

Influence of Public Health Campaigns on Childhood Cancer Awareness and Early Detection in an Urban African Setting: A Mixed-Methods Study

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Abstract

Background: Childhood cancer survival rates in low- and middle-income countries (LMICs) are significantly lower than in high-income regions, primarily due to delays in diagnosis that can be addressed. While public health campaigns are increasingly activated to raise awareness, their impact remains limited, especially in sub-Saharan Africa. This study examined how such campaigns influence awareness of childhood cancer, health-seeking behaviours, and early detection efforts in Abuja, Nigeria, situated in the Federal Capital Territory (FCT).

Methods: An explanatory sequential mixed-methods approach was employed. Quantitative data were obtained through a cross-sectional survey of 358 residents, healthcare professionals, NGO representatives, and caregivers across six FCT area councils, using stratified sampling to ensure stakeholder inclusion. The questionnaires assessed awareness, exposure to campaigns, perceived barriers, and health-seeking behaviours. To further explain these findings, qualitative data were collected through semi-structured interviews with 15 key informants, including pediatric oncologists, oncology pharmacists, and other specialists directly involved in the care of children with cancer. Data analysis included descriptive and inferential statistics such as chi-square tests and logistic regression, complemented by thematic analysis of qualitative responses.

Results: Awareness of childhood cancer was generally high at 86.5%; however, 19.8% of respondents could not recognise any early warning signs. Only 46.9% reported exposure to awareness campaigns, with clear differences between urban and rural areas. Although 77.6% of those exposed believed the campaigns helped reduce delays in seeking care, no significant link was found between campaign exposure and rejection of harmful beliefs ($p > 0.05$). Major barriers included financial constraints (77.6%), fear of stigma (51.9%), and cultural beliefs (43.0%). Clinicians consistently noted that catastrophic out-of-pocket costs are a key factor in mortality, yet current campaigns do not adequately address this issue.

Conclusions: Public health campaigns in Abuja have boosted visibility but still face limited reach and minimal influence on behaviours leading to late presentation. Economic challenges and ongoing socio-cultural beliefs hinder awareness. To effectively reduce childhood cancer mortality, strategies must combine community education with financial support and health system improvements. These campaigns should go beyond merely spreading information; they must also tackle affordability and access issues that limit the benefits of increased awareness.

Keywords: Childhood Cancer; Public Health Campaigns; Early Detection; Health-Seeking Behaviour; Low- And Middle-Income Countries; Mixed Methods; Nigeria

Background

Childhood cancer poses a major yet unequal global health issue. While high-income countries (HICs) see over 80% five-year survival rates, low- and middle-income countries (LMICs) often see rates below 30% [1,2]. This gap is due to systemic failures in early detection, prompt referral, and treatment access, not biological differences in the disease [3,4]. The WHO's Global Initiative for Childhood Cancer (GICC) aims for a 60% worldwide survival rate by 2030, emphasizing early diagnosis as a key priority alongside treatment and supportive care [5].

Nigeria, the most populous country in Africa, faces a significant childhood cancer burden, estimated at 5–10 cases per 100,000 children each year, though underreporting remains an issue [6,7]. In Abuja's Federal Capital Territory (FCT), the presence of major healthcare centers such as the National Hospital Abuja, University of Abuja Teaching Hospital, and Federal Medical Center Jabi provides a supportive framework for better outcomes. Nevertheless, clinical data show that over 70% of children still present at advanced stages of disease [8].

Diagnostic delays in childhood cancer occur through multiple mechanisms. Patient delay—the interval between symptom onset and first healthcare contact—reflects caregiver recognition and symptom interpretation. Health system delay includes misdiagnosis, insufficient investigations, and weak referral pathways. Treatment initiation is delayed when diagnosis is confirmed but access to appropriate oncology services is limited [9,10]. In theory, public health campaigns aim to address patient delay by enhancing symptom recognition and encouraging health-seeking behaviour [11].

Evidence from various African contexts indicates that the success of campaigns depends on cultural adaptation, integration, and strengthening the health system. For example, in South Africa, adding childhood cancer education to Road to Health booklets led to improved referrals in primary care [12]. Initiatives in Ghana and Uganda that used community radio and engaged traditional leaders yielded better results than generic messaging strategies [13,14]. Nonetheless, there is limited rigorous empirical evidence on how these campaigns affect mortality-related pathways, especially in urban West African settings [15].

The FCT offers a unique setting for assessing campaign success. Abuja has higher levels of education, more extensive media access, and better healthcare facilities compared to other Nigerian regions. These factors could theoretically enhance the impact of awareness campaigns. Yet, if late presentation continues despite these advantages, it highlights the limitations of awareness efforts and underscores the importance of structural barriers.

This study fills an empirical gap in campaign evaluation by exploring: (1) current awareness levels and their distribution regarding childhood cancer; (2) patterns of campaign reach and exposure; (3) how the campaign influences health-seeking behaviours; (4) ongoing barriers to early detection; and (5) clinical views on the campaign's effectiveness and factors affecting mortality.

Methods

Study Design

We employed an explanatory sequential mixed-methods design [16]. Quantitative data were collected first, followed by a qualitative inquiry aimed at explaining and confirming the statistical findings. This method was chosen to blend broad population-level insights with detailed clinical interpretation, all while ensuring ethical considerations for caregiver participation.

Study Setting

The Federal Capital Territory, established in 1976, comprises six Area Councils: Abuja Municipal Area Council (AMAC), Bwari, Gwagwalada, Kuje, Kwali, and Abaji. AMAC is the main urban area with the largest population and most developed infrastructure, while the other councils exhibit varying degrees of peri-urban and rural characteristics. The diverse demographics of the FCT—including different ethnicities, socioeconomic backgrounds, and migration patterns—provide important insights for analysing how campaign effects vary among different population groups.

Quantitative Component

Sampling and recruitment

The sample size was determined using Cochran's formula for large populations, with a 95% confidence level, a 50% proportion estimate, and a 6% margin of error, resulting in $n = 267$. After accounting for a 10% non-response rate, the target sample size was set at 296; ultimately, 363 valid questionnaires were collected.

Stratified sampling ensured representation across four stakeholder strata: the general public (50%), healthcare professionals (20%), NGO/advocacy representatives (20%), and parents/caregivers (10%). Within the public stratum, geographic distribution across area councils reflected population proportion with deliberate oversampling of under-represented councils. Recruitment combined physical distribution at health care facilities and community events with online dissemination via professional networks and organisational platforms.

Data Collection

A structured questionnaire was developed through an iterative process involving paediatric oncologists and academic supervisors. It comprised sections on: (A) sociodemographic details; (B) awareness of childhood cancer and early warning signs; (C) exposure to public health campaigns across digital, broadcast, print, and community outreach platforms; (D) health-seeking intentions; and (E) perceived barriers, including financial, cultural, and systemic obstacles. The campaign's effect on early health-seeking behaviour was assessed using a 5-point Likert scale. Barriers were evaluated with multiple-response questions.

Data collection occurred from February to June 2024 and was administered electronically via Google Forms; paper questionnaires were used as an alternative when digital access was limited. Participation was voluntary and based on informed consent, with no identifiers recorded.

Statistical Analysis

Data were analysed with IBM SPSS Statistics 31. Descriptive statistics summarised the sample composition and awareness levels. Chi-square tests examined the relationships between campaign exposure and categorical outcomes such as awareness and belief systems. Binary logistic regression assessed the predictive links between exposure and mortality-related behaviours. Significance was defined at $p < 0.05$.

Qualitative Component

Participant Selection

Fifteen paediatric oncologists, oncology pharmacists, and senior residents were purposively sampled from three major tertiary centres. Saturation was determined by redundancy in emerging themes. Prior research indicates that 9–17 interviews typically achieve saturation in homogeneous expert samples [17,18].

Data Collection

The semi-structured interviews focused on: (1) observed shifts in parental awareness and presentation methods; (2) the reach and impact of the campaign; (3) systemic obstacles to early detection; (4) economic factors affecting care-seeking; and (5) key interventions to reduce mortality. They were carried out either in person or through video conference, recorded with consent, and transcribed word-for-word.

Analysis

Thematic analysis was conducted following Braun and Clarke's six-phase approach [19]. Researchers repeatedly read the transcripts, generating initial codes that were grouped into potential themes. These themes were then reviewed for clarity and uniqueness, defined, named, and aligned with research objectives. Trustworthiness was confirmed through member checking and maintaining audit trails.

Integration

The quantitative and qualitative findings were integrated at the interpretation stage. Discrepancies (e.g., high perceived campaign influence versus persistent late presentation) were examined through a qualitative lens. Convergence and divergence were transparently reported.

Ethical Considerations

Ethical approval was granted by the Ethics Review Board of the University of Abuja and the FCT Health Research Ethics Committee. Caregivers only took part in the quantitative part to minimize potential psychological stress. Confidentiality was preserved via pseudonymization and secure data storage. The study followed the principles outlined in the Declaration of Helsinki.

Results

Sample Characteristics

Out of 363 valid questionnaires, 358 were analyzed, resulting in a response rate of 98.6%. The distribution among stakeholder groups was as follows: the general public made up 66.2% (n=237), medical personnel 12.0% (n=43), NGO/CSO representatives 11.7% (n=42), and parents/guardians 3.9% (n=14). Female respondents accounted for 62.0%, and 97.9% had completed tertiary education. Geographically, most respondents were from AMAC (59.0%), which mirrors the population distribution, although rural councils like Abaji (3.6%) and Kwali (2.8%) were also represented.

The highly educated sample is both a strength and a limitation: it indicates awareness among those most likely to grasp campaign messages, but it could lead to an overestimation of awareness in the overall population.

Awareness of Childhood Cancer

General awareness was high, with 86.5% (n = 217) claiming to have heard of childhood cancer. Nonetheless, knowledge of symptoms was inconsistent. The most recognised symptom was unexplained weight loss (22.6%), followed by swelling (18.5%) and persistent fever (16.8%). Notably, 19.8% of respondents reported not being able to identify any symptoms. Awareness of specific warning signs was low: leukocoria was recognised by only 8.3%, unexplained bruising or bleeding by 9.6%, and persistent headache also by 9.6%.

Campaign exposure and reach

Campaign exposure was uneven: 46.9% reported exposure, 51.8% reported none, and 1.3% were uncertain. This near-even split indicates substantial penetration gaps despite ongoing NGO activities (particularly the Okapi Children Cancer Foundation and the Medicaid Cancer Foundation) and periodic government collaboration.

Among the exposed respondents, the perceived campaign influence on early health-seeking was predominantly positive: 52.0% rated it as solid (5/5), and 21.6% as strong (4/5). Only 15.7% reported minimal or no influence.

Barriers to Early Detection of Cancer

Financial constraints were the most reported barriers (77.6%), followed by fear of stigmatisation (51.9%), cultural beliefs (43.0%), lack of trust in the healthcare system (21.9%), and distance to the hospital (19.0%). These barriers were not mutually exclusive; respondents often identified multiple constraints.

Statistical Associations

Chi-square analysis showed no statistically significant link between campaign exposure and rejection of awareness-related attitudes (Table X). Exposure was not significantly connected to rejecting views such as childhood cancer as a "death sentence" ($\chi^2=0.991$, $p=0.320$), the equivalence of traditional and orthodox medicine ($\chi^2=1.892$, $p=0.169$), or belief in prayer-only treatment ($\chi^2=1.535$, $p=0.215$).

Similarly, logistic regression revealed non-significant predictive relationships, but the odds ratios consistently pointed to protective effects. For example, belief in a death sentence had an OR of 0.63 ($p = 0.237$), belief in traditional medicine had an OR of 0.63 ($p=0.128$), and belief in prayer-only had an OR of 0.67 ($p = 0.168$).

Qualitative Findings

Campaign Reach and Perceived Effectiveness

Clinicians acknowledged modest improvements in awareness, particularly among educated, urban families. One pediatric oncologist observed: *"Parents now present early... however, this is seen mostly in the educated and middle- and upper-class families"* [KII-1]. However, others noted minimal population-level change: *"No significant change has been noted in parents' awareness"* [KII-2]; *"Parents are still coming late with their children"* [KII-4].

Campaigns were consistently characterised as urban-centric and NGO-dependent, with limited rural penetration: *"These activities are usually limited to the main city of Abuja'. The rural areas and villages are not covered"* [KII-12]. Even heightened awareness among elites did not translate to reduced mortality without addressing affordability.

Economic Barriers as a Primary Driver of Mortality

Clinicians unequivocally identified financial constraints as the dominant mortality factor, which campaigns inadequately addressed. Representative quotations include the following:

"The single biggest factor contributing to childhood cancer mortality in FCT that is not being addressed by health campaigns is lack of funds." After presentation and diagnosis, most parents cannot afford the cost of prolonged treatment" [KII-1]

"There's one thing to be aware of, that yes, these are symptoms of cancer and all that, but if I'm aware of something, but I don't have the means, how helpful is that knowledge?" [KII-4]

"NGOs need to work together and clamour for financial support from the government in terms of subsidy or free childhood cancer costs" [KII-7]

The absence of childhood cancer coverage under Nigeria's National Health Insurance Authority (NHIA) scheme was repeatedly cited as a critical policy gap.

Systemic and Cultural Barriers

Misdiagnosis at the primary care level and weak referral systems were highlighted: "Many children are repeatedly treated for malaria or infections before anyone suspects cancer" [KII-1]. Cultural beliefs remained strong despite increased awareness: "Some parents believe the illness is spiritual or caused by witchcraft, so they initially visit prayer houses or traditional healers" [KII-6].

Integration of the Findings

Quantitative and qualitative results aligned on important aspects: (1) awareness campaigns increase visibility but have inconsistent reach; (2) perceived impact on health-seeking behaviour is greater than actual behavioural changes observed; (3) financial obstacles outweigh the advantages of awareness; and (4) ongoing structural issues within the health system remain. The lack of significant statistical links between exposure and beliefs, along with clinician reports of continued late patient presentations, suggest that while awareness is necessary, it alone is not enough to reduce mortality.

Discussion

This study shows that public health campaigns about childhood cancer in Abuja, Nigeria, are highly visible among educated urban groups but have had limited success in changing behaviors toward early detection. Three main findings are particularly important.

The gap between general awareness and specific symptom knowledge reflects patterns seen in other LMIC contexts. While many recognize "cancer" as a concept, they often struggle to identify early warning signs, especially those requiring careful observation like leukocoria and bruising, rather than obvious symptoms such as weight loss or swelling [20,21]. This has significant clinical implications: children with advanced retinoblastoma caused by unrecognized leukocoria tend to have much poorer outcomes than those who seek early ophthalmologic care due to their symptoms.

Secondly, the lack of a significant link between campaign exposure and rejecting harmful beliefs—despite consistent trends—implies that attitude shifts need ongoing, intensive interaction rather than one-time exposure. The HBM suggests that behavior change relies on perceived susceptibility, severity, benefits, and barriers; our results show that campaigns might raise per-

ceived severity but often fall short in tackling perceived barriers [22,23]. This insight has practical value: campaign strategies should directly include messages aimed at reducing barriers and offering resource navigation support, rather than just focusing on symptom education.

Third, and most importantly, the dominance of financial barriers in both quantitative and qualitative data questions the idea that awareness deficits are the main modifiable factor affecting mortality. Even in a highly educated group with nearly universal awareness, 77.6% saw cost as the main obstacle. Clinicians were clear: awareness alone, without affordability, leads to "diagnosis without treatment" situations that can increase mortality by extending the time between diagnosis and death without improving survival. This supports Knaul et al.'s view of childhood cancer as a "tracer condition" for assessing health system performance and financial protection [3,24].

The study's geographical context—Abuja as Nigeria's most advantaged urban centre—where infrastructure and education are most favourable. If financial barriers dominate mortality pathways, the situation in less-resourced regions is likely to deteriorate significantly. This provides empirical support for prioritising financial protection mechanisms such as NHIA inclusion, subsidised diagnostics, drug access programmes, and awareness initiatives.

Our findings help clarify a debate in global childhood cancer control: whether to focus more on raising awareness or improving treatment access given limited resources [25,26]. The evidence indicates there's no need to choose one over the other: awareness efforts alone have diminishing returns unless financial barriers are addressed, and expanding treatment capacity won't be effective if families seek help too late. Successful strategies should combine both approaches, with campaign redesigns that include "awareness-plus" elements such as clear information on available financial aid, assistance with NHIA enrollment, and stronger referral linkages.

Limitations

The sample, with 97.9% holding tertiary education, restricts how well the results apply to less-educated groups who may encounter greater awareness and access obstacles. Online recruitment tends to favor urban participants, introducing bias. The cross-sectional nature of the study prevents conclusions about cause-and-effect relationships related to the campaign. Additionally, self-reports of exposure and behavioral intentions might not accurately reflect actual actions. Although ethically justified, excluding caregivers from the qualitative part removed insights from those with direct experience of diagnostic and treatment processes.

Implications for Policy and Practice

The findings endorse targeted recommendations: (1) redesign campaigns to focus on symptom specificity and resource navigation rather than just raising general awareness; (2) formally include childhood cancer in NHIA benefit packages with dedicated funding for pediatric oncology; (3) enhance primary healthcare training to improve early cancer detection; (4) foster NGO-government collaborations to broaden campaign outreach to peri-urban and rural councils; (5) advocate for "awareness-plus" approaches that integrate education with financial counseling and referral services.

Conclusions

Public health campaigns in Abuja have increased awareness of childhood cancer, but their reach is limited and their influence on early detection behaviours remains weak. The continued occurrence of late-stage diagnoses, even among well-educated groups, shows that simply providing information is not enough; financial hurdles and health system limitations play a larger role. Reducing mortality effectively will need combined efforts that include community education alongside measures to im-

prove affordability and strengthen healthcare infrastructure. Campaigns should go beyond spreading information to directly tackle economic and access-related barriers, which undermine the benefits of awareness. The Abuja case indicates that the main challenge in childhood cancer survival has shifted from lack of awareness to affordability, especially in urban low- to middle-income settings with fairly developed infrastructure, requiring strategic changes by advocates, policymakers, and health planners.

Declarations

Ethics Approval and Consent to Participate

This study was approved by the University of Abuja Ethical Review Board and the FCT Health Research Ethics Committee. All participants provided informed consent.

Consent for Publication

Not applicable—no individual identifying data included.

Availability of the Data and Materials

Anonymized dataset is available from the corresponding author on reasonable request.

Competing Interests

The author has no competing interests to declare.

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Authors' Contributions

Adekanye Oluwakemi Sharifah and Dr Okonokhua Oziengbe Lewis conceived, designed, conducted, analysed, and drafted the manuscript. Prof. Umar Kari supervised all stages and approved the final version of the manuscript.

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