NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Wednesday, 5 November 2025

Session 3

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

Energizer Time: Let’s Recharge! ⚡

Leader

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Texas Children's Global Health Network

Oral Abstracts & Discussion: Expanding Horizons: Cross-Cutting Health Challenges and Innovations in Care

Moderators: Dr. Mabene Tsotako, Dr. Josephine Denise Birungi

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26TH NETWORK MEETING | NWM2025

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Texas Children's Global Health Network

SCALE-ing Hope in Kayunga: Transforming Sickle Cell Care from Birth Onward

Presenter: Dr. Mirembe Angella Nanteza

Co-authors: Nahirya P.N, Birungi J.D, Namazzi R, Akullo A, Kasirye P, Tumusiime I, Nabadda S, Kiragga D.

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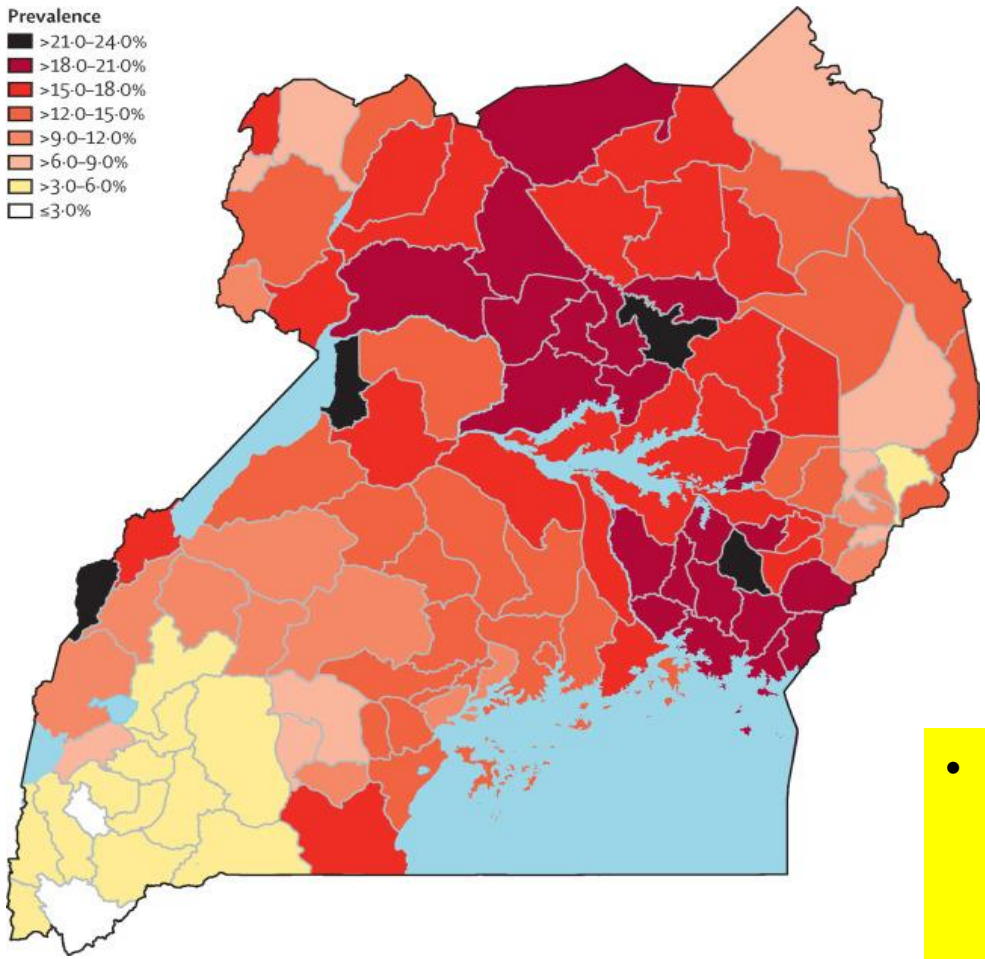
Baylor College of Medicine Children's Foundation Uganda

Agenda

- Background
- Program description
- Key Achievements
- Lessons learned
- Acknowledgements

Background

Map of Uganda highlighting SCD burden by district



Sickle cell disease (SCD) remains a leading cause of childhood morbidity and mortality in Sub-Saharan Africa.

In Uganda, overall SCD prevalence is 2.3 to 23.9%, and national gene prevalence is 13.3%

In Uganda, approx. 20,000 babies are born with SCA annually, and 30-45% die before their fifth birthday

The SCALE Program, launched in October 2024, aims to integrate essential SCD care into primary health care systems.

- ***Focus:***
  - Early diagnosis,
  - Timely treatment,
  - Decentralized care to reach children where they live

Program Description/Implementation

Capacity Building and Delivery

- Trained health workers on Essential SCD care package

- Conducted community outreaches

- Trained lower-level facility staff to support decentralized SCD care

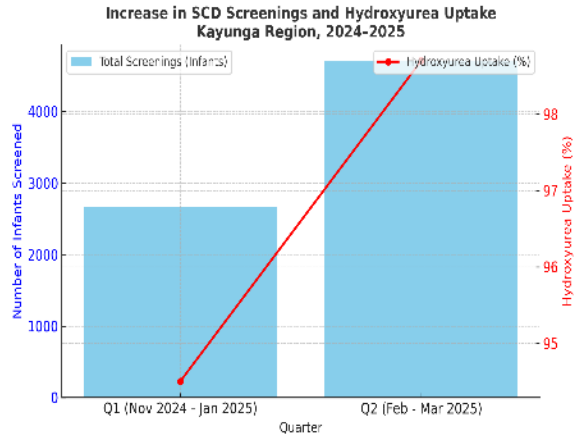
Structure and Partnerships

Data-driven design using SCD and live birth data from DHIS2

3-year funding from Bristol Myers Squibb Foundation through Texas Children's Global HOPE

Implemented by Baylor Foundation Uganda in partnership with Ministry of Health, Makerere University and Uganda Paediatric Association

Key Achievements and Outcomes



98%

98% from 60% Newborn screening rate

94%

94% linkage to care among diagnosed infants.

98.7%

98.7% from 94.5% of children in care are now on hydroxyurea

60

New health workers trained and mentored

1,171

Children screened in 21 community outreaches → 12 new Hb SS cases linked to care.

2

New SCD clinics were opened at Kangulumira and Bbaale Health Centre IVs.

Lessons learned and Next Steps

Key enablers:

- Early diagnosis and decentralized care can be achieved rapidly through mentorship and integration.
- Sustainability requires ongoing capacity building and integration into existing platforms (immunization, community health).

Challenges:

- Missed early diagnosis in older children
- Lack of a harmonized national SCD data system.
  - Addressed through strengthened referral linkages, mentorship, and ongoing PDSA cycles (e.g., monitoring hydroxyurea adherence).

Next Steps:

- Geographic expansion to Lira and Mbale districts (Years 2-3).
- Continue collaboration with MOH and partners to reduce commodity costs and increase government ownership.
- Sustain impact through mentorship, monitoring, and integration into national systems.

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Diagnostic Stewardship as a Catalyst for Antimicrobial Resistance Control Strategies: Lessons from Uganda

Presenter's Name: Ritah Namusoosa & Dr. Majwala Robert

Affiliation: Uganda National Institute of Public Health & Baylor College of Medicine Children's Foundation-Uganda

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Agenda

Background & Study Objectives

Implementation Approach

Program Coverage & Evaluation Methods

Key Findings & Lessons Learned

Next Steps and Recommendations

Antimicrobial Resistance: Attributable Mortality

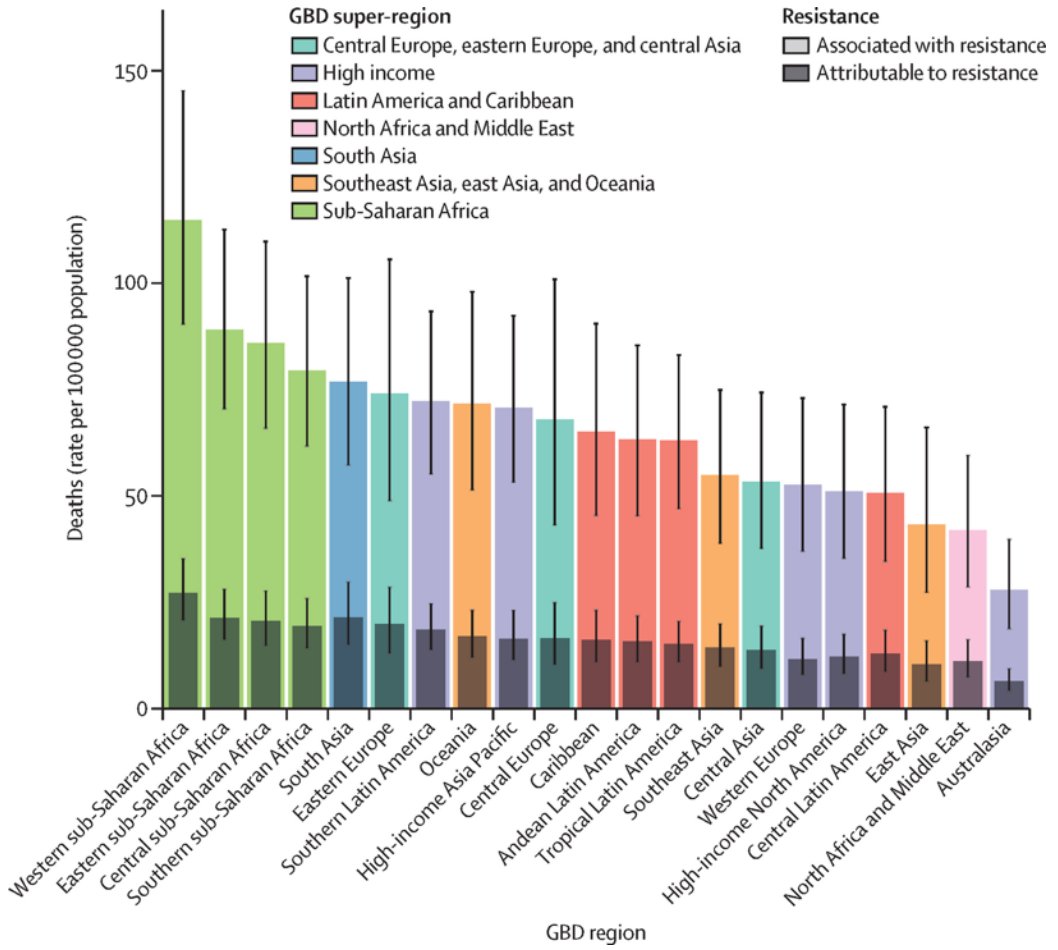


Figure 2 All-age rate of deaths attributable to and associated with bacterial antimicrobial resistance by GBD region, 2019

AMR-associated mortality is comparable to that of tuberculosis, malaria, and HIV

Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis
Murray, Christopher J L et al.
The Lancet, Volume 399, Issue 10325, 629 - 655

Underlying Challenges in AMR

- Limited access to effective antibiotics
- Delays in diagnosis
- Weak laboratory capacity
- High prevalence of resistant pathogens

Growing AMR Threat & Limited Diagnostics in Uganda

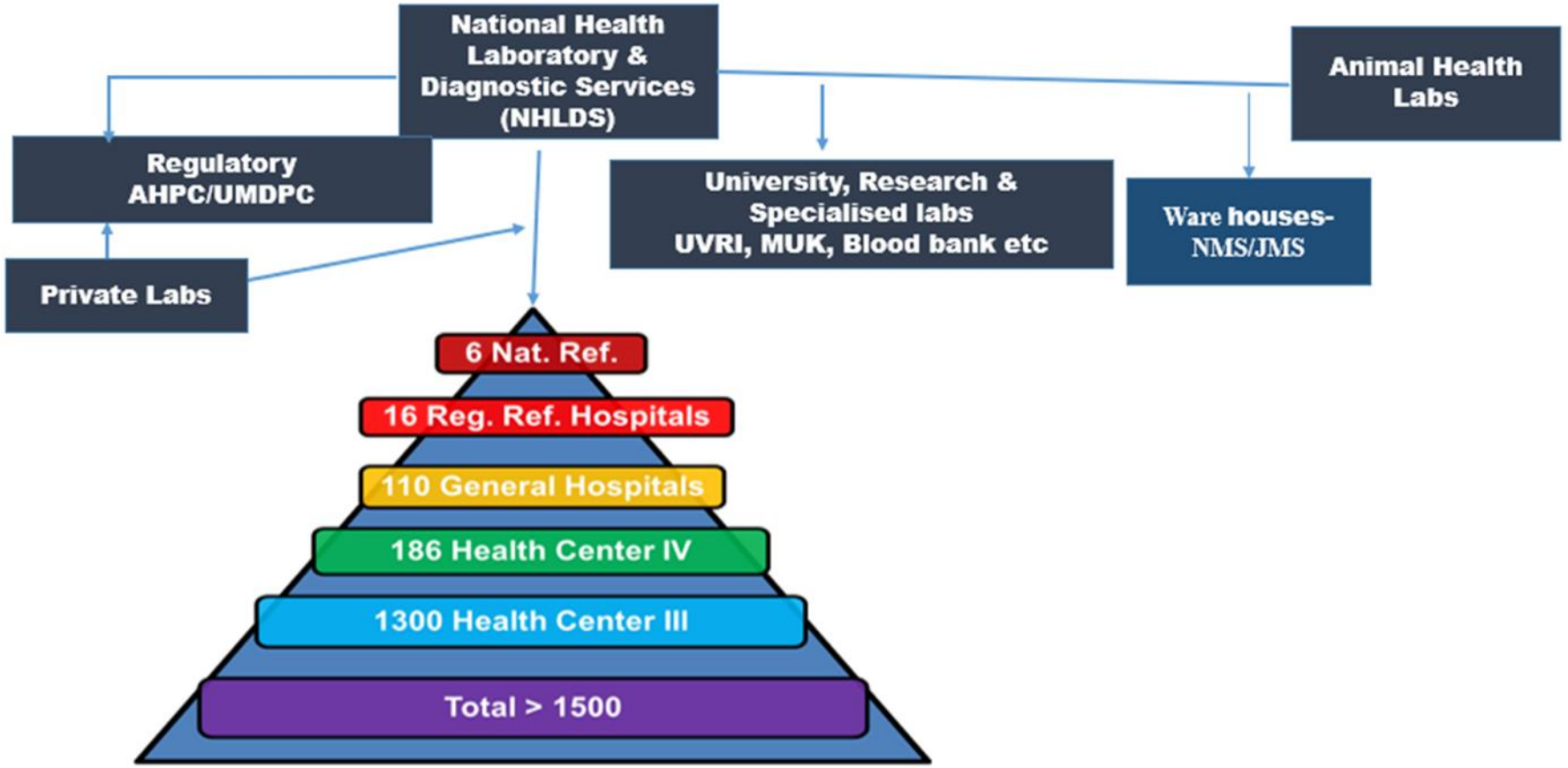
- AMR poses a **critical threat to public health** in Uganda
- High infectious disease burden and **antimicrobial overuse** in humans and animals
- **Limited access** to diagnostics leads to empirical prescribing

Diagnostic stewardship optimizes test utilization and curbs AMR

Study Objectives

- To assess the integration and impact of diagnostic stewardship within Uganda's AMR surveillance framework
- To evaluate improvements in diagnostic test utilization, sample referral, and antibiotic prescribing

Implementation Approach

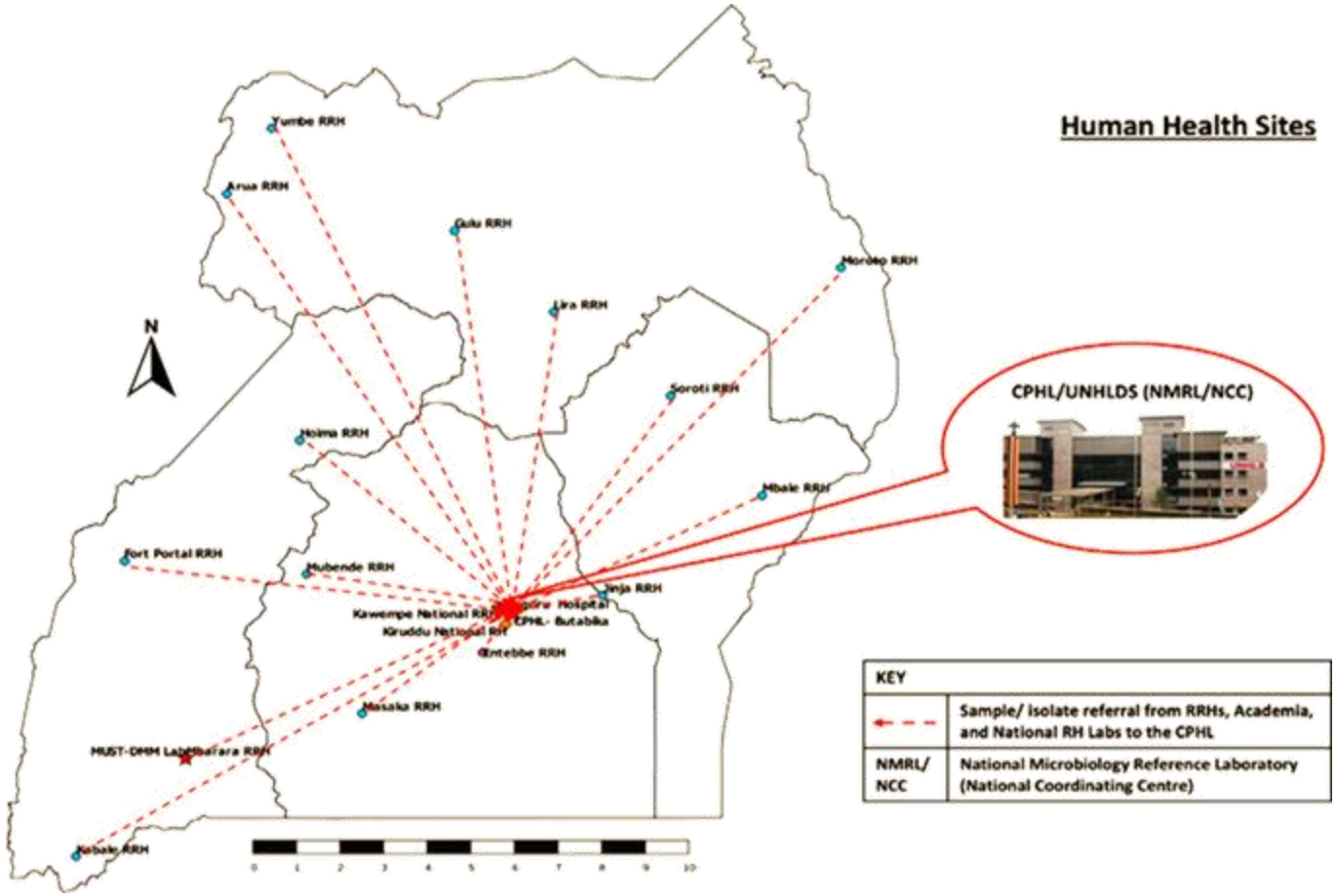


Key interventions

- Training and mentorship
- Strengthening specimen referral systems
- Standardizing diagnostic Algorithms
- LIS/WHONET deployment And data feedback
- Multidisciplinary collaboration

Program Coverage

- Covered 15/17 health regions with
  - 14 AMR surveillance sentinel sites
  - 82 general hospitals
- Through the National AMR Surveillance System



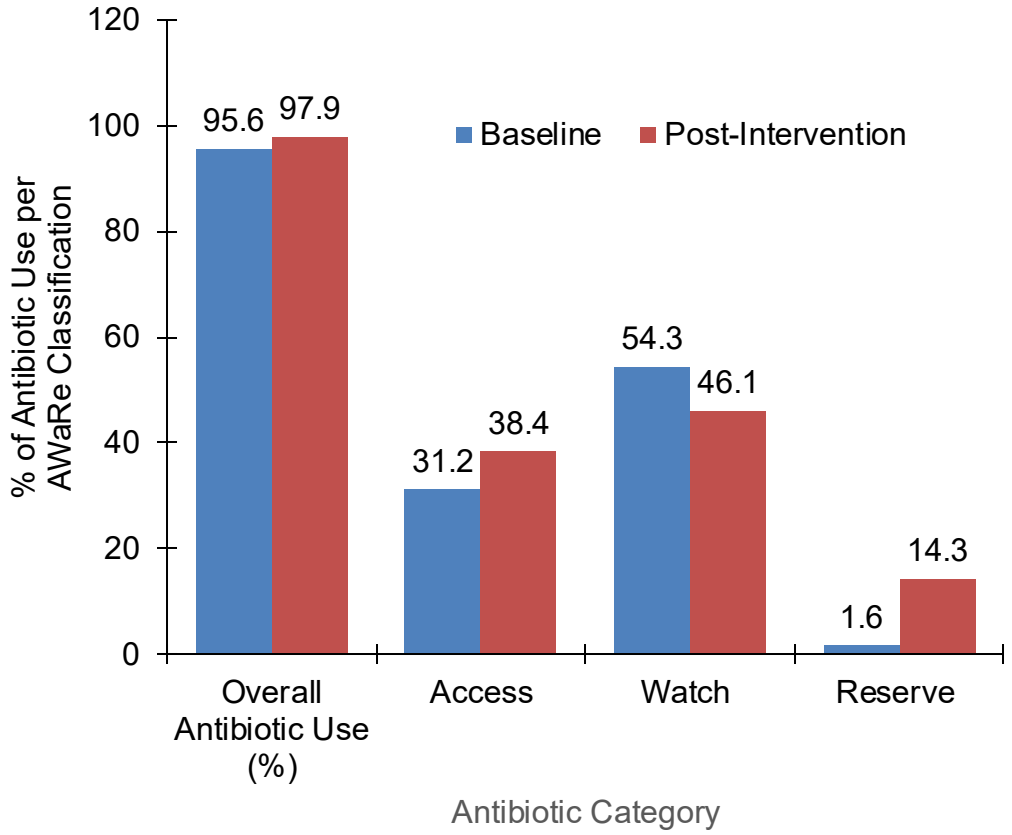
Program Evaluation

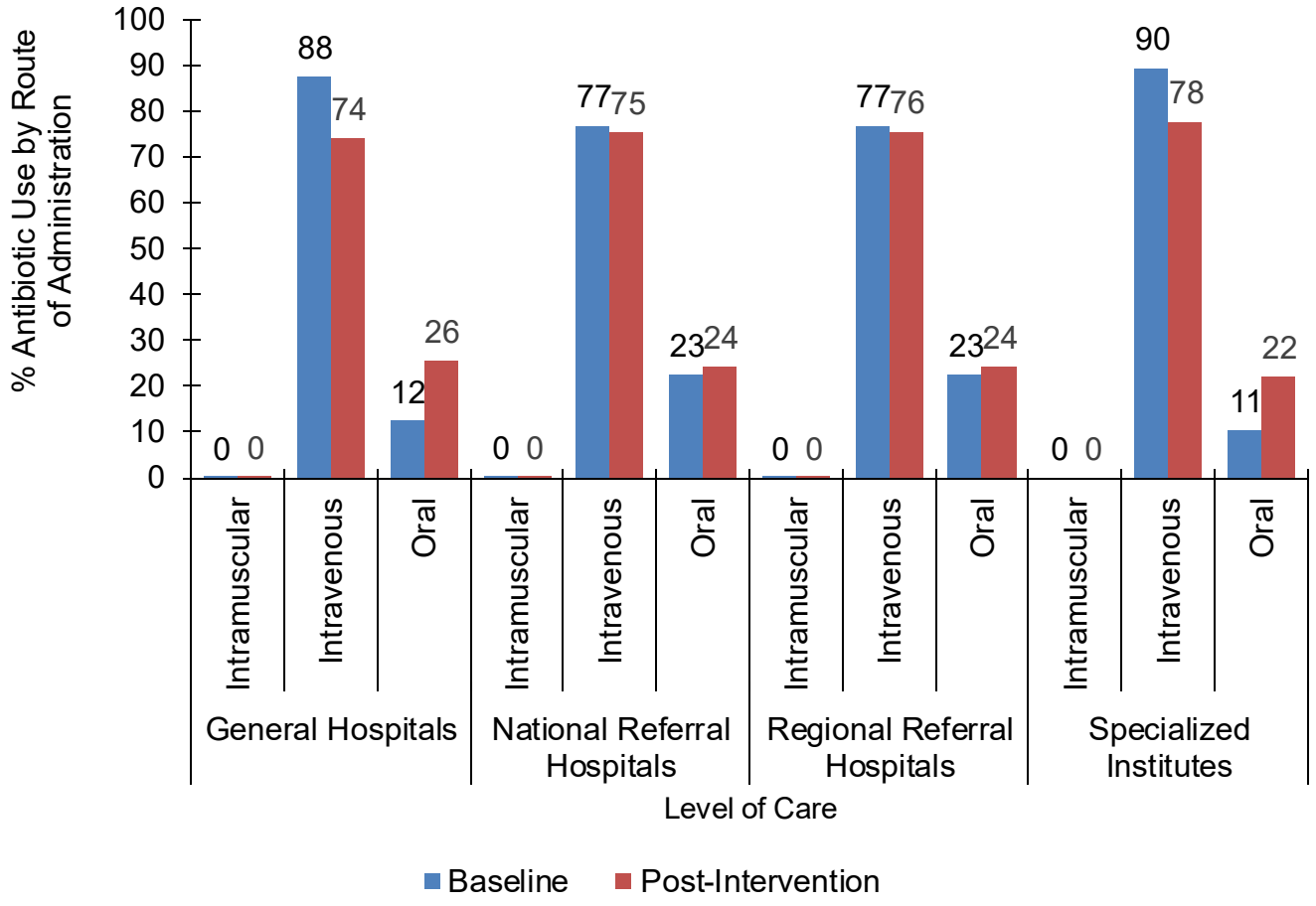
- National AMR data
- World Health Organization-modified point prevalence surveys (WHO- PPS) for antimicrobial use (AMU) data
- Baseline: Oct 2022–Sep 2023 vs Post-intervention: Jan–Dec 2024
- Statistical analysis
  - Descriptive statistics were used to summarize baseline and post-intervention data
  - Differences in proportions analysed using the Chi-square test
  - Pearson correlation analysis was used to assess the association between antibiotic use and resistance

Diagnostic Uptake

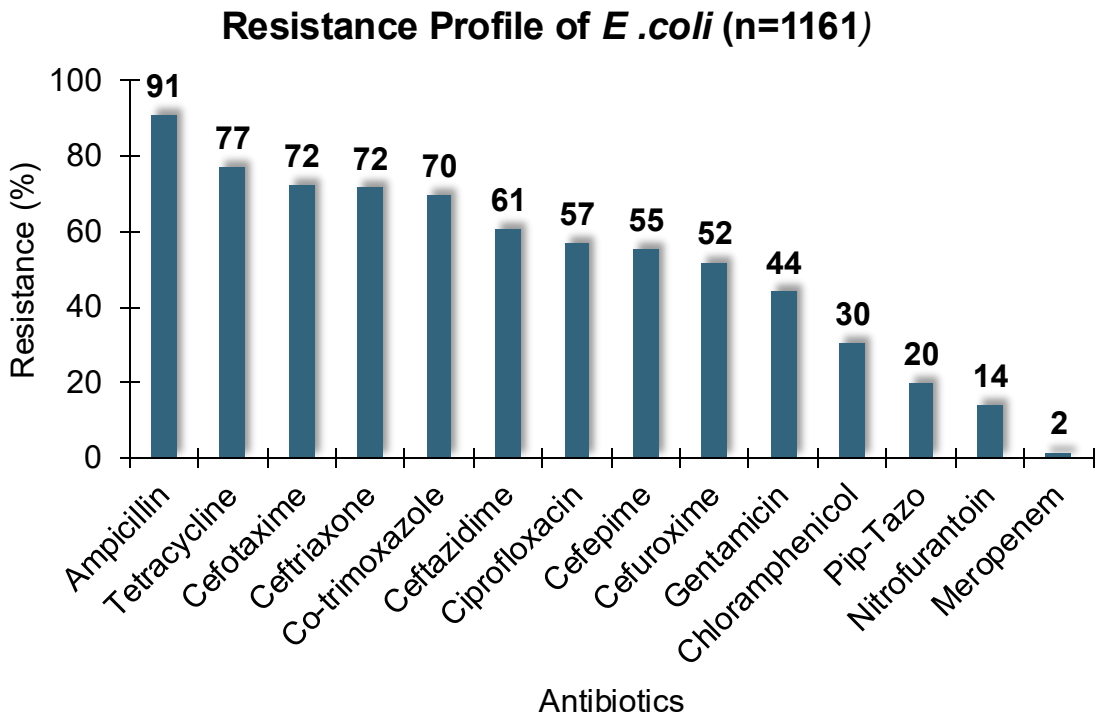
Indicator	Baseline (Oct 2022 - Sep 2023)	Post-Intervention (Jan - Dec 2024)	Change	p-value
Gram stain test use	12%	26%	+14%	0.014
Culture referrals	600	968	+368	0.047
Culture uptake at Regional Referral Hospitals (RRHs)	< 1%	2.6%	+1.6%	0.039
Culture uptake at Specialized Institutes	< 1%	4.3%	+3.3%	0.039

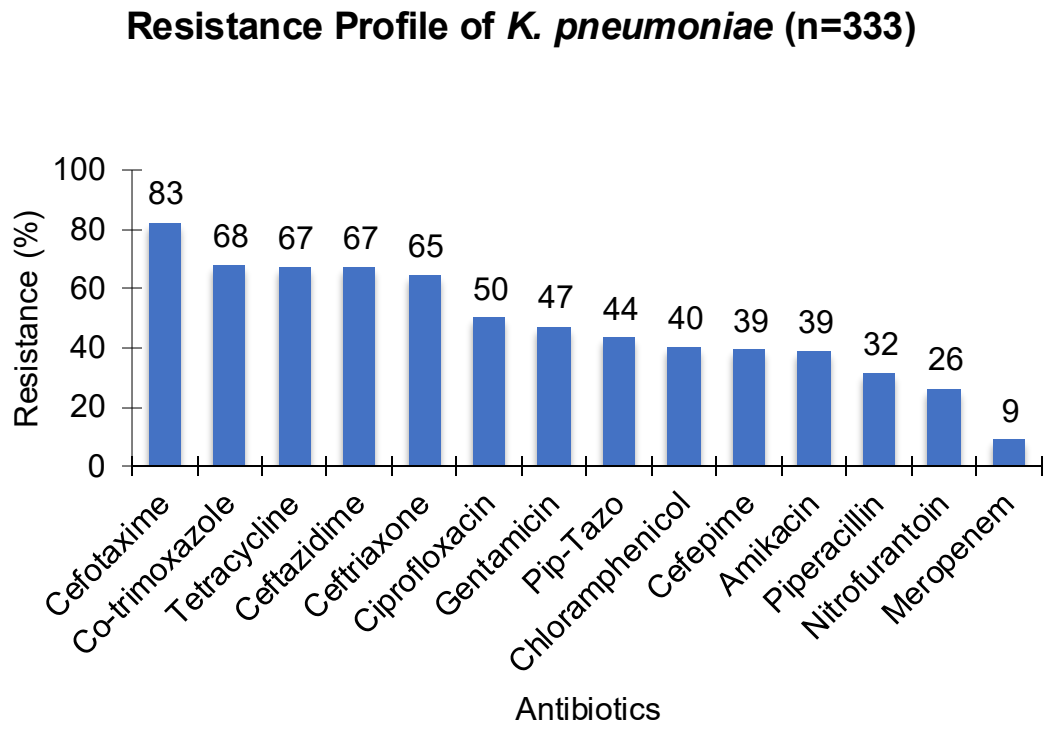
Antibiotic use



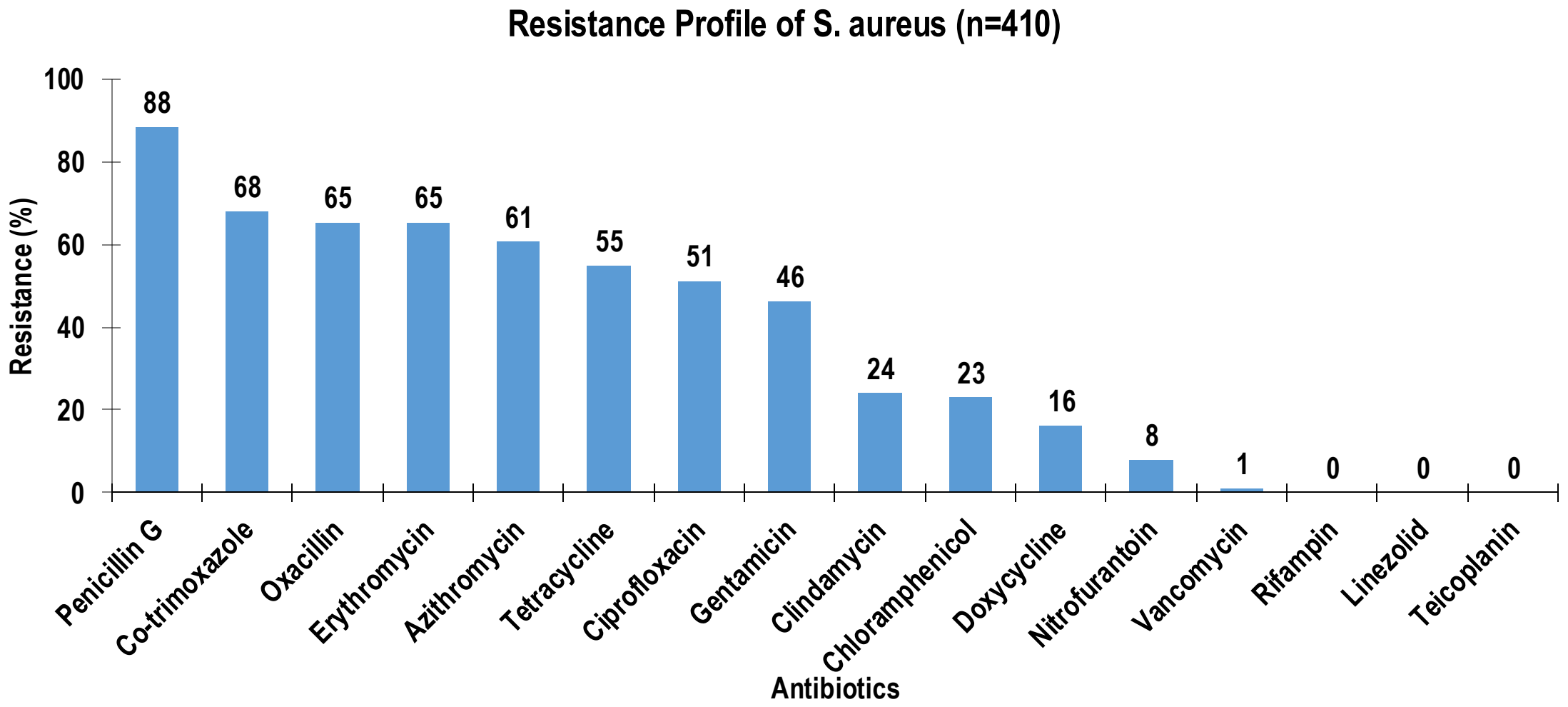


Antibiotic Resistance Profiles in 2024





Antibiotic Resistance Profiles in 2024



Strong correlation between antibiotic use and resistance ($r = 0.74$, $p = 0.004$)

Lessons Learned

- Mentorship and clinician feedback improved diagnostic use
- Local AMR data guided rational prescribing
- Small lab improvements influenced behaviour
- Challenges
  - Supply delays
  - Limited data sharing

Next Steps and Recommendations

- Scale up model nationwide
- Integrate stewardship indicators in monitoring frameworks
- Develop national AMR dashboard linking laboratory, and pharmacy data
- Adapt for other LMICs with tiered health systems

Acknowledgement

- Baylor College of Medicine Children's Foundation-Uganda
- Uganda, Ministry of Health
- The Global Fund
- US Centers for Disease Control and Prevention
- African Society for Laboratory Medicine
- Infectious Diseases Institute
- The Fleming Fund

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Texas Children's Global Health Network

Beyond the Hospital Gates; Structural Barriers, Cultural Realities, and the Struggle for Dignified Pediatric Palliative Care in Rural Botswana

Authors: S. Sosome, T. Kaang, B. Maloge, R. Kimutai, M. Matshaba

Presenter:
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(Clinical Social Work)
Paediatric Hematology Oncology Unit

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Botswana-Baylor Children's Clinical Centre Of Excellence

Agenda

- Background
- Context
- Outreach Map
- Methods and Field Realities
- Results and Lessons Learned
- Conclusion and Call to

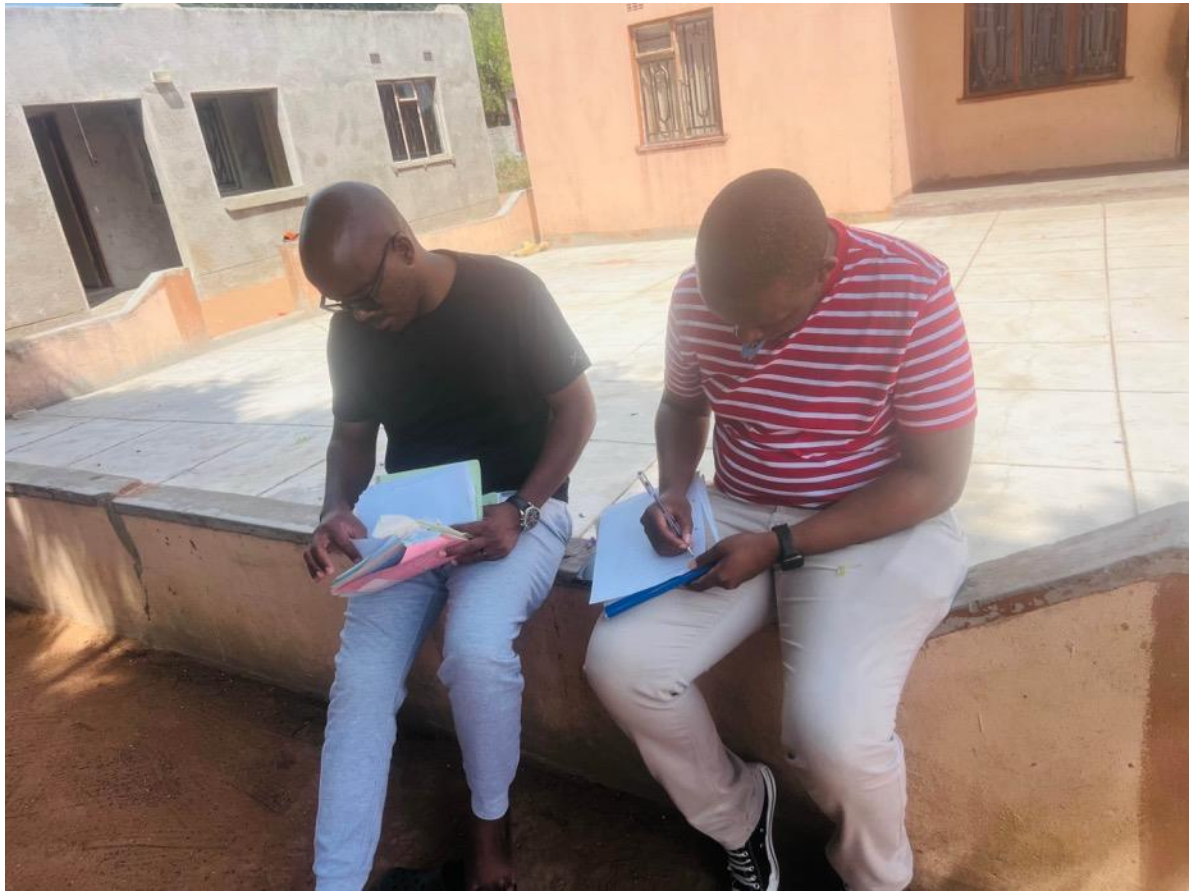
Botswana-Baylor Children's Clinical Centre Of Excellence

Background

- Pediatric palliative care remains underdeveloped, fragmented, and urban-centered.
- Rural families of terminally ill children face overwhelming emotional and logistical challenges.
- Systemic inequities — from transport to medication shortages — deepen suffering.
- Cultural silence around death and illness perpetuates misunderstanding and stigma.
- Grief unfolds in isolation, far from psychosocial and medical safety nets

Context

- Despite national frameworks, home-based palliative care in rural Botswana is still a challenge.
- Families care for dying children without trained support.
- Ambulances are few, morphine scarce, and welfare systems exclude many unemployed mothers.
- As biomedical care fades, families turn to traditional healers — driven by hope, culture, and necessity.
- These choices, while culturally grounded, often drain finances and deepen emotional strain.



Outreach

Methods & Field Realities

- Ethnographic study: 12 rural outreaches, 25 caregivers, 10 providers, direct field observations.
- Analytic Lens: Grounded theory and systems-thinking.
- Teams offered symptom control, emotional support, and limited psychosocial care.

Constraints:

Morphine stock-outs and addiction stigma

Lack of bereavement tools and legacy-building activities

Cultural discomfort with discussing death

Observation:

Without trained staff or follow-up, dying children are left unseen, unheard, and unsupported.

Results / Lessons Learned

Families equated palliative care with “doctors giving up.”

Absence of community based follow-up left caregivers spiritually disoriented.

Mothers described walking kilometres, selling belongings, and borrowing money for transport .

Pain, fear, and silence shaped many children’s final days.

The outreach revealed urgent needs for:

- Psychosocial training for rural health workers
- Welfare reform to support unpaid caregivers
- Culturally rooted interventions—storytelling, rituals, and memory-making

Conclusion & Call to Action

Beyond the hospital gates, pediatric palliative care remains fragmented, reactive, and under-resourced. Families perceive abandonment where compassion should live.

Call to Action:

- Build community-integrated palliative networks
- De-stigmatize pain management and morphine use
- Fund family-centered social protection programs
- Develop legacy-based, culturally aligned psychosocial support

Final Message:

Only when care extends into villages, homes, and hearts can every child in Botswana die with dignity and every mother grieve without despair.

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Transforming Drug Resistant Tuberculosis (DR-TB) care: Success of a fully Ambulatory Model

Lessons from Namisindwa, Uganda

Presenting Author: **Clark Joshua Brianwong**

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Baylor College of Medicine Children's Foundation Uganda

Agenda

- Background
- Methods
- Results
- Implications of the results
- Conclusion
- Acknowledgement

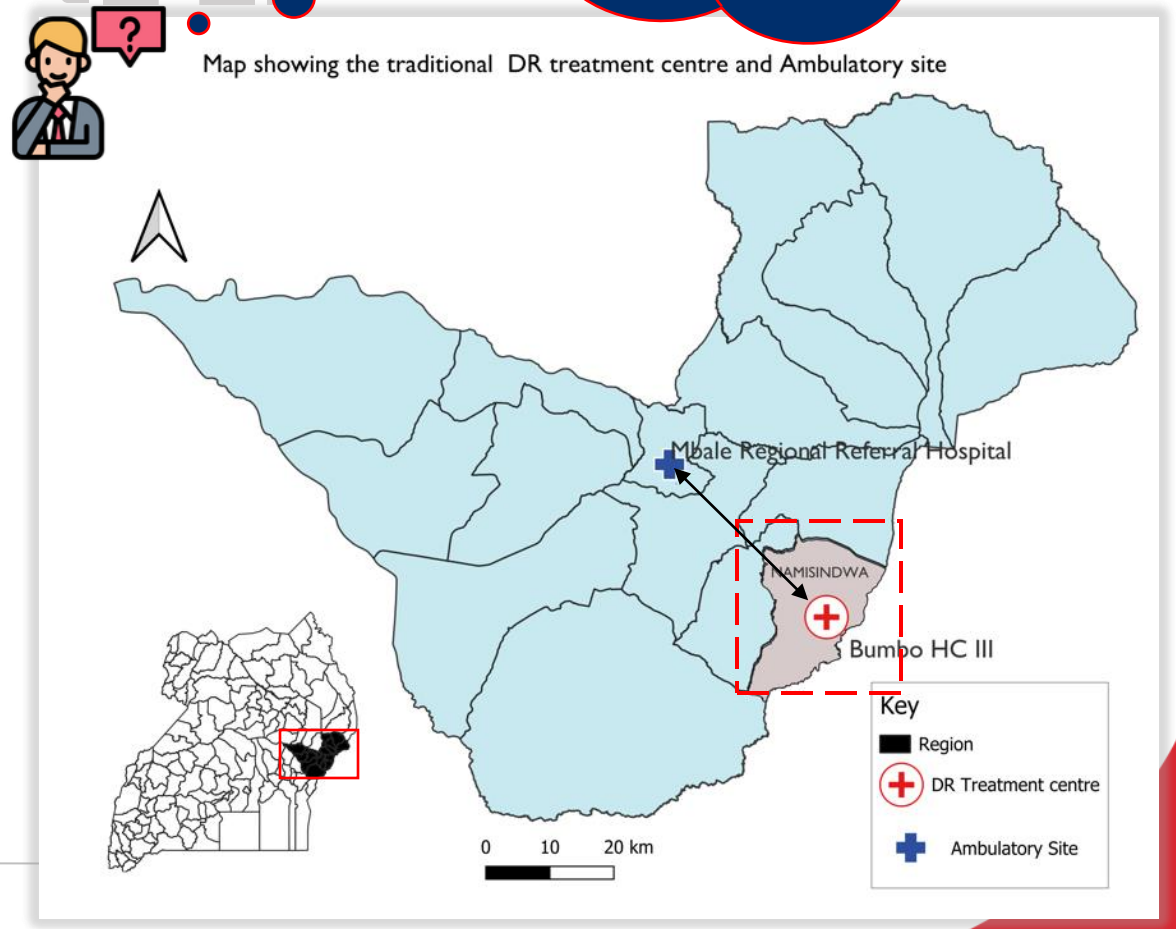
Background

The Ugandan mixed method Model:

- DR TB treatment begins at tertiary hospitals and later patients are transitioned to ambulatory care after stabilization
- Patient continue daily directly observed therapy (DOT) at local health centers and visit tertiary hospitals for monthly monitoring

The Challenge

High drop out during transition to Ambulatory care
Limited space during outbreaks, porous boarder points

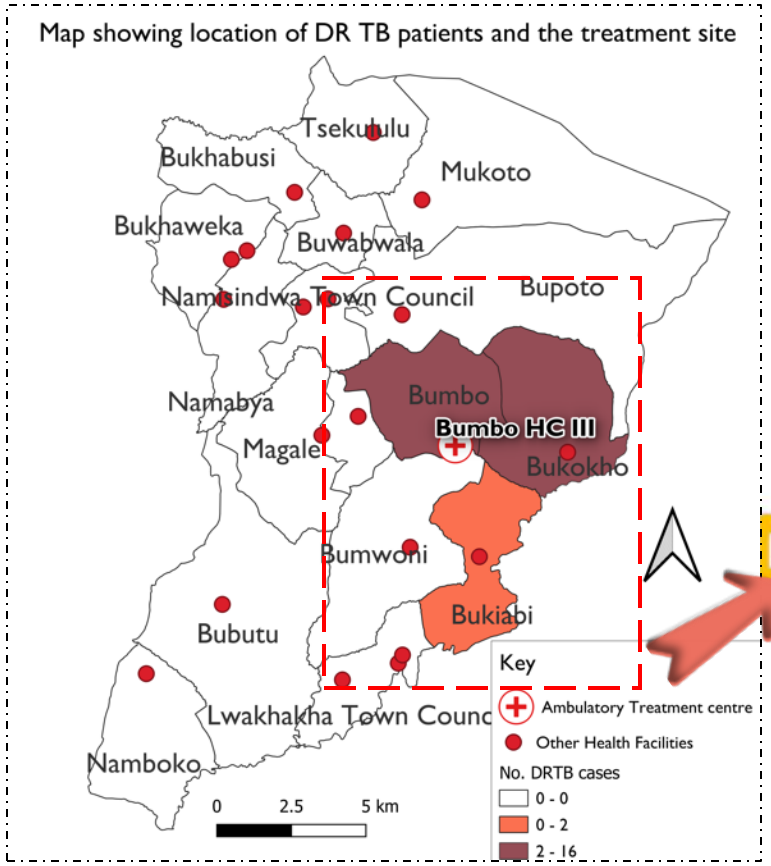


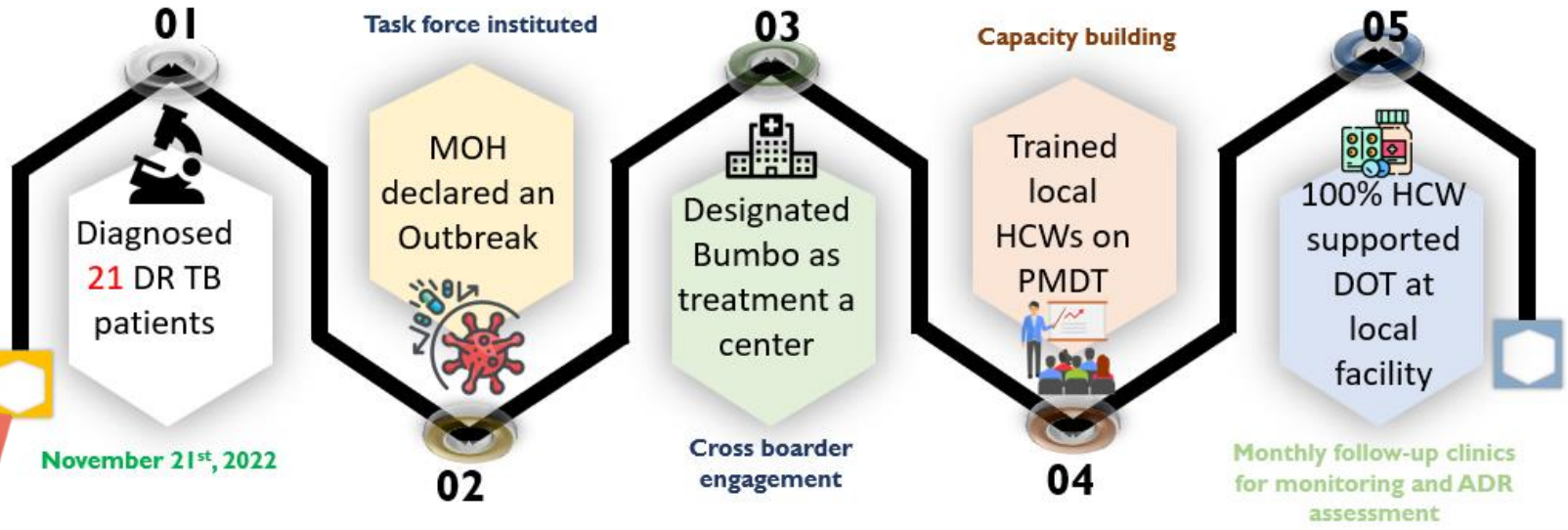
The Crisis: An Outbreak Exposes the Gaps

Nov 18, 2022: MOH was notified of a DR-TB outbreak in Namisindwa district. Triggered by a community screening in Bumbo Town Council. **32 samples** tested, revealing **14 confirmed Rifampicin-Resistant (RR) TB cases.**

Methods

- We compared outcomes of DR-TB patients treated using a fully ambulatory care model at Bumbo Health Center III, Namisindwa, during an outbreak (October 2022 to March 2023) with the traditional mixed model.





Bumbo town had an Attack Rate of 57 per 100,000

Data was abstracted from the electronic TB register and HMIS tools

Results

Patient data was collected from the DR-TB treatment register from October 2022 to March 2023.

Description of the DR TB patient at the sate-lite site

62% were female

Median age (43.5 years).

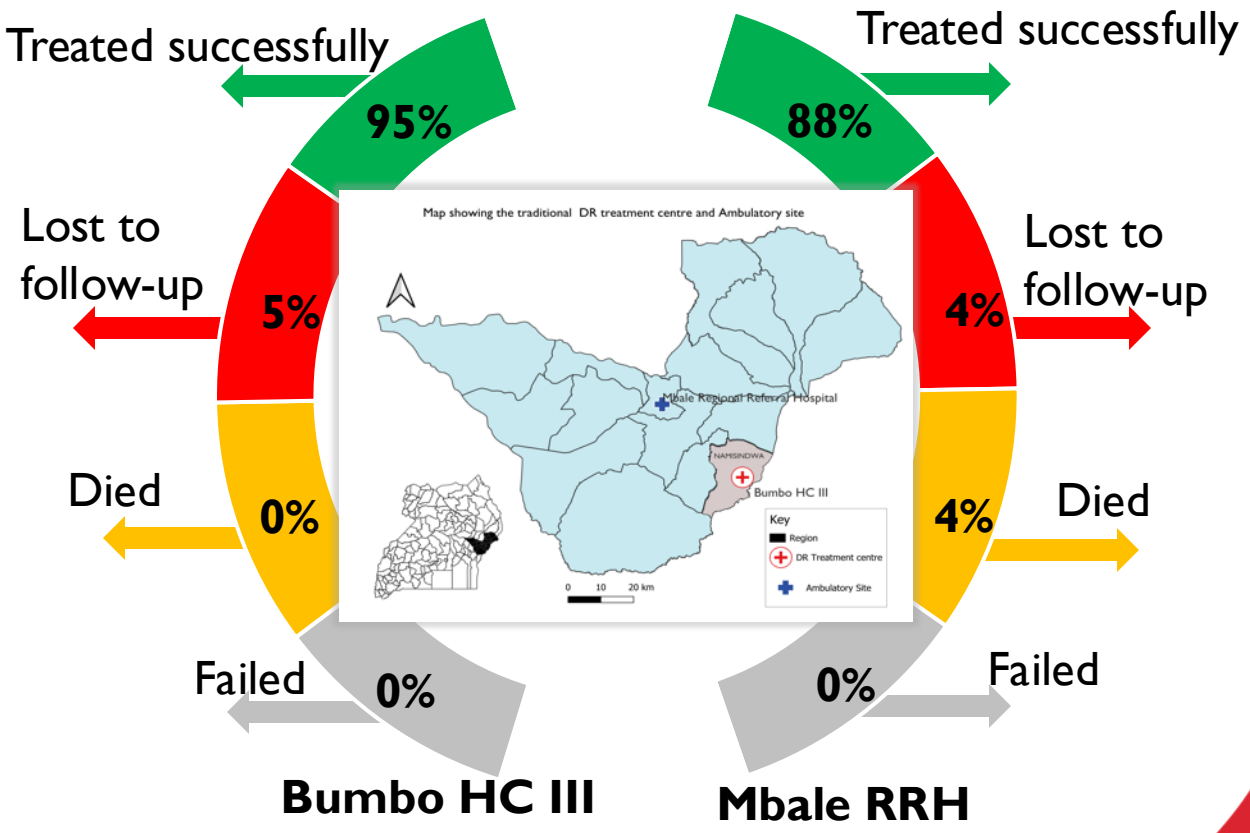
19 were new DR TB; 1 previously on 1st line &1previously on 2nd line

19% HIV coinfected

86% on modified short-term regimen (mSTR)

100% Health-worker led DOT

Treatment Outcomes at tertiary site vs Ambulatory site



Implications for Resource limited settings

Integration of cross-border issues into TB/HIV programming

Development of targeted interventions for at-risk populations through POE TB screening, geospatial mapping to track and serve mobile communities.

Following the success of the Bumbo pilot, Uganda's health Ministry operationalized five additional DR-TB treatment sites.

This model represents a scalable, resilient approach for expanding DR-TB services in other high-burden, low-resource contexts.

Continued investment in training, data systems, and logistics is key.

Conclusion and Acknowledgement

Conclusion: This approach supports Uganda's DR-TB decentralization strategy and demonstrates the potential of community-based care models to improve treatment outcomes nationally

- PEPFAR
- USAID
- Ministry of Health, The National TB & Leprosy Program
- Baylor Foundation Uganda
- Mbale Regional Referral Hospital
- USAID Local Service Delivery Activity- (Uganda Protestant Medical Bureau)
- District and City Local Governments
- Tuberculosis Survivors

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Shadows That Linger: Psychological and Cultural Dimensions of Maternal Grief After Pediatric Palliative Loss in Botswana

Authors: S. Sosome, T. Kaang, B. Maloge, R. Kimutai, M. Matshaba

Presenter:
Mrs. Sewelo Sosome, BSocSci, MSW (Clinical Social Work)
Paediatric Hematology Oncology Unit

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Agenda

- Background
- Description & Context
- Lessons Learned
- Next Steps
- Conclusion & Takeaway

Botswana-Baylor Children's Clinical Centre Of Excellence

Background

- Mothers in the pediatric oncology unit endure long, emotionally taxing caregiving journeys.
- After their child's death, many face psychological collapse: five recent cases required psychiatric admission.
- Traditional rituals, though meaningful, are short and symbolic; grief is rarely explored beyond the burial.
- Post-loss, mothers lose not only their children but also identity, income, and emotional stability.
- Limited psychosocial aftercare leaves bereaved mothers in silent suffering.

Description & Context

- Qualitative insights from five bereaved mothers reveal multi-layered loss: emotional, economic, familial, and existential.
- The end of hospital caregiving creates a traumatic void, a loss of purpose and community.
- Absence of structured grief support or trauma-informed follow-up leads to psychological distress and psychiatric admissions.
- Community social workers often lack specialized grief training, deepening systemic neglect.

Lessons Learned

- Grief is nonlinear: Anticipatory grief during illness differs from the rupture of death.
- Culture helps but is limited: Rituals offer closure but not sustained emotional healing.
- Systemic care gap: No follow-up or structured bereavement care after a child's death.
- Zero-cost solutions exist: Storytelling circles, caregiver groups, and ritual-based healing.
- Preparation matters: Integrate emotional and spiritual preparation into palliative care.

Next Steps

- Introduce a Post-Burial Debriefing Protocol within pediatric palliative care units.
- Train frontline social workers in trauma-informed, culturally grounded grief care.
- Develop “Memory Mothers” bereaved caregivers trained to guide others.
- Co-create self-care tools (grief journals, affirmation cards, home rituals).
- Embed psycho-spiritual counseling and storytelling into anticipatory grief work.

Conclusion & Takeaway

- Maternal grief after pediatric loss in Botswana is profound, complex, and underserved.
- Clinical silence deepens suffering where culture alone cannot heal.

Takeaway Message:

- By blending indigenous healing wisdom with trauma-informed care, we can build low-cost, culturally anchored grief models that restore dignity, connection, and hope for bereaved mothers.

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Retrospective Study Assessing Hypertension Prevalence and Associated Risk Factors among Adolescent and Young Persons Living with HIV in the Post-COVID-19 Period at Baylor Foundation Uganda Center of Excellence

Presenter: Victoria Ndyanabangi

Co-authors: Cathbert Tumusiime, Lameck Kiyimba, Richard Jjuuko, Dithan Kiragga.

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Baylor College of Medicine Children's Foundation Uganda

Agenda

Background.

Methods.

Results.

Conclusion

Takeaways

Introduction

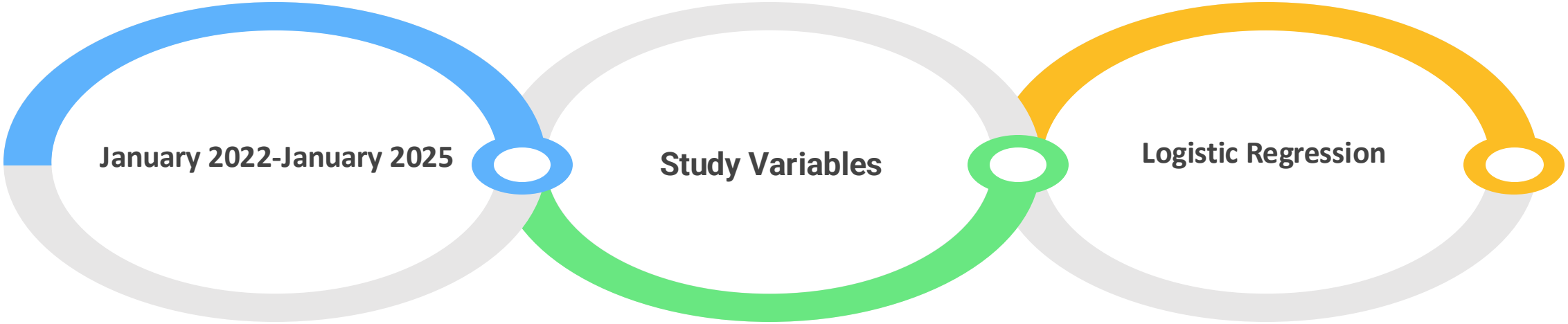
The 2022 consolidated guidelines for the prevention and treatment of Human HIV and AIDS in Uganda guided **integrating hypertension (HTN)** screening and management into routine service provision to persons living with HIV (PLHIV) in the post-COVID-19 period.

Client's who previously would have been receiving care for Hypertension at the hypertension clinic now get screened, diagnosed, managed at the ART Clinic.

This abstract demonstrates how Baylor Foundation Uganda (BFU) shifted from vertical disease management to an integrated clinical and public health care model that promotes universal access and social justice

Methodology

Burden of hypertension among adolescents and young adults living with HIV, associated risk factors, including age, sex, body mass index (BMI), mid-upper arm circumference (MUAC), HIV transmission mode, smoking, or alcohol use



Analysis was conducted using electronic medical records from the Baylor Uganda Clinical Center of Excellence

Identified predictors of hypertension, with significance set at $p<0.05$. Data were analyzed using STATA v17 under IRB-approved protocol H-26616

Results.

- We analysed data from **776** clients. Female (66.1%), with a median age of **14** years (IQR: 11–18).
- Nutritional status was largely favourable, with over **80%** exhibiting a normal MUAC, and **61.1%** (n=463) presenting with a healthy weight.
- Consensual sexual activity was the most reported mode of HIV transmission **(56.9%).**
- A vast majority **(97.1%)** reported no history of smoking, while nearly 2 in 10 disclosed a history of alcohol use.

- Notably, the prevalence of hypertension among these adolescents and young adults was ***9.53%*** (95% CI: 7.66%–11.82%).
- In multivariable logistic regression analysis, individuals aged 15–19 years had significantly lower odds of hypertension compared to those 10–14 years (OR: 0.51; 95% CI: 0.27–0.95; p=0.034).
- **Males** were nearly **twice as likely** to have hypertension compared to females (OR: 1.98; 95% CI: 1.22–3.21; p=0.005).
- Clients who had been on ART for **over 15 years** had significantly higher odds of hypertension compared to those who spent five or fewer years on ART (OR: 4.29; 95% CI: 1.18–9.99; p=0.001).
- Other variables, including MUAC category, BMI status, infection route, smoking history, and alcohol use, were not significantly associated with hypertension.

Results.

Variable	Category	OR (95%CI)	P-value
Age	10-14 years	*Ref.*	*Ref.*
	15-19 years	0.51 (0.27 – 0.95)	**0.034**
	20-24 years	0.96 (0.51 – 1.82)	0.914
Sex	Female	*Ref.*	*Ref.*
	Male	1.98 (1.22 – 3.21)	**0.005**
MUAC	Normal	*Ref.*	*Ref.*
	Severe	1.40 (0.31 – 6.32)	0.665
	Moderate	0.57 (0.22 – 1.45)	0.236
BMI	Health weight	*Ref.*	*Ref.*
	Under weight	0.77 (0.38 - 1.58)	0.483
	Overweight	1.12 (0.62 – 2.02)	0.715
Mode of HIV transmission	Consensual sex	*Ref.*	*Ref.*
	Sexual abuse	4.73 (0.15 – 148.80)	0.377
	Unknown	0.75 (0.03 – 16.92)	0.855
	Vertical	0.38 (0.02 – 8.42)	0.543
Smoking_hx	No	*Ref.*	*Ref.*
	Yes	3.63 (0.14 – 90.95)	0.433
Alcohol_hx	No	*Ref.*	*Ref.*
	Yes	0.66 (0.03 – 13.77)	0.792
Duration on ART	0 – 5 years	*Ref.*	*Ref.*
	6 – 10 years	0.88 (0.48 – 1.63)	0.685
	11 – 15 years	0.86 (0.38 – 1.91)	0.705
	>15 years	4.29 (1.18 – 9.99)	**0.001**

Take-aways.

Adolescents and young adults have a risk of hypertension.

Males are more at risk of getting hypertension.

Under-reporting or under-diagnosing hypertension as the JNC 8 Scale is what was referenced for national guidelines, which is for adults.

Ambulatory BPs were not done.

A prospective study is suggested for appropriate references for age

This abstract demonstrates BFU shifted to an integrated clinical model that promotes universal access and social justice

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Integrating lay health worker-supported blood pressure screening into routine HIV care identifies people with hypertension and links them to care at health facilities in Malawi

C.M. Cox, V. Guzani, A.C Mazenga, G. Kaunda, S. Chu, K.R. Simon

Background

- People living with HIV are at risk of poor outcomes from cardiovascular disease.
- Integration of blood pressure (BP) measurement in routine HIV care facilitates early detection of hypertension and linkage to treatment.
- Since 2022, Malawi HIV ART guidelines have recommended integrated BP screening for PLHIV 30+ years.
- We describe the integration and scale-up of BP screening and referral into continuum of HIV care utilizing community health workers (CHWs) at 95 health facilities in 5 districts supported by Tingathe program with Baylor Foundation Malawi.

Description

Integration of BP screening at ART clinics at 95 health facilities

CHWs were trained to:

- deliver health education talks about hypertension
- identify people eligible for BP measurement
- measure BP using automated cuffs
- refer people with elevated BP (>140/90) or taking BP medication for clinical evaluation

Description

- Training package included
  - video demonstrations of BP measurement
  - modeled health talks on BP lifestyle modification
  - documentation and reporting
  - PRACTICAL sessions

- Trained CHWs:
  - integrated screening into ART triage
  - tracked eligibility, BP results, and referrals.

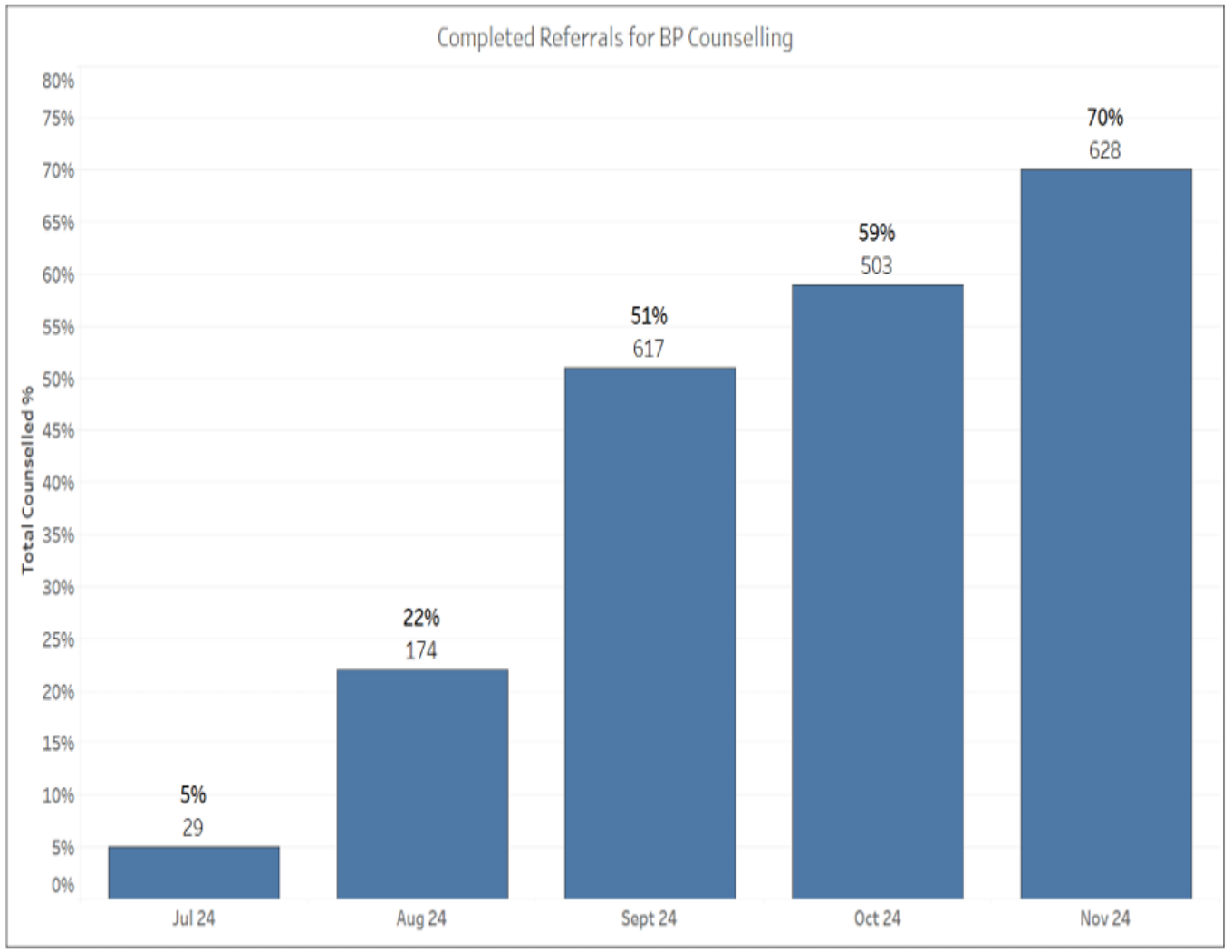
- Routine program data from February to November 2024 was analyzed.

Lessons Learned

- BP screening integration began in February 2024 with
  - 10% (n=10) sites reporting week 1
  - 49% (n=47) on week 2
  - 90% (n=86) by week 5
- By July 2024: 96% sites (range: 88-100%) consistently reporting weekly
- From February – Nov 2024: 106,837 blood pressures were measured
  - 6.6% (n=7072) had high BP (>140/90).

Lessons Learned

- With intensified support: Counseling sessions for people with high BP increased consistently from July 2024 (Figure 1).



Conclusions/Next Steps

Leveraging a CHW-supported longitudinal care cascade for PLHIV to integrate Blood Pressure screening in routine ART care is feasible and facilitates identification and linkage to care.

Quantification of medical treatment linkage for those identified with high blood pressure is underway.

Questions & Answers ❓

NWM2025

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Texas Children's Global Health Network

Workshop: Smash the Silos! Working Cohesively When Resources are Tight

Dr. Elizabeth Davis,

Dr. Florence Anabwani-Richter

Baylor College of Medicine BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

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

JOHANNESBURG, SOUTH AFRICA • 3–7 NOVEMBER 2025

Texas Children's Global Health Network

Smash the Silos! Working Cohesively When Resources are Tight

Elizabeth Davis (USA)[1,2], Florence Anabwani-Richter (Eswatini)[3], Brigid O'Brien (Malawi)[4], Jemimah Nyirongo (Malawi)[4], Teresa Steffy (Lesotho)[5]

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Baylor College of Medicine | BAYLOR GLOBAL HEALTH

Fundația Baylor Marea Neagră

Objectives

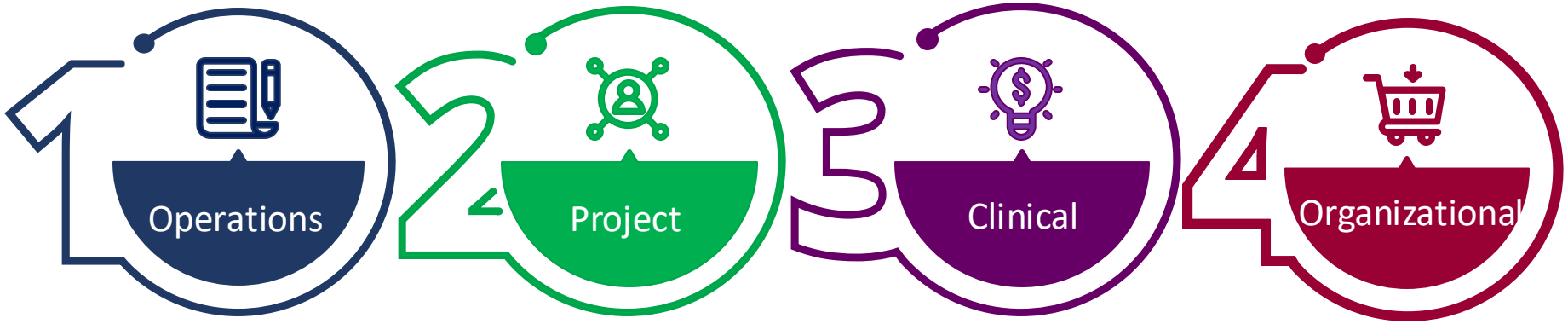
1. Describe the negative impacts of silos on healthcare systems
2. Critique existing siloed services or redundancies in local work settings
3. Apply a toolkit of strategies to break down silos and work more cohesively.
4. Develop strategies to foster cross-collaboration across the network

What are Silos in Healthcare?

- Isolated departments, specialties, or services
- Function independently with minimal coordination
- Physical, organizational, or technological separation

Examples of Silos

Silos: Independent departments pursuing goals without cross-functional alignment or shared strategy



Fragmentation in processes, workflows, or support services that impact organizational efficiency (e.g. Informatics vs. End Users)

Individual projects operate in isolation, lacking coordination, transparency, or shared goals with other initiatives across the organization.

Different specialties work in isolation, leading to fragmented care/processes (e.g. Oncology vs. Palliative care, Emergency vs. Internal Medicine)

Departments or teams operate in isolation from one another, sharing little information, communication, or collaboration across units (e.g. Separate Programs vs. Finance teams)

The Smash Game

Smash Game Set-Up

1. Divide into 10 groups
2. Distribute soft blocks
3. Hand-out Challenge Cards for Activity 1 (5 mins)

 **Smash the Silos!!** 

4. Form collaborative teams (2 teams each)
5. Hand-out Challenge Cards for Activity 2 (5 mins)
6. Smash the Silos
7. Team Debriefing (5 mins)
8. Final Reflections

Rapid Fire Smash the Silos Q & A Debrief Session

Rapid Fire Smash the Silos Q & A Debrief Questions: What does each shape represent?

Shape	Representation
■ Square	Staff, infrastructure
△ Triangle	Time, limited funding, expertise, data, capacity-building initiatives
● Round:	Communication tools, collaboration, interoperability
✿ Irregular / Cylindrical:	Conflicting priorities, bureaucracy

Rapid Fire Smash the Silos Q & A Debrief Questions:

1. What was frustrating?
2. How does the Smash game reflect real-life silos?
3. What's one thing your team does that should be shared network-wide?
4. Who's the first person you call when you need help from another team?
5. What's one process you think would be easier if two teams worked more closely?
6. How often do you communicate with someone outside your immediate team?
7. Name one project that would benefit from more cross-functional input.
8. How do you usually find out what other departments are working on?
9. What did this teach you about resourcing and collaboration?
10. If you could fix one collaboration bottleneck instantly, what would it be?
11. What's a small action that could improve cross-team collaboration today at no additional cost?
12. Which "round block" did our team lack most?

Outcomes of Working in Silos vs Collaboratively

Aspect	Silos	Collaboration
Resources	Fragmented, insufficient	Shared and optimized
Outcomes	Delays, duplication	Stable, integrated care
Communication	Poor, vertical	Open, multidirectional
Morale	Frustrated teams	Energized, empowered teams

Building a Toolkit: Communication

Communication Best Practices: Across Departments

Practice	Example
 Use Shared Language	Define terms clearly – avoid internal acronyms unless explained
 Clarify Roles & Expectations	“Who does what, by when, with what info?”
 Confirm Understanding	“Can you repeat the plan back so we’re aligned?”
 Use Simple, Agreed Protocols	Templates, checklists, timelines known by all teams
 Plan Early & Together	Invite key departments into planning phase, not just implementation

Communication Best Practices: For working in a team

Practice	Example
 Be Clear & Concise	Keep language simple and direct
 Listen Actively	Give full attention, don’t interrupt
 Be Respectful & Supportive	Value all contributions
 Clarify & Confirm	Restate key points to check understanding
 Use the Right Channels	Match method (chat, email, meeting) to the message
 Give Constructive Feedback	Focus on improvement, not blame

Communication Checklist:

1. Did each person understand the priority?
2. Were unclear terms explained?
3. Was there a confirmation loop?
4. Did any assumptions lead to failure?

Building a Toolkit:
Conducting a SWOT Analysis

SWOT Analysis

https://www.cipd.org/en/knowledge/factsheets/swot-analysis-factsheet/

SWOT Analysis

Situation

At your foundation, you have received news that you will have significant funding cuts due to the US Funding cuts. Work with your group to design a SWOT to collaborate across the network/your foundations to continue to work toward shared goals in the context of funding cuts.

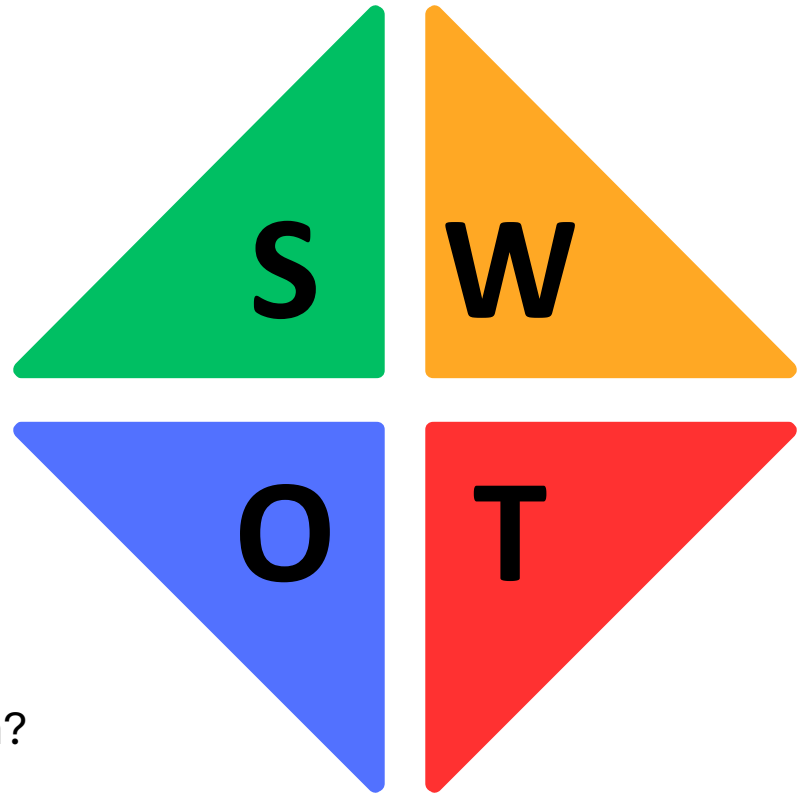
SWOT Analysis Diagram

STRENGTHS

- What do we do well as an organization?
- What is unique about us?
- Where do we stand out?

WEAKNESSES

- What are some gaps in the services we provide?
- Where are we lacking knowledge or resources?
- Where can we improve in patient care?



OPPORTUNITIES

- What strengths could we leverage for collaboration?
- How can we address shifting priorities?
- What external factors can the organization use to achieve its objectives?

THREATS

- What external challenges could negatively impact the organization?
- What weaknesses do we have that could expose us to threats?

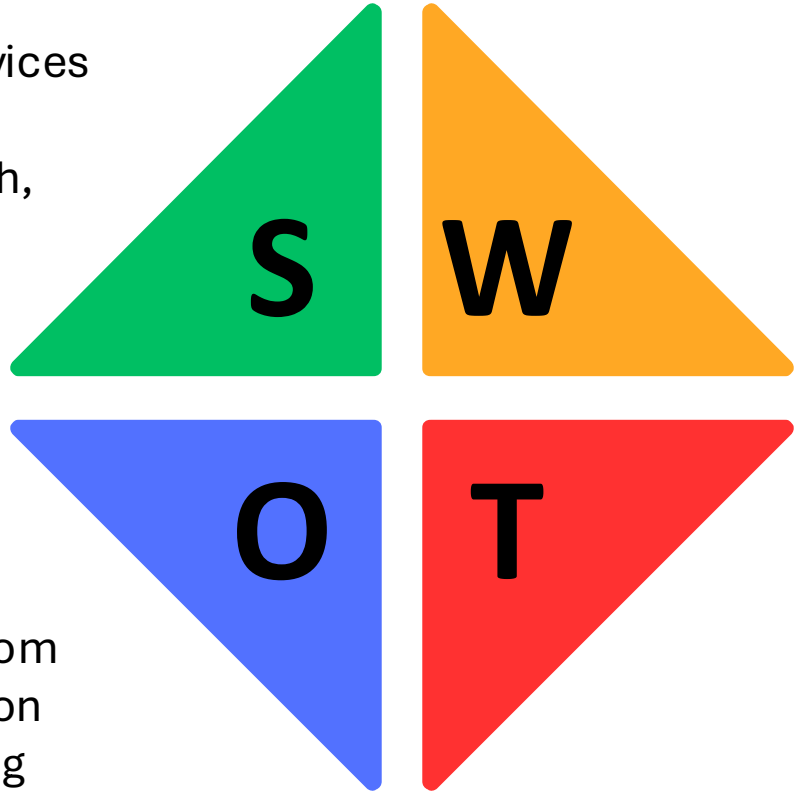
SWOT Analysis Diagram

STRENGTHS

- Diversity of clinical services (pediatrics, cardiology, surgery, maternal health, nutrition, etc.
- Research
- Diversity of expertise

WEAKNESSES

- Lack of familiarity of activities at other foundations
- Need for platform for communication across the network
- Lack of familiarity with other experts across the network



OPPORTUNITIES

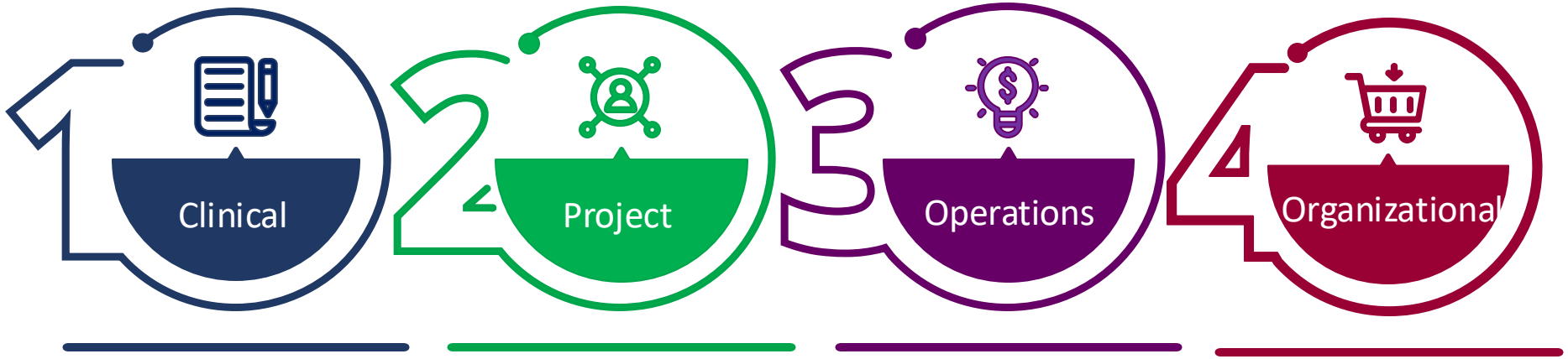
- Opportunity to learn from others within network on successful grant writing
- Opportunities to share expertise across network for clinical care and streamline services

THREATS

- Continued uncertainty in the global health landscape
- Impact of the stop work orders to local partnerships
- Need for continued focus on successful and competitive grant-writing

Building a Toolkit:
Strategies to Identify and Smash Silos

Strategies Handout



Guiding Principles to Break Down Silos
Commit to a shared vision
Create a culture of COLLABORATION
Check biases and work to understand one another
Look at the total system of care with multiple perspectives
Enhance communication across departments, levels, units
Foster interprofessional and interdisciplinary TEAMWORK
Socialize across teams
Conduct interprofessional team-building and training sessions
Coordinate quality and safety efforts
Center care around patient needs and shared-decision-making
Have a patient-centered rather than disease-specific focus
Align incentives to shared outcomes and system-wide goals
Use integrated/standardized EMRs
Utilize digital collaboration tools

Silo Smash Ideas

Clinical

- Establish a "medical home" for a patient as the primary provider who coordinates with patient's other specialists.
- Create a specialist directory that is accessible by all teams
- Conduct weekly or biweekly case review meetings with other providers to discuss shared patients and coordinate care
- Discuss patients with other providers in real time while the patient is in clinic
- Leverage the EMR to share notes and results
- Establish a system to know what other prescribed treatment they have received between visits with you.

Research

- Create rotational research assignments across technical units
- Implement centralized knowledge management platforms
- Incentivize collaborative research projects
- Standardize process for reviewing and approving project ideas
- Keep all departments informed of ongoing projects
- Find common ground among funders
- Share data

Silo Smash Ideas

Operational

- Leverage Microsoft Teams to communicate within and across sites
- Encourage cross-departmental collaboration during inter-departmental meetings
- Conduct regular operational syncs between departments to align demand planning, resource allocation, and delivery schedules

Organizational

- Conduct team-building activities that include all of organization allowing for cross-interactions among the teams
- Leverage multiple communication platforms to enhance transparency and lateral information flow.
- Maintain clinically relevant indicators by aligning data metrics and reporting for evidence-based decisions.
- Unify facility-based and outreach data reporting via one database to streamline data and avoid duplication.

Taking it to the Next Level: Network Collaboration

Thinking Beyond Silos

Exploring Opportunities for Sustainable Global Health Network Collaborations

Thinking Beyond Silos

Leveraging our collective expertise, we can ignite innovation and dismantle operational silos together!

X = Actively Engaged	0 = Something to work towards (future goals)	Diabetes Services	Anemia Detection	Vision Screening	Nutrition/Nutritional Recovery	Immunization	Newborn Screening	Well-child visits	Early Childhood Development	Adolescent Services	Adult Transition	HIV/AIDS Prevention	HIV/AIDS Care and Treatment	HIV exposed child (-)	TB Services	Hepatitis	Family planning/Reproductive Health	Teen Pregnancy	Maternal Health	Prenatal screenings	Cervical Cancer Screening	Cancer Prevention, Treatment and Care	Sickle Cell Disease	Emergency Medicine	Pediatric Surgery	Livelihoods	Health Professional Training	Community Health Worker Training	Nurse Training	Midwife Training	Global Health Corps	Global Child Health Residency	Short-Term Learner Program	Global Health Security	Refugee and Migrant support	Rural Medicine/Outreach	Palliative Care services	Psychosocial Support	GBV prevention/Response	OVC Support	Vaccine Research	Permaculture/Gardening
ARGETNTINA		x	x	x	x		x	x									x	x	x	x	x					x	x									x						
BOTSWANA		0		0	x	x	0	x	x	x	x	x	x	0	x		x	x	x	x	x	x		0	0	x	x	x		0	x	x	x	0		x	x	x				
COLOMBIA			x	x	x	x	x	x	x								x	x	x	x	x					x	x	x		x		x			x	x		x				
ESWATINI		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	0	0	0	x	x	x	x	0	x	x	0	0	0	x	x	x	x	x	0	0
LESOTHO					x	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	0				x	x	x		x	x					x	0	x	x	x		
MALAWI					x					x	x	x	x	0	x		x	x	x	x	x	x	x	x	x		x	x			x	x	x					x				x
ROMANIA		x			x		x	x	x	x		x	x	x	x	x	x	x	x	x	x				x		x							x				x				
TANZANIA					x	x				x		x	x	x	x		x		x				x				x	x		x	x					x	x	x	x	x		
UGANDA					x	x		x	x	x	x	x	x		x	0	x	x	x		x	0				x	x	x			x	x		x	x	x	x	x	x	x	0	

Cross-Network Rapid Silo Smashing

Take 3 minutes to think and share with your team:

1. List the top 5 areas in which your site lacks expertise.

2. List the top 5 areas in which your site excels and could share expertise with other sites.

Rapid Fire Smash the Silos Q & A Debrief Session

- 🔔 Welcome to the Rapid-Fire Challenge – GHNWM Edition! Get ready for a high-energy session of quick thinking, fast reflexes, and fun competition.
- 🧠 The rules are simple: Questions will be asked one at a time. Hit your buzzer first to answer, but only if you're confident!
- ⚠️ Speed matters, but accuracy counts: A wrong answer gives others a chance to steal the opportunity; so think fast and think smart.
- 🤝 Friendly competition is encouraged:
- 🎉 Let's get started! Buzzers ready, minds sharp! Let the Rapid-Fire Challenge begin!

Cross-Network Rapid Silo Smashing

Volunteer from each site shares something they want to do better at their site

Audience members race to buzzer to say how your site can fill the gap with an idea on how to collaborate

Key Take Home Points

- Silos in healthcare lead to poor patient outcomes, inefficiencies in the system, redundancies, higher costs, and low staff morale
- Opportunities and tools exist to identify and break down silos in every organization
- Effective teamwork improves safety and efficiency
- Foster open communication across teams within Foundations to enhance coordination and shared understanding
- Align goals and priorities to promote unified action toward operational excellence
- Leverage collective expertise by encouraging cross-functional collaboration and knowledge exchange
- Build a culture of trust, accountability, and collaboration to strengthen cohesion within the Global Health Network


Siyabonga
Asante sana
Zikomo kwambiri
Siyabonga kakhulu
Muchas gracias
THANK YOU
Ke leboha haholo
Mweebale nnyo
Vă mulțumesc mult
Ke a leboga
Ahsante
Vă mulțumesc
Zikomo

Workshop: Smash the Silos! Working Cohesively When Resources are Tight

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

Tea Break ☕

15-minutes