Texas Children's Global Health Network

26TH NETWORK MEETING hosted by BAYLOR BLACK SEA FOUNDATION | NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Thursday, 6 November 2025

Session 1

Please Scan the QR code to view the online Program Guide.

Baylor College of Medicine | BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

Energizer Time: Let’s Recharge! ⚡

Leader

NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Texas Children's Global Health Network

Workshop: Abstract to Publication

Dr. Heather Haq,

Dr. Shubhada Hooli,

Dr. Morgan Sekou

Baylor College of Medicine BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

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Texas Children's Global Health Network

From Abstract to Publication

Dr. Heather Haq

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Workshop Objectives

By the end of this workshop, you'll be able to:

1. **Understand** the abstract-to-publication journey
2. **Structure** a scientific manuscript using IMRaD
3. **Identify strategies** to select an appropriate target journal
4. **Use key tools** & templates to support writing

Live Poll

Join at menti.com | use code 9171 9933

So, you have an abstract…

Why publish?

So, You Have an Abstract… Why Publish?

Publishing helps to:

 Advance science & fill knowledge gaps

 Share best practices & improve health outcomes

 Build your professional reputation

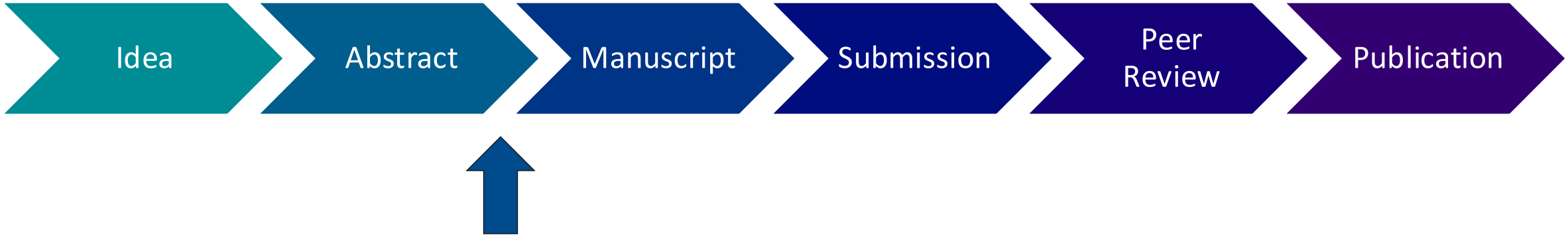
 Influence policy, practice, or future research

From Abstract to Publication: The Journey

Live Poll

- What is the highest stage you've completed with an abstract?
- What is the highest stage you've completed with a manuscript?

The Publication Journey



Authorship & Collaboration

- Discuss authorship early
  - Who is likely to be an author
  - Assign roles
  - How author order will be determined
- Meaningful inclusion: "***Nothing about us without us***"
  - Ensure engagement of investigators from sites where data is generated
- Ensure institutional/Executive Director approval

Authorship Criteria

ICMJE INTERNATIONAL COMMITTEE of MEDICAL JOURNAL EDITORS

Defining the Role of Authors and Contributors

2. Who Is an Author?

The ICMJE recommends that authorship be based on the following 4 criteria:

- Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
- Drafting the work or reviewing it critically for important intellectual content; AND
- Final approval of the version to be published; AND
- Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Ensure everyone meets authorship criteria; if not, give them an opportunity to do so!

Choosing a Target Journal - Considerations

- Scope & Fit
- Target audience
- Indexing – is it listed in **PubMed**?
- Impact metrics
- Open Access & Fees
  - Article Processing Charges
  - Are waivers available for LMICs?
- Article types accepted
- Similar articles
- Formatting & limits

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- Article types accepted
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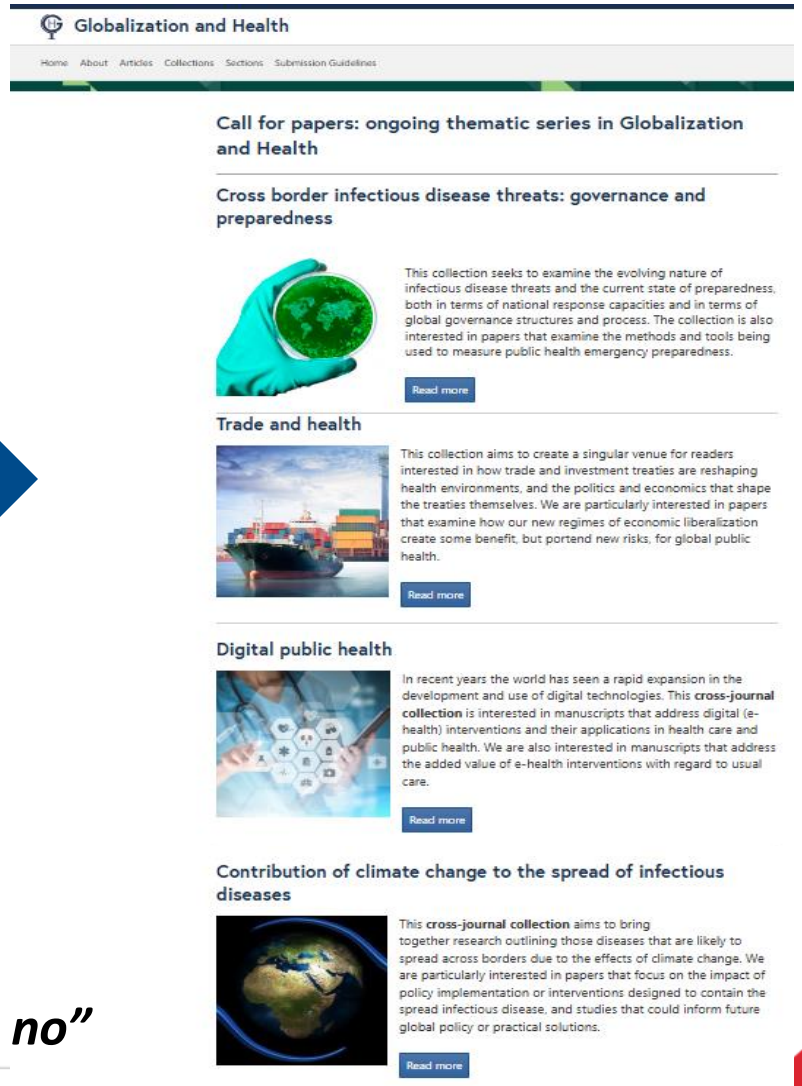
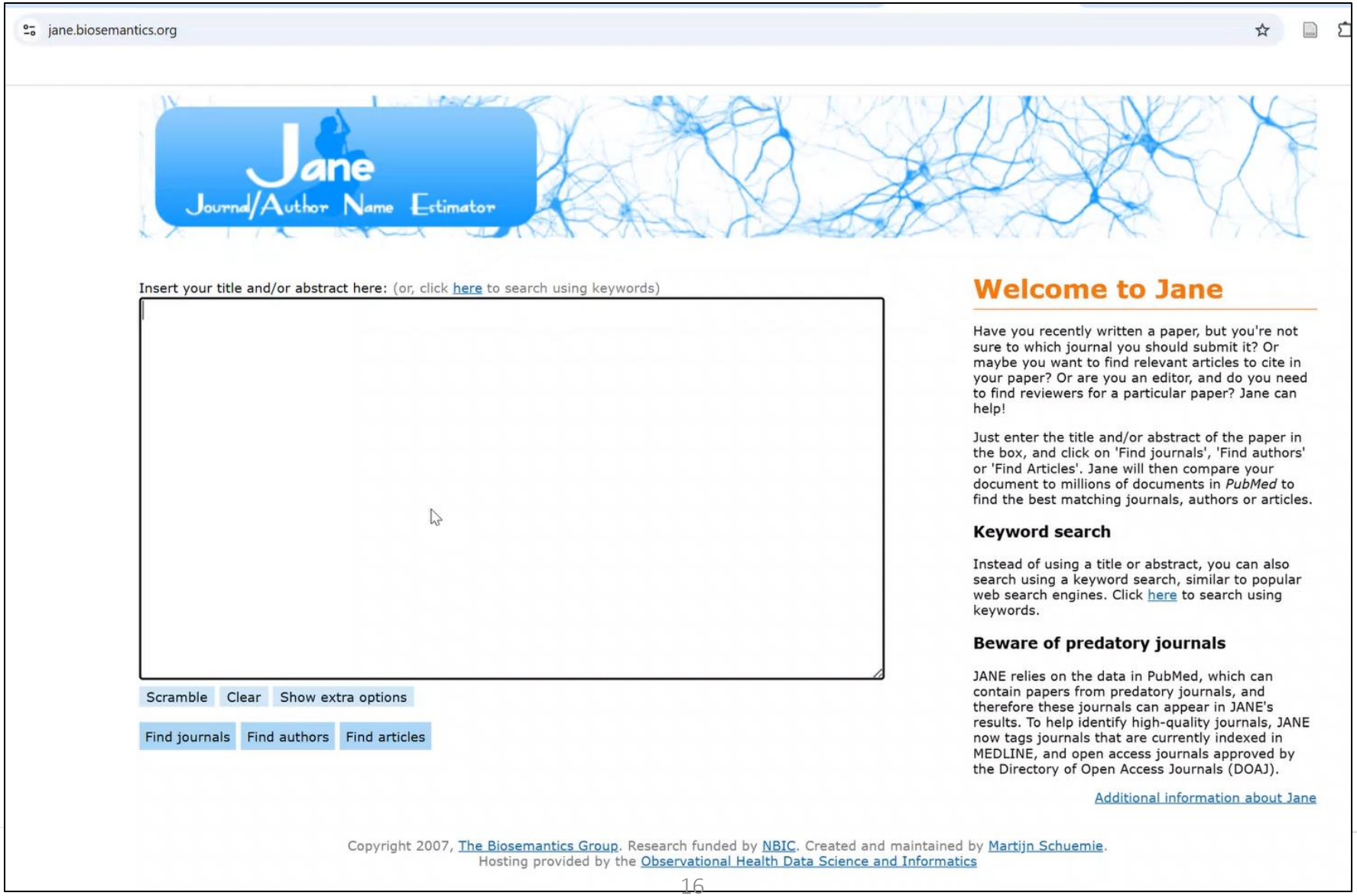
Calls for Papers



Reminder: "The worst they can say is no"

Choosing a Target Journal



Beware of Predatory Journals 🚩

Predatory publishers charge authors for services like peer review, indexing, and preservation, but **do not provide them.**

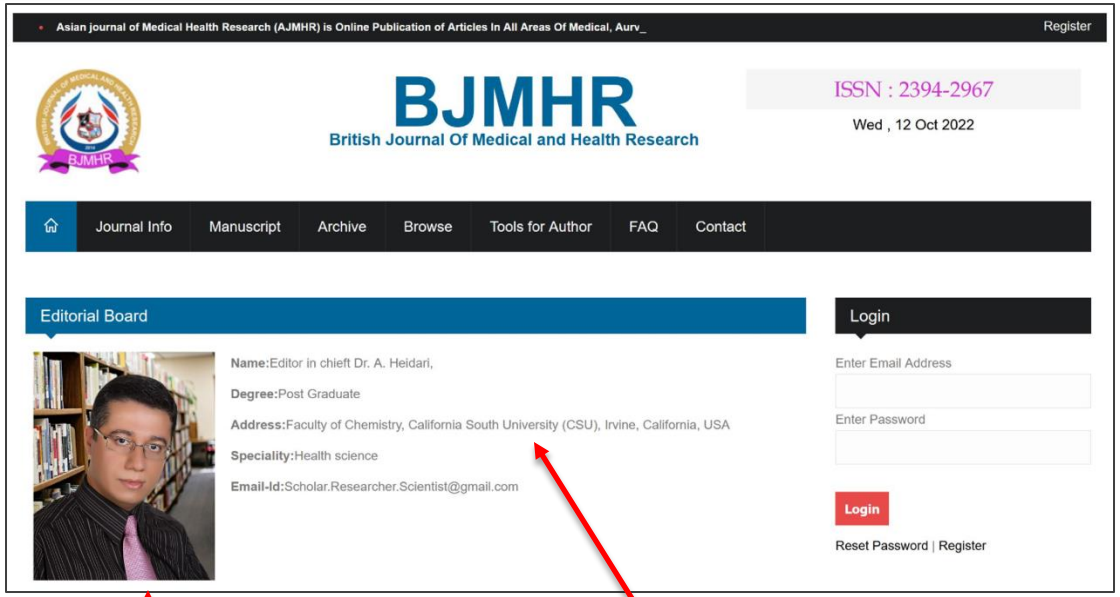
This potentially **damages** academic reputations.

*Note: Open access publishers often charge these fees too, but they are **transparent** about it and **provide the services** advertised*

Example of a Potential Predatory Journal

Journal title is very similar to other journals

No list of latest published articles.. Just a call for papers



Digitally altered image

Google search reveals California South University is not a legitimate institution.

https://guides.libraries.uc.edu/predatory_journals

Live Poll

- I face the following barriers to engaging in research…
- How much do you perceive the following factors to be barriers to publishing a manuscript?

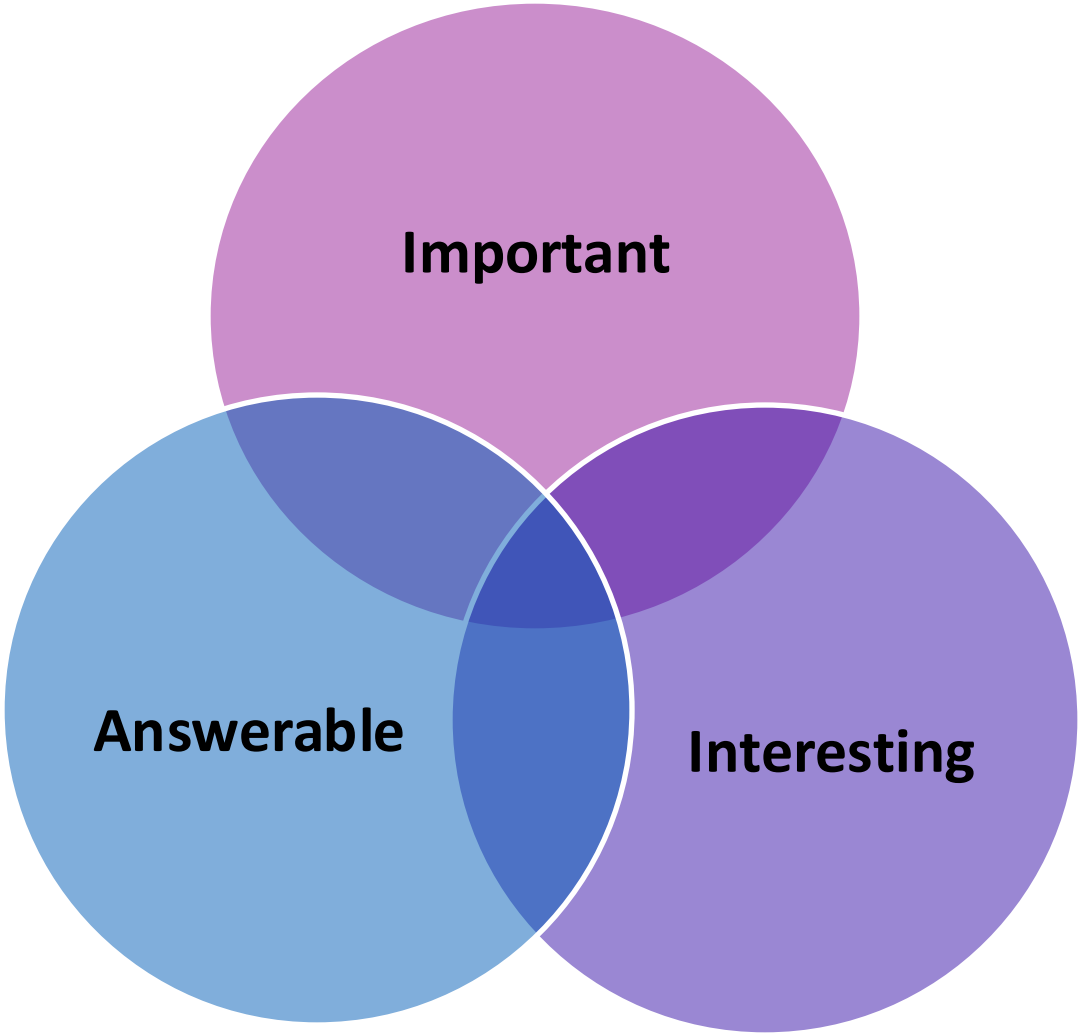
Live Poll

- Open Q&A

Join at menti.com | use code 9171 9933

Refining your Research Question

What makes a good research question?



A good research question should be…

Feasible	Enough subjects Time and funds Technical expertise Manageable – not too ambitious

Developing & Refining Your Research Question

- Strong research starts with a clear question
- For clinical/epidemiological studies, start with **PICO**

Developing & Refining Your Research Question

- Strong research starts with a clear question
- For clinical/epidemiological studies, start with **PICO**

Population	Which population?	Under 5 year-olds
Intervention or Exposure	What are you interested in studying?	Pulse oximetry integration at health centers
Comparison	How are you going to compare the groups?	Children living in different bomas
Outcome	What are you interested in understanding?	Deaths due to pneumonia (within 24 hours) after a clinic visit

Refining a Clinical Question using PICO

Population
Intervention/Exposure
Comparison
Outcome

Original: Do Children Living with HIV More Frequently Experience Severe Pneumonia?

Population Exposure Outcome

Refining a Clinical Question

Original: Do Children Living with HIV More Frequently Experience Severe Pneumonia?

Population Exposure Outcome

Population	**Age:** Children aged 0-24 months **Case definition:** Hospitalized with pneumonia **Setting:** Kamuzu Central Hospital **Time frame:** January 2023 and December 2023
Intervention/Exposure	Living with HIV (HIV-infected)
Comparison	HIV-exposed uninfected and HIV-uninfected
Outcome	Proportion (prevalence) of pneumonia in each HIV-status category

Refining a Clinical Question

Original: Do Children Living with HIV More Frequently Experience Severe Pneumonia?

Population Exposure Outcome

Population	**Age:** Children aged 0-24 months **Case definition:** Hospitalized with pneumonia **Setting:** Kamuzu Central Hospital **Time frame:** January 2023 and December 2023
Intervention/Exposure	Living with HIV (HIV-infected)
Comparison	HIV-exposed uninfected and HIV-uninfected
Outcome	Proportion (prevalence) in each HIV-status category

Better: Among children aged 0-24 months hospitalized with pneumonia to Kamuzu Central Hospital between January 2023 and December 2023, what proportion were living with HIV, HIV-exposed uninfected, and HIV-uninfected? How did the severity and hospital outcomes of these children differ?

Refining a Clinical Question - Practice

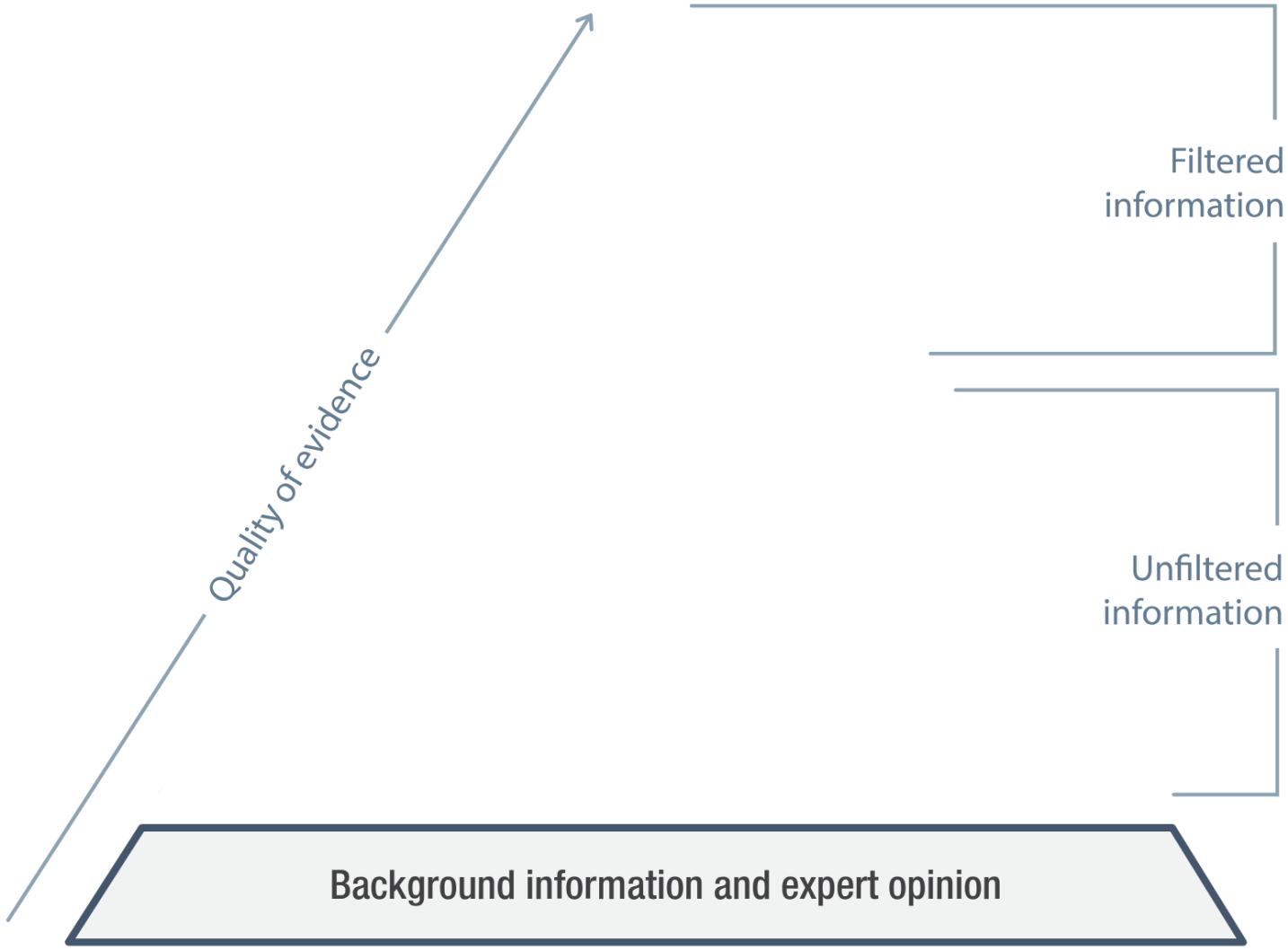
Original: How do we increase documentation of vital signs in children evaluated at outpatient clinics?

Better: What are the barriers and facilitators of vital sign measurement and documentation in children under 5 years old evaluated for emergency care at clinics in the vicinity of the Botswana Center of Excellence?

How do I focus my research question?
Literature Search

Conducting a Literature Search

Hierarchy of Evidence



Why should I conduct a Literature Search?

- Understand what is **already known**
- Identify **key questions** that need further research
- Determine **methods** used in past studies
- Avoid duplication

Tools for Literature Searches

Literature Search

PubMed

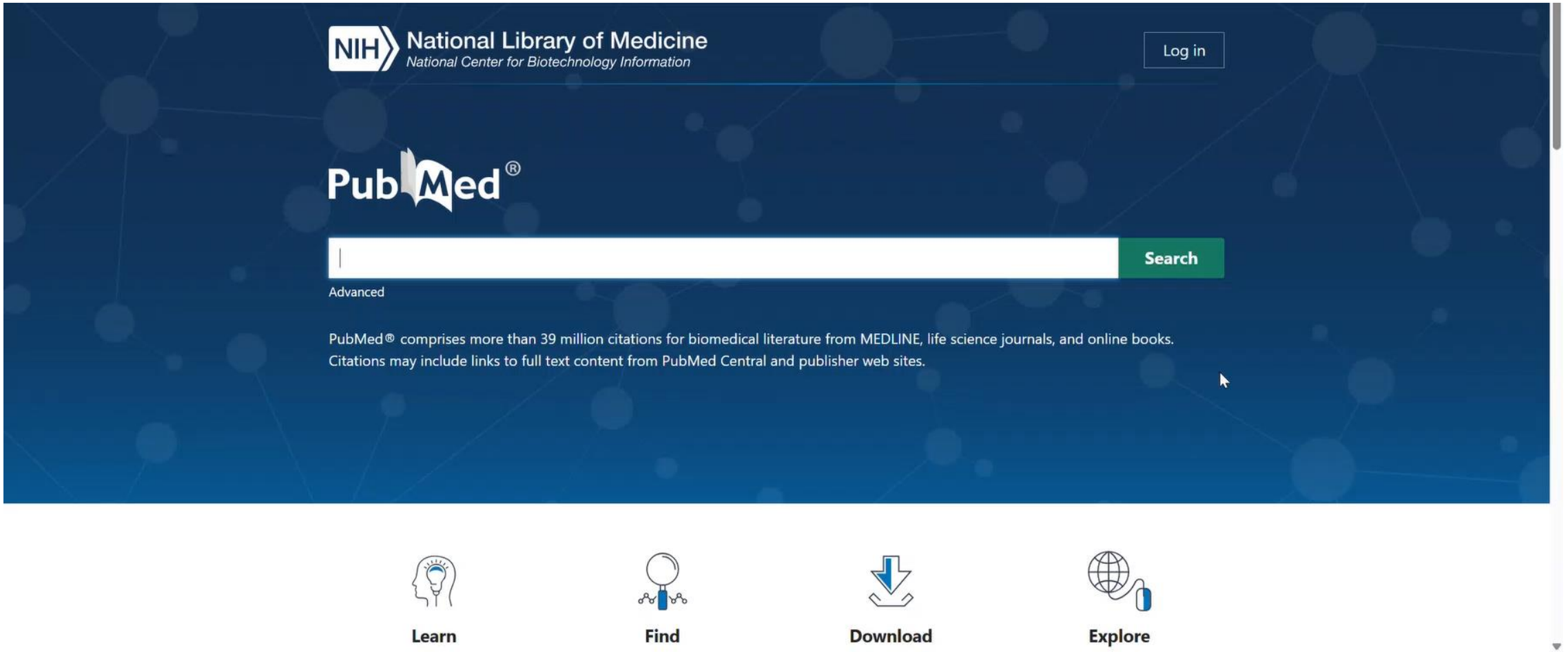
Google Scholar

Managing Papers

zotero

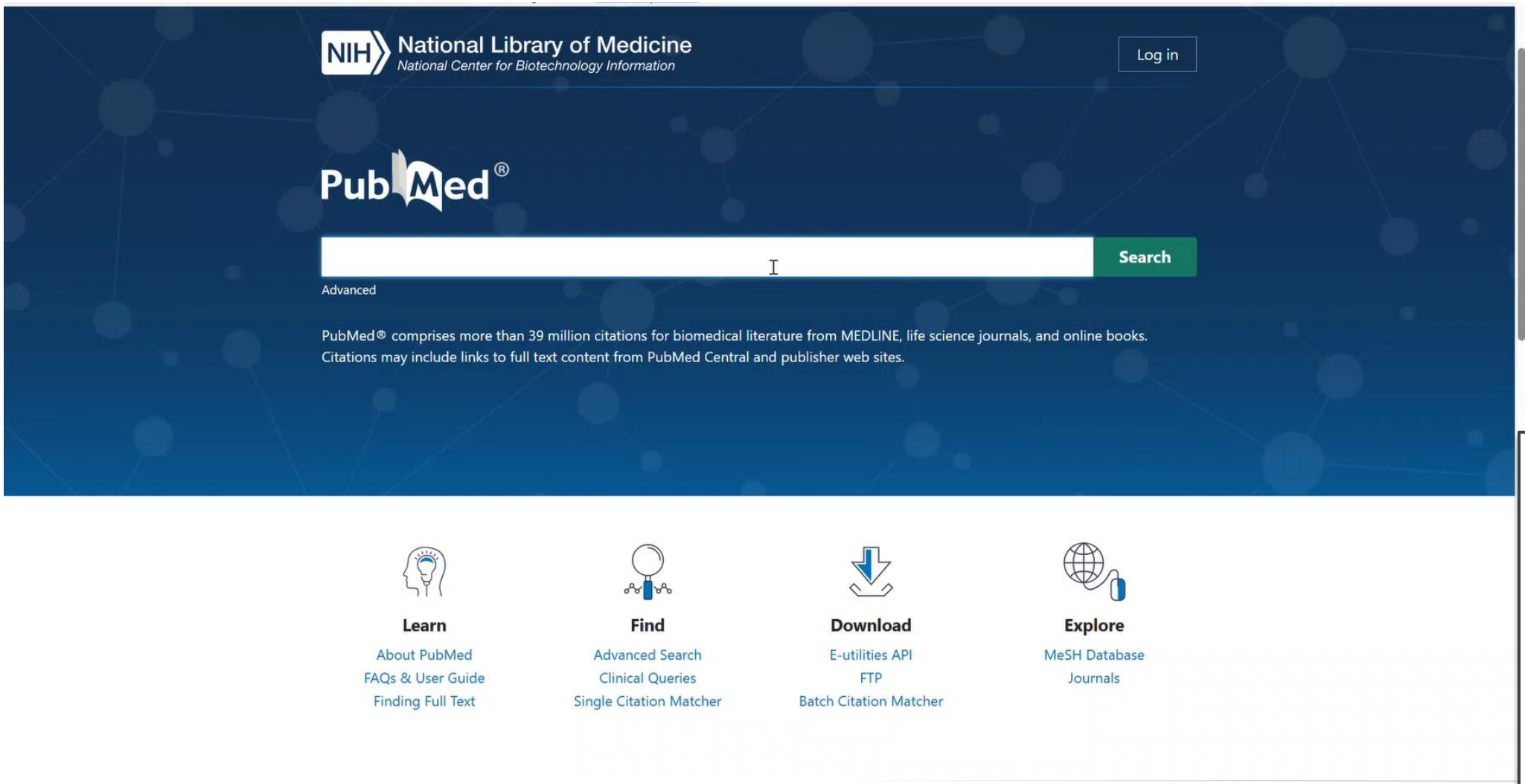
ProQuest RefWorks

PubMed Simple Search



Finding Medical Subject Headings - MeSH Terms

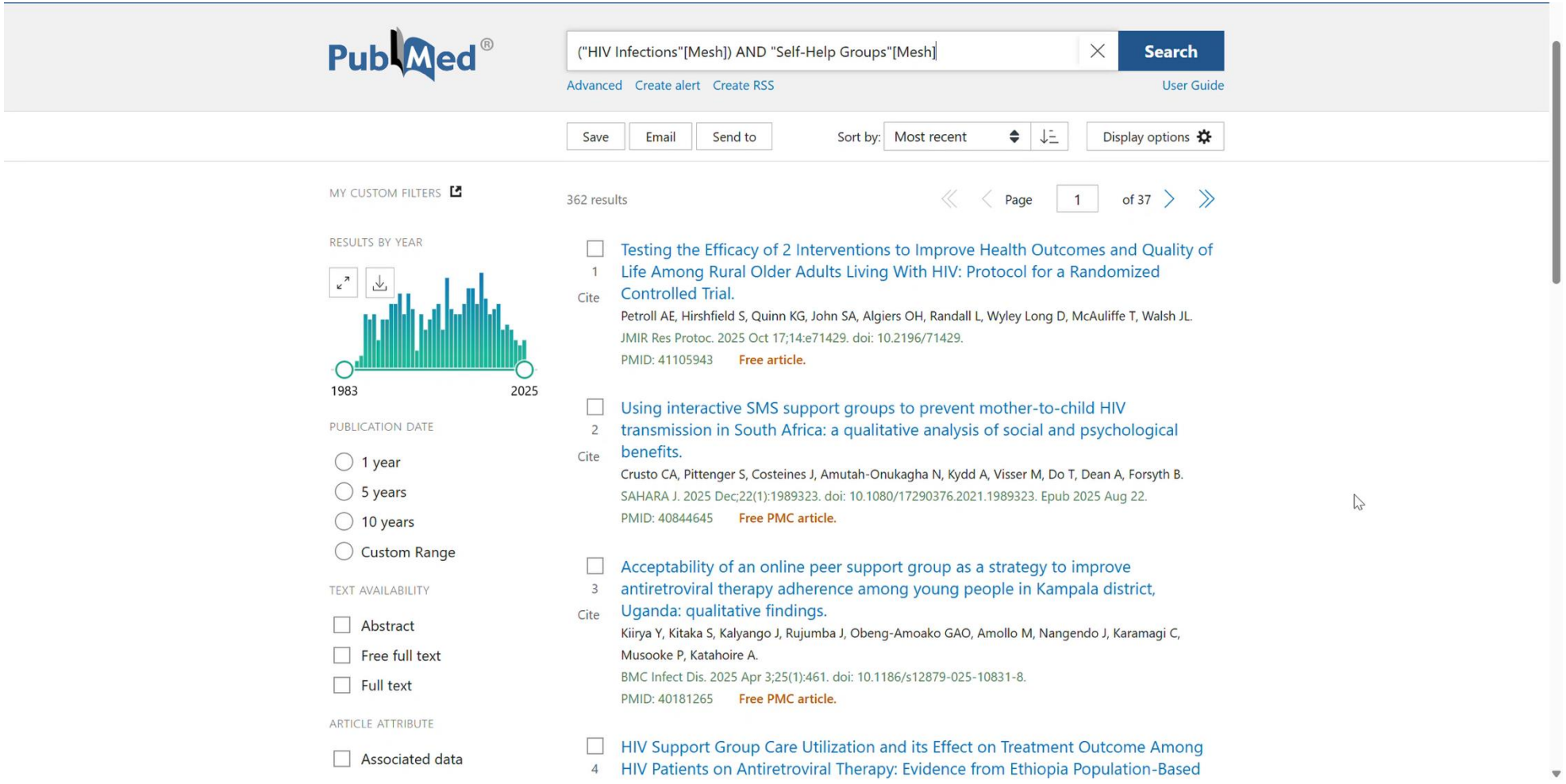
MeSH provides a consistent way to find content with different terminology but the same concepts.



MeSH terms

- Adolescent
- Adult
- Female
- HIV Infections / therapy*
- Humans
- Male
- Nigeria
- Self-Help Groups / standards*
- Social Media / standards*
- Social Support*
- Young Adult

Building a Quick MeSH Search



Saving the Results

PubMed®

("HIV Infections"[Mesh]) AND "Self-Help Groups"[Mesh]

Search

Advanced Create alert Create RSS Clipboard (3) User Guide

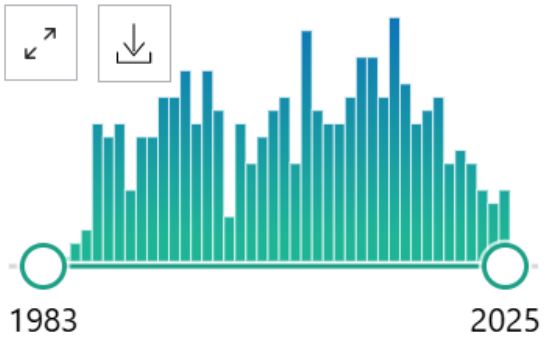
Save Email Send to

Sort by: Most recent

Display options

MY CUSTOM FILTERS

RESULTS BY YEAR



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Clear selection

Page 1 of 37

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Citation manager

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Cite

f 2 Interventions to Improve Health Outcomes and Quality of
der Adults Living With HIV: Protocol for a Randomized

nn KG, John SA, Algiers OH, Randall L, Wyley Long D, McAuliffe T, Walsh JL.

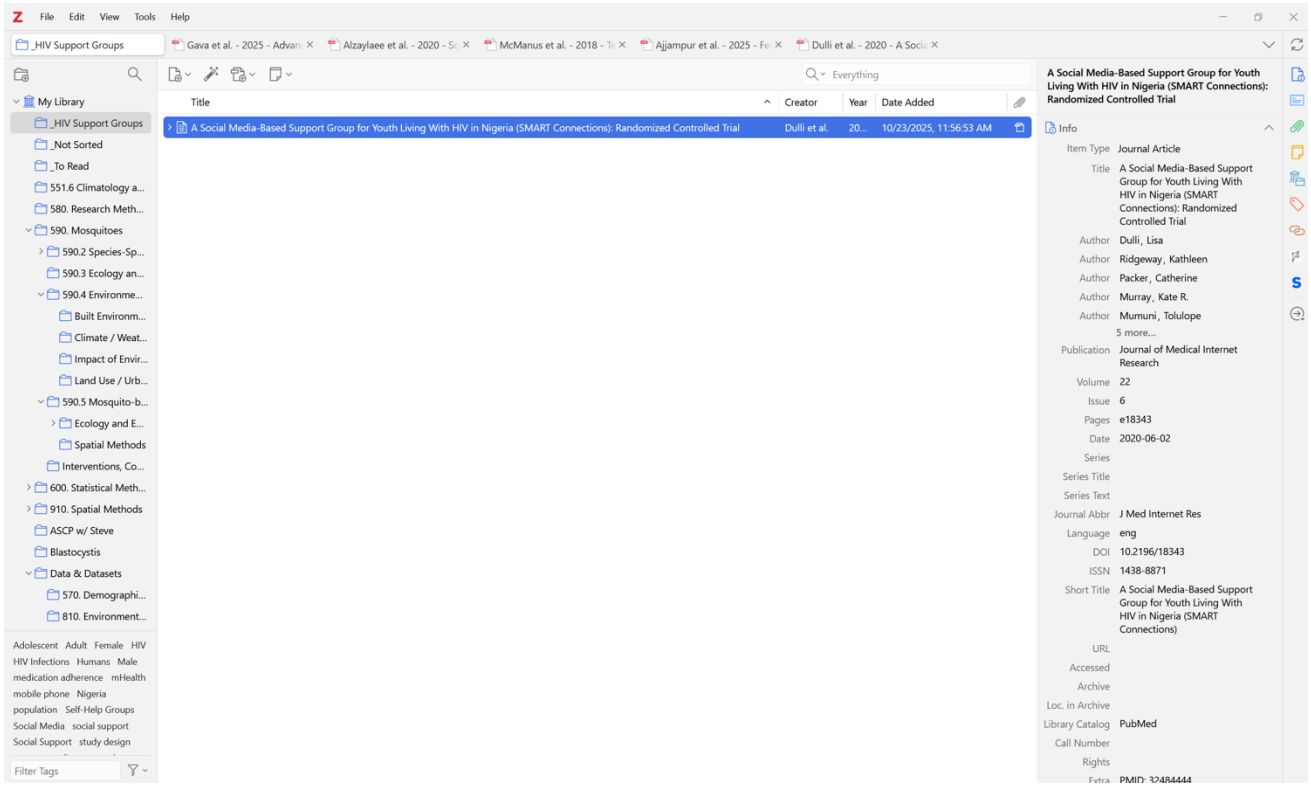
JMIR Res Protoc. 2025 Oct 17;14:e71429. doi: 10.2196/71429.

PMID: 41105943 Free article.

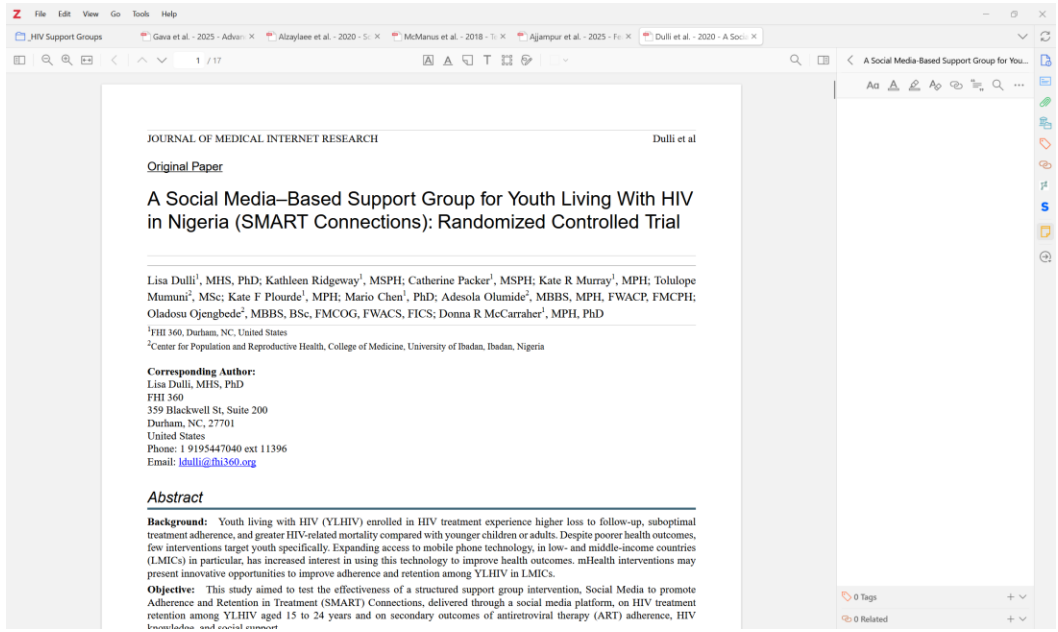
Item in Clipboard

Citation Management using Zotero

Citation Manager

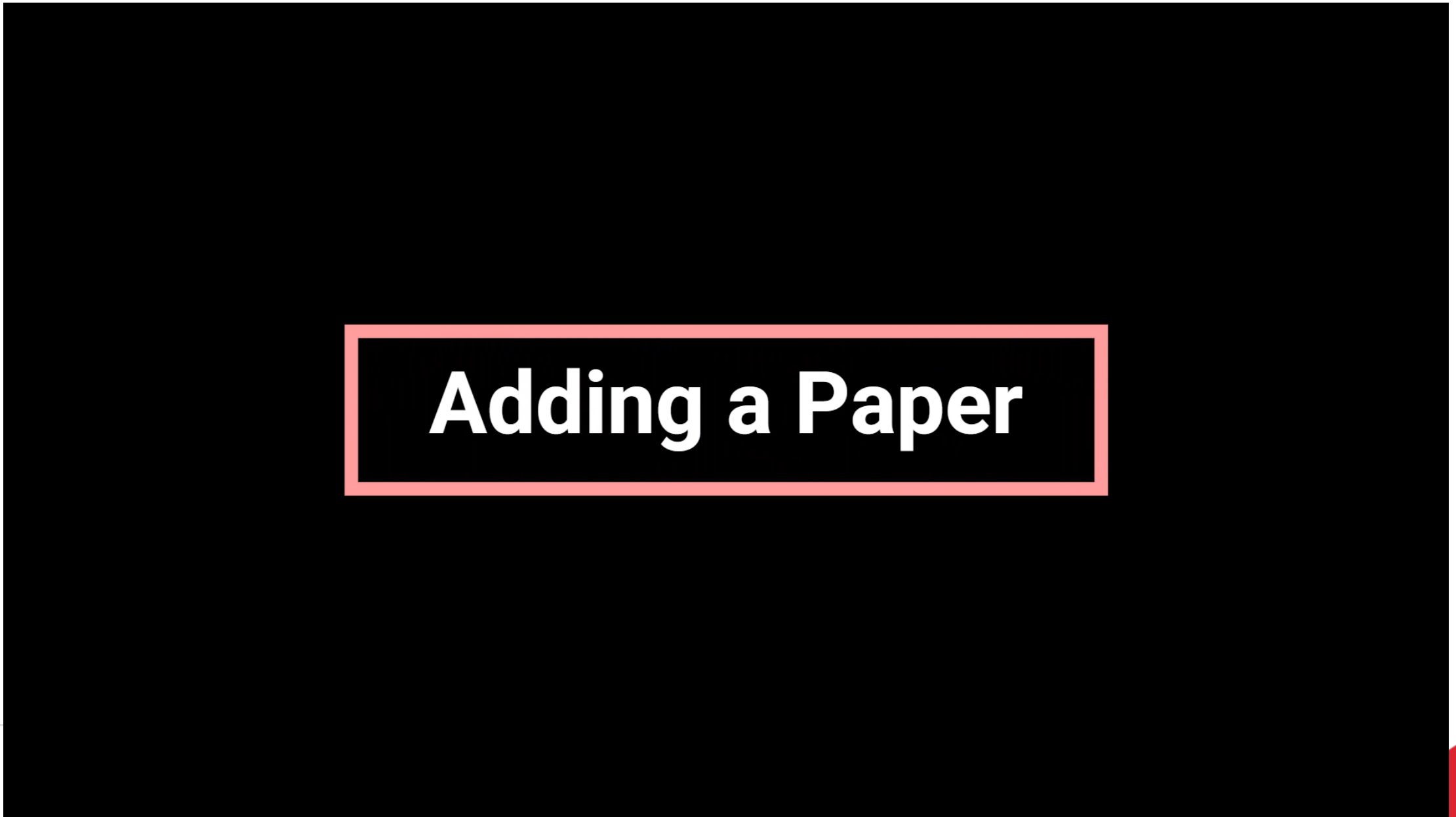


Read Papers & Take Notes

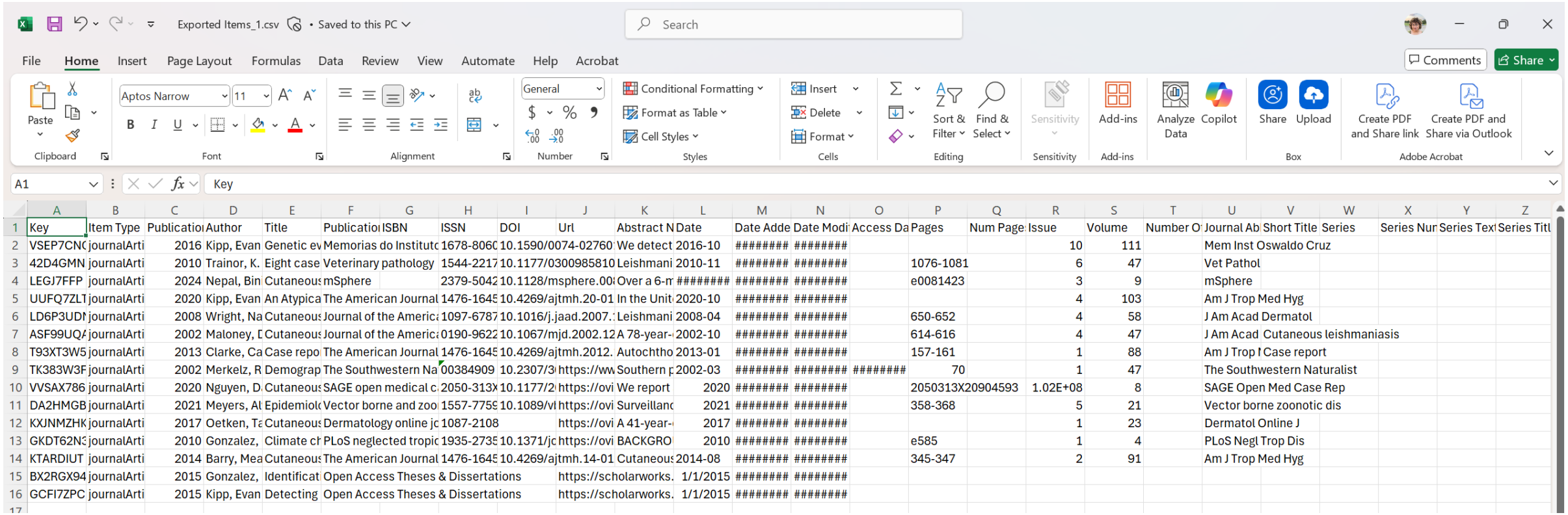


Mobile App

Using Zotero for Reading & Note Taking



Capability to export to .csv



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
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6	LD6P3UDI	journalArti	2008	Wright, Na	Cutaneous	Journal of the Americ	1097-6787	10.1016/j.jaad.2007.1	Leishmani	2008-04	########	########			650-652		4	58		J Am Acad Dermatol						
7	ASF99UQA	journalArti	2002	Maloney, D	Cutaneous	Journal of the Americ	0190-9622	10.1067/mjd.2002.12	A 78-year-	2002-10	########	########			614-616		4	47		J Am Acad	Cutaneous leishmaniasis					
8	T93XT3W5	journalArti	2013	Clarke, Ca	Case repo	The American Journal	1476-1645	10.4269/ajtmh.2012.	Autochtho	2013-01	########	########			157-161		1	88		Am J Trop I	Case report					
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10	VVSAX786	journalArti	2020	Nguyen, D	Cutaneous	SAGE open medical c	2050-313X	10.1177/2	https://ovi	We report	2020	########	########		2050313X20904593		1.02E+08	8		SAGE Open Med Case Rep						
11	DA2HMGB	journalArti	2021	Meyers, Al	Epidemiol	Vector borne and zoo	1557-7759	10.1089/vl	https://ovi	Surveillanc	2021	########	########		358-368		5	21		Vector borne zoonotic dis						
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Note: I also have a python script available to pull manuscripts straight from PubMed by entering MeSH terms.

Ethical Use of AI in Research

Where can LLMs fit in research?

BRAINSTORM

EDITING

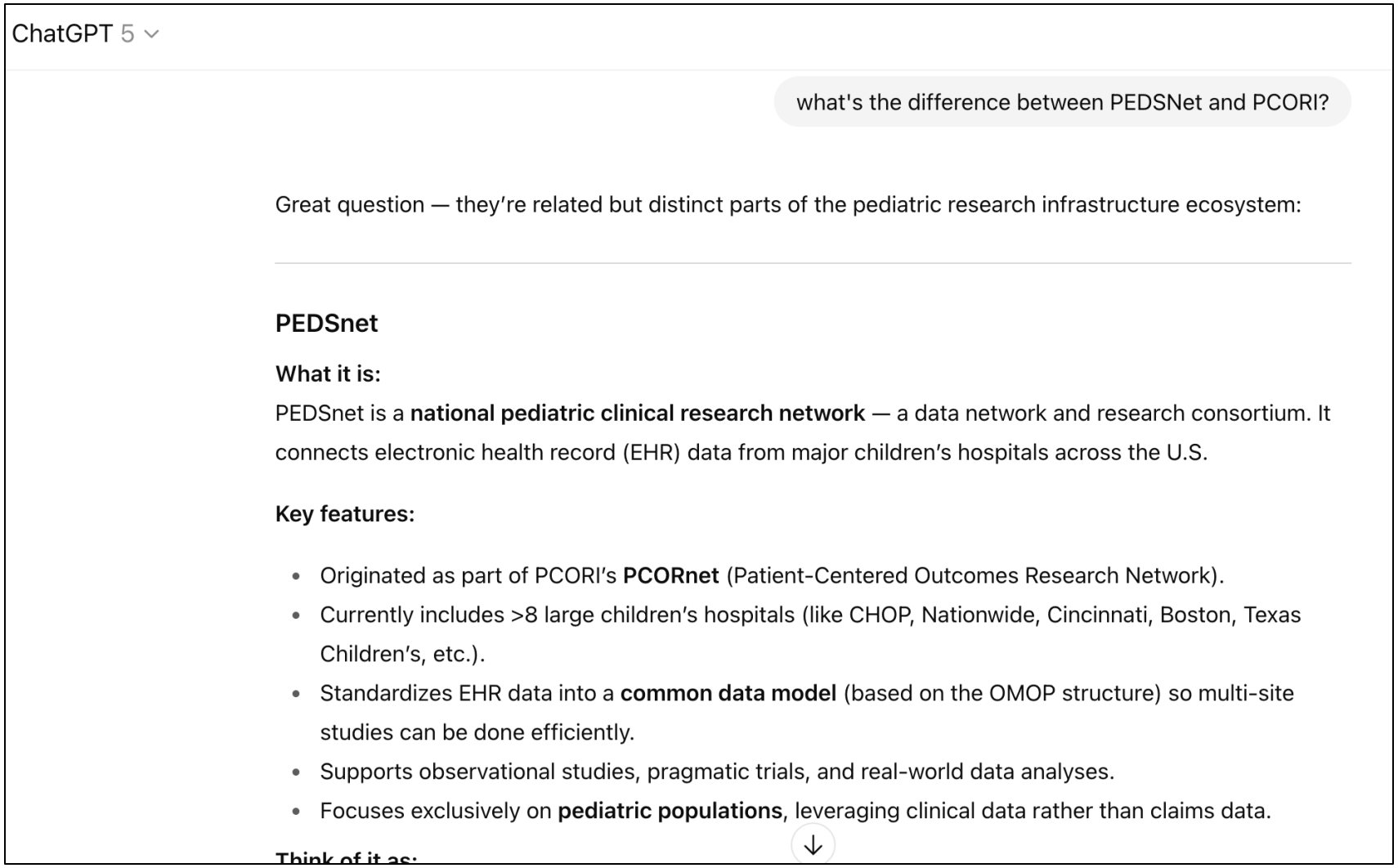
LIT REVIEW

(NOT A SUBSTITUTE)

TRANSLATION

Processing Your Ideas

Microsoft Copilot
ChatGPT



How can LLMs support language?

Clearer English phrasing without changing your message

Faster editing so you spend time on science, not commas

Consistent style & structure across sections

Big risks to watch for

Plagiarism: submitting AI-written text as your own

Fabricated citations or “hallucinations”

Hidden bias: outputs reflect training data bias

Over-reliance: weakens critical skills in reading & writing

Privacy: sensitive or unpublished data

ICMJE (2024) - Essentials

- Be transparent: Acknowledge AI use
- AI tools cannot meet authorship criteria – do not list as authors
- Verify and take responsibility for any AI-assisted text or images
- Do not cite AI as a source; cite the original, verifiable references
- Reviewers/editors: avoid feeding manuscripts into AI without permission

Ethical vs. Unethical

✅ Ethical: language editing of YOUR draft with disclosure

✅ Ethical: summarize literature; verify against originals (you will find mistakes)

❌ Unethical: AI writes entire sections

❌ Unethical: citing AI-invented references

❌ Unethical: delegating your interpretation or

Manuscript Structure using IMRaD

IMRaD Structure

- **I**ntroduction – why this study?
- **M**ethods – what you did
- **R**esults – what you found
- **D**iscussion – What it means

Methods Section

Methods: General

- Often the most critical part of the manuscript
- Describe the research in **enough detail** that another skilled investigator in the field could replicate your study
- Easy place to start = copy and paste the study or clinical protocol
- Tip: You can often draft this section before all results are in!

Methods: Outline

- Create subheadings for methods – may vary based on journal author guidelines
  - **Study design**
  - **Ethical approval**
  - **Study setting**
  - **Population/participants**
    - Inclusion/Exclusion criteria
    - For prospective studies, describe participant recruitment and enrollment as well as randomization procedures
  - **Data collection/source**
    - Administrative database, medical record review, survey, etc.
    - Dependent (disease or outcome), independent (intervention or exposure) variables, and other measures
  - **Data analysis**

Methods - Example

Ajjampur SSR et al. *The Lancet*. 2025;406(10502):475-488. doi:10.1016/S0140-6736(25)00766-4

Methods

Study design and participants

DeWorm3 was a community-wide, cluster-randomised controlled trial comparing biannual community-wide MDA to standard-of-care school-based deworming conducted in Benin, India, and Malawi between Oct 10, 2017, and Feb 17, 2023. DeWorm3 was reviewed and approved by the National Ethics Committee for Health Research (002–2017/CNERS-MS) of the Ministry

study methods are provided here and a detailed description of the methods has been published previously (appendix 2).[15] In each country, predefined geographical areas contained within a single governmental administrative unit and comprising at least 80 000 individuals were selected to be the study sites. Criteria for selection were baseline soil-transmitted

on behalf of their households. Data collected during the census included demographic information (the head of the household or responding adult provided the sex of all

country reporting guidance. WASH facilities were grouped and categorised according to the 2017 WHO–UNICEF Joint Monitoring Programme criteria.[16]

At baseline, 150 participants per cluster were sampled by age-stratified random sampling to include

Study design

Study setting

Ethical approval

Previously published methods

Sampling frame

Selection criteria

Data collection

Variables / Categorization

Sampling

Randomisation and masking

Clusters were randomly assigned in a 1:1 ratio to community-wide MDA or school-based deworming.

Procedures

In intervention clusters, a single oral dose of 400 mg of albendazole was provided biannually for 3 years via community-wide MDA by community drug distributors

Cross-sectional assessments of soil-transmitted helminth prevalence were conducted at the end of the study (24 months following the sixth MDA round;

Outcomes

There were two prespecified primary outcomes, individual-level soil-transmitted helminth infection and cluster-level transmission interruption, both measured by qPCR 24 months after the final round of treatment at

Statistical analysis

All analyses and power calculations to detect differences in prevalence by group and in transmission interruption at the cluster level were conducted in R (version 4.4.2). A

individual's cluster was assigned to, with a two-sided type I error rate of 0·05. Participants were included in the analysis set if, 24 months after the last round of

For ease of interpretation, we estimated the effect as the prevalence ratio for each group using modified Poisson regression with robust variance estimation and

Randomization, if applicable

Comparative groups

Study variables

Outcome(s) & Assessment Method

Power

Software

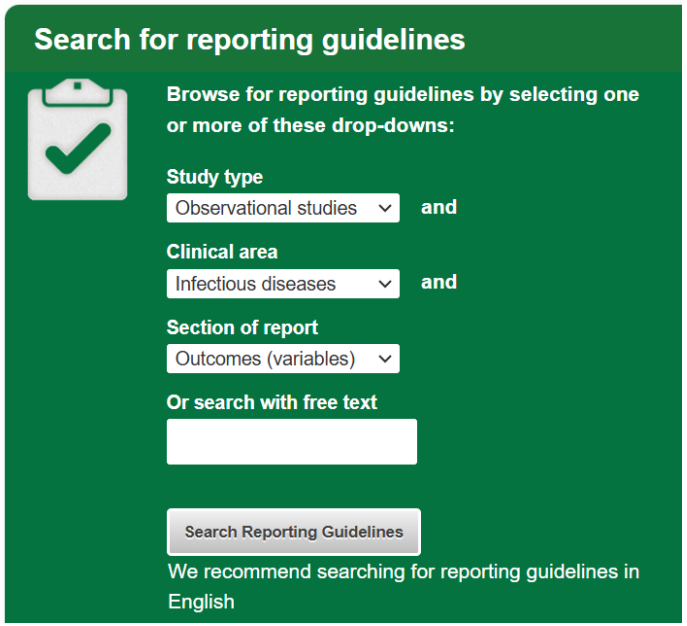
Significance level

Statistical methods

Checklists for Reporting Guidelines

equator network

Enhancing the QUAlity and Transparency Of health Research



Reporting guidelines for main study types

Randomised trials	CONSORT	Extensions
Observational studies	STROBE	Extensions
Systematic reviews	PRISMA	Extensions
Study protocols	SPIRIT	PRISMA-P
Diagnostic/prognostic studies	STARD	TRIPOD
Case reports	CARE	Extensions
Clinical practice guidelines	AGREE	RIGHT
Qualitative research	SRQR	COREQ
Animal pre-clinical studies	ARRIVE	
Quality improvement studies	SQUIRE	Extensions
Economic evaluations	CHEERS	Extensions

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

	Item No	Recommendation
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any prespecified hypotheses
Methods		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection

Statistical Analyses

First, **descriptive analysis**

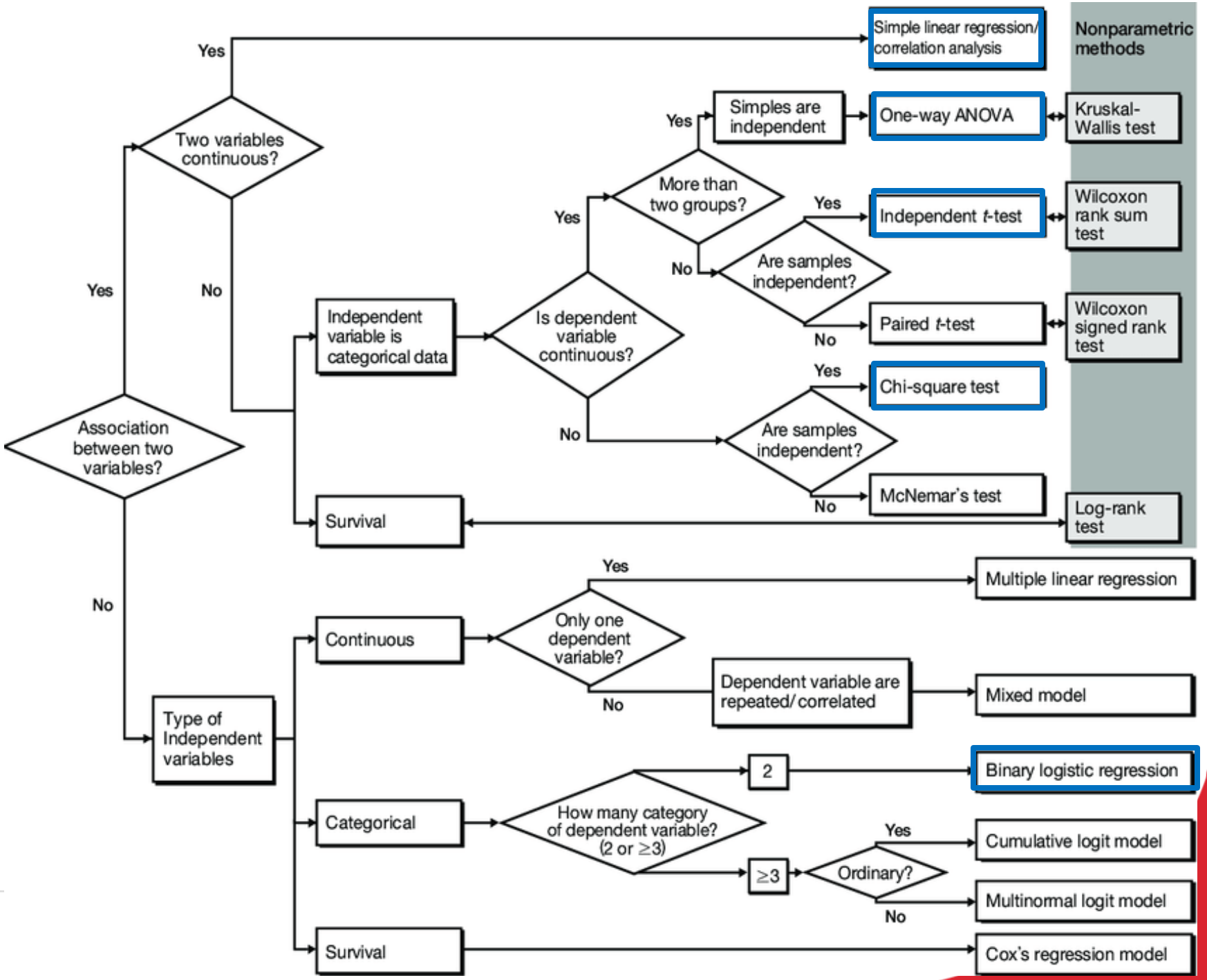
- Use **proportions** and **rates** to summarize data
- Typically mean, SD, proportions (non-normal data = median & inter-quartile range)

Followed by **statistical analyses** to test hypotheses and assess associations

Purpose of Statistical Tests

- Identify **patterns** and **test hypotheses**
- Quantify **uncertainty** and **support conclusions**
- Ensure **objectivity** in data interpretation
- Helps **avoid false or misleading conclusions**

Statistical Approach



Results Section

Results should provide a clear, objective description of your study findings.

1. Start with description of participant/sample characteristics (**proportions, rates, or means ± SD**)
   - Non-normal data = median & inter-quartile range

Outline your results using tables/figures

First paragraph of results & Table 1 are usually description of the study population

A baseline epidemiological survey for malaria and schistosomiasis reveals an alarming burden in primary schools despite ongoing control in Chikwawa District, southern Malawi

Blessings Chiepa [a,b,*], Rex Mbewe [a,c], Michelle C. Stanton [b], Blessings Kapumba [a], Eggrey Kambewa [a], Lucy Kaunga [a], John Chiphwanya [d], Themba Mzilahowa [e], Christopher M. Jones [b], J. Russell Stothard [b]

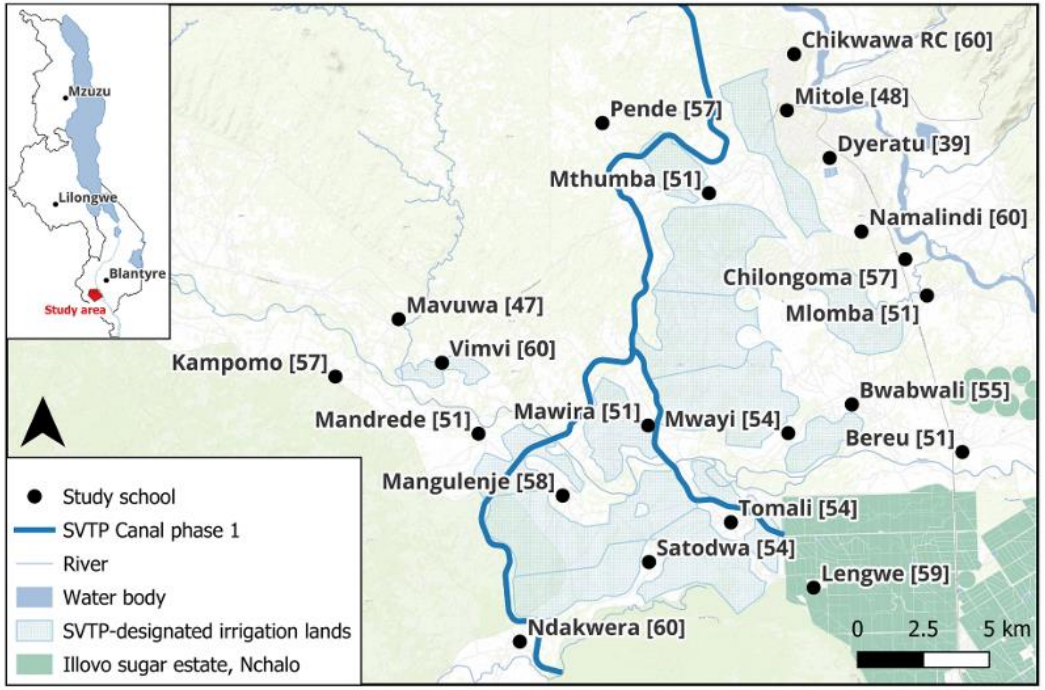


Fig. 1. Map of the study area showing the total number of participants across the 21 sample schools. The inset map on the top left corner shows the study location within Malawi.

Methods

3.1. Demographics and characteristics of study participants

Table 1
Demographics and characteristics of study participants.

Variable	Response	*N*	%
Sex	Female	554	48.9
	Male	580	51.1
Age (years)	8	141	12.4
	9	159	14.0
	10	231	20.4
	11	248	21.9
	12	355	31.3
Self-assessed health	Fine	1003	88.4
	Not fine	131	11.6
Bednet ownership	Yes	923	81.4
	No	211	18.6
Slept under bednet last night	Yes	685	60.4
	No bednet	211	18.6
	No	124	10.9
	No response	114	10.1
Previously taken a malaria test	Yes	1114	98.2
	No	20	1.8
Treated for malaria previously	Yes	1077	95.0
	No	57	5.0
Previous schistosomiasis treatment	Yes	837	73.8
	No	297	26.2
Play or wash in ponds, rivers, etc. near home	Yes	603	53.2
	No	531	46.8
Play or wash in ponds, rivers, etc. at school	No	1089	96.0
	Yes	45	4.0
Type of waterbody at home	NA	531	46.8
	River	442	39.0
	Other	105	9.3
	Dam	50	4.4
	Pond	6	0.5
Type of waterbody at school	NA	1089	96.0
	Other	42	3.7
	River	3	0.3
Total		1134	100

Primary & Secondary Outcomes

3.2. Prevalence of malaria and schistosomiasis
3.3 Malaria and schistosomiasis co-infection

Table 2
Malaria and schistosomiasis prevalence per school.

School name	Malaria prevalence		Intestinal schistosomiasis prevalence		Urogenital schistosomiasis prevalence		Malaria + urogenital schistosomiasis co-infection prevalence		Total no. of participants	Total no. of school enrolment
	n	%	*n*	%	*n*	%	*n*	%	*n*	*n*
Bereu	1	2.0	1	2.0	13	25.5	1	1.9	51	3500
Bwabwali DP	4	7.3	0	0	6	10.9	0	0	55	1693
Chikwawa RC	4	6.7	0	0	30	50.0	3	6.4	60	1269
Chilongoma	3	5.3	0	0	29	50.9	2	3.3	57	633

3.4. Schistosomiasis infection intensity

Table 3
Haematuria results showing visible haematuria in urine as "yes" and not observed as "no". Parasite density (eggs/10 mL urine) as observed by microscopy for urogenital schistosomiasis is reported according to the number of eggs visible.

School name	Visual haematuria		Parasite density (eggs/10 ml urine)			
	No	Yes	0	1–10	10–50	50+
Bereu	44	7	38	6	2	5
Bwabwali DP	54	1	49	4	2	0
Chikwawa RC	58	2	30	9	12	9
Chilongoma	49	8	28	17	5	7

^ Could have opted for graph instead

3.5. Spatial distribution of malaria and schistosomiasis

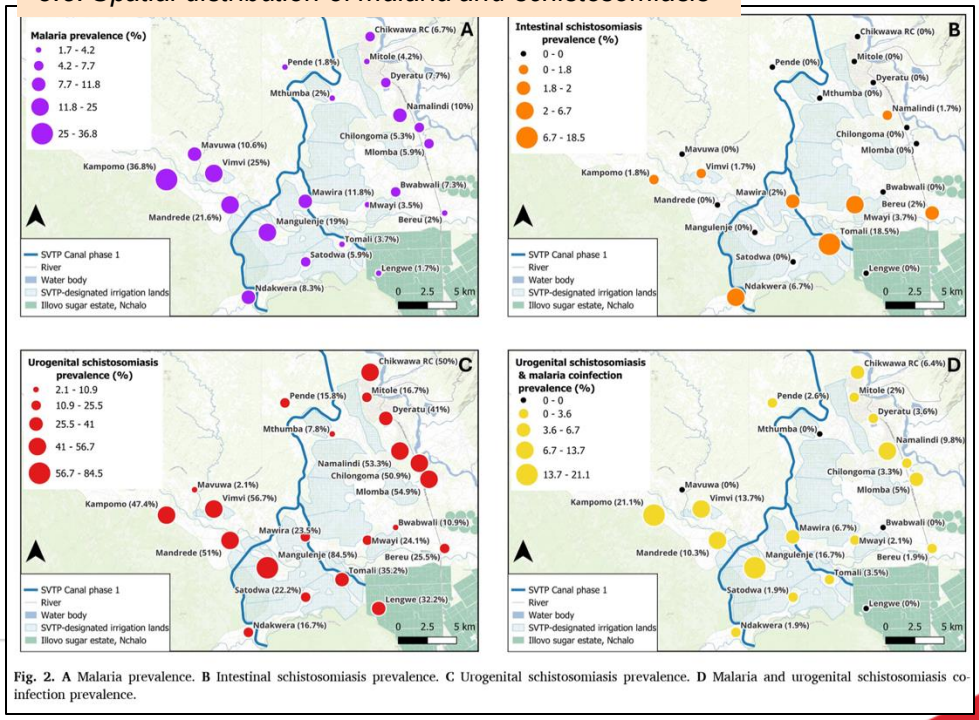
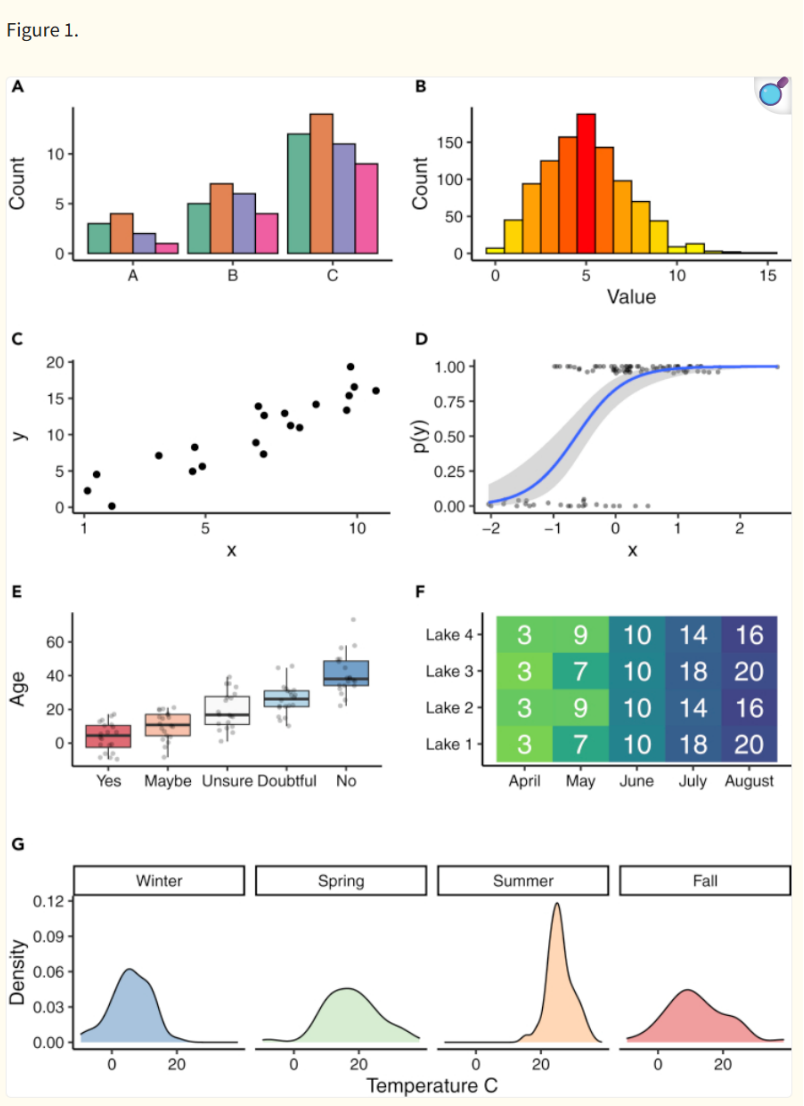


Fig. 2. A Malaria prevalence. B Intestinal schistosomiasis prevalence. C Urogenital schistosomiasis prevalence. D Malaria and urogenital schistosomiasis co-infection prevalence.

Data Visualizations

1. Visualizations should be self-explanatory
2. Use an appropriate **chart type**
3. Take care when choosing colors!
   - Consider colorblindness



Notes on data visualizations

- Tables and figures should be fully interpretable without additional information (including titles and captions)
- Refer to journal instructions for style, formatting, and number requirements

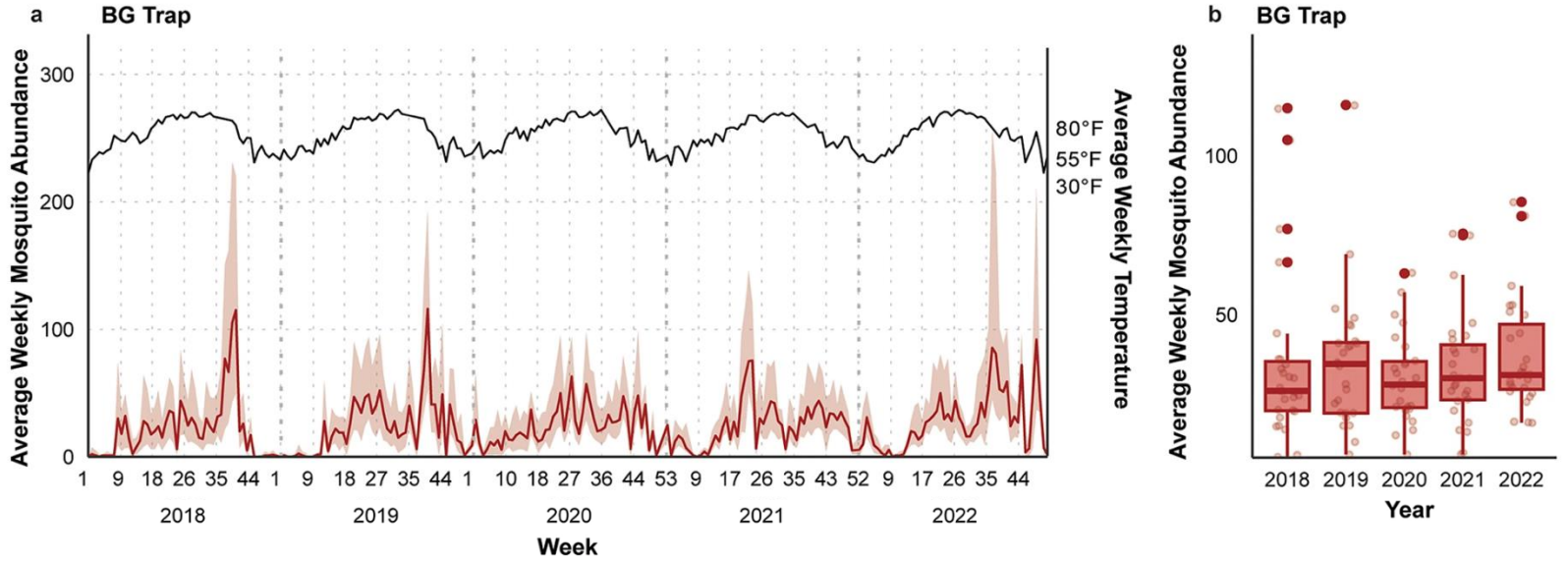


Fig 1. Seasonal and annual variations in mosquito abundance by trap type in Harris County, Texas (2018–2022).
Panels (**a**), (**c**), and (**e**) **display median weekly** mosquito abundance, with **shaded regions** representing the **interquartile range** for (**a**) BG traps, (**c**) gravid traps, and (**e**) CDC light traps placed in storm sewers. The **secondary axis** shows mean weekly temperature. Panels (**b**), (**d**), and (**f**) present boxplots summarizing mosquito abundance from May to October for (**b**) BG traps, (**d**) gravid traps, and (**f**) CDC light traps placed in storm sewers. **In the boxplots, lower and upper fences correspond to the 25th and 75th percentiles, with bars extending to 1.5 times the interquartile range. Statistically significant FDR-adjusted p-values are displayed with asterisks [$p < 0.05$ (*), $p < 0.01$ (**), $p < 0.001$ (***)]. Kruskal–Wallis tests** indicated significant differences in mosquito abundance across years in the gravid and CDC light traps. Post hoc Dunn's tests, corrected for multip le comparisons using the false discovery rate, were performed for pairwise comparisons with significant differences summarized in Supplementary Table S1.

Jibowu et al. 2025. Scientific Reports.

Discussion Section

Discussion & Conclusion – The So What?

- Goal: to state how your findings relate to the published literature
  - Start with a brief description of the main findings (max 3 sentences)
- Questions to ask yourself:

Discussion - Example

4. Discussion

Restate objective, findings, broad interpretation

Our study undertook a contemporary baseline epidemiological survey for malaria and schistosomiasis in primary schools in Chikwawa District, Malawi. Both malaria and schistosomiasis remain alarmingly high. We consider these levels to pose a current and future serious public health problem locally. Moreover, our surveillance comes at a time when the Chikwawa District is undergoing rapid landscape changes due to ongoing irrigation canal construction (Malawi Government, 2023),

First finding, context, comparison, implication

Our study found that the general malaria prevalence across 21 schools was 9.7% (110 out of 1134) with seven out of 21 schools reporting a prevalence equal to or greater than 10%. In terms of recent malaria control activities, there has been IRS in Malawi between 2018 during the next wet season to account for such seasonality. Although malaria prevalence rates have been declining in Malawi (Mategula et al., 2023) and the rest of East Africa region (WHO, 2023), our findings signify that these declines have stagnated and there is more work to be done to reduce the malaria burden to acceptable levels.

Second finding, interpretation & context

The prevalence for urogenital schistosomiasis was 35.0% (397 out of 1134) overall with six schools having prevalences of equal to or greater than 50%. Mangulenje primary school was particularly alarming, having a prevalence of 84.5% (49/58). Field observations also recorded a higher number of participants with advanced schistosomiasis as seen by visual blood in the urine (macro-haematuria) (Table 3). Urogenital schistosomiasis was concentrated in schools along the Shire River and Mwanza River. Furthermore, 442 out of the 1134 participants (39%) reported playing around rivers. Studies have shown that children who regularly swim in rivers are almost 10 times more likely to be infected with schistosomiasis (Ansha et al., 2020). Therefore, the high prevalence of urogenital schistosomiasis in schools along the Shire and Mwanza Rivers is expected. Similarly, the high prevalence of malaria and uro-

Third finding, interpretation & context

The overall prevalence of intestinal schistosomiasis was 1.9% (21 out of 1134) with one school having a prevalence greater than 10%. Although this is a low prevalence, an emergence of intestinal schistosomiasis alongside a high prevalence of urogenital schistosomiasis is a concern that could accelerate into an outbreak as seen in a study along Lake Malawi (Kayuni et al., 2020). The transmission of intestinal

Fourth finding, Interpretation & future directions

In terms of spatial patterning, malaria, and schistosomiasis prevalences were heterogeneous by school. However, a more detailed analysis will follow, particularly incorporating surveys done during the wet season. Schools in the western part of the study area had a high preva-

Recommendations

In the wake of our findings, we recommend that national control programmes reflect on how their programmes are implemented. Whilst malaria control programmes seem to be effective, we support the targeted intervention approach. For instance, there is a need to develop malaria elimination programmes that deliberately target school-going children and primary schools with a high prevalence of malaria. On the other hand, we recommend that authorities investigate Mangulanje

Chilopa et al. 2024. Current Research in Parasitology & Vector-borne Diseases

Discussion: Strengths & Limitations

Goal: to explicitly identify your paper's weaknesses/biases *(before reviewers do!)*

Example Limitations

Discuss:

- Several limitations & impact
- How limitations were avoided or mitigated

This study is subject to limitations. Most notably, the data were derived from routine sources and, therefore, the analysis was complicated by missing data. We addressed this both through careful comparison of the complete case cohort and the full cohort, as well as through imputation. Results were consistent across all methods. However, routine viral load and CD4 data had too much missingness to be evaluated as outcomes following ART initiation. Observational studies evaluating treatment initiation strategies are also subject to immortal time bias, which we addressed through statistical methods, but we cannot exclude residual confounding. Certainly, the high rates of mortality observed in the Kaplan–Meier curves are not attributable solely to the absence of ART initiation. The reduction in the unadjusted and adjusted HRs in the Cox models using a time-dependent variable for timing of ART initiation suggests that we effectively addressed this bias. The clinical settings described in this study, while established as public–private partnerships, are each part of and predominantly supported by the Ministry of Health in each country. The settings are representative of care provided nationally, but with the benefit of caring for a higher volume of CAHIV due to referrals. The CAHIV described may also have more advanced disease due to referral bias but, in general, had immune status that aligned with CAHIV in other studies in other high-burden settings [29]. Due to the prolonged analytic period, there were changes in health policy, and in general, children were initiated on ART after a shorter interval during the most recent study period. This was adjusted for through inclusion of treatment time period in the model. The decreased age, increased malnutrition, and immune suppression among children treated during the most recent time period may reflect a survival bias present among the children treated between 2013 and 2015 but also indicates the ongoing need for improved case finding of CAHIV. Finally, with observational retrospective studies, it is difficult to exclude misattribution errors through inaccurate data entry, although steps were taken to limit this risk through manual data checks. Further, prospective randomized studies are unlikely to be performed to address this question in CAHIV.

Kay et al. 2022. Clinical Infectious Diseases.

Conclusion - short & sweet!

- Final paragraph, sometimes under a separate subheading
- Goal: to state…so what?
  - Summarize your most important take home message(s)
  - Future direction or implication
  - **Don't overstate** your conclusions – must be **justified** by your results

5. Conclusions

Despite ongoing control, our study reveals an alarming prevalence of malaria and schistosomiasis in Chikwawa District. Our data provide contemporary evidence for health policymakers to reflect on how control programmes are being implemented and, looking to the future, how best to monitor landscape changes caused by large-scale irrigation projects and climate change. For example, there is a clear need to introduce integrated control programmes that target school-aged children and recommend further follow-up studies to investigate seasonality effects.

Implication

Future Direction

Conclusion - short & sweet!

- Final paragraph, sometimes under a separate subheading
- Goal: to state…so what?
  - Summarize your most important take home message(s)
  - Future direction or implication
  - **Don't overstate** your conclusions – must be **justified** by your results

CONCLUSIONS

This study provides critical data indicating that rapid initiation of ART, within 2 weeks following initiation of TB treatment, is not associated with an increased risk of death or death and LTFU. The data support existing recommendations from the WHO to initiate ART within 2 weeks in CAHIV who are being evaluated for presumptive TB or who are being treated for HIV-associated TB.

Kay et al. 2022. Clinical Infectious Diseases.

Introduction Section

Introduction: Viewing as a Conversation

Scholarly journals

- ✅ Publish papers
- ✅ Promote scholarly conversations

Think of a manuscript as a contribution to the conversation.

- ✅ Listen & understand (literature search)
- ✅ Demonstrate your knowledge of what's been said (intro)
- ✅ Signal your shared interest & intention (intro)

Lingard et al. 2015. Perspectives on Medical Education; Photos: https://www.animateyour.science; www.freepik.com

To position a manuscript as a compelling conversation turn…

Lingard et al. 2015. Perspectives on Medical Education.

Introduction - Things to discuss

- Background
  - ***How broad should I start?***
    - Depends how much information exists and your target audience
  - **What aspects of the literature should I describe to illustrate current knowledge?**

Introduction - Example

Optimal Timing of Antiretroviral Therapy Initiation in Children and Adolescents With Human Immunodeficiency Virus-Associated Pulmonary Tuberculosis

Alexander Kay [1,2,3,✉,2], Jose Mendez-Reyes [4,5], Tara Devezin [6,7], Meenakshi Bakaya [8], Teresa Steffy [9,10,11], Sandile Dlamini [12], Amos Msekandiana [13], Tara Ness [14,15], Jason Bacha [16,17,18], Pauline Amuge [19], Mogomotsi Matshaba [20,21,22], Moses Chodota [23], Phoebe Nyasulu [24,25,26], Lineo Thahane [27,28,29], Lumumbwa Mwita [30,31,32], Adeodata Kekitiinwa [33,34,35], Andrew DiNardo [36,37], Bhekumusa Lukhele [38,39,40], H Lester Kirchner [41,42], Anna Mandalakas

Identify a problem

People with human immunodeficiency virus (PHIV) are 18 times (uncertainty interval: 15 to 21 times) more likely than human immunodeficiency virus (HIV)–negative people to develop tuberculosis (TB) [1]. Children and adolescents with HIV (CAHIV) also experience increased risk of TB following TB exposure, with increased risk in infancy and adolescence [2–5]. Antiretroviral therapy (ART) reduces TB incidence in CAHIV, but the risk remains elevated above that of HIV-negative children [5, 6].

Children and adolescents with HIV also have a higher risk of death due to TB than their HIV-negative peers. Recent programmatic data from cohorts in Kenya and South Africa suggest that the adjusted hazard ratio (aHR) for mortality ranges from 4.84 to 7.99 in ART-naive CAHIV and 3.69 to 5.11 in CAHIV treated with ART [7, 8]. Children and adolescents with HIV with preserved immune function are at reduced risk of mortality secondary to HIV-associated TB as compared with children with advanced HIV [5].

Establish a gap

Universal and rapid initiation of ART in CAHIV has clear benefits for mortality reduction and improved quality of life [9]; however, concerns about immune reconstitution syndrome (IRIS) and drug interactions have led to uncertainty about the timing of ART initiation relative to TB treatment initiation in CAHIV who are ART naive.

A systematic review of studies in adults was conducted to inform the 2021 World Health Organization (WHO) HIV Guidelines and found that ART initiation within 2 weeks of TB treatment as compared with within 8 weeks resulted in no increase in mortality regardless of CD4 count, and with no difference in viral suppression or AIDS defining events [10]. These data led to a WHO recommendation to initiate ART as soon as possible and within 2 weeks of TB treatment initiation in all PHIV, including CAHIV, given the other known benefits of rapid ART initiation.

Gaps & consequences

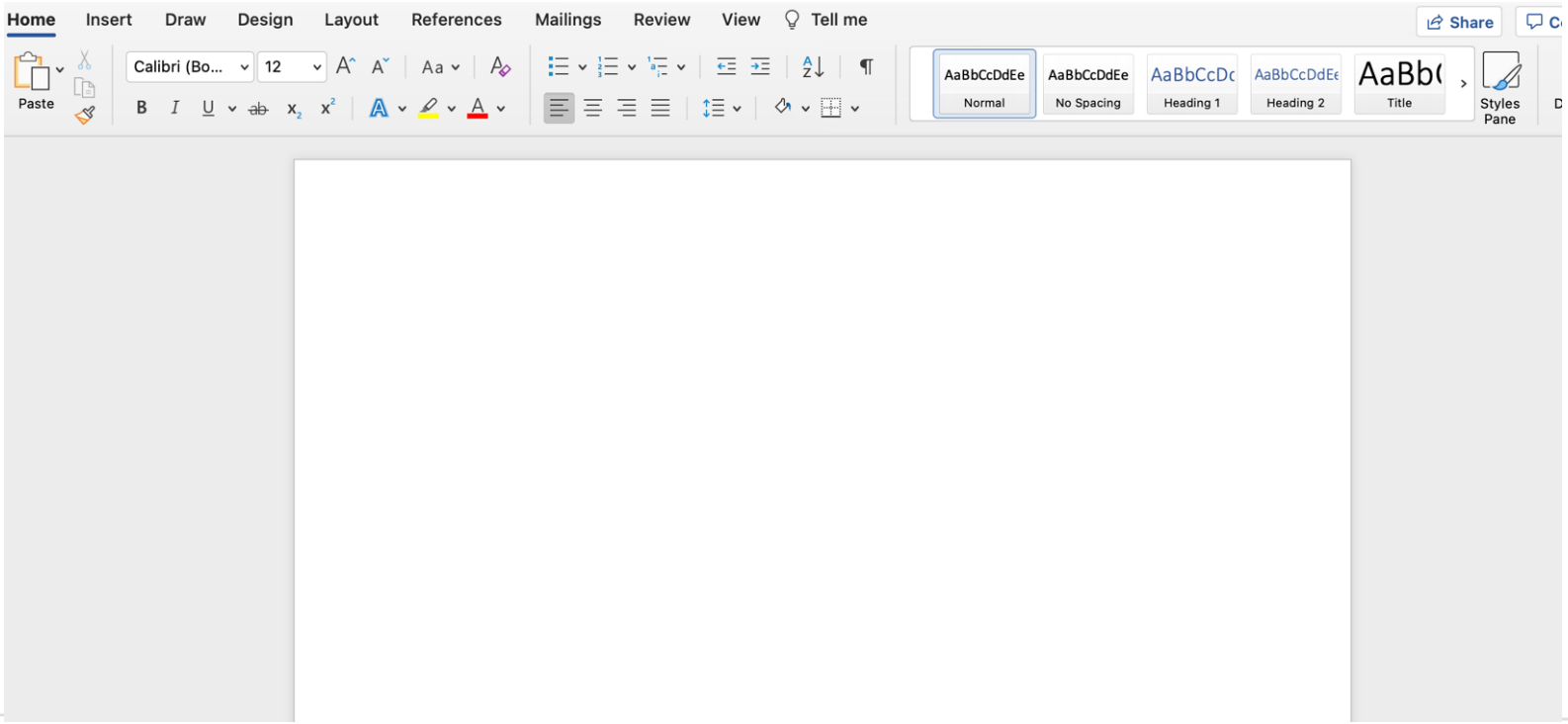
There is a scarcity of evidence in CAHIV to guide the timing of ART initiation from within 2 weeks compared with within 8 weeks of initiating TB treatment. Further, only limited data suggest that ART initiation within 8 weeks of TB treatment improves HIV-associated TB treatment outcomes [11]. To address this knowledge gap, we evaluated the risk of mortality associated with the timing of ART initiation in ART-naive CAHIV treated for pulmonary TB (pTB) in a large, multinational retrospective cohort from TB/HIV high-burden settings throughout sub-Saharan Africa.

Objective

General Writing Tips

General writing tips

- Overcoming inertia
  - Cure for writer's block – just start writing!
  - Perfection is not the goal



General writing tips - writing assignment calculator

- Time management
  - Set deadlines (eg. 6 months from study conclusion)
  - Schedule blocks of time for writing
    - Consider time of day, location

General writing tips

- Stay organized
  - Write with a **specific journal** and **article type** in mind
  - Follow a structure / template /checklist to keep you on track
  - Use **reference management** programs in early drafts to stay organized
    - Avoid going down the reference "rabbit holes" - consider drafting without stopping to look up references, and adding references later

General writing tips

- Collaborative Writing
  - Collaborate with others and hold one another accountable
  - Come up with a plan for circulating draft amongst all authors
  - Get feedback from senior author on an early draft
  - Ask an experienced mentor to review a draft
    - Highlight specific areas for targeted input

Live Poll

- I would like to learn more about…
- Future workshops (open-ended)

Join at menti.com | use code 9171 9933

Resources

Additional Resources

- Your colleagues
- TCH Writing Service
  - writingsupport@texaschildrens.org
  - Team of professional writers based in Houston, TX
  - Will review & polish manuscript drafts (3 week turnaround time)

Thank You!

Heather Haq, MD, MPH
Morgan Sekou, PhD, MPH
Shubhada Hooli, MD, MPH

Workshop: Abstract to Publication

Session Evaluation

A quick, 1-minute “check in” to listen to your views. Your voice matters!

Please Scan the QR code to participate in the Session Evaluation.

https://www.surveymonkey.com/r/NWM2025SessionEval

NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Texas Children's Global Health Network

Oral Abstracts & Discussion: Quality Improvement in Action: Strengthening Systems and Services

Moderators: Dr. Tamanda Hiwa, Dr. Dithan Kiragga

Baylor College of Medicine BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

NWM2025

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Texas Children's Global Health Network

ENHANCING COMFORT & SUPPORT FOR PAEDIATRIC CANCER PATIENTS & THEIR GUARDIANS THROUGH CLEAN & SAFE HOSPITAL ENVIRONMENTS: A QUALITY IMPROVEMENT INITIATIVE AT KAMUZU CENTRAL HOSPITAL(KCH), MALAWI

Memory T. Sabantini, Florence Chilu, Sellina Lemon, Tabitha Chimtengo, Jessie Simkonde

Baylor College of Medicine BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

Agenda

Item 1 : Introduction

Item 2: Purpose

Item 3: Methods

Item 4: Results

Item 5: Conclusion

INTRODUCTION

- Extended hospital stays during cancer treatment causes significant emotional and physical strain on both patients and guardians.
- A clean, safe and supportive environment can significantly improve comfort.
- Data collected in October 2024 at KCH revealed that only 14% of the rooms met the locally developed cleanliness and organisation standards
- Significant risk for infection, safety and discomfort

PURPOSE

- To enhance the cleanliness and organisation of paediatric cancer patient rooms by 80% within five months (October 2024 to February 2025)

  . Creating a more comfortable, supportive and healing environment

METHODS

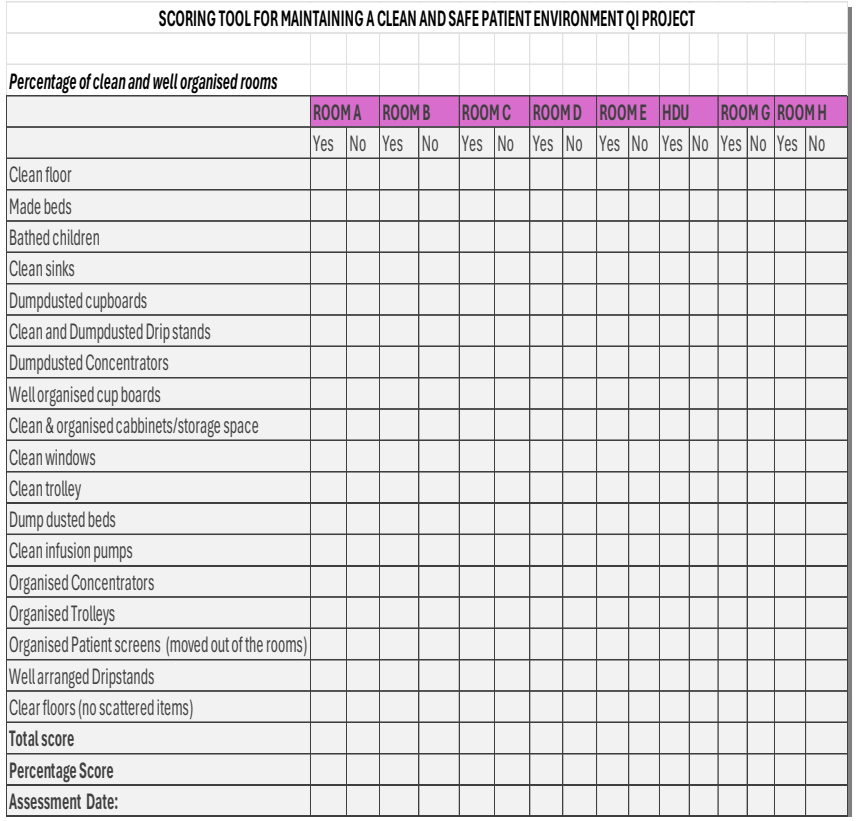
SCORING TOOL FOR MAINTAINING A CLEAN AND SAFE PATIENT ENVIRONMENT QI PROJECT

Percentage of clean and well organised rooms

	ROOM A		ROOM B		ROOM C		ROOM D		ROOM E		HDU		ROOM G		ROOM H	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Clean floor																
Made beds																
Bathed children																
Clean sinks																
Dumpdusted cupboards																
Clean and Dumpdusted Drip stands																
Dumpdusted Concentrators																
Well organised cup boards																
Clean & organised cabbinets/storage space																
Clean windows																
Clean trolley																
Dump dusted beds																
Clean infusion pumps																
Organised Concentrators																
Organised Trolleys																
Organised Patient screens (moved out of the rooms)																
Well arranged Dripstands																
Clear floors (no scattered items)																
Total score																
Percentage Score																
Assessment Date:																

- A locally developed scoring tool assessed cleanliness and organization of patient rooms and overall patient environments
- The tool was tailored to the context and needs of the Unit.
- Two distinct team members pretested the tool and adjustments were made prior to Data collection

METHODS



SCORING TOOL FOR MAINTAINING A CLEAN AND SAFE PATIENT ENVIRONMENT QI PROJECT

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Clean floor																
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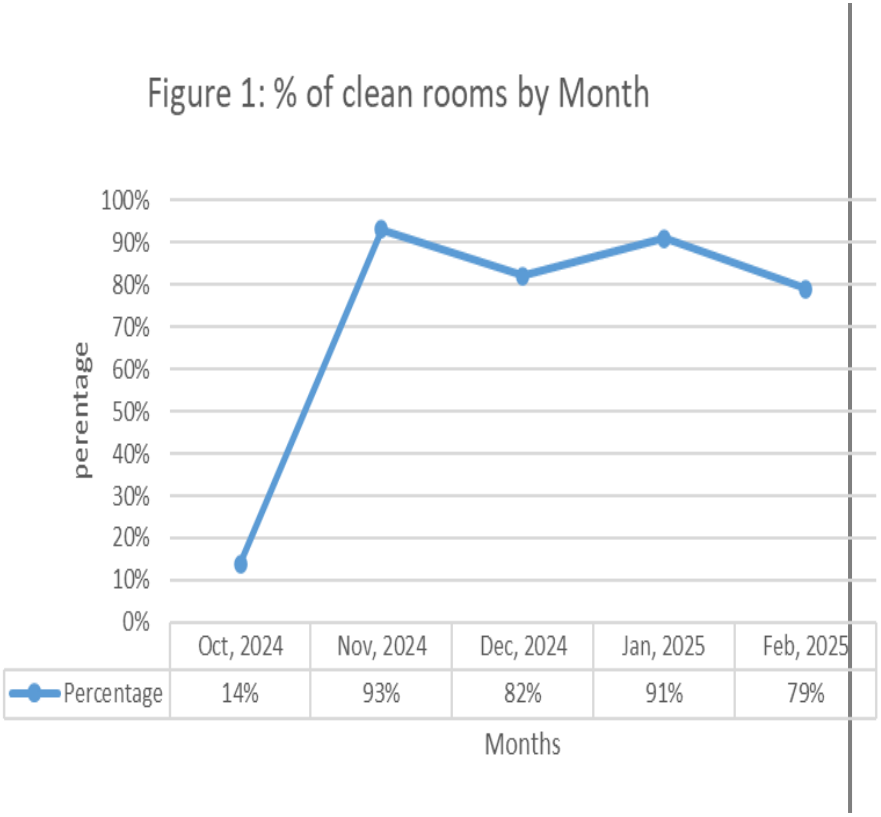
Clear floors (no scattered items)																
Total score																
Percentage Score																
Assessment Date:																

- The tool measured patient and room cleanliness, organization, and equipment arrangement
- Rooms scoring 90% or above were considered clean.
- 41% of the interventions involved guardians' participation and 59% staff involvement
- Guardian satisfaction was measured mainly through observation
- Data was collected and analysed Monthly

RESULTS



- By end February, 86% of patient rooms met cleanliness and organization criteria on average. Although monthly scores varied
- Following a decline in December 2024 (82%), roles were reassigned and additional activities implemented, resulting in a 91% score in January 2025.
- All activities were maintained through February 2025, which saw the lowest score of 79%.
- Resource shortages and staffing challenges impacted some activities
- Guardians satisfaction had improved

CONCLUSION

- Involving guardians as active participants In their child's care/environment; culturally acceptable, low-cost strategy that increases engagement
- A structured approach to improving cleanliness and organization significantly enhances comfort for paediatric cancer patients and guardians.
- Project integration into routine ward activities and ongoing health education on patient and room cleanliness and organisation
- Re-inforce expectations and responsibilities through structured onboarding for both staff and newly admitted patients
- Consistent supply of essential resources: soap, bins and bin-liners, macintosh, beddings, diapers etc
- Guardian satisfaction through interviews/ structured observation tool

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Texas Children's Global Health Network

Viral Suppression Among Children and Adolescents Living with HIV (CALHIV), 0-19 Years in Bukedi, Mid-Eastern Uganda.

Presented by: Charles Amaku

Co-authors: C.A. Amaku[1], F.M. Mugenyi,[1] A. Onyege[1], P. Serunjogi[1], K. Katulege[1], W. Akobye[1], A. Mugume[1], D. Kiragga[2], D. Kwarisiima[3]

Agenda

- Background
- Methodology
- Results
- Lessons learnt
- Next Steps
- Acknowledgements

Background

47,949 PLHIV were active on ART by the end of March 2024.

6.1% of PLHIV on ART were CALHIV (0-19 years).

26.4% CALHIV in the region were receiving ART in the 5 districts of intervention.

>95% VLS rate among adults receiving ART by end of March 2024 while a lower VLS rate, 71% among CALHIV during the same period.

Our objective was to improve VLS from 71% in March 2024 to 90% by December 2024.

Methodology

01 Data Review in the EMR and VL Dashboard

02 Established Multi disciplinary Teams

03 Supported Improved service Delivery systems

04 Harmonised documentation and Data management systems

Delivery System
- Changed mix of clinical care providers.
- Patient visits/appointments.
- Patient flow.
- Home visits.
- Involvement of higher cadres.
- Roles alignment.

Community Resources
- Child Development Centers (CDCs).
- Network of people Living with HIV (PLHIV).
- Schools; leadership & nurses
- Village health teams (VHT).

Self Management
- Target caregivers of CALHIV.
- Enhance family support.
- Set goal for viral suppression.
- Barriers to viral suppression.
- Caregiver/patient literacy.

Decision Support
- Prescriptions & weight bands for pediatric dosages.
- Simplified medication information.
- Simplified Viral load test results interpretation for patients.
- HIVDRT and use of results.
- Early warming signs for VL NS.

Clinical Information System
- Who's coming or not?
- Who's getting better or worse?
- National VL and HIVDRT dashboard
- Uganda EMR & audit tools

CQI team Composition

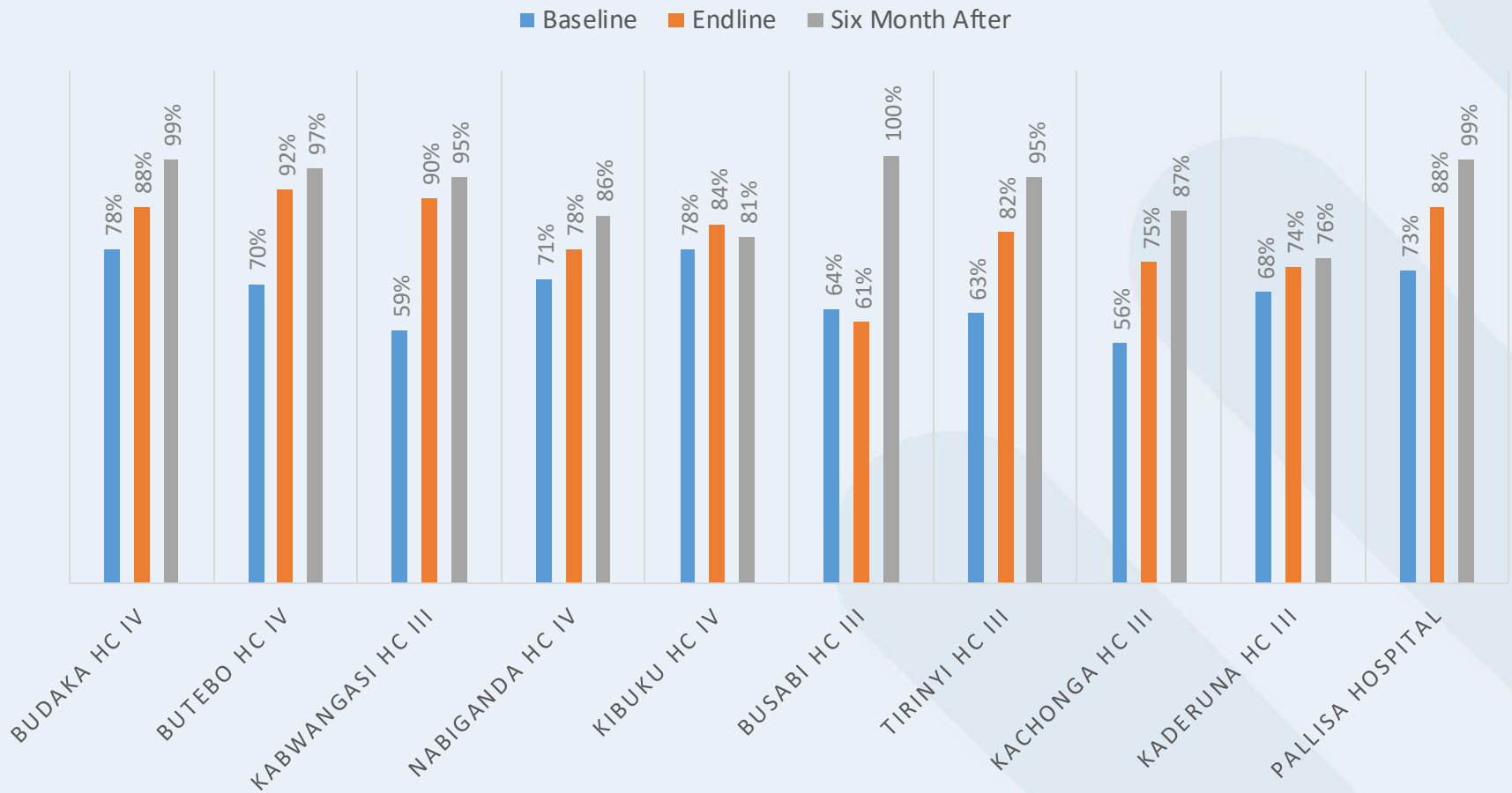
Nurse Counsellors	Clinicians (Doctors, Clinical Officers, Nursing Officers)
• Counducted adherence counseling and assessments • Conducted disclosure support sessions with caregivers and clients. • Led home visits • Documented psycho-social assessment and adherence counseling in physical and electronic records. • Led psycho-social components of switch and case discussions	• Case reviews and management. • Led switch and clinical case discussions. • Home visits to selected clients. • Updated client records in EMR. • Managed and scheduled patient appointments.
Project/District Staff (Doctors, Public Specialist, Social Workers)	**Community Health Workers (Expert Clients, Peers, VHTs)**
• Coordinated different sites participating sites. • Mentored and coached clinical, and psycho-social care providers. • Tracked Viral Load (VL) and HIVDRT results. • Participated in home visits for selected patients • Supported dissemination of clinical care protocols. • Conducted analysis and monitored the progress of the intervention.	• Pre-appointment and Pre-medication reminders • Coaches/Mentors for DOTs • Patient literacy • Adherence assessment/scores • Linkage or navigation to services • Disclosure support • Prepared clients for home visits

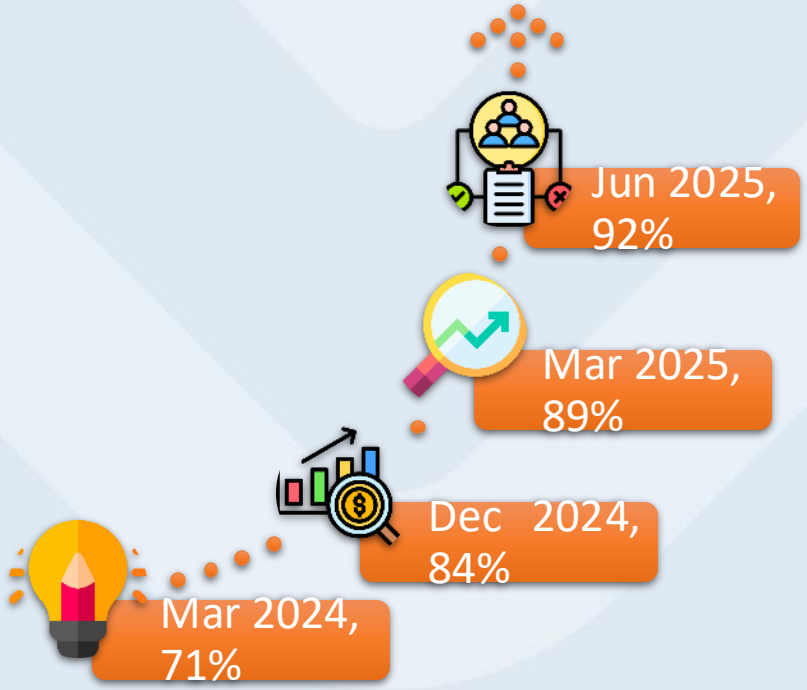
What we did in pictures

Key Interventions: patient chart reviews, home visits, caregiver literacy, & clinical decision support during patient encounters

Results

VIRAL LOAD SUPPRESSION AT INTERVENTION SITES AT BASELINE, END LINE AND SIX MONTHS POST INTERVENTION





Lessons Learnt and Next Steps

Lessons Learned

No additional funds were required to support the intervention

Self support system developed through the identification and utilization of influential and committed family members.

Single intensive adherence counseling was followed by adherence reminder phone calls

Need to prioritize Paediatric Regimens. Sites like Kibuku HC IV and Nabiganda HC IV had periods of stockout

Start small and with priority intervention sites and spread to other sites.

Peer-to-peer learning transferred skills to non-intervention sites.

Next Steps

Sustain

Interventions for Self-management, clinical decisions, delivery system, and use of community resources

Scale Up

Intervention to other Health Facilities.

Monitor

Supply chain for commodities for Paediatric ARVs

Conduct

Rapid scale-up of intervention using staff and quality improvement teams

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Texas Children's Global Health Network

Enhancing Voluntary Medical Male Circumcision Service Quality In Mubende Region, Uganda: A Local Government-led Approach

Presenter: Henry Kalungi

Co-authors: Evelyn Nabulime, Richard Jjuuko, Silaas Mutimba, Isooba Lubogo Patrick, Samuel Aheebwa, Zalwango Annet, Micheal Juma, Dithan Kiragga

Agenda

Background

Description

Evaluation and outcomes

Lessons learnt

Next Steps

Background

NATIONAL MANDATE

The Ministry of Health (MoH) Uganda adopted a "**National Safe Medical Circumcision policy**" recommending VMMC services for all men.

VMMC is defined as a critical component of the national HIV combination prevention strategy.

VMMC PREVENTIVE INDEX

60%

Reduction in HIV transmission Risk

VMMC significantly reduces the risk of heterosexual HIV acquisition among circumcised men

THE LOCAL GAP

76%

Service Quality Score

In Mubende region, service quality was low (74/98) as of **March 2023**

Root Cause: Reliance on **'Roving VMMC teams'** (non-resident, non-district staff), making quality **monitoring and sustainment** difficult

This performance gap highlighted the critical need to:

Establish sustainable, district-owned structures to monitor and provide VMMC quality services

Description

DIAGNOSIS & STRATEGY

Conducted a **service quality assessment** using an MoH-approved tool.

Prioritized Gaps

- Limited trained personnel & outdated SOPs
- Inadequate logistics (stock-outs)
- Poor IPC and weak post-op follow-up

Output: Data-based micro-plans developed by District Teams, aligned with PEPFAR priorities.

SUSTAINED QUALITY & MONITORING (CQI)

Real-Time Improvement

- Sites monitored quality aims through **weekly journals**
- Tested innovations using **Plan-Do-Study-Act (PDSA)** cycles

Client Support System

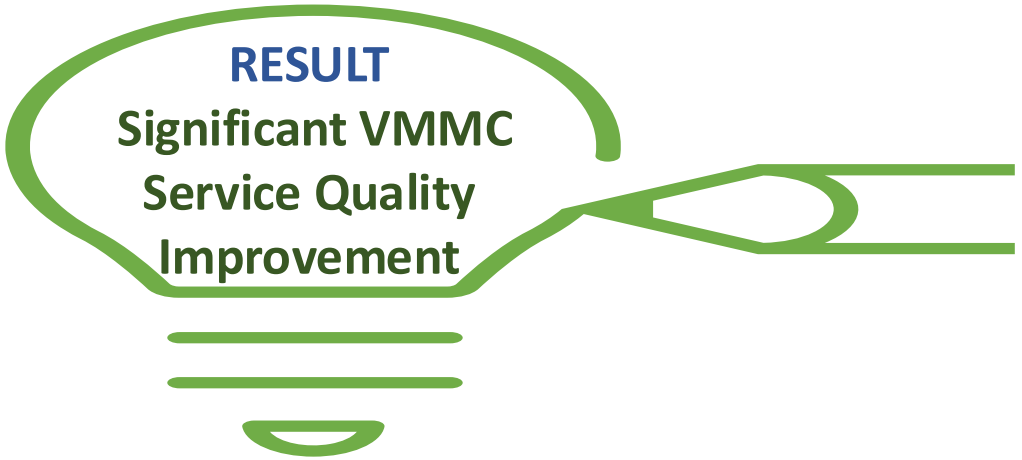
- **BFU Toll-Free Number** provided to every client.
- Used for **continuous** support, counselling, adverse event (AE) reporting, and follow-up

CAPACITY BUILDING & ACCREDITATION

20 Health Care Workers trained

Infrastructure & Disseminated Equipment and SOPS

District VMMC FP Monitored Supplies Weekly



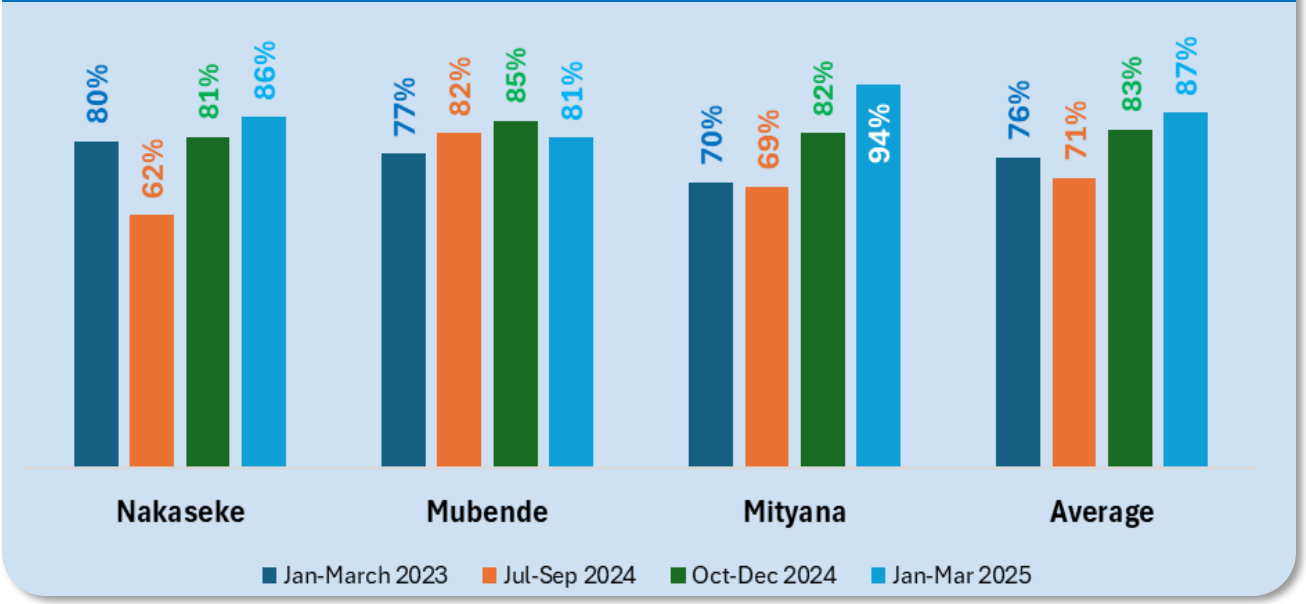
Evaluation & Outcomes

76%
BASELINE QUALITY SCORE
March 2023

+11%
ABSOLUTE GAIN

87%
FINAL QUALITY SCORE
Jan – March 2025

TRENDS OF VMMC SERVICE QUALITY EQA SCORES



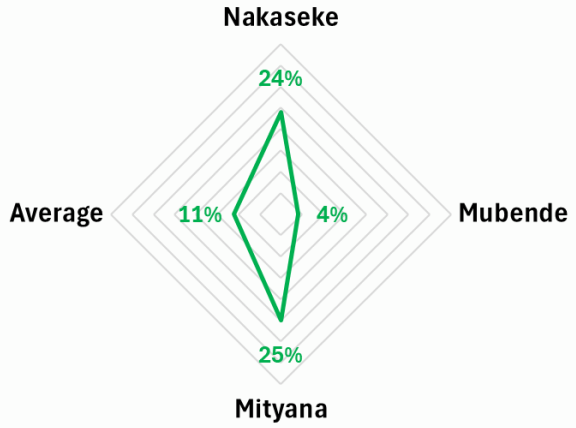
SUSTAINABILITY

External **"Roving teams"** eliminated to Resident-trained **district VMMC teams**

SAFETY & CLIENT CARE

AE rate below 2% predicted National AE Rate

Follow up by BFU **toll-free**



Percentage Improvement

Lessons Learnt, Next Steps & Acknowledgement

Lessons Learnt:

- ✓ Training of a larger pool of VMMC teams mitigates gaps caused by abrupt transfers of staff.
- ✓ The local government-led approach led to sustained gained of VMMC service quality.
- ✓ Continuous Quality Improvement (QI) models and close monitoring enabled significant improvement.

Next Steps:

1. Scale Up the Local Authority-led approach to other districts in Uganda
2. Sustain quarterly VMMC quality assessments and mandated data use for continuous and proactive decision-making

Acknowledgements:

MOH, District Local Governments of Nakaseke, Mubende & Mityana

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Texas Children's Global Health Network

More Than a Pilot: Lesotho QI Basics Course Takes Flight

R. Mahlaha, M. Ndaule, P. Khali & P. Kuleile

Baylor College of Medicine BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

Overview

- Background
- Methods
- Results
- Successes and challenges
- Conclusions and next steps

Background

Quality Improvement Community of Practice supports program and project development within the Network.

Improving knowledge about QI methodology was a priority for participants.

The QI Basics curriculum was developed by colleagues in Houston and piloted across the Network in 2024.

Baylor Lesotho rolled out the initiative to the COE and five satellites (SCOEs) using a step-down training model.

Our aim was to foster a culture of continuous improvement by enhancing staff capacity to successfully use QI to improve service delivery.

Methods

Train-the –trainer approach

Selected participants from COE and all staff from five satellite COEs.

Champions at each site conducted the step-down trainings and coordinated communication with participants and the COE through a WhatsApp group.

Collaborative prioritization and hands-on learning

Participants encouraged to identify and prioritize site-specific opportunities for improvement.

Using QI tools, participants designed QI projects address issues at their sites and within their departments.

Results

Effectiveness of step-down model

- Course completion:
  - Peer-led sessions supported consistent participation.
  - Course completion: 100% and 90% participants at the COE and the 5 SCOEs respectively.
- Knowledge acquisition:
  - Participants reported having gained an understanding of the use of QI basic tools and concepts.

Capacity building:

- Facilitators reported increased confidence.
- QI activities integrated into routine QI meetings.
- From intervention to implementation: all sites initiated at least one QI project.

Successes

The train-the-trainer model was highly successful:

Participation and course completion rates were high.

Knowledge acquisition was strong, as indicated by post-test results .

Revitalized and new QI activities:

Dormant projects resumed and new projects were initiated.

Enhanced collaboration:

Improved teamwork, idea-sharing, volunteerism.

Collaboration between SCOEs and COE.

Capacity building:

100% staff participation in some of the sites, and increased ability of staff to use QI tools.

Structural impact:

Establishment of local QI committee to oversee QI initiatives Foundation-wide.

Challenges

Misperceptions:

Some staff viewed QI as a "blame tool".

Data quality concerns:

Documentation errors led to scepticism about baseline metrics.

Complexity barriers:

Indicators and tools required simplification for broader accessibility.

Lessons Learned

Localization:

- Importance of adapting material to local context and including Inclusive design:
- Future iterations must include patients and caregivers.

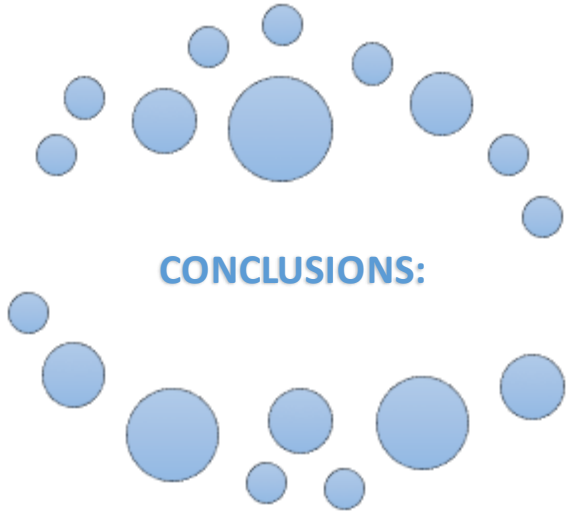
Sustained engagement:

- Addressing cultural resistance by framing QI as a **shared improvement goal**.

Next steps and conclusions

Next steps

Simplification & translation:	Streamlining content, providing Sesotho resources.
Expanded stakeholder reach:	Developing a patient/caregiver module for informed engagement.
Strengthen data culture:	Training teams on documentation standards to build trust in metrics.



The QIB course roll-out objectives achieved.

Teams empowered to lead improvement projects and collaborate effectively.

Addressing linguistic and complexity barriers will democratize QI participation and sustain gains.

Acknowledgements

Thank you
(Rea leboha)

- The Executive Director, Dr. Thahane
- The Medical Director, Dr. Isaac
- The Technical Director, Dr. Sekese
- The Head Nurse, ‘M’e Esther
- All QI Basics Course Trainers
- All QI Basics Course Participants

“A journey of a thousand miles begins with a single step.”
~ Lao Tzu

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Texas Children's Global Health Network

Expert Consensus on Quality Measures for the Management of Severe Malaria Complications in Children Under Five in Sub-Saharan Africa: A Modified Delphi Study

Authors: Shenila Lallani, MD, Joyee Vachani, MD, MEd, Krystle Bartley, BS, Elizabeth Davis, MD, Emily Hartford, MD, MPH, Rishi Mediratta, MD, MSc, MA, Stephen Oguche, MBChB, Sheila Owusu, MBChB, MPH, Heather Haq, MD, MHS

Baylor College of Medicine BAYLOR GLOBAL HEALTH

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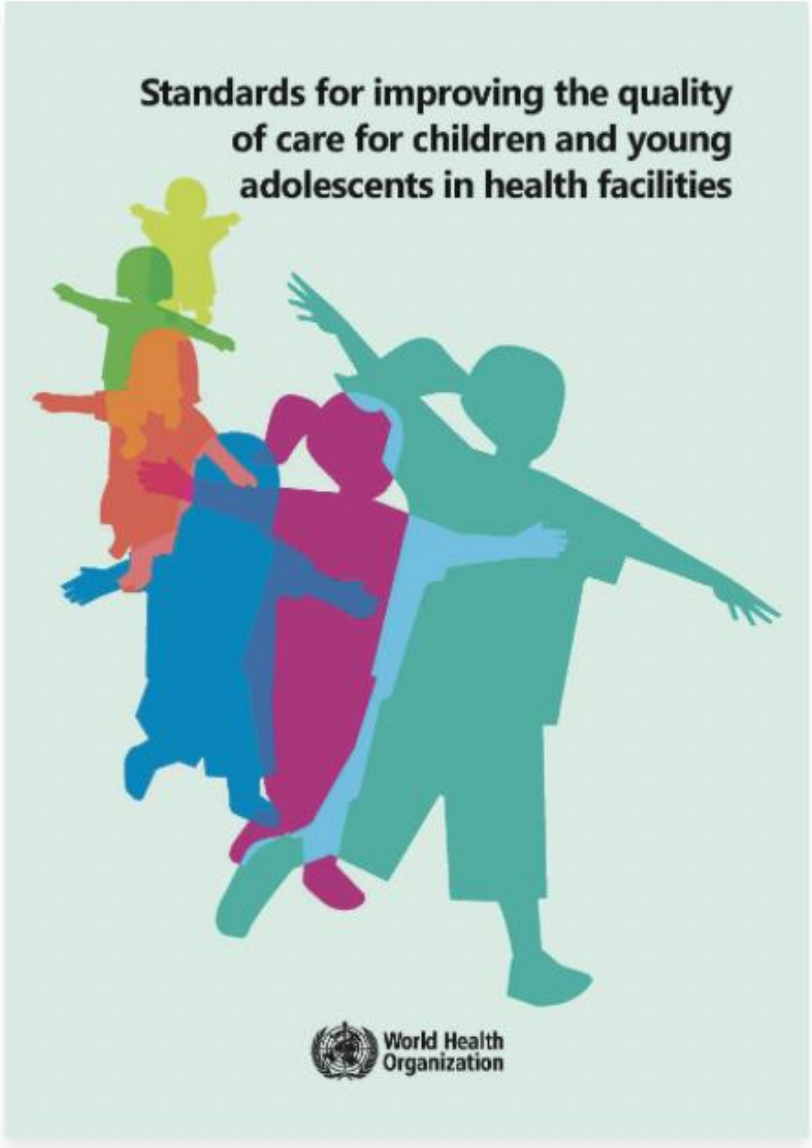
Background

- Malaria remains a leading cause of mortality among children under five in low-and-middle-income countries (LMICs).
- ~420,000 deaths occur annually in children under 5 due to complications of malaria
  - More than 90% of these deaths occur in sub-Saharan Africa
- Estimated 134 million adverse events during hospitalizations in LMICs that lead to 2.5 million deaths annually
- Management of severe malaria and its complications are not included in existing WHO Standards for Improving the Quality of Care for Children/Adolescents

Study Aim

- To expand quality measures for management of severe malaria and its complications in children under 5 admitted to tertiary care hospitals in sub-Saharan Africa
- The study employed the modified Delphi technique to derive expert consensus on the quality measures.
- These measures built on the quality measures currently presented in the WHO's *Standards for improving quality of care*.



Methodology

Recruitment Process for Delphi Panelists

- Call for nominations distributed via global health subcommittee listservs of major national pediatric organizations
- Selected panelists offered $200 as compensation for their time and expertise

Inclusion criteria	Panelist Selection	Exclusion criteria
- Physicians with minimum 3 years' post medical school experience, working as a frontline provider in pediatric hospital units in sub-Saharan Africa - Proficient in English	47 nominated, **14 from 9 countries** selected based on: • Clinical experience • Malaria-specific expertise • Research experience and scholarly dissemination • Local and national collaborations • Experience in QI and health systems development • Overall enthusiasm	- No more than 2 experts from one country - Lack of availability during the study timeframe.

Creation of Initial Quality Measures (QM)

- The study team drafted an initial set of 37 quality measures
  - Derived from multiple sources and modeled after those in the WHO's *Standards for Improving Quality of Care*
- QMs categorized into input, process/ output measures, and outcome measures
- Focused on the 4 most common causes of morbidity and mortality of severe malaria:
  - Severe anemia
  - Cerebral malaria
  - Hypoglycemia
  - Acute kidney Injury

What must be in place to provide desired care

Input

Whether the desired process of care was provided

Process/Output

Effect of provision & experience of care on health and people-centered outcomes

Outcome

Delphi Process

Round	Panelist Task	Study Team Task
1	Review the initial quality measures **3-prong Evaluation Strategy** - Approve the QM as is - Approve with Modifications (provide recommendations) - Reject the QM	Analyze panelist response based on consensus threshold below: • >80% Approve -> QM achieved consensus • >50% Reject -> QM abandoned • <80% Approve, <50% reject -> QM modified based on panelist recommendations
2	Review the modified quality measures from round 1 **3-prong Evaluation Strategy** - Approve the QM as is - Approve with Modifications (provide recommendations) - Reject the QM	Analyze panelist response based on consensus threshold below: • >80% Approve -> QM achieved consensus • >50% Reject -> QM abandoned • <80% Approve, <50% reject -> QM modified based on panelist recommendations
3	Review the modified quality measures from round 2 **2-prong Evaluation Strategy** - Approve the QM as is - Reject the QM	Analyze panelist response based on consensus threshold below: • >80% Approve -> QM achieved consensus • <80% Approve -> QM abandoned
4	Evaluate each QM using the National Quality Forum Criteria **5-Point Likert Scale** Importance, Scientific Acceptability, Usability, Feasibility	Determine mean for each QM and each criteria

Results, Conclusions, Next Steps

Results

Surveys

- 3 Iterative Rounds
- Achieved Consensus on all 37 measures

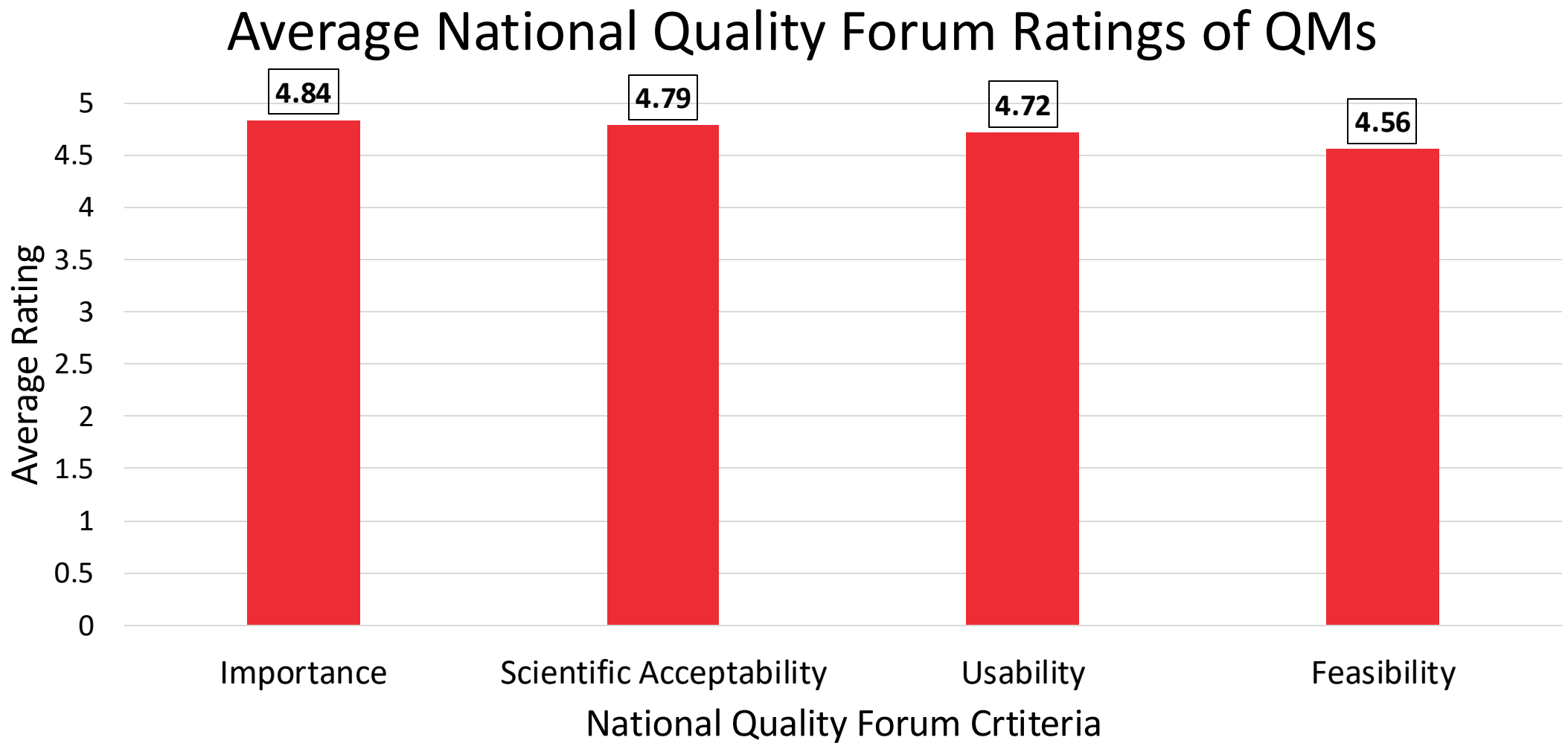
Quality Measures

- Proper assessment, investigation, and treatment of complications
  - cerebral malaria
  - severe anemia
  - acute kidney injury
  - hypoglycemia

Quality Measures

- 9 Input Measures
- 24 Process/ Output Measures
- 4 Outcome measures

Results Round 4



Take Aways and Next Steps

- Successfully utilized a modified Delphi method to achieve expert consensus on a set of 37 QMs for the management of complications of severe malaria
- Strengths:
  - Diverse representation of experts from different regions of SSA
  - 100% participation from panelists in all 4 rounds
  - None of the proposed measures met threshold for reject
- Weaknesses:
  - Virtual approach limited limited interactive discussion between panelists
  - Excluded experts from Francophone countries and those where English is not as widely spoken
- Next steps: these QMs can serve as a foundation for hospital-based QI initiatives to optimize pediatric malaria care

Final QMs

References

National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Health Care Services, Boardon Global Health, Committee on Improving the Quality of Health Care Globally. Crossing the Global Quality Chasm: Improving Health Care Worldwide. Washington (DC): National Academies Press (US), 2018 http://www.ncbi.nlm.nih.gov/books/NBK53565

English, M., Esamai, F., Wasunna, A., Were, F., Ogutu, B., Wamae, A., Snow, R. W., & Peshu, N. (2004). Delivery of paediatric care at the first-referral level in Kenya. *Lancet (London, England)*, *364*(9445), 1622–1629. https://doi.org/10.1016/S0140-6736(04)17318-2

Hoque, D. M., Rahman, M., Billah, S. M., Savic, M., Karim, A. Q., Chowdhury, E. K., Hossain, A., Musa, S. A., Kumar, H., Malhotra, S., Matin, Z., Raina, N., Weber, M. W., & El Arifeen, S. (2012). An assessment of the quality of care for children in eighteen randomly selected district and sub-district hospitals in Bangladesh. *BMC pediatrics*, *12*, 197. https://doi.org/10.1186/1471-2431-12-197

Sidik, N. A., Lazuardi, L., Agung, F. H., Pritasari, K., Roespandi, H., Setiawan, T., Pawitro, U., Nurhamzah, W., Weber, M. W., & Indonesian Paediatric Hospital Assessment Group (2013). Assessment of the quality of hospital care for children in Indonesia. *Tropical medicine & international health : TM & IH*, *18*(4), 407–415. https://doi.org/10.1111/tmi.12061

Lazzerini, M., Shukurova, V., Davletbaeva, M., Monolbaev, K., Kulichenko, T., Akoev, Y., Bakradze, M., Margieva, T., Mityushino, I., Namazova-Baranova, L., Boronbayeva, E., Kuttumuratova, A., Weber, M. W., & Tamburlini, G. (2017). Improving the quality of hospital care for children by supportive supervision: a cluster randomized trial, Kyrgyzstan. *Bulletin of the World Health Organization*, *95*(6), 397–407.

Shields, L., Zhou, H., Pratt, J., Taylor, M., Hunter, J., & Pascoe, E. (2012). Family-centred care for hospitalised children aged 0-12 years. *The Cochrane database of systematic reviews*, *10*, CD004811. https://doi.org/10.1002/14651858.CD004811.pub3

Austin A, Langer A, Salam RA, Lassi ZS, Das JK, Bhutta ZA. Approaches to improve the quality of maternal and newborn health care: an overview of the evidence. Reprod Health. 2014;11(Suppl 2):S1

World Health Organization. (2018). Standards for improving the quality of care for children and young adolescents in health facilities. Geneva: World Health Organization.

De Vos, M., Graafmans, W., Kooistra, M., Meijboom, B., Van Der Voort, P., & Westert, G. (2009). Using quality indicators to improve hospital care: a review of the literature. *International Journal for Quality in Health Care*, *21*(2), 119–129. https://doi.org/10.1093/intqhc/mzn059

Kavanagh, P. L., Adams, W. G., & Wang, C. J. (2009). Quality indicators and quality assessment in child health. *Archives of disease in childhood*, *94*(6), 458–463. https://doi.org/10.1136/adc.2008.137893

Miller MR, Elixhauser A, Zhan C. Patient safety events during pediatric hospitalizations. *Pediatrics* 2003; 111: 1358–66.

McDonald K, Romano P, Davies S, *et al.* Measures of pediatric health care quality based on hospital administrative data: The pediatric quality indicators: Prepared for the Agency for Health Care Research and Quality. AHRQ, 2006.

Quach, A., Tosif, S., Nababan, H., Duke, T., Graham, S. M., Were, W. M., Muzigaba, M., & Russell, F. M. (2021). Assessing the quality of care for children attending health facilities: a systematic review of assessment tools. *BMJ global health*, *6*(10), e006804. https://doi.org/10.1136/bmjgh-2021-006804

References

Perin, J., Mulick, A., Yeung, D., Villavicencio, F., Lopez, G., Strong, K. L., Prieto-Merino, D., Cousens, S., Black, R. E., & Liu, L. (2022). Global, regional, and national causes of under-5 mortality in 2000-19: an updated systematic analysis with implications for the Sustainable Development Goals. *The Lancet. Child & adolescent health*, *6*(2), 106–115. https://doi.org/10.1016/S2352-4642(21)00311-4

Chilot D, Mondelaers A, Alem AZ, Asres MS, Yimer MA, Toni AT, Ayele TA. Pooled prevalence and risk factors of malaria among children aged 6-59 months in 13 sub-Saharan African countries: A multilevel analysis using recent malaria indicator surveys. PLoS One. 2023 May 31;18(5):e0285265. doi: 10.1371/journal.pone.0285265. PMID: 37256889; PMCID: PMC10231787.

World Malaria Report 2023. World Health Organization 2023. https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-20
Buck E, Finnigan NA. Malaria. [Updated 2023 Jul 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK551711/

World Health Organization. (2012). Management of severe malaria: a practical handbook. Geneva, Switzerland: World Health Organization.

Hsu, C., & Sandford, B.A. (2007). The Delphi Technique: Making Sense of Consensus. *Practical Assessment, Research and Evaluation, 12*, 10.

Waggoner, J., Carline, J. D., & Durning, S. J. (2016). Is There a Consensus on Consensus Methodology? Descriptions and Recommendations for Future Consensus Research. *Academic medicine: journal of the Association of American Medical Colleges*, *91*(5), 663–668.

Humphrey-Murto, S., Varpio, L., Gonsalves, C., & Wood, T. J. (2017). Using consensus group methods such as Delphi and Nominal Group in medical education research. *Medical teacher*, *39*(1), 14–19.

World Health Organization. Pocket book of hospital care for children: Second edition. Guideline for the management of common childhood illnesses. Geneva, Switzerland: WHO, 2013.

Nair, R., Aggarwal, R., & Khanna, D. (2011). Methods of formal consensus in classification/diagnostic criteria and guideline development. *Seminars in arthritis and rheumatism*, *41*(2), 95–105.

Alali, K. F., Crouse, H. L., Rus, M. C., Marton, S., & Haq, H. (2024). Debriefing Trainees After Global Health Experiences: An Expert Consensus Delphi Study. *Academic pediatrics*, *24*(1), 155–161. https://doi.org/10.1016/j.acap.2023.07.014

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Texas Children's Global Health Network

Innovation in Data Management for Social Impact: How the Baylor Foundation Colombia Is Revolutionizing Its Processes and Expanding Its Reach.

Diego Salguero | Maritza Medina

Baylor College of Medicine | BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

INITIAL CHALLENGE

"Overcoming years of fragmented information management, which hindered traceability, impact assessment, and evidence-based decision-making."

OBJECTIVE

Project Purpose:

Design and implement a data management system that aligns the organization's social mission with efficient technical operations.

Objective:

Establish a unified monitoring framework with key indicators in health, education, social determinants of health, and institutional management to strengthen governance, transparency, and sustainability.

The social determinants of health (SDH) are the social, economic, cultural, and environmental conditions in which people are born, grow, live, work, and age — and which have a decisive influence on their health status.

METHODOLOGY

PHASE
01

Data cleansing and parameterization of essential variables.

PHASE
02

Validation of information needs with each project leader.

PHASE
03

Development of control dashboards by focus area, integrating Kobotoolbox, HC*, and Power BI

PHASE
04

Data upload and field testing.

PHASE
05

Technology transfer and capacity building.

Kobotoolbox: Tool for monitoring and analyzing social project data, free for NGOs (Data collection).
Power BI: It is a Microsoft tool for analyzing and visualizing data through interactive dashboards and reports (Analysis).
Electronic Health Record

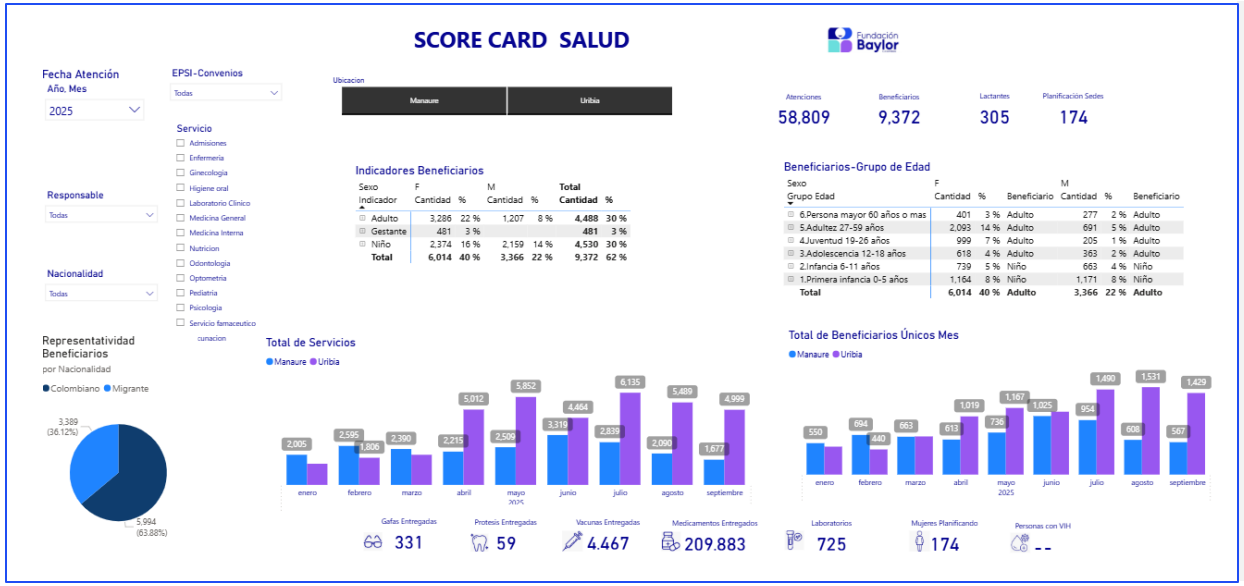
OUTPUTS

87.000
Cleansed Records

4.284
Systematization of unique users

28
Indicators

25
Trained Staff



RESULTS

Data-driven decision-making – reliable, timely, and integrated information for planning and evaluation.

Transparency and accountability – clear performance indicators across all strategic areas.

Operational efficiency – optimized processes for data collection, analysis, and reporting to donors and other audiences.

Alignment with the social mission – connects social impact objectives with technical and administrative management.

FUTURE OUTLOOK

1. Strengthen more in-depth analyses that allow for detailed diagnostics and the construction of epidemiological profiles.
2. Georeferencing of the population.
3. Consolidate our position as a reference for Global Health network.
4. Development of an integrated dashboard for managing agreements.

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Texas Children's Global Health Network

Scaling Up Quality Improvement Amid Resource Constraints: Leveraging Technology, Local Expertise, and Inter-Network Collaboration for Impact

*Florence Anabwani-Richter[1], Matheo Ndaule[2], Nomazizi Maqalika[3], Tapiwa Tembo[4], Lindokuhle Dlamini[1], Phumzile Dlamini[1], Andrew Kunje[4], Richard Jjuuko[5], Stephen Olinga[5], Babongile Nkala[1], Constance Nyasulu[4], Jacqueline Balungi Kanywa[5]

[1]Baylor College of Medicine Children's Foundation Eswatini, [2]Baylor College of Medicine Children's Foundation Mokhotlong, Lesotho, [3]Baylor College of Medicine Children's Foundation Maseru, Lesotho, [4]Baylor College of Medicine Children's Foundation Malawi, [5]Baylor College of Medicine Children's Foundation Uganda.

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Fundația Baylor Marea Neagră

Background

Utilization of pooled expertise

- Persistent funding disruptions in sub-Saharan Africa require innovative, cost-conscious service quality strategies.
- Leveraged connections made during the 25th Global Health Network (GHN) meeting.
- Formed a Collaborative Quality Improvement (QI) Nexus by Global Health Network (GHN) teams across Eswatini, Lesotho, Malawi and Uganda.
- We combined technology, local capacity-building, and inter-network partnerships to drive quality improvement in resource-limited settings.

The Collaborative QI Nexus Team at the 25th Global Health Network Meeting

Methods

Hybrid Cascade Training Model

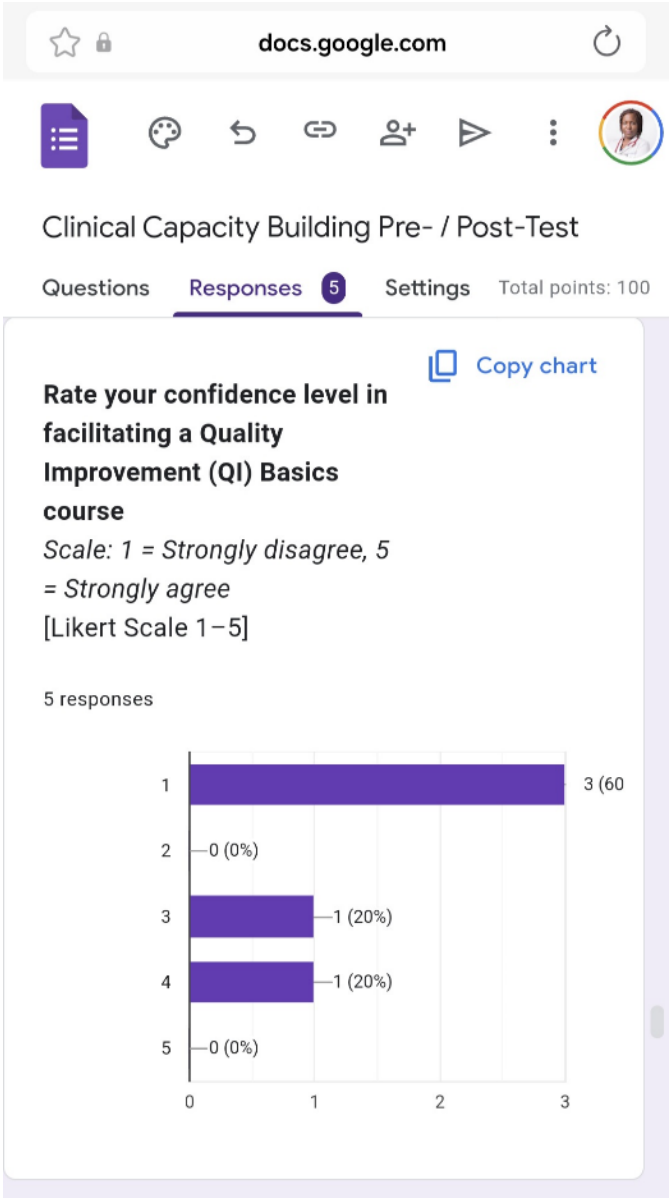
- Certified QI champions, Quality Improvement Basics (QIB) curriculum.
- **10–34** multidisciplinary staff/session.
- **4–6** fortnightly sessions on Fridays to minimize service disruption.
- **QI topics:** core QI methodologies including Plan-Do-Study-Act (PDSA) cycles, process mapping, and root-cause analysis.
- Different QI projects integrated into daily operational workflows.
- Virtual peer learning was enabled via panel discussions, e-learning, and WhatsApp polls.
- Leveraged collaboration with Texas Children's GHN experts.

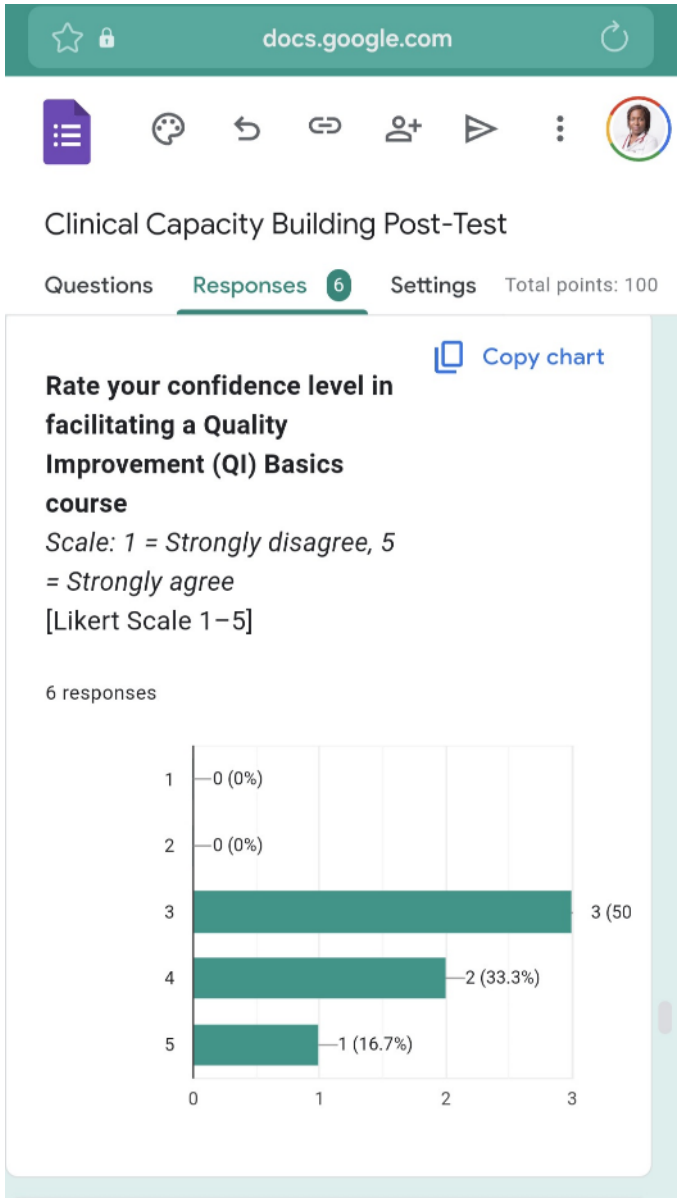
Thobile Bhembe (Baylor Foundation Eswatini QI Champion) facilitating a Continuous Quality Improvement (CQI) session.

Results

Collaborative Impact:

- **30** QI training sessions across all sites
- **381** total staff trained.
- **29** QI projects initiated.
- Median viral load (VL) turnaround time reduced from **14** days to **1** day in Eswatini (Point-of-Care HIV VL platform).
- Sample transport costs reduced.
- Same-day clinical decision-making for unsuppressed patients.
- Improved workflow efficiencies across all sites.
- Increased confidence in facilitating QI Basics Courses.





Results

Scholarly Output

- Lateral growth as an outcome of collaborative Quality Improvement (QI) discussions, fostering innovation and cross-functional learning.
- Developed and submitted two QI abstracts accepted for presentation at the:
  - Kamuzu University of Health Sciences Research Dissemination Conference.
  - 26th Texas Children's Global Health Network Meeting.
- Positioned the team for sustained gains, expanded collaboration, and strategic visibility in global health forums.

Andrew Kunje (Baylor Foundation Malawi) representing the Collaborative QI Nexus at the Kamuzu University of Health Sciences Research Dissemination Conference.

Lessons learned

Leveraging Technology and Local Expertise

- Technology and collaboration can accelerate innovation, scholarly outputs and local adaptation.
- Virtual platforms fostered real-time problem-solving and cross-border learning.
- WhatsApp polls facilitated quick feedback loops.
- Continuous communication, teamwork, and effective delegation drove our efficiency and collaborative success.
- Reliable internet connectivity remains a critical barrier to virtual engagement and data sharing.

Conclusion

Call to Action

- We demonstrated that strategic use of technology, local champions, and cross-country collaboration can significantly improve service delivery.
- Sustainability depends on integrating QI into routine professional development and ensuring robust digital infrastructure.
- We invite different Foundations to invest in reliable internet bandwidth, integrate QI training into professional development frameworks, and support participation in communities of practice to sustain impact and drive innovation across borders.

Baylor Foundation Eswatini Continuous Quality Improvement (CQI) Team: L-R Bhekisisa Mavimbela, Florence Anabwani-Richter, Nonhlanhla Dlamini, Lindokuhle Dlamini, Phepsile Lukhele-Mlotsa.

Acknowledgements

Our Intra-Network Collaborative QI Nexus

Questions & Answers ❓

Tea Break ☕

15-minutes