



Quarterly Newsletter of the Association of Public Health Physicians of Nigeria

APHPN NEWSLETTER

JULY- SEPTEMBER 2026

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UPDATE FROM THE PRESIDENT

Dream Big for the Next Conference, Dream Big for Public Health

Esteemed Elders, Senior Colleagues and Colleagues I welcome you all to the last quarter of 2026. The APHPN leadership has remained steadfast in being a strong voice and policy advocate for effective public health practice and primary healthcare in Nigeria.

With our membership drawn from academia, hospitals, civil society, private sector and industry; APHPN with its strategically distributed human resources for health across the Federal, State and Local Government levels of administration, governance and leadership recognizes a unique opportunity to play key roles in steadying the course of the ship of national development.

By our training as public health physicians we bring in the best of various dimensions as clinicians, administrators, management and business development experts. The current leadership of our dear association urges all its members to be bold, pragmatic and articulate ambassadors for effective public health policy and practice improvements in Nigeria.

Let us make a huge difference within our individual spheres of influence.

APHPN wants to see stronger collaboration driven by members across the State in strategic positions between Government and Industry; Academic and Disciplinary Public Health as exemplified by the Medical Officer of Health and Doctors in the Civil Service Bureaucracy.

The association is ever proud of her members serving as Commissioners, Heads of Service, Permanent Secretaries, Vice Chancellors, Chief Medical Directors, Medical Officers of Health, Captain of Industry/Entrepreneurs, Association/Civil Society Leaders, Programme/Project managers etc.

This EXCO continues to reach out to these leaders to solicit their awareness and continued support for strategic advancement of public health and development within their states and in Nigeria. While in office, and while in power don't forget to work for Public Health; after all, as extolled by one of our leaders, Prof. MC Asuzu "Public Health is a vocation for all"

As the year 2026 gradually comes to a close let us now set our sights on the 2027 APHPN Annual General Meeting and Scientific Conference in Abuja. I urge all members to plan, prepare and participate fully in this conference and exhibit projects executed at the State and National level. Remember, it is the largest convocation of Public Health Physicians in Nigeria. Let us generate new knowledge, let us debate contemporary issues and let us collectively chart a positive course for continuing improvement in public health policy and practice in Nigeria. It also provides an opportunity to hear from and celebrate public health icons in Nigeria. Mark the dates in your calendar and be a part of history.

I commend the efforts of the local organizing committee for the conference, and I urge them to do much more to give us an unforgettable experience.

In the last quarter there has been celebrations of promotions and appointments for our members. I charge all of them to carry out their new roles with a greater commitment to service and excellence.



I commend State chapters that had elections for a change of leadership. For those states still pending, please hasten up! Administratively such change of EXCO leadership should be completed in 2026; as it is long overdue!

Finally, I commend all our members to the blessings of the last quarter of 2026!

Long live APHPN!

Long live the Federal Republic of Nigeria.

Be guided by the principle of Innovation for Common Good.

Dr. Terfa Kene

President

Association of Public Health Physicians of Nigeria

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UPDATE FROM THE SECRETARIAT 3rd Quarter, 2026

Dr. Augustine Ajogwu

Since the ground breaking ceremony for the APHPN Headquarters and Estate in Karshi, Abuja, on the 7th April, 2026 a lot of work has been done by the APHPN secretariat and the Solap Groups to co-create a design that will suit the purpose for the Headquarters, as a legacy project for the Association. Plans are on the way to commence work on the project as soon as possible.

We still call on our members who are yet to key into the estate project to do so. To continue to create awareness among our members and to update everyone on the project, there has been virtual fortnight engagements with our members to provide update on the project. Feel free to engage the secretariat and the solap groups for more clarifications. It is our wish to carry everyone along as we journey together on this project.

Riding on the current mission of the Dr Terfa Kene led administration on Innovation, Common good, Service, Research and partnership, the Association of Public Health Physicians of Nigeria (APHPN) joined the Society for Public Health Professionals of Nigeria (SPHPN) on their 6th Annual Conference jointly organized by SPHPN and Professional Association of Public Health Nurses of Nigeria (PAPHNON) from 24th-29th August 2026, with a theme **“PUBLIC HEALTH IN A CHANGING WORLD, INNOVATION, EQUITY AND GLOBAL HEALTH SECURITY”** in Abuja.

The conference highlights the need to build resilience and improve surveillance for the emerging infectious and non-infectious disease threat especially in fragile health systems, incorporate digital innovation for health equity in technology adaptation, policy and partnerships. Adapt public health strategies to reduce climate related emergencies and combat non-communicable disease surge using primary health care for equity and universal health coverage. It also advised on leveraging data science for disease prevention and collaborative public health practice in Nigeria. The APHPN Congratulates the President and Members of SPHPN for the outing.

The Association Public Health Physicians of Nigeria state branches are as also making tremendous effort towards transition from their various previous administration to a new one. Few state branches have had their annual general meeting and have conducted election.

There are still other state branches yet to conduct election despite their having over stayed the required term in office. We congratulate states that have transitioned to new exco and urge state branches yet to conduct election to do so, to help bring new life to the APHPN in the respective states.

GOOD WILL MESSAGE FROM ASSOCIATION OF PUBLIC HEALTH PHYSICIANS OF NIGERIA (APHPN) TO SOCIETY FOR PUBLIC HEALTH PROFESSIONALS OF NIGERIA (SPHPN) ON ITS 6TH ANNUAL CONFERENCE TAGGED ABUJA 2026.

The Association of Public Health Physicians of Nigeria (APHPN) wishes to felicitate with the Society for Public Health Professionals of Nigeria (SPHPN) on its 6th Joint Conference with professional Association of Public Health Nurses of Nigeria (PAPHNON) Tagged ABUJA 2026.

The Theme of this year's Conference **“PUBLIC HEALTH IN A CHANGING WORLD, INNOVATION, EQUITY AND GLOBAL HEALTH SECURITY”** and the Subthemes captured the changing public health landscape. Public Health Innovations should be geared towards improving public health services, improve research output for actionable public health decision making and common good.

As a corporate member of SPHPN and providing the current leadership, APHPN is committed to supporting activities that will impact the health of Nigerians. We wish you successful deliberations.

Signed
Dr Terfa Kene

Dr Augustine Ajogwu
National President
Secretary General

43RD APHPN ANNUAL GENERAL MEETING/ SCIENTIFIC CONFERENCE ABUJA, 2026



ASSOCIATION OF
PUBLIC HEALTH PHYSICIANS
OF NIGERIA

43RD APHPN

ANNUAL SCIENTIFIC CONFERENCE
AND GENERAL MEETING

ABUJA 2027



CALL FOR ABSTRACTS

THEME

Renewing Nigeria's Public Health
Architecture: Hope, Equity, Resilience
and Digital Innovation

SUB-THEMES

1

Multisectoral, Multi-Strategic, Multi-Disciplinary Action
for Health: Engaging Non-Health Sectors to Advance
Public Health Objectives

2

Digital Health Innovations to Improve Access and Quality
Leveraging Telemedicine and AI to Bridge Gaps in
RMNCAH+N and Geriatric Care

3

Combating Health Worker Brain Drain and Health Workforce
Retention: Task-Shifting and Task-Sharing as a Panacea to
Public Health-Driven Primary Care

4

Climate Change Adaptation & Mitigation in Public Health
Addressing How Environmental Shifts Exacerbate Public
Health Challenges in Health and Social Care

5

Commercial Determinants of Health and the NCD Epidemic
Regulating the Production and Consumption of Alcohol,
Tobacco and Ultra-Processed Foods for a Healthier Population.

ABSTRACT GUIDELINES

• Word format

• Maximum 300 words (excluding author(s)
details, titles, affiliations, contact details)

• Times New Roman, 12 pt

• Double line spacing

• Maximum 6 keywords

• Sections: Title, Author(s), Affiliation(s),
Contact details of corresponding
author(s), Background, Objective(s),
Methods, Results, Conclusion

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Please submit abstracts
via the conference website
<https://aphpnabuja2027.org/>

SUBMISSION WINDOW

10th August, 2026 – 10th November, 2026

Researchers, practitioners, policymakers, academics
and students are invited to submit original abstracts
for oral or poster presentation.

PUBLIC HEALTH SPOTLIGHT

The Global Burden of Perinatal Mental Health Distress and Birth-Related Psychological Trauma

Introduction

Maternal mental health is a critical yet frequently disregarded issue that determines the character and experience of a woman's health during the perinatal period. The perinatal period has been defined differently by different authorities; for example for the World Health Organisation defines it as the period from the 22 completed weeks of gestation upto 7 days postnatal. The extended clinical definition stated that it is the period between 28 weeks gestation to 28 days postnatal. While for Mental health, the extended perinatal mental health definition presented it as the period from the 3rd trimester up to 2 years postpartum. This is because the emotional and hormonal effects of pregnancy and motherhood last long after birth.

Early motherhood, childbirth, and pregnancy can be extremely difficult for women, as they frequently lead to substantial modifications in their financial situation, physical appearance, and overall well-being. Consequently, numerous women undergo mental health transformations that may adversely affect their overall health and, consequently, the welfare of their families and children. The perinatal period represents a window of heightened vulnerability for maternal mental health. Globally, it is estimated that 10% of pregnant women and 13% of new mothers experience a mental health disorder, primarily depression or anxiety. (WHO, 2023) In a global scale, the systemic failure to recognise psychiatric distress as a core component of maternal morbidity has led to severe consequences, including impaired maternal-infant bonding, developmental delays in children, and, in severe cases, maternal suicide—which remains a leading cause of death among postpartum women globally.

Maternal mental health disorders are significantly more common in low- and middle-income countries (LMICs) than in high-income countries. According to the WHO, approximately 15.6% of pregnant women and 19.8% of postpartum women in developing nations experience a mental health disorder. In some highly disadvantaged or conflict-affected regions, the pooled prevalence of common perinatal mental disorders (CPMDs) spikes much higher, reaching up to 33% to 37%.

Maternal Mental Health Disorders in Nigeria

Maternal mental health in Nigeria is a critical public health concern, with an estimated 14% to 30% of postpartum women experiencing depressive symptoms and perinatal mental health disorder. Traditional postpartum care in Nigeria focuses almost exclusively on physical recovery and infant immunization, frequently overlooking maternal psychological well-being. The stigma surrounding mental illness in Nigeria discourages affected women from seeking professional help, leading many to suffer in silence. Cultural perceptions often associate postpartum distress with spiritual or supernatural causes rather than treatable medical conditions, further exacerbating barriers to timely intervention.

(Jidong et al)

In Northern Nigeria, the prevalence of maternal mental health disorders is generally higher than the national average, with research showing postpartum depression (PPD) rates ranging between 21.8% and 44.5%. In specific clinical or high-stress localized studies, symptom presentation scales can spike even higher. (Adedoyin Et al)

Untreated maternal distress is associated with adverse outcomes, including impaired mother-infant bonding and suboptimal child growth. (Gelaye et al., 2016). This mental trauma is frequently triggered by a perceived threat to the life of the mother or the infant, severe medical complications, or a lack of support during labor.



Dr. Aishatu Abubakar Sadiq MBBS, PgDip, MPH-FE, PhD
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Kaduna State Ministry of Health

Acknowledgment:

Kaduna State Mental Health and Substance Abuse Agency (KADSAMHA)

Forms of maternal mental Health

Maternal mental health disorders represent a spectrum of psychological conditions that may arise during pregnancy and extend into the postpartum period. The types include

1. **Maternal Blues:** This is the mildest and most common form experienced by up to 80% of mothers within the first few days after delivery, characterized by transient tearfulness, mood lability and anxiety, which typically resolves spontaneously within two weeks without intervention.
2. **Perinatal depression:** This can be more persistent in perinatal period. It usually begins during the antenatal period or at any time in the first year after birth. It presents with sustained low mood, feelings of guilt and inadequacy, exhaustion, loss of interest, changes in sleep and appetite, and difficulty bonding with the infant.
3. **Maternal Anxiety:** Mothers experience excessive and uncontrollable worry about their own health and that of the baby, accompanied by restlessness, palpitations and panic attacks.
4. **Obsessive-compulsive disorder:** In some women, maternal anxiety presents with an intrusive, distressing thoughts of harm coming to the baby, leading to compulsive checkings, cleaning or avoidance behaviors. The mother may remain horrified by thoughts which in reality poses low risk to the baby.
5. **Post-traumatic stress disorder:** This occurs particularly following a traumatic delivery, emergency caesarean section, stillbirth or severe obstetric hemorrhage, post-traumatic stress disorder may develop, marked by flashbacks, nightmares and avoidance of reminders of the birth..
6. **Postpartum psychosis:** This is the most severe maternal mental health disorder. It is a psychiatric emergency affecting 1-2 per 1000 deliveries, usually with abrupt onset within the first two weeks postpartum. It presents with confusion, delusional beliefs, hallucinations, extreme mood swings and disorganized behaviors with significant risk to both mother and infant and requiring urgent hospitalization.
7. **Other conditions include tokophobia**, which is a morbid fear of childbirth, and adjustment and substance use disorders, all of which reflect the complex interplay of biological, psychological and social stresses surrounding motherhood. It is not a single cause, but a combination of these factors that increases the risk for maternal mental health disorders

Poor mental Health and babies

Mental health conditions impact significantly on maternal functioning and prevent the mother from being emotionally available to meet the demands of her child. Poor maternal mental health (MMH) could have lifelong consequences on a child. It predicts stunted growth and adverse neurological development in the children of the affected mothers, disrupts mother and child bonding and healthy childhood attachment with long-term adverse effects.

Risk Factors

The risk factors associated with poor MMH vary across cultures and the world regions. In high-income countries (HICs), psychosocial risk factors have been significantly associated with the onset of depression after delivery. However, there are conflicting results for obstetrics risk factors which may be because health centres are more accessible, and child delivery is relatively safe in these countries.

In low- and middle-income countries (LMICs), obstetric complications have been associated with poor MMH, where the clinical practice is often of poor quality and delivery associated with higher rates of maternal and infant morbidity and mortality. In essence, maternal depression is one of the most common complications affecting 19.8% of women in LMICs.

The common risk factors for Maternal Mental Health disorders are enumerated below;

1. Biological / Physical Factors

- Personal or family history of psychiatric illness (depression, anxiety, bipolar)
- Hormonal changes
- Teenage or advanced maternal age
- Chronic medical illness, anemia, HIV, severe nausea/vomiting
- Sleep deprivation

2. Psychological Factors

- Unplanned / unwanted pregnancy
- Fear of childbirth / negative attitude to motherhood
- Low self-esteem, perfectionism
- Previous trauma or childhood abuse
- -History of premenstrual dysphoric disorder

3. Obstetric & Infant Factors

- High-risk pregnancy, previous miscarriage, stillbirth, infertility
- Complicated delivery, emergency C-section, preterm birth
- Neonatal Intensive Care Unit (NICU) admission, low birth weight, congenital abnormality
- Difficulty breastfeeding
- Previous perinatal mental illness

4. Interpersonal / Relational Factors

- Lack of partner support / single motherhood
- Intimate partner violence, marital conflict
- Lack of family/social support
- Recent bereavement or loss
- Poor relationship with own mother

5. Socio-Economic / Cultural Factors

- Poverty, low income, financial stress
- Low education level, unemployment
- Unplanned pregnancy stigma, gender-based preference for child
- Substance use / alcohol by mother or partner
- -Isolation, migrant status, urban slum residence

Health System Factors

- Poor Antenatal Care / Post Natal Care
- Negative experience with health workers
- Unmet need for information about pregnancy and childcare
- Lack of Integration of mental health into Primary Health Care: Routine ANC and postnatal care primarily focuses on physical complications (e.g., blood pressure, infection, bleeding). Screenings for psychological distress are rarely integrated into standard maternal healthcare pipelines.
- Severe Centralisation of Care: Specialist mental health services are concentrated almost exclusively in secondary and tertiary institutions or the country's eight federal neuropsychiatric hospitals. This layout isolates rural and low-income populations from accessing treatment.
- Budgetary Neglect: Less than 3% of Nigeria's national health budget is allocated to mental healthcare, leaving public infrastructure severely dilapidated and lacking the resources required to roll out holistic models of care.

Obstetric violence and Psychological Trauma

A critical catalyst for birth-related psychological trauma in developing nations is the prevalence of obstetric violence (OV). This term encompasses the verbal abuse, humiliation, physical coercion, and non-consensual medical interventions inflicted upon women by healthcare providers during labor and delivery.

In many public healthcare facilities across Nigeria, systemic overwork and burnout among midwives and doctors have institutionalized a culture of harsh maternal treatment. Cross-sectional data in Nigeria highlight that a staggering 32.3% to nearly 50% of facility-based deliveries involved some form of obstetric violence, most notably non-dignified care, verbal insults, and abandonment. Procedures such as episiotomies or manual placenta removals are often performed without adequate anesthesia or informed consent. This institutional betrayal strips women of their autonomy and dignity at their most vulnerable moment, transforming an empowering lifecycle event into a deeply traumatizing violation. The psychological scars of such experiences deter women from seeking institutional care for future pregnancies, perpetuating a vicious cycle of unsafe home deliveries and elevated maternal mortality rate

Postpartum depression among Teenage mothers

Teenage mothers experience postpartum depression at a rate up to twice as high as adult mothers, facing unique psychological and social vulnerability.

Stigma, disrupted education, and feelings of hopelessness often accompany early motherhood. Insufficient caregiving help from family members, especially the child's father, strongly correlates with severe depressive symptoms.

A multi faceted program combining reproductive health education, financial assistance, and accessible mental health services are essential support required for teenage or adolescent mothers. interpersonal psychotherapy and community support groups will help to reduce the feelings of isolation

Public health effects of MMHD

The public health effects of maternal mental health disorders (MMHDs) extend far beyond the individual mother. Globally, and particularly in developing nations like Nigeria, the societal and epidemiological impacts are structured across four main public health pillar.

1. Maternal mortality and obstetric complications

- **Leading Cause of Death:** Suicide linked to severe perinatal depression and postpartum psychosis is a leading cause of maternal mortality globally, accounting for up to 27% of late postpartum deaths in some regions.
- **Obstetric:** This include higher rates of preeclampsia, gestational diabetes, and postpartum hemorrhage (PPH).
- **Disrupted Care-Seeking:** Mothers experiencing severe depression are significantly less likely to attend the recommended antenatal and postnatal care, creating gaps in preventive medical care

2. Infant Physical Health and Survival

- **Birth Outcomes:** Untreated maternal mental disorders predisposes to high prevalence of low birth weight (LBW) and preterm delivery.
- **Malnutrition and Stunting:** Depressed or severely anxious mothers frequently struggle with the physical demands of exclusive breastfeeding or basic infant nutritional care. This results in under-nutrition, growth stunting, and wasting
- **Preventable Childhood Illnesses:** Infants of mothers with untreated depression have higher incidences of infectious illnesses like pediatric diarrhea and respiratory infections, as self-care and immunization compliance drop.

3. Child Neurodevelopment and Intergenerational Mental Illness

- **Impaired Attachment:**
- The MMHD in early maternal-infant bonding alters the child's neurological response to stress.
- **Cognitive and Behavioral Deficits:** As the children grow, they exhibit lower cognitive performance, delayed language acquisition, and a higher risk of behavioral issues like Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorders.
- **Transgenerational Transmission:** Children of mothers with chronic perinatal depression are **three times more likely** to suffer from depression, anxiety, or substance abuse conditions during adolescence and adulthood, perpetuating a cyclical public health issue
- 4. Maternal mental health services in Nigeria face severe systemic, financial, and cultural challenges that leave conditions like postpartum depression and anxiety largely undiagnosed and untreated.

Challenges of the Nigeria maternal health services

1. Shortage of Professionals and Infrastructure

- **Extreme workforce deficit:** Nigeria has fewer than 300 psychiatrists for a population of over 200 million people.
- **Facility centralization:** Specialized mental health care is heavily concentrated in urban secondary and tertiary teaching hospitals, making it largely unavailable at primary healthcare centers where most rural women seek antenatal and postnatal care.
- **Frontline strain:** Midwives and primary health workers lack adequate mental health training and face severe time constraints during routine visits, preventing early detection.

2. Cultural Stigma and Beliefs

- **Social judgment:** Deep-seated social stigma surrounds mental illness, forcing many Nigerian mothers to hide their symptoms out of fear of discrimination or being labeled as weak.
- **Spiritual misattribution:** Traditional and cultural beliefs often attribute psychological distress to spiritual failure or weakness rather than medical conditions, delaying professional intervention

3. Financial and Economic Barriers

- **Out-of-pocket costs:** Health insurance coverage remains exceptionally low (covering fewer than 10% of Nigerians), meaning women must pay directly for medical and mental health services. [1, 2]
- **Poverty and illiteracy:**

Perinatal distress and Socioeconomic stressors

In developing countries, the burden of perinatal distress is amplified by pervasive socioeconomic stressors. Nigeria, as Africa's most populous nation, serves as a poignant case study for this of widespread poverty, gender inequality, high fertility rates, and a fragile healthcare infrastructure creates a high-risk environment for maternal psychological morbidity.

Research indicates that the prevalence of postpartum depression (PPD) in Nigeria sits significantly higher than global averages. Regional studies utilizing the Edinburgh Postnatal Depression Scale (EPDS) have reported varying but consistently elevated rates: approximately 21.8% in Jos, 33.7% in Ilorin, and as high as 34.6% to 37.8% in parts of southern and eastern Nigeria like Enugu, Delta, and Ibadan. A state-wide assessment confirmed that perinatal distress in Kaduna State is a significant public health issue affecting 1 in 7 women, a rate consistent with regional estimates in Nigeria

The etiology of this distress is deeply rooted in social determinants. Nigerian women frequently navigate chronic financial insecurity, lack of social security, and marital instability. Furthermore, preference for male children in certain cultural contexts places immense psychological pressure on pregnant women, where the birth of a female infant can trigger marital rejection, familial hostility, and subsequent depressive episodes.

Birth-related trauma in Nigeria is also intrinsically linked to the country's high maternal mortality ratio. Entering a labor ward in Nigeria is frequently accompanied by a profound fear of death. The reality of poorly equipped facilities, frequent power outages during emergency surgeries, and severe shortages of skilled healthcare personnel turns the birthing process into an inherently terrifying ordeal, laying the groundwork for severe post-traumatic stress.

Challenges of the Nigeria maternal health services..Cont

4. Policy and Integration Gaps

- **Lack of routine screening:** Mental health assessments are rarely integrated into standard antenatal and postnatal protocols.
- **Slow policy execution:** While frameworks like the National Mental Health Act exist, consistent implementation, funding, and enforcement at the grassroots level remain

5. Gender and Sociocultural Pressures

- **Male child preference:** Deeply rooted cultural preferences for male heirs place immense psychological distress on mothers. Women who give birth to girls are frequently blamed, facing marital disharmony, threats of abandonment, or polygamy, which dramatically spikes perinatal depression.
- **Judgment of non-traditional births:** Mothers who deliver via Cesarean section (C-section) or suffer from unplanned pregnancies face significant social judgment, as traditional norms heavily romanticize natural, uncomplicated childbirth.
- **Lack of spousal support:** Postpartum recovery is often viewed strictly as a "woman's job." A lack of emotional and practical support from husbands forces new mothers to handle strenuous domestic duties alongside newborn care, leaving them vulnerable to severe exhaustion and anxiety

Conclusion

Maternal mental health conditions—spanning from postpartum blues to severe perinatal depression and psychosis—constitute a silent crisis deeply impacting Nigerian families. Driven by economic hardship, obstetric trauma, and harsh cultural pressures like gender preferences and birth stigmatization, these disorders are heavily compounded by systemic barriers. Nigeria's response is critically hindered by severe psychiatric workforce shortages, centralized urban facilities, high out-of-pocket costs, and a reliance on untrained traditional birth attendants. Overcoming this crisis requires an immediate, multi-sectoral paradigm shift. Nigeria must mandate routine, culturally adapted screenings during antenatal and immunization visits through clinical task-shifting, expand paid maternity leave to the informal sector, and actively partner with faith-based and community leaders to dismantle social stigma. Safeguarding the mental health of mothers is a fundamental development imperative. By implementing these structural and cultural reforms, Nigeria can protect both the bodies and the minds of its women, ensuring healthier generations and a more equitable society.

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Recommendations

1. **Clinical Integration:** There is a need for policy implementation of mandatory routine mental health screenings during child immunisation and antenatal visits using culturally adapted screening tools. We also need to scale up task-shifting frameworks to train Community Health Extension Workers (CHEWs) and midwives in basic psychological first aid.
2. **Community Alignment:** The National and Subnational mental health agencies in collaboration with the Primary Health Care Development agencies needs to formally train and partner with Traditional Birth Attendants (TBAs) to recognize warning signs for mental health distress and build structured community referral systems including targeted community campaigns to address poor spousal support and local cultural pressures, such as the preference for male heirs or the stigma surrounding C-section births.
3. **Financial & Policy Reforms:** The National Health Insurance Authority (NHIA) needs to expand its packages to explicitly cover perinatal mental health consultations and medications. The government with the support of critical stakeholders need to fully fund and implement the National Mental Health Act at state and local government levels.
4. **Workplace and Legal Reforms**
 - Extended and enforced paid maternity leave: The current 3 to 4 months of maternity leave—often only enforced in the formal public sector is insufficient for complete physical and psychological recovery. Policies should be updated to mandate a minimum of 6 months of paid leave, extended explicitly to the informal sector where millions of Nigerian women work.
 - Paternity leave legislation: National and state-level laws must institutionalize mandatory paternity leave (currently non-existent or limited to just a few days in select states). This legally encourages husbands to share early childcare burdens, directly reducing postpartum exhaustion and anxiety.
 - Workplace mental health policies: Private and public institutions should introduce structured "return-to-work" programs that offer flexible hours, dedicated nursing spaces, and confidential counseling access for returning mothers.
5. **Education and Religious Engagement**
 - Faith-based leader coalitions: Since millions of Nigerians look to pastors and imams before doctors, State Ministries of Health should partner with religious bodies (like CAN and NSCIA). Training clerics to screen for clinical signs and refer women to medical professionals—rather than treating severe distress solely as a spiritual attack—drastically cuts down delayed interventions.
 - School-based reproductive health education: The Federal and State Ministry of Education should integrate maternal health and psychological self-care into the senior secondary school curriculum. Educating young Nigerians early helps dismantle the negative cultural norms of childbirth and reduces generational stigma surrounding mental illnesses.
 - Premarital counseling curriculum: Work with local registries, churches, and mosques to embed maternal mental health and postpartum expectations into mandatory pre-marital counseling programs. This prepares couples for the psychological shifts of parenthood before conception.
 - Perinatal mental health is deeply entwined with socioeconomic vulnerability. Addressing the structural drivers of poverty and limited education is as critical as clinical intervention. By integrating trauma-informed, task-shared mental health services into the PHC framework and financing them through existing National and subnational insurance schemes, the country can significantly improve maternal and child health outcomes nation-wide.

NEWS IN BRIEF

APHPN at the 20th Africa International Housing Show (AIHS @20 – Legacy Edition)

The Association of Public Health Physicians of Nigeria (APHPN) proudly participated in the 20th *Africa International Housing Show (AIHS @20)* held at the Transcorp Centre, Abuja, under the theme: *Housing Solutions for Low-Income and Informal Workers in Africa.*



The APHPN delegation was led by our Innovative President, Dr Terfa Kene, alongside Prof. Abah Stephen (President, SPHPN), Dr Philippa Momah (APHPN Elder), Dr Juliette Ango (National Treasurer, APHPN), Dr Esther Agmadalo Cegbeyi (Secretary, APHPN FCT-Abuja Branch), and Dr Chris Okoh (PRO, APHPN FCT-Abuja Branch).

CONGRATULATIONS TO AN ICON



Prof. Chundung Miner led the Executive Council of APHPN Plateau State Branch warmly congratulates *Dr. Pokop Bupwatda* on his *re-appointment for a second tenure* as *Chief Medical Director, Jos University Teaching Hospital (JUTH)*.



APHPN President, Dr. Terfa Kene, in a group photograph with the APHPN Vice President, Prof. Omosivie Maduka; Prof. M. C. Asuzu; SPHPN President, Dr. Stephen Abah; and other APHPN members participating in the 6th SPHPN and 37th PAPHON Conference held in Abuja.

MEET THE NEWLY ELECTED EXCO OF GOMBE STATE



From right to left
Dr Lamingo John - Chairman, Dr Danimoh Mustapha Abdusalam - Immediate Past Chairman, Dr Nuhu Yusuf Babale - Secretary, Dr Hauwa Adamu Saurayi - Treasurer and Dr Imran Al Hassan Bojude - PRO

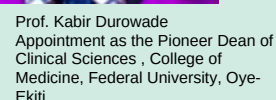
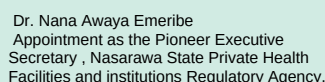
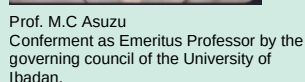
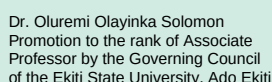
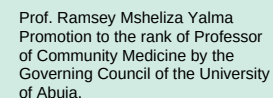
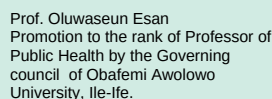
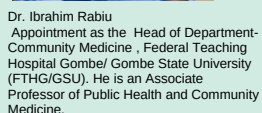
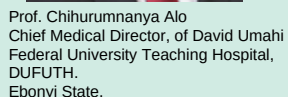
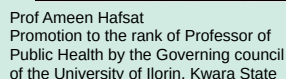
APHPN PLATEAU JOINS STAKEHOLDERS TO ADVANCE HEPATITIS ELIMINATION ON WORLD HEPATITIS DAY 2026*

The Association of Public Health Physicians of Nigeria (APHPN), Plateau State Branch, was among the key partners that joined the Plateau State Ministry of Health, the World Health Organization (WHO), APIN Public Health Initiatives, and other stakeholders to commemorate World Hepatitis Day 2026 in Jos.



Representing the *Chairman of APHPN Plateau State Branch, Prof. Chundung Miner, Dr. Franca Dabang,* who also served on the planning committee, delivered the Association goodwill message. She reaffirmed APHPN's commitment to supporting evidence-based interventions, strengthening public health systems, and working closely with government and development partners to eliminate viral hepatitis.

APHPN celebrates its members who have risen to enviable heights of service to Mankind.



APHPN Congratulate its members on the Occassion of their Inaugural lecture that was held Successfully.

**THE VICE CHANCELLOR
KADUNA STATE UNIVERSITY
PROF. ABDULLAHI I. MUSA**
Cordially invites you to the

**21st Professorial
Inaugural Lecture**

TOPIC
**FROM ACCESS TO AGENCY:
REIMAGINING REPRODUCTIVE
HEALTH IN NORTHERN NIGERIA**

Date: Thursday 13th, August 2026 **Time:** 11:00 am
Venue: 1000 Seater Auditorium.
Kaduna State University , Kaduna - Nigeria

RSP:
Inaugural Lecture Committee
0803 311 0091, 0904 446 6964

Prof. Awawu Grace Nmadu
MBBS, MPH, PhD, FRCP
Professor of Community Medicine and Public Health
College of Medicine,
Kaduna State University





REV. FR. MOSES ORSHIDO
AAU UNIVERSITY
MAKURDI, BENUE STATE



TELEVISION
LIVE
STREAM

26th

INAUGURAL LECTURE

TITLED

FOOD, THE FORGOTTEN PRESCRIPTION: CENTRALITY OF DIET IN HEALTH PROMOTION, PREVENTION AND CONTROL OF CHRONIC DISEASES FOR THE REPRODUCTIVE AGES

To Be Delivered By >>>

PROFESSOR PRISCILLA
MWUESE UTOO

Chairperson

PROFESSOR TIMOTHY
TERSEER ALABAR

Vice Chancellor MOAU



DATE

THUR 3RD SEP, 2026

TIME

12PM EXHIBITION
2PM LECTURE

VENUE

COLLEGE OF HEALTH
SCIENCES AUDITORIUM I

TICKET

(08064608224)
(08123649682)



Join us Live



04

DAYS TO GO

Global Public Health Dates of Significance: October - December 2026

CULLED FROM THE WORLD HEALTH ORGANIZATION AND UNITED NATIONS WEBSITES



OCTOBER 10TH ,2026



NOVEMBER 17TH ,2026



NOVEMBER 15TH ,2026



WORLD AIDS DAY
DECEMBER 1ST ,2026



NOVEMBER 18TH TO 24TH ,2026



INTERNATIONAL DAY OF PERSONS WITH DISABILITIES
DECEMBER 3RD ,2026



UNIVERSAL HEALTH COVERAGE DAY
DECEMBER 12TH ,2026