

FESTMIH



NEWSLETTER

2026

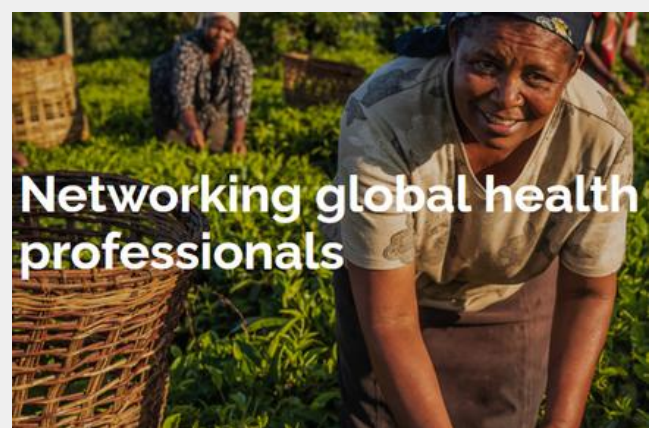
3RD ISSUE

We are delighted to present Issue 3 of the FESTMIH Newsletter for the fourth quarter. Moving through Q4 alongside the international days dedicated to disaster risk, food security, child health, disability, and epidemic preparedness, this edition explores the structural and human dimensions of prevention, care, and health equity across borders.

This edition follows the rhythm of United Nations International Days across the fourth quarter of 2026. Rather than treating clinical practice, ecology, and structural policy as separate silos, our contributors show how deeply they intersect. We begin with **disaster risk reduction**. Drawing on his medical work following the 2023 earthquake in Hatay, **Guenther Froeschl** challenges our fixation on short-term technical fixes and argues that genuine resilience begins with prevention, health literacy, and equity. For **World Food Day**, we revisit the botanists who starved during the 1942 siege of Leningrad to protect the world's first global seed collection, connecting agrobiodiversity directly to the widespread micronutrient deficiencies clinicians encounter today. Marking **World Children's Day**, representatives from the **German Society of Tropical Paediatrics and International Child Health** outline how bedside ultrasound, decentralized training, and pragmatic task-shifting strengthen care for vulnerable newborns and children in under-resourced hospitals. For the **International Day of Persons with Disabilities**, field accounts from the Democratic Republic of the Congo, South Sudan, and Bangladesh demonstrate that tackling neglected tropical diseases requires far more than halting transmission: it demands mobility aids, mental health support, and placing lived experience at the center of care. To close the issue, **Piero Olliario** and **Els Torreele** dissect the anthropogenic drivers and political choices behind recurring epidemics, making the case for a coordinated, public-interest research model over proprietary biodefence priorities. As always, this newsletter depends on the commitment of our community. Thank you to everyone who contributed their field notes, rigorous data, and frontline perspectives to this issue. We warmly welcome your contributions for upcoming editions, whether you would like to submit a brief case reflection, an operational update, or a critical viewpoint from your work.

Warm regards,

The FESTMIH Newsletter Team



Networking global health professionals

October 13th
International Day for Disaster Risk Reduction

October 16th
World Food Day

November 20th
World Children's Day

December 3rd
International Day of Persons with Disabilities

December 27th
International Day of Epidemic Preparedness

Mini NEWS OF THE MONTH
NOTM - September 2026

<https://www.festmih.eu/>

FESTMIH

INTERNATIONAL DAY FOR DISASTER RISK REDUCTION

**October
13th**

Rethinking Resilience: Lessons from the Rubble of Hatay

Disaster response often fixates on immediate technical rescue, yet the longest shadow of any catastrophe unfolds long after the emergency crews depart. Medical lead Dr. Guenter Froeschl reflects on his humanitarian deployment in Hatay following the February 2023 earthquake, where mobile teams treated thousands in makeshift camps suffering from cold, respiratory infections, and profound trauma. Linking international disaster relief with domestic climate realities like European heatwaves, he challenges technocratic fixes and makes the case for investing in long-term public health literacy, equity, and genuine prevention.

**October
16th**

WORLD FOOD DAY

The Seeds They Did Not Eat: From Leningrad to Clinical Malnutrition

During the 872-day siege of Leningrad, botanists starved to death rather than consume the world's first global seed collection, defending genetic options for an uncertain future. Today, that sacrifice speaks directly to a modern global health dilemma: while 645 million people face hunger, healthy diets remain unaffordable for 2.7 billion, and over five billion suffer from severe micronutrient deficiencies due to extreme crop homogenization. This feature traces how preserving agrobiodiversity from Vavilov's expeditions to the Svalbard vault is fundamental to combating hidden hunger in clinical medicine.

WORLD CHILDREN'S DAY

**November
20th**

Empowering the Frontline: Point-of-Care Ultrasound and Pediatric Equity

With 4.8 million children still dying before their fifth birthday each year, global child health requires pragmatic, decentralized solutions that overcome severe workforce shortages. In this interview, representatives from the German Society of Tropical Paediatrics and International Child Health (GTP) discuss their international bedside ultrasound network (IPUN), the emerging promise of AI-guided diagnostic mentoring, and vital task-shifting models in rural maternity clinics in Malawi. Their experience proves how peer-to-peer training and sustainable partnerships turn human rights commitments into life-saving clinical practice.

**December
3rd**

INTERNATIONAL DAY OF PERSONS WITH DISABILITIES

Beyond Disease: Centering Lived Experience in Disability-Inclusive Care

Eliminating neglected tropical diseases requires far more than halting pathogen transmission; it demands lifelong care for the millions living with chronic morbidity and social stigma. Through personal accounts from the Democratic Republic of the Congo, South Sudan, and Bangladesh, this field report highlights individuals who regained mobility, work, and community standing after receiving corrective surgery, assistive footwear, and mental health support. It illustrates why people with lived experience must actively lead advocacy and why disability inclusion belongs at the core of all NTD programs.

INTERNATIONAL DAY OF EPIDEMIC PREPAREDNESS

**December
27th**

Politics and Pathogens: Human Drivers and Equity in Epidemic Response

Infectious disease outbreaks are expanding in scale and frequency, driven by human encroachment into natural habitats, industrial farming, and intensifying global mobility. In this critical policy review, Piero Olliaro and Els Torreele argue that current global health security frameworks disproportionately prioritize the commercial interests and border defenses of high-income nations while neglecting recurrent endemic crises. Drawing on evidence from Ebola, mpox, and COVID-19, they call for a public-interest pharmaceutical ecosystem that treats medical innovation as a shared global good.



NOTM SEPTEMBER 2026

Papers, Calls, Events and Tools

Closing this issue, our Mini News of the Month brings the monthly rubrics into the quarterly format. The Editors' Choice presents two studies on why prevention fails at the clinic door: a latent class analysis of tuberculosis preventive treatment adherence among people living with HIV in Ethiopia, and a qualitative look at the group health talks through which most parents receive their vaccine information. Alongside these, you will find open calls and fellowships, autumn conferences and trainings across Europe and the Eastern Mediterranean, two new digital tools from Colombia and Tanzania, and a Society Space introducing the Netherlands Society for Global Health.



“PREVENTION IS THE PURSUIT OF HAPPINESS”

The 2026 International Day for Disaster Risk Reduction, observed on 13 October, carries the theme “Resilience Starts at Home”. **Dr. Guenter Froeschl** has seen what happens when the home is gone. He talks about the weeks he spent in Hatay (Turkey) after the February 2023 earthquake, about what remains once the cameras leave, and about why he distrusts purely technical fixes.

Let us start with you. Who are we talking to?

I am a medical doctor, a specialist in internal medicine, infectious diseases and tropical medicine, and I added a Master of Science in International Health, which is about development cooperation and humanitarian aid. I work at LMU University Hospital in Munich, where I am a board member of the CIHLMU Center for International Health and head the Teaching and Training Unit, with our PhD and master's programmes in International Health, as well as a working group on humanitarian aid. And that is my second life, as a humanitarian aid worker. I have been deployed on missions with Médecins du Monde, Médecins Sans Frontières and the Red Cross, to several countries and in all kinds of contexts.



HATAY 2023

© NYTimes - 'No More Antakya'

When the earthquake struck on 6 February 2023, your own organisation's office in Hatay was in the middle of it. How did you end up there?

I knew about it immediately. I was a board member of Médecins du Monde (MDM) at the time, and the organisation had an office in Hatay.

I am half Turkish and fluent in the language, so I asked the director of our institute straight away whether he would agree to my going on a mission again, and he said yes at once. The local infrastructure of MDM was destroyed and the staff dispersed, part of it dead, so any assistance would have to be implemented from outside. My proposal was taken up immediately. Deploying is not the same as entering a country as a tourist, though. You need clearance from the local government, and as a non-citizen that took me several days.

By the time I arrived, the clearance of rubble and the search for survivors were under way, and I came in as medical team lead for the mobile units ...

In those first days, attention is concentrated almost entirely on the search for survivors, because the chance of survival declines very rapidly. That is often a very technical response. The question that follows, is how to care for the many thousands who have been displaced. The city itself was entirely destroyed and practically empty. Everyone who survived had moved to the outskirts or into the mountains with nothing. And it was February. In that part of Turkey it is cold, and it was raining.

Your teams recorded more than 3,000 consultations across roughly 40 villages, and around a quarter of them were respiratory infections. That is not what most people picture after an earthquake.

The pattern of health needs that we observed belongs to the aftermath rather than to the earthquake itself: overcrowding in makeshift shelters, people sleeping on the ground, cold and damp. We saw a great many respiratory infections, and later substantial outbreaks of scabies in the shelter colonies.

And the surgical cases?

That was beyond our capacities. We were not a team of surgeons or anaesthesiologists, and not trained to cover extensive traumatology. Emergency medical tents went up very quickly, often built by military services, who are trained for exactly that. Turkish disaster response is very strong, and many patients were transferred to other cities in Turkey, some abroad. Turkey is a large country with a well-functioning health system. Our own services were directed at basic medical needs of the difficult to reach dispersed population, mostly located in the surrounding mountain region.

AFTER THE CAMERAS LEAVE

The immediate response period, with incoming donations and support, seem to have been well funded and organised. But a city cannot be rebuilt in a few weeks. What happens over the months that follow?

For the first hours and days people are essentially on the street, and plastic sheeting is distributed so that they can put up the most basic tents themselves. Then come the proper United Nations tents, about 23 square metres, and you could soon see huge tent cities everywhere. After a few weeks the Turkish authorities began ordering containers, which replaced the tents. Containers are firm structures: you can install a kitchen, heat them, connect water and sewage. Industrial compounds in other Turkish cities converted entirely to producing them. Families could be housed in them and cook for themselves, so ready-made food was no longer required. The Turkish response was genuinely impressive.

What we cannot imagine is losing something we have taken for granted since birth, namely that the ground we stand on is firm. In the mountain areas, where the damage was lighter and a good number of buildings would have been habitable, we found people sleeping outside all the same. They were in such distress, suffering from post-traumatic stress disorder, that they would not enter a solid building. The trust was gone. And then, after some months, people remain in the container cities. Many are still there today. What used to be your home, with your neighbours and your social life, has disappeared. You are suddenly like a refugee in a place you are not familiar with any more, aware that this cannot be your future but with no idea what your future looks like.

AND THE ATTENTION HAS MOVED ON ...

What do German newspapers report about this today? Nothing. Attention to disasters is very immediate. Who is asking now what has become of the people affected by the earthquakes in Venezuela in June? There is no attention, and people feel that. Thousands are living under these conditions while reconstruction goes on.

That is why the theme "Resilience Starts at Home" matters. As the smallest unit of society, the home cannot be overstated. It is where we live, where we thrive, where we take in our sense of protection. To lose it, in any disaster, natural or man-made, is profoundly distressing.

THE HEAT AT HOME

Germany has no relevant earthquakes, but this summer it had the heat: a national record of 41.8 °C, breaking the previous record the day before that, close to 12,000 heat-related deaths by the end of July. What should we be doing here?

All of this can be summarised as distress to the human being. I am against misusing terminology simply to make something sound more striking so that somebody reacts to it. But in the final metres it comes down to the distress of the individual, or of that small unit, the family, the home. That is what people dying of heat is. The political response is one thing. But we reach often for technical solutions: homes must be insulated against heat as well as cold, we need air conditioning, we must prepare workplaces. That is partly right. Yet these are technical solutions, and the fixation on technical solutions is itself part of the problem.

There is a decisive difference to an earthquake. If I live on a fault line I know there is a risk. It may come tomorrow or in a hundred years, and it is nature. I can reduce my vulnerability by building differently, or by living elsewhere. Climate change and pollution are another matter. I was always puzzled by the argument over whether we can accept 2.5 degrees or whether it should be 1.5. Again the focus is on the technicality, and in my view that is counterproductive. It is not politics that will change this. It is the mindset and the action of every single person as member of our global community.

I would compare it to eating and drinking. There is little point in demanding that politics prohibit one food or subsidise another. Everyone knows that a greasy burger and two beers a day is unhealthy, and people continue to consume it anyway. That is a question of mindset. We still have role models who are entirely unhelpful here, and I will not say which very prominent Bavarian politician I have in mind. Pointing fingers at others is equally unhelpful. It is ourselves who have to change, and as a society become role models, in order to reduce what we do to this planet.

And it is not only a matter of degrees centigrade. That framing is too narrow. It is pollution. It is the abuse and overuse of resources. We are extraordinarily vulnerable on this planet. Sometimes I think we are like bacteria on a golf ball: we alter the environment slightly and the colony dies away. We are nothing more than that here, so fragile, and we are simply unable to recognise it. The way we mistreat our habitat makes me sad.

There is no magic trash bin in the world, where I decide I would like a new mobile phone or a new computer and the old one just simply disappears. Stop dreaming about this. That is the decisive difference, because here it is our own agency that is responsible. It is me, Guenter, and you, Maximilian, and not some technical or political body somewhere that ought to take the right decision.

Building heatproof or earthquake-proof houses is a technical solution again. It is much more a matter of being aware of the risks we can reduce, mitigate and prepare for. And it is not about stockpiling twenty tins of tomato soup. That can be a small part of it, but it is not the point. It begins with oneself and then extends to society, and it has to come from each individual.

WHERE THE MONEY SHOULD GO

Early warning is the part of disaster risk reduction with the strongest evidence behind it, and one of the thinnest budgets. Those budgets are shrinking. If you had a modest sum to spend, where would it go?

Into education. School education, making this a subject and treating it realistically. It is not about fear. Fear is not a good guide. It can produce short-term reactions, and resilience is explicitly not about short-term reactions; those are mostly counterproductive. Unfortunately, politics operates in short periods, usually the length of a mandate, and beyond that it often does not seem to care. So I would begin early, in schools, with addressing the risks of daily life. It is a matter of better health literacy: understanding what health is, understanding risk, understanding the basic statistics behind it. People take alarm at a virus somewhere without grasping that their personal risk is minimal, and that they ought to be concerned with something else entirely when they travel there. Take as an example Zika virus, or Ebola, and all of a sudden every other risk around them disappears from their perception ...

Another aspect is equity, and in order to be able to address it we need to collect data and use it in a responsible way that aims at reducing inequities. Where do people live? How do they live? What housing, what socioeconomic situation? The most vulnerable are not us in a prosperous Munich suburb. They are more likely a population already displaced twice in the past ten years by armed conflict, living with an extreme climate and under food scarcity. Take almost any place in the Sahel: a whole set of extreme exposures and vulnerabilities coinciding.

And in the end it is again our own behaviour, including in global politics. We bear responsibility for armed conflicts, and for chronically fragile situations, because we have interests in resources or in political orientations there. So we have to be transparent about our own decisions, in order at least to mitigate the man-made elements of the distress those populations face.

I cannot offer you the one instrument I would implement. But I would target the education of the general public. I would want people to understand the risks, and the consequences of their own behaviour, at home and when they travel.

“GLORY IS LIKE A HEROIN SHOT”

A phrase that stuck after COVID: there is no glory in prevention. Nobody talks about the evacuation where nobody died, or the outbreak that stopped at five cases. Travel medicine has the same problem. People come to us for malaria prophylaxis, which matters, when in many of those countries a road accident is far more likely to kill them. Can prevention ever attract the same light?

To me, glory is like a heroin shot. Too many crave it, and I am not interested in such immediate effects. Why do people stop and stare when something happens? People are indignant about it, but it is entirely natural and evolutionarily important. We stop and try to analyse the situation, and it is not even a conscious decision, because we are assessing risk and learning for our own future behaviour. When the zebra stops to watch its brother taken by lions, that is a moment of learning. What did my brother do wrong? Obstructing the people who can help is a different matter, and a real problem. But the immediate response of a human, like of any animal, is that. This is the underlying mechanism of short-lived media attention to catastrophic events.

But as a professional working in this field, I would not see “glory” as anything to strive for. I am interested in the analysis of situations in order to learn from them. We have learned a great deal from the COVID pandemic. The difficulty is the way we shape media and political attention, and that is probably where the idea of glory comes from. Quick attention, immediate response, and that is what everyone goes for. As scientists we are interested in the analysis and the learning, so that we can respond better and prevent. None of us wants another pandemic like COVID.

And prevention itself? What is it actually aiming at?

At our feeling safe, secure and happy in a place where we want to be. It is the pursuit of happiness in the end. That may sound flat, but I believe it matters. What do we strive for? Happiness. And its most basic element is the absence of distress. I want the ground to be firm. I want my home around me, and my family. I want not to have to worry about food, or about the safety of my children in the future. I want to see a landscape worth seeing. Nobody wants destroyed nature. Even those who go out and buy an enormous car that adds to the problem of pollution want the beautiful nature and the green grass. That is what prevention describes, because prevention means avoiding everything that endangers our vision of a happy and fulfilling life.

I have great regard for media that return repeatedly to countries no one else is looking at, that go back years after the attention has subsided. What is happening now, ten years after Ebola in Liberia or Sierra Leone? What is happening to the affected populations many years after the 2004 tsunami? I very much like media that go to these places and ask what became of those societies, how they are now, and what they learned from that disaster. All of this is an important element of prevention.

The Seeds They Did Not Eat

Leningrad, 1942, and what a besieged seed bank still says about food security

by Maximilian Förster

In the summer of 1942, two groups of people in the same besieged city were asked what was worth going hungry for. One was given extra bread to play a symphony. The other sat on tonnes of edible seed and did not touch it. Eighty years on, the second group's argument has become a global health question.



© Inside the Plant Institute seed bank.
Photograph: Courtesy of the VIR

On 9 August 1942, the Leningrad Radio Orchestra played Shostakovich's Seventh Symphony in the Grand Philharmonia Hall. Hitler had chosen that date months earlier for a victory banquet at the Astoria Hotel, and the city knew it. The concert went out over loudspeakers, into the streets and towards the German lines.

Getting eighty people onto that stage had taken two months. The first rehearsal in March was called off after fifteen minutes because the musicians could not hold their instruments. Karl Eliasberg, the conductor, went looking for retired players, convalescents in hospitals and soldiers with musical training who could be released from the units defending the city. The authorities issued the orchestra extra food rations. Three musicians died during rehearsals anyway. When some of the players objected to spending what strength they had left on a difficult modern score, Eliasberg threatened to withdraw the rations, and the objections stopped.

That is worth sitting with. In a city where several hundred thousand people would starve to death, bread was being spent as an instrument of cultural policy, and it worked.

Less than two kilometres away, on St Isaac's Square, a converted palace held the largest seed collection in the world. Inside it a small group of botanists were doing the opposite arithmetic. They were surrounded by rice, wheat, peas, maize and potatoes, all of it edible, all of it catalogued and labelled. Across the 872 days of the siege, at least nine of them starved to death without touching the collection.

A law announced in Saratov

Nikolai Vavilov was thirty-three when he stood up at the Third All-Russian Congress on Breeding and Seed Production in Saratov on 4 June 1920 and announced what he called the law of homologous series in variation. Related species, he argued, vary in parallel ways, so the traits catalogued in one well-studied species predict the traits waiting to be found in its relatives. His audience compared the idea to Mendeleev's periodic table. Two years later the paper appeared in the Journal of Genetics, edited by William Bateson.

The prediction had a practical edge. If variation runs in series, it can be hunted. Between 1923 and 1933 Vavilov and his colleagues mounted expeditions to some sixty countries, and out of that fieldwork came his second idea, the centres of origin of cultivated plants. Crop diversity, he showed, is not spread evenly across the world.

It clusters in a small number of regions, most of them mountainous, most of them in what we would now call low and middle income countries: the Ethiopian highlands, the Andes, Mesoamerica, Central Asia, the Near East. Agriculture in Europe and North America was living off genetic capital accumulated somewhere else, by farmers nobody had thought to credit.

By 1940 the Leningrad collection ran to hundreds of thousands of samples, among them roughly 35,000 wheats and 10,000 maizes. That August, Soviet security officers arrested Vavilov in the Carpathians while he was out collecting. He was sentenced to death in July 1941, the sentence was commuted to twenty years, and on 26 January 1943 he died of malnutrition in a prison in Saratov. The city where he had announced his law was the city in which he starved.

Bread was being spent as an instrument of cultural policy, and it worked.

The arithmetic in the palace

A seed collection is not an archive. It is a population that has to be kept alive. Most crop seed loses viability within a few years in ordinary storage, so an accession that is not periodically sown, grown and reharvested is one that dies quietly on the shelf. This is why the botanists of the Plant Institute did not simply lock the doors and wait. Through the siege they went on planting. They rescued potato stock from an experimental station in the path of the advancing army, sowed plots within range of German guns, and defended the fields against a population that was, entirely reasonably, hungry.

The choice they faced is usually told as a story about heroism, and it is easy to see why. It is more useful as a story about arithmetic. The collection could have kept a handful of people alive for a few months, or a city of two million for very close to no time at all. Against that stood material representing the only surviving copies of landraces from five continents, many of them from farming systems that would not outlast the century. The botanists judged that the second value exceeded the first, and they were explicit about it.

Whether they were right is not obvious, and there is no reason to pretend otherwise. At least nine people died to preserve options for a future that, in the winter of 1942, had no guarantee of arriving. What is clear is that they were not confused about what they were doing. They had made a decision about time horizons, which is exactly the decision that public health institutions are asked to make and are usually bad at.

From one palace to a global system

Vavilov's argument was that crop diversity is finite, unevenly distributed and erodible. The eighty years since have proved him right in a way he would not have enjoyed.

The FAO's Third Report on the State of the World's Plant Genetic Resources for Food and Agriculture, published in 2025 and drawing on submissions from 128 countries and seventeen research centres, found that nine crops now account for more than 60 per cent of global crop production: sugarcane, maize, rice, wheat, potato, soybean, oil palm fruit, sugar beet and cassava. Within those nine, production rests on a small number of varieties. The same report found that 42 per cent of crop genetic diversity is no longer present in at least one area where it had been recorded ten to fifteen years earlier.

A word of caution about a statistic you will meet everywhere else. The claim that 75 per cent of crop genetic diversity was lost during the twentieth century is attributed to FAO and repeated in almost every popular treatment of this subject. Khoury and colleagues traced its provenance in *New Phytologist* in 2022 and found that it rests on very limited data and a baseline nobody can reconstruct. It has functioned as an effective communication tool rather than as a measurement. The 42 per cent figure is more recent, more transparent, and quite alarming enough. The institutional answer to erosion is duplication, and the Leningrad model now has a backup. The Svalbard Global Seed Vault holds copies of collections from almost every country. It is not a doomsday cabinet but a working insurance policy, and it has already paid out.

ICARDA deposited 116,484 samples from its genebank near Aleppo between 2008 and 2014, then withdrew them in 2015, 2017 and 2019 to rebuild its collections in Lebanon and Morocco once the Syrian war made the Aleppo site impossible to operate. It remains the only genebank to have made a withdrawal. Ukraine's national collection in Kharkiv, the tenth largest in the world, had duplicated roughly four per cent of its 150,000 accessions when the war reached the city in 2022.



© The cabbage patch in front of St Isaac's Cathedral in 1942. Photograph: Б.Кудояров/Courtesy of the VIR

For a medical readership the fair question is what any of this changes in a consultation.

Start with the calories, where the news is better than it has been for some years. FAO and its partner agencies reported in July 2026 that 7.8 per cent of the world's population, around 645 million people, went hungry in 2025, down from 8.1 per cent in 2024 and 8.6 per cent in 2022. That is a third consecutive year of improvement and it deserves to be said plainly, even though Africa still carries the largest absolute burden. The more uncomfortable figure in the same report is that a healthy diet remains unaffordable for roughly 2.7 billion people.

The gap between calories and diet quality is where crop diversity enters clinical medicine. When production narrows to a handful of energy dense staples, diets narrow with it, and what disappears first is not energy but micronutrient density. Passarelli and colleagues estimated in the Lancet Global Health in 2024 that more than five billion people have inadequate intakes of iodine, vitamin E and calcium, and more than four billion of iron, riboflavin, folate and vitamin C. The clinical corollaries will be familiar to anyone working in tropical or travel medicine:

What this has to do with medicine

iron deficiency anaemia and its interaction with malaria and helminth burden, folate insufficiency and neural tube defects, iodine deficiency and cognitive development, vitamin A deficiency and both blindness and measles mortality. Those estimates model intake rather than status and do not account for industrial fortification, so they overstate inadequacy for nutrients routinely added to purchased staples, iodised salt above all. A modelling analysis in the same journal in 2026 took up precisely that gap, weighing what large scale fortification programmes achieve against what they cost to run. Fortification is the fastest lever available and it works. It is also not a substitute for a food system that rests on more than nine plants.

The 42 per cent figure is more recent, more transparent, and quite alarming enough.

BY THE NUMBERS

872 days	Length of the siege of Leningrad, from September 1941 to January 1944
At least 9	Staff of the Plant Institute who starved rather than consume the collection
9 crops	Account for more than 60 per cent of global crop production (FAO, 2025)
42 %	Of crop genetic diversity no longer found in at least one area where it was recorded ten to fifteen years earlier (FAO, 2025)
645 million	People affected by hunger in 2025, down from 8.6 per cent of the world population in 2022 (SOFI, 2026)
2.7 billion	People for whom a healthy diet is unaffordable (SOFI, 2026)
5 billion+	People with inadequate intakes of iodine, vitamin E and calcium (Passarelli et al., 2024)
116,484	Seed samples ICARDA deposited in Svalbard from Aleppo, and later withdrew

Eighty minutes, 872 days ...

The concert on 9 August 1942 lasted a little over an hour. The siege lasted 872 days. Both groups in this story were doing the same thing that week, which was defending something whose value could only be collected later, by people they would never meet.

The botanists turned out to be right, though not quite in the way they expected. The collection survived. The institute still stands in St Petersburg. And the principle they were defending, that genetic diversity is a public good worth protecting at cost, is now written into the Svalbard vault, into the international treaty system, and into every national genebank that duplicates its holdings abroad.

World Food Day asks how the world is going to feed itself. Part of the answer sits in cold rooms, in accessions collected by people whose names appear nowhere in the clinical literature. It is worth remembering that the practice of keeping them began in a city where the alternative was to eat them.

Sources: FAO, IFAD, UNICEF, WFP and WHO, *The State of Food Security and Nutrition in the World 2026* (Rome, July 2026). FAO, *Third Report on the State of the World's Plant Genetic Resources for Food and Agriculture* (Rome, 2025). Passarelli S et al., *Global estimation of dietary micronutrient inadequacies: a modelling analysis*, *Lancet Global Health* 2024;12:e1590-e1599. Khoury CK et al., *Crop genetic erosion: understanding and responding to loss of crop diversity*, *New Phytologist* 2022. Parkin S, *The Forbidden Garden of Leningrad* (2024). Bulatova N, *Archives: the law of homologous series in variation*, *Comparative Cytogenetics* 2020;14:3. Svalbard Global Seed Vault / NordGen, deposit and withdrawal records.

WORLD CHILDREN'S DAY

Empowering the Frontline: Point-of-Care Ultrasound and Paediatric Equity
Dr. Sarah Kotsias-Konopelska

World Children's Day marks the adoption of the Convention on the Rights of the Child, and with it the promise that every child is entitled to the best health care that can be had. Dr. Sarah Kotsias-Konopelska has spent twenty years working out what that promise looks like on a ward with no radiologist in the building. A paediatrician in Berlin with a diploma in tropical medicine and hygiene, she has worked in Malawi, Tanzania, South Africa, Mexico and Ecuador, joined the board of the German Society of Tropical Paediatrics and International Child Health in 2014 and has chaired the society since 2021. She talks about putting an ultrasound probe into the hands of the clinician at the bedside, about safety in a Malawian maternity service that has no doctor on site, and about keeping global child health projects running on evenings, weekends and shrinking budgets.

World Children's Day marks the day the world wrote down that every child has a right to the best healthcare that can be had. Yet roughly 4.8 million children still die before their fifth birthday, almost half of them in their first month of life. Having worked in Malawi, Tanzania, South Africa, Mexico and Ecuador: when you read numbers like that, what do you actually see? Isn't it frustrating to know how many of these deaths are preventable, and how do we move from reading these facts in paralysis to actual, systemic action?

Yes, looking at those numbers might at first be very frustrating, but I'd like to rather see them as guidance and as needed information on what still needs to be done, but also on what has been achieved. Especially in times of turmoil and uncertainty we should not forget that progress has been made and that we still need to continue. Bearing in mind that there is always a certain lack of information about lives that never make it into the numbers.

For us as medical personnel those statistics are at the same time vivid pictures of children and families we all have cared for in various regions of the world. They depict children whose chances of receiving adequate treatment or mere survival could be dramatically hampered because of where they happened to be born or under what political or legal framework they happened to live. They depict settings where parents who did everything they could, sometimes travelling for hours to reach a hospital, would then encounter a health system that simply did not have the resources, staff or equipment needed at that moment. Those experiences in our daily work help us move from frustration to using our expertise for action towards asking what could be changed and working towards achievable and sustainable solutions.

Within our German Society of Tropical Paediatrics and International Child Health (GTP) we are putting much effort into projects co-shaping health systems: we are supporting upscaling of skilled health workers by contributing to national specialty and subspecialty trainings, we are enhancing interdisciplinary care and improvement of referral structures by actively connecting facilities and disciplines within our projects, and we are aiming at creating political and financial sustainability of those projects and health care access and provision in general by closely cooperating with local governing entities. And this is in no way a one-sided endeavour. Looking at how our activities have evolved throughout the past 40 years of GTP's existence we can confidently say that we are acting within a growing network of international professionals and institutions.

For us as GTP, the message of World Children's Day is not only that every child has a right to the best healthcare we can provide. It is a reminder that this right creates an obligation for all of us. As paediatricians, we have an important role, but we cannot solve this alone. Our responsibility is to use our clinical knowledge, our voice and our professional interdisciplinary networks to strengthen partnerships and advocate for systems in which every child has a realistic chance to receive good care, regardless of where they are born and under what legal or political framework they live.

In most of the countries you work in, ultrasound belongs to radiology. Building a paediatric programme next to that has to be done carefully. How do you make the case that a paediatrician should be scanning, without it turning into a fight over territory?

Our activities around paediatric bedside ultrasound really started out as a grassroots project. Almost 20 years ago some of our German colleagues, who were by training proficient in ultrasound as it is part of our national curriculum, used it when needed while treating patients in various regions of the world. At first individual courses were conducted at a number of hospitals across the globe and ultimately our IPUN (International Paediatric Ultrasound Network) was created in 2021. There is good evidence that, when rapidly available and appropriately used, bedside ultrasound can improve the care and outcomes of acutely ill children, particularly in resource-limited settings where access to conventional imaging may be constrained by time, cost or availability. The IPUN project helps to create an infrastructure for appropriate and locally needs-adapted use of ultrasound within paediatrics.

Ultrasound is relatively cost-effective compared with imaging modalities such as CT or MRI, and technological advances have made devices increasingly portable, from compact machines to handheld systems that can display images on a phone or tablet. But for us, the key point is not the technology itself. It is what ultrasound can add when it is brought directly to the bedside and used by the clinician caring for the child.

We therefore do not see paediatric bedside ultrasound as competing with radiology. Instead, we focus on clearly defined applications where an immediate assessment can make a difference, for example identifying a pleural or pericardial effusion in an emergency or guiding an essential procedure such as a pleural tap. Defining these areas together with our radiology colleagues has been crucial. It allows paediatricians to answer specific, time-critical clinical questions at the bedside, while radiology can focus its expertise and capacity on more complex or less urgent diagnostic examinations. In addition, bedside ultrasound can help us identify which children need further imaging and thereby support more targeted referrals.

Our experience in hospitals in Tanzania, Malawi, The Gambia, Nepal and Bhutan has been very encouraging. Rather than creating competition, the programmes have fostered increasing collaboration and interaction between paediatrics and radiology. Feedback from both sides has been positive, particularly regarding how the approach can complement existing services and improve the way patients move through the diagnostic process.

Ultimately, I think the most important principle is that this should not be about who “owns” ultrasound. It should be about making the right diagnostic tool available to the right clinician, at the right time, for the benefit of the child.

Point-of-care ultrasound is often described as a yes-or-no instrument: fluid or no fluid, effusion or none. But your project is built around a curriculum, not around devices. What is being handed over in those courses that a checklist could never carry?

For us within IPUN the term “point of care” carries the meaning of “delivering services at the point of care”, meaning at the bedside of the patient, thus quickly answering crucial questions regarding pathology and treatment. Our IPUN courses, curriculum developments and selection of devices are therefore mainly based on the question: “with what ultrasound investigations are we able to address the most urgent paediatric medical issues?” Course content is therefore created and adapted in close communication with and informed by the medical staff of the individual paediatric departments where the courses are taking place. Exchange about local experiences with curriculum, courses, legal aspects and infrastructure of the project among staff from all sites during our network meetings further shapes content and structures. A good example of what is being handed over during a course is Bhutan. The current IPUN project lead in Bhutan is a former participant of an IPUN course in Nepal. Inspired by what he experienced with the IPUN team of Kathmandu University Hospital in Dhulikhel, he returned to his own institution and, with support of the medical council, created an own IPUN infrastructure at the Gyaltsuen Jetsun Pema Wangchuck Mother and Child Hospital in Bhutan, currently mainly supported by Nepalese tutors.

The current funding ends this year, and you are already writing the follow-up, keeping the existing sites, hopefully adding new partner institutions and bringing in an AI component for self-learning. Your own annual conference in March was called “Artificial Intelligence and Health Apps in International Child Health”, with a panel titled “Hype, Hope or/and Harm”. For a clinical officer learning to scan, which of those three is it?

AI being used in a well-understood and at the same time medically and ethically correct manner is a big hope for global health and will greatly shape service delivery world-wide. We see big potential for all areas of medicine, particularly health care literacy, prevention and diagnostics. For the clinical officer you mention (and data supporting this has already been published), AI applications offer decentralised learning and mentoring opportunities. This clinical officer can perform an AI-guided ultrasound scan correcting probe positioning and giving feedback on image interpretation without the needed presence of another experienced colleague. Such and other developments give great hope for service delivery and for the scale-up of medical proficiency in remote areas.

Not everything GTP does is paediatrics. In southern Malawi a paediatrician and a gynaecologist are working on obstetric care at a clinic that is run entirely by nursing staff, with no doctors on site: training in recognising high-risk pregnancies, a mobile CTG, antenatal ultrasound, resuscitation. How do you build safety into a service that has no physician in the building?

Safety is created through knowledgeable and experienced staff working within a well-functioning infrastructure and not by job titles like “doctor” and “nurse”. In many regions of the world shortage of medical staff is a big burden for health systems and health care delivery relies much more on non-physician medical staff like nurses, clinical officers and midwives than in Germany, for example. Task shifting is a global reality and bears some risks but also much potential. Our focus is to strengthen existing structures and health care workforce by contributing equipment, answering to the requests for training support or knowledge exchange and thus to further empower the staff and systems on the ground in their endeavour to deliver good health care for pregnant women and their babies and families. And it works. Since the project began, the number of stillbirths and of complications for mothers and babies during birth at Thyolo District Hospital has been cut down considerably. But the project does not stop in the delivery room, there is also activity around prenatal care and family planning.

You have said that political decisions are making already difficult work harder. Donors have cut sharply, and the UN warned last year that clinics are closing and vaccination programmes are being interrupted, with the fall in child mortality already slowing by more than 40 percent since 2015. Where does all of that land in an organisation that runs on evenings and weekends?

Here, again, we can choose between hope and despair and most of us are still able to be on the hope-side. As many of our projects rely on German government funding and collaborate with other projects run by funding from other international entities, we are directly affected by the funding cuts. At the same time, and this might be a particular strength of our very big international network, we still feel quite flexible in finding other ways to make our projects work. The GTP is a growing but still a fairly small NGO and pretty much all activities are completely executed by colleagues on a volunteer basis with a lot of motivation, creativity, expertise and energy to overcome difficult times. We have become somewhat professional in working with financial burdens and we will not be disheartened. However, we do call on governments to come together and to base their decision-making on the mutual goal to create global equity and ensure human rights on a global scale and to acknowledge and address the damaging effects of past and current financial decision-making in the global health care sector.

Last question, and you can be as speculative as you like. If the next few years go the way you hope, what will GTP be doing in five years that it is not doing today?

In five years, I hope GTP will still be very active in global child health, but that the way we work will have evolved further.

If we look back at GTP's beginnings over 40 years ago, much of the work was centred around individual people supporting individual projects or healthcare activities in particular regions or institutions. Over time, we have increasingly moved towards a more structural approach, working on health systems and infrastructure rather than isolated interventions. I expect this development to continue. I would like GTP to become even more strongly involved in interdisciplinary projects that bring together paediatrics, public health and other relevant disciplines, while also making thoughtful use of new technologies, including artificial intelligence, where these can genuinely improve the quality and reach of our work.

I also hope that, in five years, some of the issues that are currently emerging within GTP will have become central pillars of our work. This includes the health of girls and female adolescents, as well as the care and inclusion of children with disabilities and other particularly vulnerable groups. Global child health cannot be separated from questions of equity, gender and social inclusion.

GTP will also continue to help change the way we think about global health here in Germany. International experience is becoming increasingly valuable for healthcare professionals, and more and more young colleagues want to engage internationally. Our medical education, accreditation systems and university hospitals need to adapt to this reality. Global health needs to be much more firmly integrated into medical education and professional development, rather than being something that people have to pursue alongside their careers.

This also means creating structures that make international engagement possible throughout a medical career. At the moment, these opportunities can be particularly difficult for young colleagues with children. Voluntary engagement in global health should not come at the cost of professional progression or family life. The GTP board and its large group of active members include increasing numbers of younger colleagues, among them many young mothers and fathers. They are bringing new perspectives and also asking very important questions about what sustainable engagement should look like.

So I am confident that in five years GTP will not only be a society that supports global child health projects, but even more a platform that connects people, institutions and health systems within Germany and internationally, with the mutual goal to improve lives for the vulnerable population of children. A platform that helps make global child health part of everyday paediatric practice, creates opportunities for the next generation, and ensures that our commitment is reflected not only in what we do abroad, but also in how we shape healthcare at home.

Beyond Disease: NTDs, Disability and the Voices of People with Lived Experience

International Day of Persons with Disabilities

When we talk about Neglected Tropical Diseases (NTDs), we often talk in numbers: people at risk, medicines distributed, communities treated and countries moving towards elimination.

But behind every number is a person.

For people living with the consequences of NTDs, the impact can go far beyond the disease itself. Pain, disability, stigma and limited access to care can affect someone's ability to work, support their family, participate in community life and live independently. This International Day of Persons with Disabilities, we are reminded that eliminating NTDs is about more than stopping transmission. It is also about making sure that people already living with the effects of these diseases can access the care and support they need to live with dignity.

Stories from the Democratic Republic of Congo (DRC), South Sudan and Bangladesh show why disability inclusion must be part of the NTD response, and why people with lived experience have an important role to play. Lymphatic filariasis (LF) can cause long-term physical, social and economic challenges.

Pain, reduced mobility, difficulty working, isolation and stigma can all become part of daily life, often compounded by misinformation and misunderstanding. In the DRC, CBM International combines NTD control with disability-inclusive care, providing treatment, self-care and morbidity management support to people affected by LF. Alice Bategejo experienced the difference this support can make. Living with severe lymphoedema in a displaced persons' camp, Alice faced pain, reduced mobility and stigma. The condition also affected her livelihood. Before it became debilitating, she earned an income by braiding hair, preparing and selling doughnuts and selling small fish. Eventually, she could no longer continue these activities. Through CBM-supported services, Alice received medicine and learned how to manage her condition through regular foot care and self-care. As her condition improved, so did her independence. She was able to walk further, return to braiding hair and earn an income by fetching and selling vegetables. Just as importantly, she no longer experienced the same level of rejection from those around her.

Alice's story is a powerful reminder that inclusion is not an additional part of healthcare. It is central to health, dignity and wellbeing.



Alice plaiting a neighbour's hair. ©CBM



Bizly ©Tom Bradley for Lepira

In Bangladesh, Bizly's journey shows how people affected by NTDs can become powerful advocates for others.

After receiving treatment for leprosy, self-care training and protective footwear through LEPRa, Bizly became a voluntary 'Mental Motivator'. She now helps people affected by leprosy access health information, emotional support and mental health referrals. Her work takes her into the community, where she conducts door-to-door outreach, raises awareness and encourages people with symptoms to seek diagnosis. Through door-to-door outreach, she has referred almost 300 people for check-ups, helping identify 150 confirmed cases. Her story shows how people affected by NTDs can become powerful peer supporters, advocates and community leaders, helping reduce stigma, encourage early diagnosis and give others hope.



Khaleda ©Tom Bradley for Lepra

For Khaleda, the long-term impact of leprosy and the importance of disability-inclusive care. Diagnosed after years of an untreated foot ulcer, she experienced severe damage that affected her mobility and was compounded by stigma and social rejection. A leg brace, protective footwear, self-care support and mental health counselling through LEPRa have helped her regain mobility, confidence and independence. With support from her husband Sajib and a voluntary Mental Motivator, she continues to manage her condition and build a better future for her family. Her experience shows why disability-inclusive care must look beyond physical treatment. **Mobility, emotional wellbeing, relationships, independence and dignity are all part of living well.**

In South Sudan, CBM International and partners support people affected by LF through community-based care, including lymphoedema management and hydrocele surgery. Andrea had lived with hydrocele for more than two years, making farming difficult and causing him shame. After being referred for free surgery, he recovered and was able to return to farming. His story highlights the importance of accessible, trusted and stigma-free services that help people seek care and regain their independence. NTD programmes must also continue supporting people living with the consequences of disease, even as countries make progress towards elimination. For example, in Mbuji-Mayi, DRC, CBM-supported services have provided orthopaedic sandals to people affected by LF, helped establish self-help groups and are developing livelihood support.

Trachoma provides another example of how bringing services closer to communities can transform lives.



Andrea farming with his son © CBM



Mrs. Mukeina © CBM

With CBM International support, the DRC National NTD Programme launched the Sight for Africa project in 2025 to accelerate trachoma elimination. The project aims to reach more than 2.5 million people across ten districts with surgery for trachomatous trichiasis.

Among those treated was Mrs. Mukeina Mwalambo Keusi, who had endured more than a decade of severe eye pain and progressive vision loss.

Living in a remote community, she faced multiple barriers to treatment, including poor roads, conflict and limited access to specialised care.

After receiving sight-saving surgery, she experienced rapid relief. Her response captured the significance of the moment: “macho yangu inakomala” (“my eye is healed!”).

Mukeina’s story demonstrates what inclusive and accessible healthcare can make possible, restoring not only sight, but also independence, dignity and hope.

PUTTING PEOPLE AT THE CENTRE

The stories of Alice, Bizly, Khaleda, Andrea and Mrs. Mukeina are different, but they share a common message: treating disease is only part of the journey.

For someone affected by an NTD, meaningful recovery may mean being able to walk without pain, return to work, support a family, feel accepted by neighbours or access healthcare without fear.

That is why disability inclusion must be embedded throughout the NTD continuum, from prevention and early detection to treatment, morbidity management, rehabilitation, psychosocial support, assistive devices and livelihoods.

It also means listening to and actively engaging the people who have experienced these challenges themselves.

This approach is also reflected in the broader community though the NTD NGO Network's (NNN) Disease Management, Disability and Inclusion (DMDI) Cross-Cutting Group brings together a wide range of stakeholders - such as CBM International and LEPRO - to promote disability-inclusive NTD care, strengthen learning and coordination, and support advocacy across the continuum of care.

Most importantly, people with lived experience must have a meaningful voice and indeed lead in shaping the services intended for them. Bizly's journey shows what this can look like in practice. A person once affected by leprosy is now helping others find care, understand their condition and cope with the emotional impact of diagnosis.

NTD elimination and disability inclusion are not separate ambitions. They are deeply connected. A truly successful NTD response is one that not only stops disease transmission but also ensures that no one is left behind because they are already living with its consequences.

This International Day of Persons with Disabilities, let us listen to lived experience, learn from the people most affected and recognise the work of multiple organisations in building more inclusive NTD responses.

Because beyond eliminating disease, the goal must be to ensure that every person affected by an NTD can live with dignity, inclusion, independence and opportunity.

International Day of Epidemic Preparedness

Piero Olliaro (ISARIC, Pandemic Sciences Institute, Nuffield Department of Medicine, University of Oxford, UK) and Els Torreele (æqua, Geneva, Switzerland)

Human drivers and political choices underpinning infectious disease epidemics

The past few decades have seen infectious disease epidemics increasing in number, frequency, and geographical spread, with vast health and societal impact.¹ This trend is caused and sustained by anthropogenic drivers and political choices that underpin the vicious circle between these epidemics, asymmetries of global health security response, and socio-economic inequities. In other words, human activities create conditions conducive to epidemics, while investments in medical innovation are generally insufficient, unbalanced, and inequitable, and the measures put in place often end up deepening societal and economic inequalities. These elements are examined in the following sections.

The anthropogenic drivers of epidemics

An increasing source of epidemic outbreaks is zoonotic spillover. The numbers are staggering: there are over 200 known zoonoses;² approximately two-thirds of all pathogens and three-quarters of emerging pathogens are zoonotic;³ and around 5,000 mammal species carry one or more zoonotic disease.⁴ While human-pathogen encounters used to be occasional, and human chains of transmission following spillover events confined to small communities, human expansion and the growing invasion of natural habitats are making these outbreaks bigger and more devastating and, in some cases, pushing them beyond their initially confined areas, also via increased human mobility. Two illustrative examples are Ebola and mpox.

- Ebola thrives in areas of conflict, political and social instability, neglected populations, and inadequate health systems. Since its discovery in 1976, there have been 37 recorded epidemics caused by Ebola Zaire virus (EVD), nine by Sudan virus (SVD), and three by Bundibugyo virus (BVD), which between 2000 and 2025 have collectively caused approximately 34,000 suspected and confirmed cases and around 14,000 reported deaths. While outbreaks have traditionally occurred mostly in Central Africa, the largest epidemic so far developed in West Africa in 2014 to 2016 and was caused by EVD, totalling approximately 28,600 cases and 11,300 deaths.⁵ The ongoing BVD outbreak in Eastern DRC is the fastest growing Ebola outbreak ever recorded, with 5,458 cases within the first 100 days: seven times as many as the 759 cases in West Africa in 2014, and 17 times the 323 in DRC in 2018.⁶
- The health impact of mpox and its potential to spread widely have long been underestimated.^{7,8} Once confined to Central and Western Africa as two distinct clades (Clade I and Clade II) causing occasional spillovers with limited chains of onward human transmission, the monkeypox virus has progressively spread regionally and then outside Africa, first as imported cases and, since 2022, with subclades IIb and subsequently Ib establishing themselves in the human population worldwide, having acquired the capacity for person-to-person sexual transmission.⁹

The problem is not confined to the "periphery of civilisation". Industrial agriculture and animal farming in high-income countries create conditions favourable to highly pathogenic avian influenza A(H5) ("bird flu") outbreaks in poultry and dairy cows, which could potentially jump to humans.¹⁰

Health security or public health?

A fundamental question is whether epidemic and pandemic preparedness and response should be driven by public health or by health security considerations.

While a "Pandemic Agreement", rooted in principles of human dignity, equity, solidarity, and sovereignty, was adopted by 124 countries in 2025, the reality of ongoing epidemic preparedness and response reflects more a health security and economic approach driven by national interests.¹¹

On the one hand we have a Pandemic Agreement affirming that health equity and timely access to countermeasures during an emergency cannot be left to geopolitical and commercial power dynamics. On the other hand, even the World Health Organization (WHO) is incorporating a "global health security" framing, defined as the activities required "to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries".¹²

There are several shortcomings in what the global health security agenda (GHSa) covers and in how it is implemented by individual countries.

- In the first place, it focuses by definition on trans-border events: pandemics such as COVID-19, and "public health emergencies of international concern" (PHEICs) such as mpox and Ebola. Recurrent local outbreaks in endemic areas that happen not to cross borders, for example Lassa fever, plague, or Nipah virus disease, are chronically overlooked as public health problems and under-researched.
- As such, it maintains inequalities, as these outbreaks represent significant health burdens in the local populations and should be tackled where and when they occur, not only if and when they threaten other, high-income countries.¹³
- This approach also has strategic weaknesses. First, ignoring these pathogens locally increases the risk of major epidemics and international emergencies: recent examples are the mpox PHEICs in 2022 and 2024, and the hantavirus outbreak in 2026. Second, once the emergency is over, attention to these diseases wanes very quickly, and this on-and-off approach discourages long-term investment, leaving unfinished research agendas and unresolved public health problems in the endemic countries.

The asymmetries

Even for diseases within the scope of the GHSa, the blatant inequalities in access to medical innovation, for example to COVID-19 vaccines¹⁴ or Ebola medications,¹⁵ illustrate how the GHSa often equates to "national health security",¹⁶ where national interests trump global public health and solidarity.

An unhealthy tension exists between the GHSa and the right to health,¹⁷ opposing nationalism to multilateralism, the hoarding of proprietary products to the sharing of medical innovation as global public goods, and a biodefence approach driven by defence departments to a humanitarian approach supported by health and development agencies.

For instance, the UK Health Security Agency has identified a series of contact and airborne high-consequence infectious diseases (HCIDs), defined as typically having a high case-fatality rate, often lacking effective prophylaxis or treatment, being difficult to recognise and detect rapidly, and having the ability to spread in the community and within healthcare settings.¹⁸

While such diseases may indeed pose a global health threat, in reality they already and disproportionately affect impoverished populations in low-resource countries. Yet they suffer from inadequate research and public health investment, as they tend to be challenging both because of inherent complexities and because of the geopolitical and socio-economic context in which they occur. As such, they generally do not represent profitable "business cases" for pharmaceutical companies and investors.

So far, it is mainly the United States of America that has invested significantly in developing countermeasures against what it considered strategic national security threats, funding public research and product development by the private sector, and stockpiling the products. However, as we have seen, when critical public health tools are owned by commercial actors, the result is even more inequity in low-resource countries.

A way forward

Lessons drawn from successes and failures with COVID-19 and Ebola should help shape a robust health innovation system for infectious disease epidemics. To effectively tackle the challenge of infectious disease epidemics, the world cannot rely on a supply- and profit-driven, private sector-led R&D ecosystem, but needs to build a coordinated, public health-focused, end-to-end pharmaceutical ecosystem for the development, registration, availability, and use of medical innovation.^{19,20}

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NEWS OF THE MONTH - SEPTEMBER 2026

TOPICS

Editors Choice

Co-occurring risk factors for TB preventive treatment non-adherence, Ethiopia

Career & Funding

- Grants, fellowships, awards and open calls

Events & Campaigns

- Conferences, webinars and training

Digital & Tools

- GEOHCX
- Advocacy toolkit on female genital schistosomiasis



EDITORS CHOICE

Co-Occurring Risk Factors for Tuberculosis Preventive Treatment Non-Adherence Among People Living With HIV in Ethiopia:

A Latent Class Analysis

Edao Sinba Etu, Jet Fransen, Biftu Geda, Kemal Ahmed Kuti, Anteneh Fikrie, Mark Spigt

Trop Med Int Health, 2026; 31: 1250-1260. DOI: 10.1111/tmi.70164

Tuberculosis remains the leading cause of death among people living with HIV (PLHIV), who face a 14-fold higher risk of developing active disease compared to HIV-negative individuals. While tuberculosis preventive treatment (TPT) is a cornerstone of the WHO End TB Strategy, real-world completion rates in high-burden settings remain fragile. Non-adherence is rarely driven by a single isolated variable; rather, it emerges from complex, intersecting barriers. In this study from West Arsi, Ethiopia, the authors apply Latent Class Analysis (LCA) to move beyond traditional variable-centered regression and capture how risk factors cluster within individuals.

- **Overall Adherence Rate:** Across 390 adult PLHIV initiating or completing TPT, only 60% achieved adequate adherence based on the MMAS-8 scale, leaving 40% non-adherent.
- **Two Distinct Profiles:** LCA identified two clear subgroups: a "Lower risk of non-adherence" class representing 63% of participants, and a "Higher risk of non-adherence" class comprising 37%.
- **Double the Risk:** Individuals in the high-risk class were almost twice as likely to fail treatment adherence (59% non-adherence rate versus 30% in the low-risk class, $p < 0.001$).
- **The Decisive Fault Lines:** While older age, lack of formal schooling, poor TPT knowledge, and negative attitudes clustered in the high-risk group, health-system barriers proved to be the strongest discriminators. Specifically, 92% of the high-risk class identified travel distance to the facility as a major hurdle (against just 4% in the low-risk class), and 38% reported a strained relationship with their healthcare provider (against 1% in the low-risk class).

The Bottom Line for Practice

Adherence is not merely a question of patient motivation or pill counts; it is heavily mediated by relational trust and physical access. The authors emphasize that clinical programs should stop treating non-adherence as an individual shortcoming and instead introduce holistic screening tools to detect co-occurring vulnerabilities before treatment starts. Strengthening communication training for ART clinic staff, expanding task-shifting, and embedding TPT delivery within decentralized community-based primary care (such as Ethiopia's Health Extension Program) will be essential to close the adherence gap.



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GLOBAL NTDS YOUTH PLATFORM AND YOUTH NTDS FELLOWSHIP COHORT 2

The Global NTDS Youth Platform is now officially live at global-ntds.net. A new chapter of youth leadership in NTDs is about to begin. The platform serves as a dedicated space to connect young leaders, advocates, and researchers worldwide. We are particularly pleased to highlight that the youth group of the German Society for Tropical Medicine and Global Health (Junge DTG) is actively involved in this initiative. All early-career professionals, trainees, and students across our community are warmly invited to get involved, contribute their perspectives, and help shape the platform.

In parallel, the Youth NTDS Fellowship is preparing to open Cohort 2, creating a new opportunity for young people to deepen their knowledge, strengthen their leadership, build meaningful connections, and contribute directly to NTD elimination.

The first cohort, implemented by One Health Society, demonstrated what is possible when young people are given the knowledge, support, and space to lead. Building on this foundation, the fellowship is entering its next chapter through a collaboration with GANE, expanding opportunities for young leaders across Tanzania and Kenya. Applications open on 15 September 2026.

Global NTDS
YOUTH PLATFORM

**Empower the next
generation
to accelerate the
elimination of NTDs.**

Connecting youth-led organizations worldwide to combat Neglected Tropical Diseases through education, advocacy, and action.

[View Global Map](#)

[About](#)

**YOUTH NTDS
FELLOWSHIP** COHORT 2
EMPOWERING THE NEXT GENERATION FOR
NTDs ELIMINATION

COMING SOON

A 12-week regional fellowship equipping young leaders in Tanzania and Kenya with the skills, mentorship and networks to advance NTD elimination. Fellows will engage with communities, learn from experts and co-design practical, inclusive solutions to real-world NTD challenges.

[onehealth_tz](#) [www.ohs-health.org](#) [ganekenya](#) [www.ganekenya.org](#)



World Health
Organization

CALL FOR PRIORITY TOPICS: WOMEN'S, CHILDREN'S, AND ADOLESCENTS' HEALTH BEYOND 2030

As the 2030 target horizon approaches, progress on maternal, newborn, child, and adolescent health has slowed across many regions. To prepare the evidence base for the post-2030 era, the World Health Organization (WHO), UNICEF, UNFPA, and the Partnership for Maternal, Newborn & Child Health (PMNCH) invite global health experts, researchers, clinicians, and civil society to propose priority topics for upcoming analytical papers and thematic series.

- **Scope:** Suggested topics should address critical evidence, policy, or implementation gaps across sexual, reproductive, maternal, newborn, child, and adolescent health. Submissions may encompass evidence syntheses, secondary analyses of existing data, investment cases, health system enablers (such as primary care and workforce), and environmental or social determinants of health.
- **Important Note:** This is a call for analytical topics and nominations of potential lead experts or institutions, not a call for primary research grants or clinical trials. Draft analyses will be developed through 2027 and finalized by May 2028.
- **Who Can Submit:** Open to academic institutions, clinicians, non-governmental organizations, professional networks, and individual experts. Multiple suggestions are welcome.
- **Deadline:** 18 October 2026

[Online submission portal](#)



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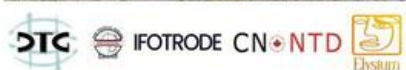
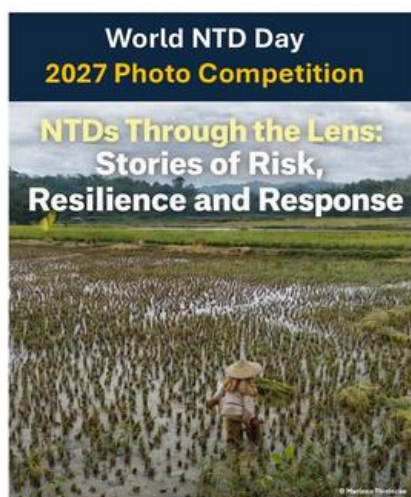


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CAREER & FUNDING | GRANTS, FELLOWSHIPS, AWARDS & CALLS



WORLD NTD DAY 2027 PHOTO COMPETITION

„NTDS THROUGH THE LENS: STORIES OF RISK, RESILIENCE AND RESPONSE“

In the lead-up to World NTD Day 2027, the DTG Working Group for NTDs, YANG, IFOTRODE, CNNTD, and Elysium, supported by FESTMIH, invite photographers, clinicians, researchers, and community members worldwide to submit original imagery capturing the human and clinical realities of neglected tropical diseases.

- **Requirements:** High-resolution original photography (minimum Full HD, no AI) with a short title and a concise caption (maximum 100 words in English). Signed consent is mandatory for identifiable persons; photos showing identifiable minors cannot be accepted.
- **Selection and Prizes:** A jury will select one winner per WHO region (€100 prize), followed by a public vote for the overall winner (€300, funded by the Andreas Ruppel Fund). Selected photos will be exhibited at a dedicated World NTD Day 2027 vernissage.
- **Deadline:** 25 October 2026.

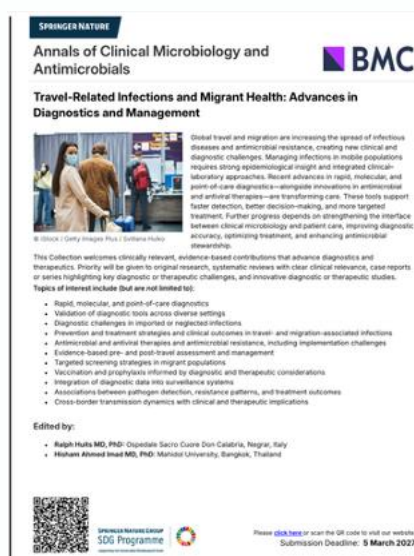
[More Information](#)

CALL FOR PAPERS | ANNALS OF CLINICAL MICROBIOLOGY AND ANTIMICROBIALS

TRAVEL-RELATED INFECTIONS AND MIGRANT HEALTH: ADVANCES IN DIAGNOSTICS AND MANAGEMENT

Global mobility, migration, and travel continue to reshape the transmission dynamics of infectious diseases and the spread of antimicrobial resistance. To address the diagnostic and therapeutic complexities at this interface, Annals of Clinical Microbiology and Antimicrobials (BMC / Springer Nature, Impact Factor 5.2) has opened a call for papers for a dedicated collection supporting UN Sustainable Development Goal 3 (Good Health and Well-Being).

- **Thematic Scope:** The collection welcomes original research, clinically relevant systematic reviews, translational studies, and well-documented case series. Priority topics include rapid and molecular point-of-care diagnostics, tool validation in resource-constrained environments, targeted screening in migrant populations, cross-border transmission dynamics, and antimicrobial stewardship in mobile populations.
- **Guest Editors:** Ralph Huits MD, PhD (Ospedale Sacro Cuore Don Calabria, Negrar, Italy / GeoSentinel) and Hisham Ahmed Imad MD, PhD (Faculty of Tropical Medicine, Mahidol University, Bangkok, Thailand).
- **Open Access & Equity:** As an open-access journal, standard article processing charges apply, with financial support and fee waiver options available for researchers facing resource constraints.
- **Submission Deadline:** 5 March 2027



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EVENTS & CAMPAIGNS

LES ACTUALITÉS DU PHARO: SFMTSI AUTUMN SCIENTIFIC MEETING 2026 (31ST EDITION)

- Dates: 7 to 9 October 2026
- Format: Marseille, France (In-Person) and Online Webinar
- Organisers: Groupe d'Intervention en Santé Publique et Épidémiologie (GISPE) & Société Francophone de Médecine Tropicale et Santé Internationale (SFMTSI)

The 31st edition of Les Actualités du Pharo brings together researchers, clinical specialists, and global health practitioners to examine critical operational and clinical hurdles across two focal themes:

- Malaria control: why is it so difficult?
- Treatment of neglected tropical diseases

Alongside plenary lectures and selected oral presentations, the meeting features dedicated poster sessions and an annual update symposium organized by the College of Academic Teachers in Infectious and Tropical Medicine, highlighting key scientific breakthroughs of the past year.

- Registration Fees: €170 standard registration; €50 for students under 30 years. Online webinar participation is free of charge, though prior registration is required.
- Registration & Details: Contact [Jean-Loup Rey](#) for registration or [Jean-Marie Milleliri](#) for general inquiries. Programme details are accessible via the SFMTSI and FESTMIH portals.

[More Information](#)

IRISH GLOBAL HEALTH NETWORK

COMMUNITIES OF PRACTICE: EMERGENCY MEDICINE IN LOW-RESOURCE SETTINGS

- Date & Format: 17 September 2026 | Online via Zoom
- Host: Irish Global Health Network (IGHN)

Join the IGHN for an interactive panel bringing e-learning concepts into dialogue with frontline emergency care in resource-constrained settings.

The session features Dr. Mulinda Nyirenda (Queen Elizabeth Central Hospital, Malawi), Niall Roche (Health Service Executive, Ireland), and Dr. Morgan McMonagle (University Hospital Waterford), facilitated by Prof. Jean O'Sullivan (Trinity College Dublin). Discussion will focus on practical triage, trauma management, and patient stabilization under acute resource limitations.



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COMMUNITY ENGAGEMENT IN GLOBAL HEALTH RESEARCH: EASTERN MEDITERRANEAN REGION

- **Dates & Time:** 29 to 30 September 2026, 18:00 to 19:30 Cairo Time (17:00 to 18:30 CEST)
- **Format:** Virtual Training (Online via Zoom)
- **Organisers:** The Global Health Network (TGHN) MENA and the Mesh Community Engagement Network
- **Moderator:** Nada Abdelrahman (MENA MESH Coordinator)

Ethical and impactful health research relies on recognizing local communities as active, equal partners rather than passive subjects. Across the Eastern Mediterranean Region (EMR), research often unfolds in complex settings marked by forced displacement, protracted humanitarian crises, and fragile health systems.

This interactive, two-day training explores practical strategies for co-designing research priorities, building enduring trust, and translating findings into meaningful local action.

Training Programme:

- **Day 1 (29 September): Foundations and Approaches**
 - Introduction to Community Engagement across the Research Cycle: Reem Elsayed (University of Oxford)
 - Approaches to Community Engagement in Health Research: Prof. Fouad M. Fouad (Liverpool School of Tropical Medicine / American University of Beirut)
- **Day 2 (30 September): Practice, Ethics, and Evaluation**
 - Regional Case Studies: Dr. Marina Sous (Magdi Yacoub Heart Foundation)
 - Ethics in Community Engagement: Dr. Aisha Abdullahi Gure (Public Health & Implementation Science Specialist)
 - Monitoring and Evaluation of Engagement Activities: Sarah Alkandari (University of Oxford)

A certificate of participation will be awarded to attendees who complete both training sessions.

- **Participation:** Free of charge (registration mandatory)

Information & Registration



Fouad M. Fouad
Professor of Social Sciences and Global Health, Liverpool School of Tropical Medicine

Reem Elsayed
DPhil Candidate in Translational Health Sciences, University of Oxford

Marina Sous
Population Health Unit Manager, Magdi Yacoub Heart Foundation

Sarah Alkandari
DPhil Researcher in Global Health, University of Oxford

Aisha Abdullahi Gure
Public Health and Implementation Science Professional

Moderator: Nada Abdelrahman
Middle East & North Africa MESH Coordinator

29 - 30 September 2026

6 pm-7:30 pm (Cairo Time)

REGISTER NOW



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COLLABORATION IN GLOBAL HEALTH: FROM LIVED EXPERIENCE TO SHARED ACTION

- Date & Time: 25 September 2026, 13:30 to 18:00 CEST
- Venue: De Krook (De Blauwe Vogel), Ghent, Belgium (In-person only)
- Organisers: Master of Global Health

How do we build effective partnerships across borders, disciplines, and lived realities when modern health threats disregard institutional boundaries? Organized by the students of the Master of Global Health, this afternoon seminar brings together students, researchers, clinicians, and policy-makers for an interactive exchange on meaningful cooperation.

The scientific and practical programme includes:

- Opening Dialogue: Welcome and framing notes with Prof. Olivier Degomme.
- Panel Discussion: "Too Hot to Handle Alone?" focusing on multi-sectoral collaboration in the face of climate change and extreme heat, featuring Prof. Steven Caluwaerts, Elizaveta Fomenko, and Dr. Jules Vertriest.
- Keynote Address: Insights on sustainable partnership models delivered by Dr. Serhat Yildirim.
- Crisis Simulation & Exchange: An interactive health emergency exercise tackling misinformation, followed by student presentations on internship and dissertation fieldwork, a poster exhibition, and an evening networking reception.

Participation is free of charge, but places are limited and prior registration is required.

- Registration Deadline: 18 September 2026
- Format: In-person attendance only
- Details & Sign-up: Accessible via the Master of Global Health event portal.

Sign-up

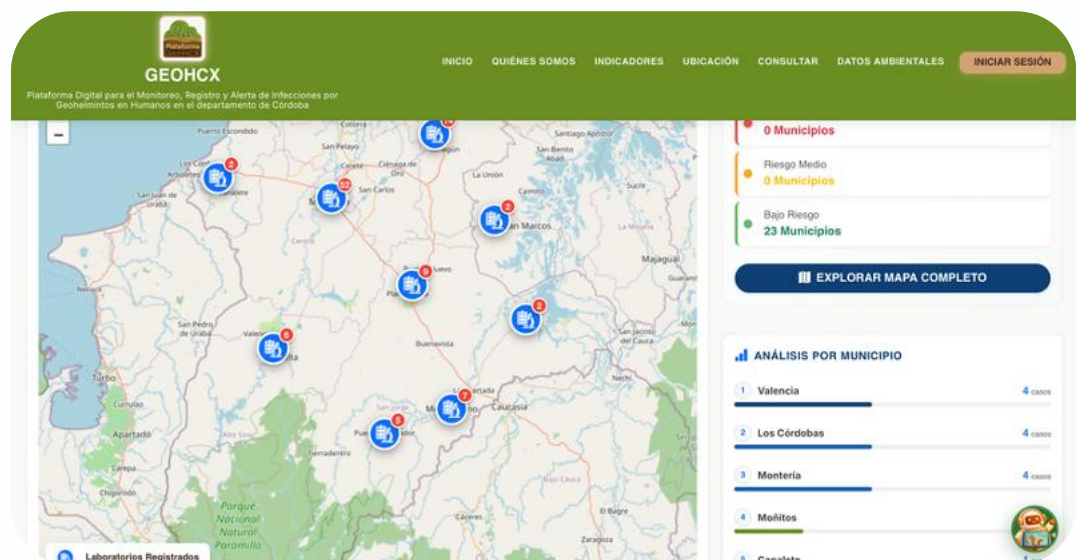


GEOHCX: DIGITAL PLATFORM FOR EARLY ALERT AND SURVEILLANCE OF GEOHELMINTH INFECTIONS IN COLOMBIA

Developed by the Microbiological and Biomedical Research Group of Córdoba (GIMBIC) at the Universidad de Córdoba, in partnership with technology collaborators Global Fénix and ArquiConcreto, GEOHCX is a dedicated digital platform designed for the monitoring, registration, and early alert of soil-transmitted helminthiasis (geohelminths) in the department of Córdoba, Colombia.

The initiative was established under the regional programme Strengthening of the Territorial Science, Technology and Innovation System through Digital Transformation and Industry 4.0:

- **Core Technology:** GEOHCX integrates Geographic Information Systems (GIS), big data analytics, and machine learning-based predictive risk models to enhance territorial public health surveillance and support rapid intervention.
- **Laboratory Network:** The platform links a network of 116 clinical laboratories across the department, enabling centralized data entry, municipal risk monitoring, and real-time mapping of positive cases.
- **Validation and Implementation:** Following successful functional piloting with clinical laboratories and academic research groups, community and operational feedback is currently being integrated ahead of full departmental rollout.
- **Sustainable Governance:** The platform establishes a shared co-administration model between the departmental Public Health Laboratory (health-system side) and the GIMBIC academic team, providing a viable blueprint for the long-term institutional sustainability of digital health tools beyond temporary grant funding.



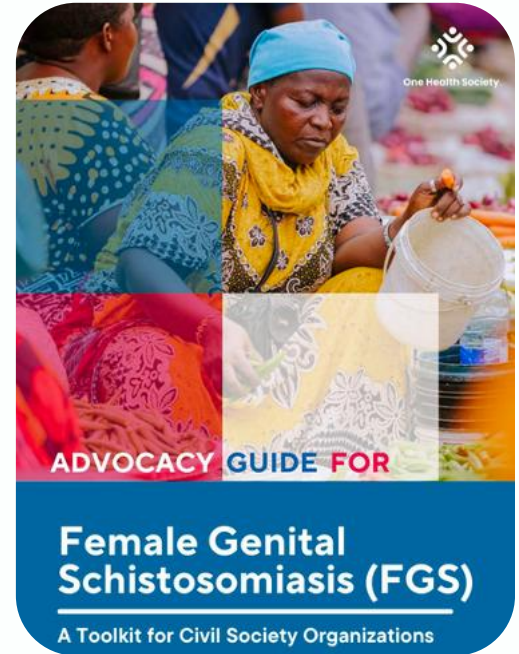
[Explore](#)

ADVOCACY GUIDE FOR FEMALE GENITAL SCHISTOSOMIASIS (FGS): A TOOLKIT FOR CSOS

PUBLISHED BY ONE HEALTH SOCIETY (OHS) TANZANIA, 2026

Female genital schistosomiasis affects an estimated 56 million women and girls across sub-Saharan Africa, with Tanzania carrying the second-highest schistosomiasis burden on the continent across 115 endemic district councils. Despite causing severe chronic consequences, including pelvic pain, subfertility, and elevated risks of HIV and HPV transmission, FGS remains widely underdiagnosed and frequently misclassified as a sexually transmitted infection due to persistent clinical training blind spots. To help civil society organizations bridge this recognition gap, One Health Society has released a comprehensive, field-tested advocacy guide developed under its Mwele Malecela Days of Action (Mwele-DOA) programme. The toolkit translates OHS's frontline experience navigating acute resource and data constraints into a practical roadmap for other organizations:

- **Navigating Data Limitations:** Reframing the absence of routine screening data as a specific, fundable ask for local surveillance rather than a barrier to advocacy.
- **A Staged-Ask Strategy:** A structured four-stage model that transitions from baseline awareness and coalition-building to institutional entry points (such as medical curricula) and long-term integration into routine sexual and reproductive health (SRH) and primary care.
- **Cross-Sectoral Framing:** Positioning FGS directly within established priorities across the HIV, cervical cancer screening, adolescent health, WASH, and agricultural sectors.
- **Multi-Track Campaigning:** Practical blueprints for peer-driven digital initiatives (such as the #FGSchallenge), local-language media engagement, and disability-inclusive outreach, including dedicated sign-language content partnerships.
- **Practical Templates:** Ready-to-use worksheets for stakeholder mapping with ministries of health, co-design workshop facilitation, risk mitigation, and monitoring and evaluation.



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SOCIETY SPACE

NETHERLANDS SOCIETY FOR GLOBAL HEALTH (NSGH)

NSGH was founded in 1907 as the 'Netherlands Society for Tropical Medicine'. In the 1970s, 'International Health' was added to its name. We serve as a platform organisation for global health professionals with a multidisciplinary background, including physicians, biologists, social scientists, pharmacists, nurses and paramedics. At the same time, we are the official scientific organisation for medical doctors with the degree 'MD Global Health Physician'. Since FESTMIH's establishment in 1986, we have been a committed member, and we have hosted ECTMIH twice: in 2007 in Amsterdam, and in 2023 in Utrecht.

NSGH at a glance

We will be celebrating our 120th anniversary in 2027, and ever since the early beginnings we have been committed to working towards equal access to good healthcare for all, in the Netherlands and worldwide. We connect people and organisations through science, education, advocacy and a strong network. We believe in a world where health is not a privilege, but a fundamental right for everyone.

We work in close collaboration with our two partner organisations: the Knowledge Centre for Global Health (KCGH) and the Training Institute for Global Health Physicians (OIG). OIG is responsible for the training of Medical Doctors in Global Health, and KCGH's main objective is to gather and share information and knowledge. Our work as NSGH is organised around four interconnected pillars:

- **Platform & Networking:** Bringing professionals together through conferences, discussions, research and active knowledge exchange.
- **Science:** Supporting research and knowledge sharing, promoting academic chairs in Global and Planetary Health, equitable partnerships and international scientific collaboration.
- **Advocacy:** Raising awareness for urgent global health issues and, when necessary, influencing policy and practice – guided by the principles of human rights, and especially the right to health.
- **Education:** Ensuring the scientific quality of the MDGH training programme and supporting capacity building through our working parties.

In 2025, NVTG underwent a name change to 'Netherlands Society for Global Health' (NSGH), thereby reflecting the need to evolve in sync with global trends and thinking about global health, including its multidisciplinary nature. In 2026, we launched our new Strategic Plan 2026-2030, which serves as guidance for the work of the three collaborating partner organisations.

Our activities and partnerships

Our 16 working groups form the backbone of our society, covering a broad range of global health themes. The Scientific Council connects science, policy and practice and provides scientific advice to NSGH, OIG and KCGH. Through the Otto Kranendonk Fund (OKF), the NSGH supports innovative global health research and capacity building, particularly in low- and middle-income countries. We jointly organise annual symposia, masterclasses and other activities that promote knowledge exchange and professional development.



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Our advocacy work – executed through our newly established advocacy council – is based on three fundamental principles: human rights, the right to health, and humanitarian law of war. In our advocacy work, we focus on issues that are central to global health, including access to good healthcare for everyone (health equity), responsible international cooperation, and equitable partnerships.

Learn more about our focus and work on our [website](#), and we particularly invite you to visit the publication platform Global Health Perspectives, our newly established online space for sharing research, scientific insights, and personal accounts of current issues in global health.

A glimpse of the activities we are organising this autumn:

- Global Oncology Masterclasses: A free 6-week Global Oncology Masterclass
- Symposium: The Health and Wellbeing of Displaced Children
- Symposium: 'Care for Newcomers – Shared Care, Shared Strength'
- NSGH Annual Symposium (22 November): 'Access, Quality and Rational Use of Medicines'. The focus is placed on the inequality in access to essential medicine by placing essential medicines at the forefront of the global debate on health equity and human rights. Special attention will be given to antimicrobial resistance and resilient health systems.

A word from NSGH's chair:

Jeannet Bos

It is an absolute honour to serve as the new Chair of NSGH, following the formidable work of Hanneke Dekker over the past years.

As a consultant in internal medicine and infectious diseases, I have worked for many years at the intersection of infectious diseases, international cooperation, and global health. My commitment to equal access to healthcare was shaped early in my career and further strengthened through my work and life in Southern Africa, Thailand, Suriname, and the Dutch Caribbean.

Although my clinical work typically focuses on individual patients, I have always been hugely interested in the ecological, social, and political forces that determine how diseases affect communities. Throughout my career, I have witnessed how large groups of people are denied access to the healthcare they need. This is health poverty, and for me, this is not only a fundamental injustice, but also an invitation to act.

I believe that global health professionals have a unique role to play in addressing these challenges, as they can have an impact through the use of a combination of scientific expertise, their hands-on, creative attitude and working experience, as well as their understanding of different global health contexts.

As Chair, I see exciting opportunities that could increase the impact and relevance of NSGH. In our fascinating and rapidly changing world, I feel that we should do our very best to equip current and future global health professionals with the background they need for the important global health tasks ahead.

September 2026

Esther Jurgens, senior policy advisor NSGH and consultant Global Health, and Jeannet Bos, Chair of the NSGH



If you have made it to this page, you have spent the last hour in the company of people who refuse to look away. You have followed a physician into the rubble of Hatay and out the other side, into the container cities where the cameras no longer go. You have stood in a besieged palace in Leningrad with botanists who starved beside edible seed, and you have followed that decision forward into the micronutrient deficiencies we still write into clinic letters today. You have watched paediatricians place an ultrasound probe into the hands of colleagues working hundreds of kilometres from the nearest radiologist, and argue that safety is built by competence and infrastructure rather than by job titles. You have met Alice, Bizly, Khaleida, Andrea and Mrs. Mukeina, whose recoveries were measured not in parasitological cure but in walking further, working again, and being greeted again by their neighbours. And you have been asked, in unusually plain language, whose security global health security is actually for.

If, somewhere between the statistics and the human realities behind them, you felt a flicker of urgency or a stubborn refusal to accept things as they are, then this edition has done what it set out to do.

We publish it into a year in which the scaffolding of this work is being visibly dismantled. Development assistance for health fell by roughly a fifth between 2024 and 2025, most of it traceable to a single donor withdrawing more than nine billion dollars. The OECD now projects that overall aid will fall again in 2026, by 6.9 per cent, and that health will absorb the deepest cut of any sector: 29 to 46 per cent below its 2024 level, which returns health assistance to where it stood in 2008. Bilateral support to sub-Saharan Africa is forecast to drop by a further 11.6 per cent this year, the third consecutive annual decline. Core contributions to United Nations agencies may end 2026 about a third lower than in 2024. And the WHO Pandemic Agreement, adopted in 2025 in a moment of rare consensus, still cannot be opened for signature: the annex on pathogen access and benefit sharing missed its May 2026 deadline, and negotiators returned to Geneva this month to try again. These are not accounting problems. They are decisions about whose survival is worth financing, taken in rooms very far from the clinics where the consequences arrive.

Pathogens read none of it. The Bundibugyo outbreak in eastern DRC recorded 5,458 cases in its first hundred days, seven times what West Africa saw in the same window in 2014. Germany, which has no relevant earthquakes, registered a national record of 41.8 °C this summer and close to twelve thousand heat-related deaths by the end of July. A seed collection lost in one war is not replaceable by a treaty signed in another decade. Human health has never respected political geometry, and cross-border cooperation is not a diplomatic luxury we can defer until the budgets recover. It is the baseline infrastructure on which all of the above depends.

What this issue offers against that backdrop is not optimism but evidence. A humanitarian physician insisting that resilience begins with health literacy and equity rather than with tinned soup and better concrete. Botanists who understood exactly what they were choosing and chose the longer time horizon anyway. A volunteer society that lost funding and kept teaching. Organisations that treat a leg brace, a pair of protective sandals and a conversation about shame as clinical interventions, because for the person in front of them they are. Researchers who insist that medical innovation is a shared global good rather than a national defence asset. None of these actors bent the global trajectory alone. Each of them changed a protocol, a curriculum, a dataset, or one person's morning.

We owe a considerable debt to the voices who made this quarter possible. Our warmest thanks go to Dr. Guenter Froeschl, for an interview of rare honesty about what remains after the emergency ends, and for insisting that responsibility is personal before it is political. To Sarah Kotsias-Konopelska and her colleagues at the German Society of Tropical Paediatrics and International Child Health, for showing what four decades of volunteer work and a well-built curriculum can do for children who would otherwise never reach imaging. To Ismat Zehra Juma and the teams at CBM International, LEPRa and the NNN Disease Management, Disability and Inclusion group, and above all to Alice, Bizly, Khaleida, Andrea and Mrs. Mukeina, who allowed their lives to be told rather than counted. To Professor Piero Olliaro and Dr. Els Torreele, for a piece that declines to be comfortable. To Jeannet Bos and Esther Jurgens, for opening the doors of the Netherlands Society for Global Health to our readers. And, as always, to Dr. Sophie Schneitler, whose editorial judgement and unwavering reliability remain the quiet backbone of this publication.

As we move into the next quarter, we leave you with the conviction that runs through every page of this issue: solidarity in global health is not produced in summit halls and it does not arrive with funding cycles. It is an active choice made in ordinary working hours. It is the question asked at the bedside, the number checked before it is published, the student taken seriously, the difficult conversation started at the end of an exhausting day. Ecosystems fail when their nodes give way, and they recover when the connections between them are rebuilt. This newsletter exists because you keep showing up for those connections. For your attention, your critique and your expertise, we are deeply grateful.

With warmth, resilience, and the stubborn belief that this work matters,

Maximilian Förster

on behalf of the FESTMIH Newsletter Team