA Members Highlight National Initiatives to Safeguard Patient Safety

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Patient safety, defined as *"a framework of organised activities that creates cultures, processes, procedures, behaviours, technologies and environments in healthcare that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce the impact of harm when it does occur"*, underpins the foundation of global health systems [1]. Health professionals, who adhere to the "first, do no harm" (*primum non nocere*) ethical principle, understand their indispensable role in leading and contributing to high-quality healthcare services that improves patient outcomes. However, common adverse events can include diagnostic or medication errors, nosocomial infections, and unsafe clinical or surgical procedures (including blood transfusions), leading to more than three million annual premature deaths [1].

Over the past two decades, global leaders have developed and adopted robust policies to guide health professionals in the delivery of high-quality healthcare services. In 2002, the World Health Assembly (WHA) approved the WHA 55.18 (*Quality of care: patient safety*), to encourage Member States to establish evidence-based approaches to improve healthcare service delivery [2]. In 2004, the World Health Organization (WHO) launched the World Alliance for Patient Safety, to offer a platform for global health stakeholders to share resources and collaborate on important patient safety initiatives aligned with six main action tracks (global patient safety challenge, patients for patient safety, reporting and learning, research, solutions, taxonomy) [3]. Subsequently, in 2009, the WHO published an international conceptual framework for patient safety to improve the collection and organisation of patient safety data (e.g. incident type and characteristics, patient characteristics and outcomes, contributing factors and hazards, organisational outcomes, detection, mitigating factors, ameliorating actions, actions taken to reduce risk) for analytical purposes [4].

Notably, the WHA adopted the resolution WHA 72.6 (*Global action on patient safety*) in 2019, which established World Patient Safety Day annually on 17 September [5]. The past two themes – "Engaging Patients for Patient Safety" for 2023 and "Improving Diagnosis for Patient Safety" for 2024 – have underscored patient safety as a collaboration between health professionals and patients and have encouraged the continued dialogue on existing barriers to achieving patient safety and high-quality healthcare services [6]. The *Global Patient Safety Action Plan 2021–2030*, launched in 2021, was comprised of seven strategic objectives: 1) engage patients and families as partners in

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safe care; 2) achieve results through collaborations; 3) analyse and share data to generate learning; 4) translate evidence into actionable and measurable improvement; 5) base policies and action on the nature of the care setting; 6) use both scientific expertise and patient experience to improve safety; and 7) instil a safety culture in the design and delivery of healthcare [7]. To support this action plan, the WHO launched the Patient Safety Rights Charter and the *Global Patient Safety Report 2024*, which outlines patients' rights and offers a comprehensive review and evaluation of national patient safety initiatives, respectively, in 2024 [8,9].

Health leadership and sustainable political investment are crucial to develop multidisciplinary and multisectoral approaches to reinforce health systems and support shared decision-making between health professionals and patients in healthcare service delivery. In this article, physicians from 14 countries – Argentina, Côte d'Ivoire, Ecuador, India, Kenya, Myanmar, Nigeria, Philippines, Rwanda, South Africa, Taiwan, Uganda, Uruguay, and Yemen – offered insight on local and national initiatives that highlight the need for robust patient safety practices across four geographic regions. They described relevant public policies, community engagement activities, and professional development trainings to empower health professionals and patients alike across global health systems.

Argentina

The Argentina health system, which supports 44 million residents, does not collect reliable statistics on patient safety and errors, due to limited infrastructure for monitoring adverse health events as well as health professionals' general reluctance to report such errors. Health institutions must adopt a culture of patient safety to reduce and prevent patient safety errors, offering continuing education opportunities for health professionals to refine their clinical skills, avoid diagnostic errors that are underestimated, including hospital-acquired infections. Aligned with the theme associated with World Patient Safety Day 2024, improving health professionals' diagnostic capabilities can help avoid preventable errors that lead to harm, disability, mortality, and affiliated malpractice lawsuits.

Over the past decade, the Argentina Ministry of Health has strived to develop relevant legislation and guidelines that promote patient safety. First, the National Program for Quality Assurance in Medical Care (Programa Nacional de Garantía de la Calidad de la Atención Médica) was adopted by *Secretarial Resolution No. 432* (Resolución Secretarial N°432) in 1992, endorsed by the National Executive Power (Poder Ejecutivo Nacional, PEN) *Decree No. 1424 (Decreto PEN N°1424)* in 1997, and ratified by the PEN *Decree No. 178 (Decreto PEN N°178)* in 2017 [10,11]. These laws called for the development of high-quality instruments to assess quality management and patient safety [10,11]. Second, the *Actions for Patient Safety in the Healthcare Field (Acciones para la Seguridad de los Pacientes en el Ámbito de la Atención Sanitaria)* was adopted in 2019 and updated in 2021, followed by the *Tools for Self-Assessment of Good Practices for Improving Quality in Healthcare Services (Herramienta para la Autoevaluación de Buenas Prácticas para la Mejora de la Calidad en los Servicios de Salud)* in 2021, presenting tangible measures to enhance healthcare service delivery and ultimately patient outcomes [12,13]. Third, the *Manual of Patient Safety (Manual de Seguridad del Paciente)* was published in July 2022, providing concrete strategies and actions for organisational strategies in patient safety as well as proposed indicators for program evaluation [14].

COMRA supports all initiatives that seek to prioritise patient safety, as a fundamental step in the design, execution, and evaluation of national and global health systems. We believe that healthcare professionals must help prevent incidents by making appropriate decisions that avoid unnecessary risks to patient safety in the clinical and community workplace. As health leaders improve monitoring systems for adverse event reporting across institutions, they can design evaluation tools to identify gaps and address any limitations in reporting schemes. We can also develop capacity building workshops that can facilitate knowledge sharing as well as establish a culture of continuous learning and interdisciplinary teamwork that prioritises patient care.

Côte d'Ivoire

The Republic of Côte d'Ivoire, a sub-Saharan African nation of 30 million residents, shares its border with five countries (Burkina Faso, Ghana, Guinea, Liberia, Mali) and the Gulf of Guinea has an abundance of natural resources (e.g. copper, diamond, gold, petroleum) and agricultural crops (e.g. cocoa beans). Since the first (2002-2007) and second (2010-2011) civil wars, the nation has experienced a rapid economic growth to become classified as a low-middle-income country. However, poverty (35% of the population living below the poverty line), food insecurity and malnutrition (23% rate of stunting), and gender inequalities remain significant challenges for health leaders [15]. In 2015, the Government of Côte d'Ivoire

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launched the universal healthcare program, and more recently has established mobile enrollment centres to expand access across the nation [16]. For this reason, healthcare professionals in the country recognise World Patient Safety Day as a unified global commitment to minimising risks and preventing harm in healthcare settings as well as ensuring that every patient receives safe and effective care.

Over the past decade, the Government of Côte d'Ivoire has implemented several initiatives to promote patient safety across the population. First, the implementation of the *National Health Development Plan* (*Plan National de Développement Sanitaire*, PNDS) was adopted in 2011, and then updated in 2015 and 2021, as a comprehensive plan with specific measures aimed at improving patient safety (e.g. enhancing the quality of healthcare services, increasing access to essential medicines, strengthening health infrastructure) [17]. Second, the Ministry of Health, in collaboration with various non-governmental organisations, has launched community campaigns to educate the public on promoting safe practices (e.g. proper medication use, infection prevention, importance of seeking timely medical care), as well as seek to reduce common healthcare-associated infections and improve patient outcomes. Finally, use of mobile technology, social media platforms, and digital health tools serve as a platform for sharing best practices, reporting safety incidents, and educating both healthcare providers and the public about the importance of patient safety [18,19].

As physicians in the Ivory Coast, the African continent, and the world, our call to action is clear: we must advocate for and implement robust patient safety practices at every level of healthcare delivery. First, we must promote a culture of safety by encouraging open communication among healthcare teams, patients, and their families to ensure that safety concerns are addressed promptly and effectively. Second, all healthcare professionals should receive regularly training on the latest safety protocols and best practices in patient care. Third, health leaders should advocate for policies that support resilient health systems capable of responding to emergencies and daily healthcare challenges, without compromising patient safety. Finally, partnering with international and regional organisations can offer a global platform to exchange knowledge and resources that can help improve patient safety. Together, by making patient safety a priority, we can ensure that healthcare is safe for everyone, everywhere.

Ecuador

World Patient Safety Day holds significant importance for physicians in Ecuador, as it highlights the critical need to address gaps in patient safety within our healthcare system. While global patient safety initiatives are recognized, Ecuador faces unique challenges, such as limited resources and varying levels of healthcare quality across regions. According to the WHO, 134 million adverse events occur annually due to unsafe care in hospitals, particularly in low- and middle-income countries, resulting in 2.6 million deaths [9]. The IBEAS study was conducted across selected Latin American countries (Argentina, Colombia, Costa Rica, Mexico, and Peru) to assess the prevalence of adverse health events in hospitals, building on the ENEAS study (involving Spain) [20]. Without comprehensive data reports on patient safety incidents in Ecuador and the wider Latin America and Caribbean region, which directly impede the development of targeted interventions and policies, more robust patient safety monitoring and reporting systems should be established and tailored to the needs of the Ecuador healthcare system.

To address this burden, the Ecuador Ministry of Health has implemented numerous initiatives to promote patient safety. First, leaders have implemented the use of care audits as an independent mechanism to investigate patient harm, which is a step toward improving accountability and care standards [9]. Second, they have developed patient safety guidelines aligned with international standards, including the *Patient Safety Manual* in 2016, which aims to improve care quality and reduce adverse events [21]. Third, they have integrated patient safety education modules into the medical and nursing school curricula, which can foster a safety culture from early academic training before clinical rotations. Fourth, healthcare professionals – including doctors, pharmacists, dentists, nurses, midwives, as well as patients themselves – can report suspected adverse drug reactions, therapeutic failures, medication errors, and events supposedly attributable to vaccination or immunization through a web portal managed by the National Agency for Health Regulation, Control, and Surveillance (ARCSA) [22]. Finally, the emergence of patient advocacy groups, although primarily focused on specific conditions like cancer, has the potential to evolve into broader patient safety movements, as observed with patients participating in safety protocol role-playing exercises in Spain. However, despite these robust initiatives, more attention to government policies and public awareness campaigns must expand these efforts.

As Ecuador physicians, our call

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to action remains to actively build a patient-centred safety culture that adheres to established safety protocols and advocates for creating national patient safety registries and improved communication strategies with patients. We must prioritise health professionals' training on delivering difficult news with empathy to patients and their families, recognizing that our approach to health communication can significantly impact clinician-patient rapport, patients' adherence to clinical recommendations, and overall patients' physical and mental health outcomes. Moreover, fostering a collaborative environment where patients are seen as integral healthcare team members can continue to strengthen the clinician-patient relationship. By empowering patients with accurate knowledge and ensuring their active participation in their care, we can enhance trust and improve safety outcomes, ultimately leading to a healthier and more resilient healthcare system.

India

Since the United Nations reported that India had the world's largest population (1.429 billion residents) in 2023, when compared to China's population (1.426 billion residents), this demographic trend presents additional challenges for the national health system, including primary care services and patient safety [23]. Over the past 75 years, independent from British rule, national health leaders have successfully strengthened health indicators (including reducing maternal and child mortality rates) [24]. With significant disruption to healthcare services during the coronavirus disease 2019 (COVID-19) pandemic, leaders implemented successful vaccination campaigns, supported digital technologies and telemedicine consultations, and established more than 250,000 Health and Wellness Centres [24]. As leaders continue to scale-up and strengthen the health system to address emerging health risks, they recognise the health burden of adverse reactions (e.g. hospital-acquired infections, unsafe surgeries and medications, faulty medical devices) can affect millions of patients each year, leading to increased health expenditure, lack of trust within health institutions, and potential demoralisation and burnout of health professionals [25].

As patient safety has gained increasing attention in India, several initiatives have adopted to enhance patient safety across the health system. In 2018, the India Ministry of Health and Family Welfare launched the *National Patient Safety Implementation Framework 2018-2025* (NPSIF), a comprehensive guideline and roadmap with six objectives, 21 priorities, and 81 interventions, toward strengthening patient safety at all levels of healthcare service delivery [26]. This document covers legal aspects, quality assessments, workforce development, infection control, and research, aiming to reinforce institutional frameworks, build a competent health workforce, and establish reporting systems of adverse effects. Also, over the past decade, the Government of India has established regulatory bodies and legislature to monitor and implement patient safety initiatives, including the National Accreditation Board For Hospitals and Healthcare Providers (NABH) in 2005, National Accreditation Board for Testing and Calibration Laboratories (NABL) in 1982, National Health Systems Resource Centre (NHSRC) in 2007, as well as the *Clinical Establishments Act of 2010, Pharmacy Practice Regulations of 2015,* and the *Drug and Cosmetics Act of 1940.*

The Indian Medical Association (IMA), in collaboration with the Patient Safety and Access Initiative India Foundation (PSAIIF), adopted the *Bangalore Declaration* on 30 June 2024, which aimed to bridge gaps and enhance collaborations between doctors and patients across the nation. IMA members believe that all physicians have an obligation to advocate for patient safety and should collectively address existing challenges, including limited health system infrastructure (including health workforce shortages) and incompliance with evidence-based clinical protocols (including infection prevention and control) [27]. We recognise the urgent need for robust patient safety initiatives, including offering continued education courses on clinical guidelines and research for health professionals and accelerating the use of digital health technology for reporting adverse events in health institutions.

Kenya

Patient safety remains a critical challenge in Kenya, with adverse events affecting three in 10 patients in hospital care settings [28]. Despite having strong clinical policies and documentation, the Kenya Ministry of Health faces significant challenges with their implementation, including high unemployment among doctors and insufficient training for health professionals, which ultimately impede patient safety initiatives and quality of care for the Kenyan population. One national study reported that suboptimal systems hindered the prompt identification of critical illnesses, limited resources for continuity of care, and disrupted the flow of care, as major causes of the delays in the healthcare service delivery in Kenya's public hospitals [29]. These findings highlight the need to reinforce strong clinical policies related to standardised effective and reliable healthcare

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priorities in Kenya.

The Kenya Ministry of Health, which envisions a nation where safety and quality are valued and promoted, has launched significant efforts to promote patient safety for 51 million residents. First, leaders adopted the *National Policy on Patient Safety, Health Worker Safety, and Quality of Care* in 2022, which is rooted in the *Constitution of Kenya 2010, Vision 2030,* and the *Kenya Health Policy 2014-2030*, aims to ensure the provision of respectful and responsive quality healthcare for a healthy, productive, and globally competitive country [29]. Second, Kenya prioritizes universal health coverage (UHC), to provide every citizen with access to quality healthcare services without financial difficulties or undue burden. Thus, the policy emphasises strengthening governance, protecting patients from avoidable harm, ensuring health professionals' well-being, and maintaining high-quality healthcare services. The *Kenya Community Health Strategy,* recognized as one of the key initiatives for UHC implementation, emphasises preventive measures by recognising that community health is the foundation of healthcare delivery and providing policy direction for community health services [30]. Kenya has robust community health units (serving defined geographical areas) that are supported by community health assistants and volunteers who provide promotive, preventive, basic curative and rehabilitative services.

To improve patient safety strategies, the Kenya Ministry of Health should enforce compliance with international safety standards, enhance healthcare professionals' employment practices, and strengthen medical licensing and accreditation systems. Investing in healthcare infrastructure and continuous professional development, particularly at the community level, is crucial to improving patient outcomes, reducing medical errors, and building a resilient healthcare system. This approach will ensure that healthcare providers are equipped with up-to-date skills and resources, enhancing the quality of care delivered across all healthcare system levels. Additionally, prioritising community-level interventions will empower local health professionals and promote patient safety from the ground up, fostering a culture of accountability and excellence in healthcare delivery. To further enhance these efforts, the Kenya Ministry of Health should actively seek collaborations with other African countries to share best practices, innovative solutions, and regional safety standards. By working together, African nations can collectively strengthen their healthcare systems, address common challenges, and drive progress towards achieving safer and more efficient care for all patients.

Myanmar

In Myanmar, patient safety initiatives supported by the National League for Democracy (NLD) government leadership have been promising. Based on recent patient safety baseline assessments and recognition of patient safety champions in 2018, Myanmar's State Counsellor Daw Aung San Suu Kyi has led efforts to increase medical standards in public hospitals and improve patient safety including blood transfusions, immunisations, and surgical procedures. The Ministry of Health and Sports was drafting a new *National Health Policy* in 2021, to replace the 1993 policy, with patient safety as one of the nine areas one, when the Myanmar's military and security forces systematically attacked civilian hospitals and clinics [31]. These Myanmar military and security forces indiscriminate violence and bombings have resulted in widespread casualties, with over 18.6 million persons seeking humanitarian need (including 2.8 million internally displaced persons) [32]. With overburdened healthcare facilities for war-related injuries and routine medical care, this violence has resulted in serious injuries and long-term health consequences, including increased health expenditure on physical and mental health challenges [33,34].

The Myanmar junta forces have also established blockades and restricted access to critical medical supplies and humanitarian relief, which have discouraged Myanmar health professionals, local aid workers, and volunteer humanitarian responders from saving lives on the frontlines [35]. They have demolished important roadways that connect various towns and cities, which hinders access to healthcare institutions [36]. This forced displacement, resulting in huge numbers of refugees living in transitory, overcrowded, and unhygienic circumstances, can promote infectious disease transmission and challenge to provision of effective healthcare to patients.

To address patient safety concerns, leading international organisations like the United Nations, World Medical Association (WMA), and Junior Doctors Network should take immediate action beyond issuing statements and declarations. They can help provide essential medicine and equipment directly to local frontline humanitarian responders, including ethnic civil society and community-based organisations, via locally led cross-border channels. These efforts can help repair and restore destroyed hospitals and clinics, ensuring that medical facilities have adequate equipment, supplies, and reliable power and communication supply.

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Also, they can provide continued education courses and training (including relevant mental health resources) to Myanmar healthcare professionals, so that they can effectively manage emergency and trauma care and other conflict-related health issues.

Nigeria

Patient safety is essential for effective healthcare delivery across the world, and although the African continent is comprised of low- to high-income nations, many remain challenged to meet patient safety standards [37]. The Nigerian health system, serving 195 million residents, has reported inadequate resources, poor administrative regulations, insufficient training opportunities in patient safety for health professionals, obsolete medical equipment and supplies, and limited technologies incorporated into healthcare visits [38]. Notably, two studies across Nigeria have reported poor healthcare professionals' adherence to patient safety measures. First, in one hospital in Enugu (eastern Nigeria), 51% of surveyed surgeons perceived poor patient safety during surgical procedures and 38% regularly used available institutional protocols (including 11.3% to prevent wrong-site surgery). A positive correlation was associated with the duration of surgical practice and their perception of patient safety [39]. Second, in four public hospitals in Kaduna (northern Nigeria), 55% of participating health professionals (doctors, nurses, pharmacists) responded positively that they consistently use strategies that enhance patient safety, 36.8% frequently reported adverse events, and 51.4% perceived that hospital managers and administrators support patient safety [40].

To address patient safety concerns, the Nigerian Federal Ministry of Health and Social Welfare launched the *National Policy and Implementation Strategy on Patient Safety and Healthcare Quality* in 2023, as guidelines to improve the safety of all medical procedures and enhance the quality of healthcare delivery [41]. Also, health leaders have directed significant efforts to educate health professionals and the general public, including regular participation in World Patient Safety Day events. In 2023, the Nigeria Federal Ministry of Health and Social Welfare, in collaboration with the Dr. Aneyo Stella Adadevoh Health Trust (DRASA), organised a public walk and public press briefing session as well as a two-day review workshop on policies and implementation strategies that promote patient safety in Nigeria.

As Nigerian physicians, we should collectively enforce current patient safety policies and advocate for new government policies, strategies, and initiatives that expand health sector funding, strengthen infection prevention and control measures, and reinforce the implementation of clinical guidelines through regular clinical audits. Also, health institutions and professional medical and nursing associations can develop capacity training sessions on best practices in patient safety, as part of the continued professional development for all health professionals. This national call for patient safety should be a priority for all health professionals across Nigeria, encouraging medical professional associations and societies to collectively contribute to minimising medical errors and empowering patients as active recipients of healthcare services.

Philippines

World Patient Safety Day calls on Filipino physicians to prioritize patient safety, address gaps in healthcare service delivery, and enhance the quality of healthcare services. In the Philippines, existing healthcare system challenges include high patient-nurse and patient-physician ratios, limited medical supplies, insufficient safety incident reporting systems, and inconsistent opportunities for professional training on pressing health topics, all of which directly impact the quality of healthcare service delivery. Hence, the celebration of this day establishes a space for exchanging ideas, best practices, and updates to encourage collective involvement of patients and health professionals in ensuring safe and high-quality patient-centered care.

To promote patient safety and harm reduction, the Philippine College of Surgeons implemented the WHO's Safe Surgery Saves Lives program in 2008. By 2010, the adoption of the Safe Surgery Checklist was still low, however, and compliance rates ranged from 0.15% to 3.6%. In fact, hospitals with lower checklist utilization experienced higher mortality rates [42]. Similarly, clinical misdiagnoses among urban obstetric providers were estimated at 30% in 2016, and specifically 25% for cephalopelvic disproportion, 33% for postpartum hemorrhage, and 31% for pre-eclampsia conditions [43]. Despite the establishment of a national pharmacovigilance system in 1994, researchers explored the use of text-based versus traditional paper-based systems to report adverse drug reactions for resident physicians in a tertiary-level hospital in Manila, concluding that paper-based systems were preferred due to fewer challenges (e.g. proper reporting syntax, internet connectivity) [44]. With additional support from the Department of Health (DOH), many hospitals across the country reported notable improvements in achieving patient safety goals by 2018 [45].

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The National Center for Patient Safety, within the Government of Philippines' DOH, launched the Safe Care Initiative in 2018, which supported health professionals' training, development of safety protocols, and auditing to improve patient safety. In 2008, the DOH established the *National Policy on Patient Health* (*Administrative Order No. 2008-0023*), and later released the *Revised Guidelines on Continuous Quality Improvement* (*Administrative Order No. 2020-0034*) in 2020, to ensure patient safety in healthcare facilities [46,47]. In observance of World Patient Safety Day 2023, the DOH promoted the "Engaging Patients for Patient Safety; Elevate the Voice of Patients!" theme to underscore the importance of patient-centred healthcare and decision-making, diversity and inclusion within the healthcare system, and the need for essential partnerships with medical professionals to create a safe healthcare environment for everyone [48].

To support academic training on patient safety for health professional students, trainees, and specialists, the Philippine Medical Association (PMA) and the Philippine Nurses Association (PNA) offer workshops, webinars, and professional development programs on patient safety. The Philippine Alliance for Patient Safety (PAPS) hosts the annual National Patient Safety Congress, and the Philippine Alliance of Patient Organizations (PAPO) is actively involved in policymaking, as part of the Health Technology Assessment Council, ensuring the adoption of safe and effective healthcare technologies and medicines. Finally, the Philippine Coalition Against Fake Medicines (PCAFM) and the Safe Medicines Network (SMN) are two multisectoral coalitions that lead advocacy efforts for strong legislative protections that combat counterfeit drugs and enhance medication safety across the nation.

As World Patient Safety Day emphasises the importance of patient-centred care and advocacy for patient safety standards, Filipino physicians view this moment as an opportunity to reaffirm their commitment to promote patient-centred care in a safe and effective healthcare system. Therefore, Filipino physicians are urged to adopt and promote patient safety protocols, utilise systems for reporting and learning from adverse events, and engage in continuous training in patient safety. Specifically, they can collaborate with regional and international organisations and advocate for stronger health policies that prioritise safety across the Philippines, Asia, and the globe.

Rwanda

In Rwanda, physicians recognise that patient safety is an integral part of high-quality healthcare service delivery, which must support sustained vigilance, foster a culture of continuous improvement, and promote health professionals' adherence to best practices and standards designed to protect patients' health and well-being [49,50]. Although no published data on adverse events exist at the national level, individual hospitals submit incident reports that help shed light on the burden of adverse events, which in turn can inform government policies and strategies on patient safety. In one recent study conducted with hospital managers from 47 public hospitals in Rwanda, authors concluded that the prevalence of adverse events and other incidents was less than 1%, namely due to adverse drug incidents (25%), loss to referrals and follow-up (25%), and surgical site infections (20%) [51]. Together with other countries, Rwandan health leaders recognise and celebrate World Patient Safety Day every year, to represent a shared commitment to ensuring that each patient receives safe and quality care across health institutions [52,53].

To prevent unintended harm or adverse consequences to patients and their community, Rwandan leaders have developed strategies, policies, and initiatives to improve and advance patient safety. First, the *Rwanda Fourth Health Sector Strategic Plan* was launched in 2018, with strategic emphasis on quality and people-centred healthcare as a foundation for promoting patient safety [50]. Each hospital has pharmacovigilance and drug and therapeutic committees, which are instrumental to monitoring, reporting, and overseeing initiatives that prevent harm due to unintended adverse reactions from medications [49]. Second, the Rwanda Ministry of Health developed Patient Rights Charters and mandated the public display of patients' rights to care in all health facilities, in efforts to ensure transparency and trust in health services. Third, the Ministry of Health initiated the hospital accreditation process in 2012, first with referral hospitals and then all health facilities, as a mechanism for improving quality and accountability as well as patient satisfaction [52]. Leaders established customer care services in all hospitals to support the timely responses to patient concerns, allowing patients to give feedback on service received as well as anonymous reporting of unpleasant experiences, which can objectively inform improvement efforts. Finally, stakeholders representing the local government, non-government agencies, and civil societies supported capacity building on professional ethics and patient rights, such as the Health Development Initiative (https://hdirwanda.org/) as a local non-governmental organisation that recently organised an inter-professional workshop on patients' rights.

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Rwandan leaders understand that ensuring patient safety is a continuous process, noting that there are always risks associated with medication errors and healthcare-associated infections [50]. Despite robust measures to improve quality of care and minimise healthcare-related risks to patients, Rwandan health leaders call for reinvigorated efforts to collaborate with all stakeholders to implement more systemic changes that prioritises patients' interests. As Rwandan physicians understand their critical role and contributions to upholding and safeguarding the fundamental "do no harm" principle, they call for continued investment in actions that further promote patient safety. Such efforts can include designing comprehensive initiatives for patient and community education and empowerment, improving safety within the clinical workplace, requiring rigorous monitoring of incidents and transparency in adverse event reporting, and promoting positive physician-patient communication. Rwandan physicians agree that they can educate and encourage patients to contribute to community-wide advocacy efforts that hold the healthcare system accountable for the implementation of evidence-based safety measures. They also highlight that self reflection and continuous medical education are essential ingredients for cultivating behaviour change in the clinical setting and commit to increased vigilance and adherence to clinical policies and guidelines (including standard operating procedures) that protect patient safety across health institutions.

South Africa

Patient safety incidents often result from poorly implemented safety policies and a culture that overlooks patient safety in the public health sector and human error in high-risk interventions in the private sector [54]. In South Africa, patient safety within the health sector is comprised of protection for medical and surgical procedures as well as physical health and well-being. First, although evidence-based guidelines are followed by health professionals in clinical practice, ranging from prescribing medications to performing surgical procedures, adverse events may occur resulting from procedures or infection [54]. In fact, medico-legal liabilities in South Africa were reported to exceed US$5 billion in 2020, with a 30% annual growth rate, in the public sector, while the criminalisation of medical errors has become rampant in the private sector [55,56]. Second, the physical safety of patients and health professionals has been affected by robbery in medical facilities across the country, leading to physical and psychological trauma [57].

To maintain high-quality patient safety management across the nation, three leading stakeholder institutions manage the administrative and policy requirements. First, the South Africa Department of Health (DoH) manages quality improvement through the *National Health Quality Improvement Plan*, as well as implementation of the Ideal Clinic and the Ideal Hospital Frameworks (https://www.idealhealthfacility.org.za/). Second, the Office of Healthcare Standards (OHSC) (https://ohsc.org.za/) helps develop regulations for patient safety, inspections and enforcement, and health facility certifications, to support quality healthcare assurance. Finally, the Office of the Health Ombud, which is directly linked to the OHSC, leads investigations of reported patient safety incidents across health facilities. All reported incidents adhere to the *National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa*, which represents collaborative efforts on patient safety between the DoH, OHSC, and the Office of the Health Ombud [58].

To promote the culture of patient safety culture in South Africa and the wider African continent, it is imperative for all health professionals to understand the evidence-based clinical guidelines that are appropriate for their daily clinical responsibilities to patient care. Continuous professional development on the best practices for infection control and adverse event reporting, coupled with health system financing for products and supplies, can equip health professionals with the knowledge and tools to uphold administrative policies. Since inadequate security systems in health facilities can impact patient safety, security assurance models for healthcare should be developed to improve the safety of patients seeking healthcare in public and private facilities in South Africa [57].

Taiwan

The Patient Safety Committee of the Taiwan Ministry of Health and Welfare has continued to lead robust patient safety initiative across health institutions for over three decades. In 1999, the Ministry of Health and Welfare (previously recognised as the Department of Health until 2013), Taiwan Hospital Association, Taiwan Non-Government Hospitals and Clinics Association, and Taiwan Medical Association established the Joint Commission of Taiwan (JCT) (https://www.jct.org.tw/mp-2.html), to promote patient safety through the delivery of quality of healthcare services. This initiative led to the establishment of the Taiwan Patient Safety Reporting System (TPR) in 2005, as an anonymous, voluntary, confidential, and collaborative learning-based medical accident

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reporting system in Taiwan [59]. Specifically, a total of 16,043 facilities (including clinics) have joined the TPR in Taiwan, and an estimated 957,310 adverse events were reported between 2005 and 2022 [60]. After the launch of the Taiwan Patient Safety Culture Survey Project in 2009, the JCT highlighted the improvement of patient safety indicators in community and regional hospitals (including staff) from 2009 to 2016 [61].

Over the past decade, the Taiwan Ministry of Health and Welfare has adopted legislature and coordinated national projects to address patient safety concerns across health institutions. First, the *Childbirth Accident Emergency Relief Act* of 2015, namely *Article 22*, mandates that health institutions establish internal risk event management and reporting mechanisms to analyse the primary causes of significant childbirth accidents, reduce the risk of childbirth accidents, and propose action plans [62]. Second, the *Medical Accident Prevention and Dispute Resolution Act* of 2022, which was enacted in 2024, requires the prompt reporting of any significant harm or death resulting from medical errors for subsequent evaluation by authorities. This policy aims to promote an efficient medical dispute-handling mechanism, harmonious doctor-patient relationships, and patient safety culture across health institutions in Taiwan [63].

Furthermore, the Taiwan Ministry of Health and Welfare has prioritised three specific activities over the past decade. In 2012, the Pilot Program for Managing Childbirth Accident Disputes was established, allowing participating institutions to conduct inspections and submit regular quality reports. In 2022, experts were invited to create checklists on postpartum haemorrhage bundle care and pregnancy-induced hypertension and preeclampsia bundle care, based on international obstetric care models (including six key obstetrics and gynaecology risk management principles). In 2023, postpartum haemorrhage educational leaflets were designed to help healthcare professionals and the general public understand prenatal, intrapartum, and postpartum care, and hence aim to lower the risk of postpartum haemorrhage and improve its clinical management.

The Taiwan Medical Association supports the ambitious goals of the Taiwan Ministry of Health and Welfare published in the *Annual Goals for Patient Safety, 2024-2025* [64]. These goals include enhancing healthcare teamwork and communication (including clinician-patient rapport and engagement with families), improving surgical and medication safety, ensuring adherence to infection control measures, preventing severe injuries (including patient falls), protecting vulnerable populations (including pregnant women and infants), and ultimately fostering patient safety culture (including reporting mechanisms of patient safety incidents) [64]. As Taiwanese physicians provide compassionate care to over 23 million residents, they recognise World Patient Safety Day each year and collectively focus on best clinical practices and policies to improve patient safety and clinician-patient engagement across health institutions in Taiwan.

Uganda

In Uganda, health professionals recognise World Patient Safety Day as a day to reflect upon the "do no harm" principle and discuss strategies that can help improve patient safety across health institutions. However, the quality of healthcare is severely compromised with high clinician-patient ratios, including a doctor-patient ratio of 1:25,725 and a nurse-patient ratio of 1:11,000, overburdened schedules, limited documentation, and inadequate healthcare infrastructure [65]. At the same time, as healthcare services have limited accessibility and availability, long distances from communities, and high costs, patients frequently seek non-traditional services that may contribute to self-medication and unregulated herbal remedies. In 2014, one national report highlighted that 5-20% and 28% of hospitalised patients in Ugandan health institutions had experienced adverse drug reactions and hospital-acquired infections, respectively [66]. Common medical errors were described as delayed or failed diagnoses, interoperative complications, and accidental needle stick injuries [66].

Uganda leaders have undertaken several initiatives to promote patient safety for health institutions serving the 45 million residents. First, the Ugandan Patient Safety Symposium, which was held in September 2018, aimed to foster inclusive dialogue, evaluate current and past patient safety initiatives, and develop a framework for future action [67]. Second, the Uganda Ministry of Health, together with community stakeholders, adopted the Patient and Client Rights Charters in 2019, as a legal and regulatory framework to improve healthcare service delivery and ultimately health indicators in Uganda [68]. Third, the Uganda Ministry of Health launched the Health Facility Quality of Care Assessment Program in 2020, to ensure standard of care in hospitals through quarterly evaluations, which has been implemented in 85% of the districts. Finally, the Patient-Centred Care Movement Africa (PaCeM-Afro), led by health professional students and recognised

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at the 74th WHA in May 2021, has continued to advocate for patient-centred care through education, research, and social media campaigns [69].

As physicians across Africa and the world, we must collectively advocate for comprehensive patient safety guidelines and policies, as well as healthcare systems with Ministry of Health oversight to ensure that patients are free from harm and avoidable risks. We can continue to educate patients on their rights and responsibilities and support sustained health professionals' training. Specifically, we can help engage communities through the Patient and Client Rights Charters, and empower patients to work collectively with health professionals in the delivery of high-quality health services across Uganda [68].

Uruguay

Over the past two decades, the Uruguay Ministry of Health has guided the patient safety initiatives based on international data sources (like the WHO), since national reports have not examined incidence and prevalence rates of adverse health events. Taking the lead, Uruguay leaders joined the WHO Patient Safety Alliance in 2006, and participated in the first global challenge ("Clean Medicine is Safe Medicine") that promoted the importance of optimal hand hygiene practices in healthcare settings. To support the initiatives of the national health system, leaders adopted *Law 18.995* (*Ley 18.995*) in 2012, which ensure the annual recognition of National Patient Safety Day on 14 April, in addition to the WHO's annual celebration of World Patient Safety Day on 17 September [70]. However, with changing leadership within the Ministry of Health, widespread initiatives on patient safety tend to be conducted annually by non-governmental organisations and professional associations, noting that 14 April offers reflections on patient safety and 17 September provides formal activities to engage audiences on patient safety.

Uruguay Ministry of Health leaders contribute to strengthening the national health system through legislation and initiatives that promote high-quality health service delivery for its 3.4 million residents. First, health leaders were using a self-assessment and guidance tool, adapted from the United Kingdom's National Health Service seven-step tool, to evaluate institutional needs and establish primary guidelines for preparing and implementing patient safety plans across institutions until 2019 [71]. Second, the *Ordinance 660/2006* (*Ordenanza 660/2006*) of the Ministry of Health was adopted in 2006, outlining that the Commission for Patient Safety and Prevention of Medical Errors (Comisión para la Seguridad de los Pacientes y Prevención del Error en Medicina, COSEPA) has the responsibility of strengthening the culture of safety for health professionals, patients, and their families in Uruguay [72]. They also approved the *Ordinance 804/022* (*Ordenanza N° 804/022)* in 2022, which reinforced previous legislation on patient safety and surveillance of adverse events [73]. Finally, Uruguay leaders conducted the first national survey on the impact of disruptive behaviours in the health sector to over 4,000 health professionals from the national health system in 2014, noting the need to address the high incidence of negative behaviours (e.g. derogatory comments, anger episodes) that hinder effective teamwork, communication, and safety for health professionals and patients alike [74]. Although these achievements have helped lead patient safety efforts across the country, evaluations related to the compliance of patient security measures across institutions have not been conducted since 2019.

As Sindicato Médico del Uruguay (SMU) members representing diverse clinical and surgical specialties, our call to action is to promote the integration of safety protocols into clinical management ("safety-inspired clinical management") of all healthcare activities. Notably, we recognised National Patient Safety Day on 14 April 2024 (and will commemorate World Patient Safety Day on 17 September 2024), as events that will help align our local and national efforts to reduce adverse events in health settings [75]. Uruguayan physicians, together with our WMA colleagues, can continue to lead efforts that empower the entire healthcare team to prioritise high-quality patient-centred care across public and private sectors, as well as directly involve family members in the clinical decision-making process.

Yemen

For Yemeni physicians, World Patient Safety underscores the urgent need to address critical issues within the healthcare system, which has endured ongoing conflict and resource shortages since 2015 [76]. The WHO has highlighted that preventable medical errors are a leading cause of harm to patients globally, and the situation in Yemen is particularly dire. The Yemen Ministry of Population and Public Health reported that hospital-acquired infections and medication errors were estimated at 20% and 15% in 2021, respectively, emphasising the urgent need to improve patient safety practices and infrastructure across the nation [77,78].

Despite its challenging circumstances, Yemenis leaders have

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adopted two significant policies and initiated several efforts to improve patient safety. First, *Law No. 26* was adopted in 2002, which criminalised health professionals who refrained from treating patients in emergency or disaster response scenarios [79]. *Law No. 4* was approved in 2009, which dually defined roles and responsibilities related to infectious disease prevention and control, criminalising actions that intentionally hinder appropriate reporting measures or increase risk of disease transmission, and guarantee patients' rights to immediate medical care in emergency scenarios [80]. Second, the WHO's Safe Surgery Saves Lives program was developed in 2009, aligning with WHO guidelines to enhance surgical safety, and aimed to standardise surgical procedures, ensure proper sterilisation, and train healthcare professionals in best clinical practices. The National Pharmacovigilance Program, established in 2009, was designed to monitor and evaluate adverse drug reactions to improve medication safety [78]. Finally, community campaigns that promote hygiene practices and vaccination adherence have been fundamental in raising public awareness and fostering a culture of safety across the population.

Physicians in Yemen and across the globe must take a proactive role in enhancing patient safety, including advocating for robust healthcare policies, engaging in continuous professional development, and adhering to international safety guidelines. Collaborations with global health organisations can provide essential support and resources to strengthen Yemen's healthcare system. By emphasising a patient-centred approach, physicians can encourage patients to actively participate in their care to reduce errors and improve safety outcomes. By fostering a culture of transparency, accountability, and dedication to excellence in patient care, physicians can lead the way toward a safer and more resilient health system for the global population.

Conclusion

World Patient Safety Day 2024 offers an opportune moment for global health leaders to evaluate current patient safety initiatives within health systems, identify risks to adverse events, and reinforce their political commitment to promoting a safety culture. Together, they can endorse the Patient Safety Rights Charter and collaborate on the implementation of the seven strategic objectives of the *Global Patient Safety Action Plan 2021–2030* across national health systems [8,9]. Using the "Improving Diagnosis for Patient Safety" theme, they can also incorporate evidence-based clinical and surgical practices for patient-centred care as well as support health professionals' engagement with patients and families as partners in healthcare service delivery [6]. By reflecting on the "first, do no harm", health professionals can apply the One Health concept to practise, as they form robust strategic- and operational-level partnerships with health stakeholders and elucidate the drivers of unsafe clinical practices and patient harm.

With expertise across clinical and surgical disciplines, WMA members serve diverse leadership roles in their academic and health institutions, national medical associations, and countries. They contribute evidence-based research findings and expert perspectives to national and global discourse on an array of topics, including patient safety, to reinforce health system resiliency. This collective article presents a valuable overview of robust community initiatives and policies that support high-quality healthcare services, essential partnerships with health stakeholders, provider-patient rapport and communication, and public awareness, and hence optimal patient outcomes. Specifically, it highlights clear examples of timely health leadership and political commitment across the African, Americas, Eastern Mediterranean, and South-East Asian regions that exemplify global solidarity and action to promote patient safety.

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