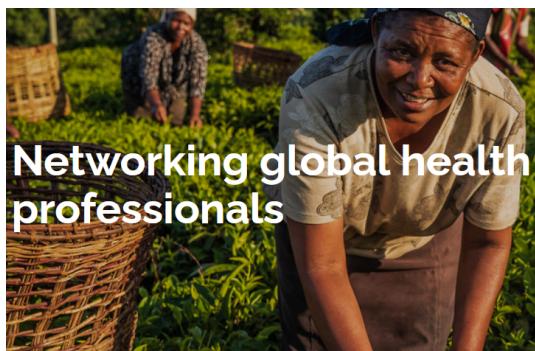


FESTMIH-NEWSLETTER

2025 Q4



WHAT TO EXPECT

January 26th/March 30th

International Day of Clean Energy/International Day of Zero Waste

January 30th

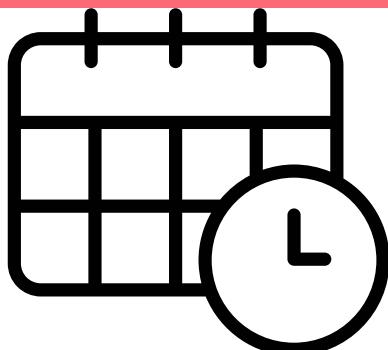
World Neglected Tropical Diseases Day

February 11th

International Day of Women and Girls in Science

March 24th

World Tuberculosis Day



Dear Readers,

As we approach the end of the year, we are pleased to share a new and very full edition of the FESTMIH Newsletter. Our last issue was short to accommodate an especially busy period. This time, we wanted to offer something more extensive. We hope you will enjoy taking this longer edition with you into the quieter days around the holidays, where there may be more space to **read and immerse yourself in the topics** that shape our field.

Once again, this issue is built around the United Nations International Days of the **first quarter of 2026**, and it has been shaped by the generous contributions of many within our community. You will find it filled with **interviews, commentaries**, and impressions from colleagues across research, clinical work, and global health practice.

In this edition, you will also find a **Mini News of the Month**, which provides a brief overview of current updates within the FESTMIH network. You can access it starting on page 5 of this newsletter.

Before you scroll the page to explore these themes, we would like to take a moment to **express our sincere gratitude**. Over the past year, many of you have shared your expertise, ideas, and experiences with us. Your contributions, whether interviews, articles, field notes, or visual insights, have shaped this newsletter into a **vibrant space for exchange** and connection. Thank you for the time, thought, and commitment you have invested. Without your active participation, this publication would not exist in the form it does today.

Looking ahead, we warmly invite you to contribute to future editions as well. Short reflections, case insights, project updates, photo essays, and commentaries are always welcome.

If you would like to highlight your work, introduce your team, or share a perspective from the field, we would be delighted to hear from you.

Warm regards,
 Your FESTMIH Newsletter Team

CELEBRATING GLOBAL HEALTH AND EQUITY



For your convenience, please find below a brief **overview** of the International days. Should you be interested in **reading more** on the topic, you are welcome to **follow the link** (Click on the title) to the corresponding article.

International Day of Clean Energy – 26 January

International Day of Zero Waste – 30 March

Climate, Energy, Waste, and Global Health

This article brings together clean energy and zero waste as two closely linked pillars of sustainable health systems. It explores how emissions, waste streams, plastics, and resource use affect climate change, antimicrobial resistance, and global health equity, particularly in low and middle income settings.

World Neglected Tropical Diseases Day – 30 January

Equity, Poverty, and Structural Neglect

Neglected tropical diseases remain a marker of deep global inequities. This contribution examines why NTDs persist, how political priorities and funding structures shape control efforts, and what long term, equitable solutions require.

International Day of Women and Girls in Science – 11 February

Gender Equity, Leadership, and Academic Culture

This section focuses on structural barriers and cultural change in academic medicine and research. Through interviews and analysis, it highlights why gender equity is central to scientific excellence, leadership, and sustainable innovation.

World Tuberculosis Day – 24 March

Tuberculosis, HIV, and Health Systems Under Pressure

Despite being preventable and treatable, tuberculosis remains one of the leading infectious causes of death worldwide. This Interview connects global policy decisions, funding dynamics, and clinical realities from high burden settings.

Mini News of the Month (NOTM)

Updates and Opportunities

A concise overview of recent developments within the FESTMIH network, including events & publications relevant to clinicians, researchers, and global health practitioners.

IT IS WITH GREAT PLEASURE THAT I WISH ALL FESTMIH MEMBERS A HAPPY HOLIDAY SEASON AND A HEALTHY 2026, BOTH GLOBALLY AND INDIVIDUALLY, FOR EACH AND EVERY ONE OF YOU.

The year 2025 was full of new developments, challenging geopolitical decisions, changes in the FESTMIH secretariat, and insights into scientific research and networking through the European Congress of Tropical Medicine and Global Health in Hamburg. The 14th ECTMIH, organized by the Bernhard Nocht Institute of Tropical Medicine (BNITM), together with FESTMIH and the German Society for Tropical Medicine, Travel Medicine, and Global Health (DTG), was a milestone in the European global health landscape.

Warm thanks go to the leadership of the BNITM and the DTG, who managed the congress impeccably with great professionalism, competence, and enthusiasm, and prepared a very useful handover document for the future. The congress inspired numerous participants from the global health community: 120 young researchers in the ECTMIH Academy, a pre congress training course, and approximately 1,300 participants in ECTMIH, a third of whom were from non European countries, representing a total of 84 nations.

The sharing and exchange of scientific research was at the center of the event, with 564 researchers presenting their work in posters and 573 researchers presenting their results and innovations in 104 sessions. Some FESTMIH societies contributed to organizing dedicated sessions, in particular:

- **Equity and solidarity in health:** overcoming obstacles to access to medicines for parasitic tropical diseases in Europe, in collaboration with ITM in Antwerp
- **Neglected topics on migrant health,** promoted by the FESTMIH working group on Migration and Health
- **Neglected Tropical Disease Advocacy Networks and Policy Transformation,** promoted by several European networks for NTDs

Young researchers from Italy, Germany, Japan, and Kenya were involved in the session Empowering the Next Generation: The Impact of Youth in Tackling Neglected Tropical Diseases. As immediate results, the session on access to medicines for parasitic diseases in Europe is leading to an article for peer reviewed journals, and the NTD networks group has launched the Call for Action by the European Networks and the Youth Networks Against Neglected Tropical Diseases.

Following the ECTMIH, the journal *Frontiers in Tropical Diseases* launched a special issue inspired by the main theme of the conference, Better Health for All in a Changing World, with a closing date of 30 June 2026. Many of the speakers' presentations are available online to conference participants via a link provided by FESTMIH.

FESTMIH 30th Anniversary Video

Celebrating 30 Years of FESTMIH

During the opening session of the ECTMIH, a special video marking the thirtieth anniversary of FESTMIH was presented. The film reflects on the society's history, its milestones in global health, and the collaborative work of its member societies throughout Europe and beyond.



[Watch Video](#)

In the coming weeks, and then in 2026, we will be working towards ECTMIH 2027 with the Institute for Global Health (ISGlobal) in Barcelona, the main partner for the conference, which will probably be held in October, with the date still to be confirmed. The experience of the Hamburg conference will serve to refine and further improve a few critical issues, in particular cost containment in these difficult times of cuts in global health funding due to the decisions of the Trump administration in the US, which has created a negative cascade for development aid funds also in some European governments.

I am very proud that we have reached the 17th edition of FESTMIH's News of the Month, which is distributed to all FESTMIH members, either directly to those who subscribe or through newsletters and the websites of member societies. The publication should contain contributions from the various societies. Once again, I encourage delegates and executive boards to share updates such as calls for grants, training courses, and scientific events, which are still mainly managed by our Secretariat.

I would like to take this opportunity to thank Sophie Schneitler and Maximilian Förster, who, together with the new secretariat composed of young scientists from the DTG, have been providing important creative input and new energy to this monthly publication since its inception. This year also saw the creation within FESTMIH of new working groups, webinars, and new partnerships with other relevant global health institutions and networks such as the NNN (NTDs NGO Network), ESCMID Global, and EDCTP.

In conclusion, despite financial challenges, FESTMIH is growing and is supported by the active commitment of the Board and the delegates of the member societies, whom I warmly thank for their constant dedication. The involvement of the members of each associated society is essential to maintain the commitment towards the biennial ECTMIH congress and to support collaborations on current global health issues in order to influence health policies toward a more equitable and sustainable future.

Ad maiora!
Marco Albonico
FESTMIH Chair

FESTMIH General
Assembly, 30
September 2025,
Hamburg.



NEWS OF THE MONTH - DECEMBER 2025

TOPICS

Editors Choice

A Systematic Review of Research and Governance in Child and Adolescent Mental Health in Africa

Events

- Travel Medicine and Health in Mobile Populations
- Diploma in Tropical Medicine & Hygiene



EDITORS CHOICE

A Delphi Consensus Checklist for Evaluating the Quality of Snakebite First Aid Education Materials
Gautam A, Birkun AA, et al. *Trop Med Int Health* 2025

Why this matters for global health

Snakebite predominantly affects rural communities in low-resource settings, where formal care is distant and first aid is often the only intervention for hours. This study offers a practical, expert-derived tool to screen out misinformation and standardise patient-safe messages across education campaigns. The authors call for validation studies, translation into local languages and periodic updates to keep the checklist aligned with evolving snakebite guidelines, with the goal of reducing preventable morbidity and mortality from snakebite worldwide.

KEY POINTS

- Snakebite envenoming remains a neglected tropical disease where harmful first-aid practices are still common, often fuelled by low-quality online information.
- The authors used a two-round Delphi process with 38 experts from 21 countries (median 16 years' experience) to agree on what "good" snakebite first-aid education must contain.
- From an initial 24 items they derived a 20-item consensus checklist, covering:
 - safety and scene management
 - calling for help and rapid transport
 - assessment of consciousness and breathing, recovery position and CPR
 - reassurance, positioning and observation of the victim
 - evidence-based bite-site care and immobilisation
 - explicit avoidance of harmful or unproven measures (tourniquets, cutting, sucking, traditional remedies, delays in seeking care).
- The checklist is intended for educators, health workers and organisations to appraise and improve first-aid manuals, posters, apps, websites and training courses.



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



secretariat.festmih@gmail.com

TRAVEL MEDICINE AND HEALTH IN MOBILE POPULATIONS

ISGlobal Online Course

- Dates: 12 January to 1 May 2026
- Tuition: 750 EUR (modules individually 200-350 EUR)



ISGlobal and Hospital Clinic Barcelona offer a comprehensive online certificate course for clinicians working with travelers, migrants, and refugees. The programme covers pre-travel risk assessment, management of imported infections, and the multidisciplinary care of mobile populations in Europe.

Modules (bookable separately):

- Management of Travel-Related Diseases (12 Jan-28 Feb, 350 EUR)
- Pre-travel Medicine and Consultation (2-27 Mar, 200 EUR)
- Migrant Health (7 Apr-1 May, 200 EUR)

Teaching includes clinical case discussions, interactive lessons, short videos, and online clinical rounds. Participants receive an ISGlobal certificate upon completion.

Course Lead: Dr Jose Muñoz (FESTMIH Board Member), with Dr Daniel Camprubí Ferrer, Dr Natalia Rodríguez Valero, and Dr Pedro Laynez Roldán.



DIPLOMA IN TROPICAL MEDICINE & HYGIENE (DTM&H) - BNITM HAMBURG

Dates: 30 March to 26 June 2026

Location: Hamburg, Germany

Format: Full-time, on-site

Language: English

The Bernhard Nocht Institute for Tropical Medicine (BNITM) offers one of Europe's oldest and most renowned DTM&H programmes, training medical doctors to diagnose, manage, and prevent tropical and travel-associated diseases. The course is designed for clinicians preparing for work in tropical and subtropical regions, as well as those treating travelers and migrants in Europe.

Course Highlights:

- Intensive clinical focus with over 120 lecturers from Africa, Asia, Europe, and South America
- Lectures, workshops, microscopy, laboratory practicals, and clinical teaching
- Strong emphasis on tropical infectious diseases, travel medicine, and global health principles
- Training in pre-travel consultations, occupational health for long-term assignments, and diagnostic microscopy of parasites

Eligibility:

Open to licensed medical doctors (MD/MBBS or equivalent). All instruction is in English.

This programme is suited for clinicians aiming to strengthen their expertise in tropical medicine and prepare for clinical work in low-resource settings or mobile populations.

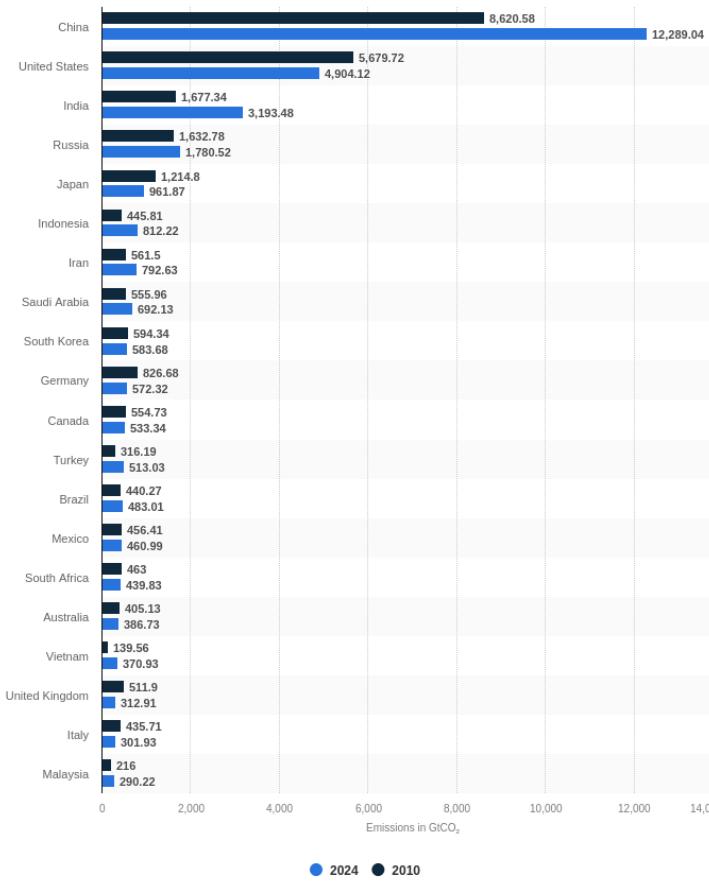
JANUARY, 26TH

MARCH, 30TH

CLIMATE CHANGE, WASTE, AND NEGLECTED DISEASES

A CALL FOR GLOBAL RESPONSIBILITY

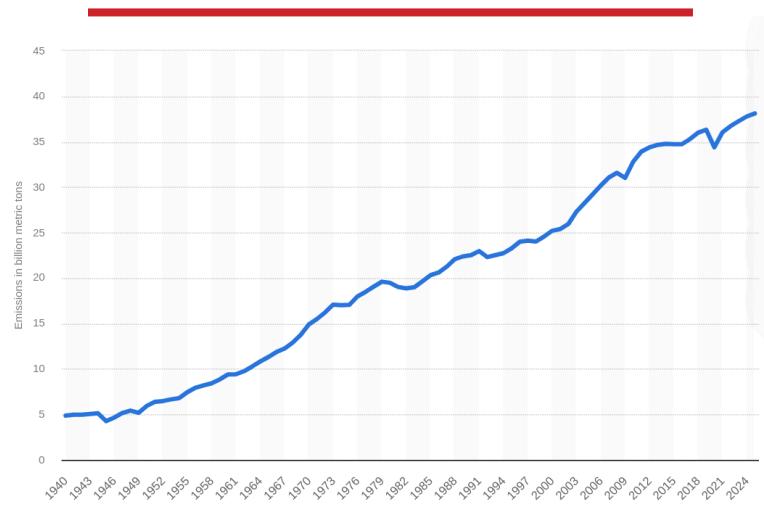
Climate change, pollution, and neglected diseases are converging into a **global health emergency** that disproportionately harms the poorest communities. Warming temperatures fuel extreme weather and spread vector-borne illnesses, while pollution and waste drive silent crises like antimicrobial resistance (**AMR**). The injustice is severe: those who contribute least to these problems often suffer the most. As the world approaches the UN International Day of Clean Energy (Jan 26) and the International Day of Zero Waste (Mar 30), we must harness their call-to-action spirit. It is time for wealthy nations - the biggest emitters and polluters - to take responsibility in solidarity with low- and middle-income countries (LMICs) for a cleaner, healthier, and more equitable planet.



Carbon dioxide emissions of the most polluting countries worldwide in 2010 and 2024 (in million metric tons)

- China remains the largest emitter
- United States follows
- India has risen sharply
- Several high income countries, including Germany and UK, show declining emissions since 2010

Statista, „Global CO₂ Emissions by Country 2024“.



Global CO₂ Emissions: Key Trend

- Global emissions have risen from about 5 billion tons in 1950 to over 40 billion tons in 2024
- The world passed 20 billion tons around 1989
- Emissions continue to reach new record highs

Statista, ‘Global CO₂ Emissions by Year 1940–2025’.

Climate Change: A Crisis of Global Inequity

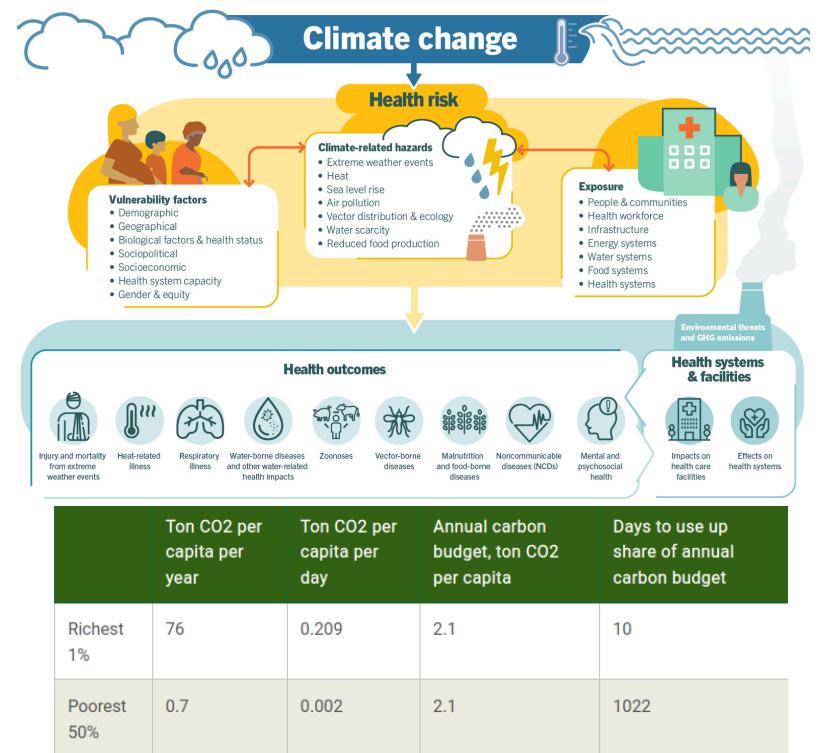
Climate change is not just an environmental issue - it is a **health crisis** and a matter of justice. Research shows that climate change could cause ~250,000 additional deaths per year between 2030 and 2050 from malnutrition, malaria, diarrhea and heat stress alone. Yet the burden will fall unevenly. “The people whose health is being harmed first and worst by the climate crisis are those who contribute least to its causes”, notes a recent WHO report.

In vulnerable regions, the death rate from climate-related disasters is already 15 times higher than in wealthier regions. This inequity is driven by a massive emissions gap: The richest 1% of people cause over twice the carbon pollution of the poorest 50%. Meanwhile, roughly 8 in 10 heat-related excess deaths occur in low- and lower-middle-income countries - communities that have contributed only a tiny fraction of historical greenhouse gases.

LMICs face devastating climate impacts (from floods to droughts) with limited resources to adapt. Redressing this means major emitters must dramatically cut emissions and finance adaptation for those most at risk (Oxfam, 2025). Simply put, climate change is amplifying global health inequalities, and climate justice must be front and center in our response.

Pollution and waste are another arena of global injustice. High-income countries consume and discard at an unsustainable pace, while poorer nations bear the brunt of the waste fallout. For example, global plastic waste generation has more than doubled from about 156 million tonnes in 2000 to 353 million tonnes in 2019. In just the last two decades, annual plastic waste production surged from ~180 million to nearly 400 million tonnes (OECD/Statista, 2024). Tragically, only about 9% of all plastic waste is recycled - the vast majority is landfilled, incinerated, or leaks into the environment.

Plastic pollution chokes oceans and wildlife, and breaks down into microplastics that have been found in air, water, and even human blood. Wealthy nations generate far more waste per capita than others, yet they often export waste to LMICs or leave poorer communities to deal with the environmental damage. A 2023 WWF report highlighted that despite consuming almost three times less plastic per person, low-income countries face a lifetime cost of plastic pollution that is 10 times higher than high-income countries. These costs include managing overflowing landfills, cleaning up litter, and impacts on fisheries, tourism, and health. Such structural inequities mean that the poorest communities pay the steepest price for a throwaway culture they didn't create. The International Day of Zero Waste reminds us that solving the waste crisis isn't just about recycling more - it's about a fairer system of production and consumption. Curbing single-use plastics, improving waste management infrastructure, and holding big polluters accountable are critical steps to protect vulnerable populations and ecosystems.

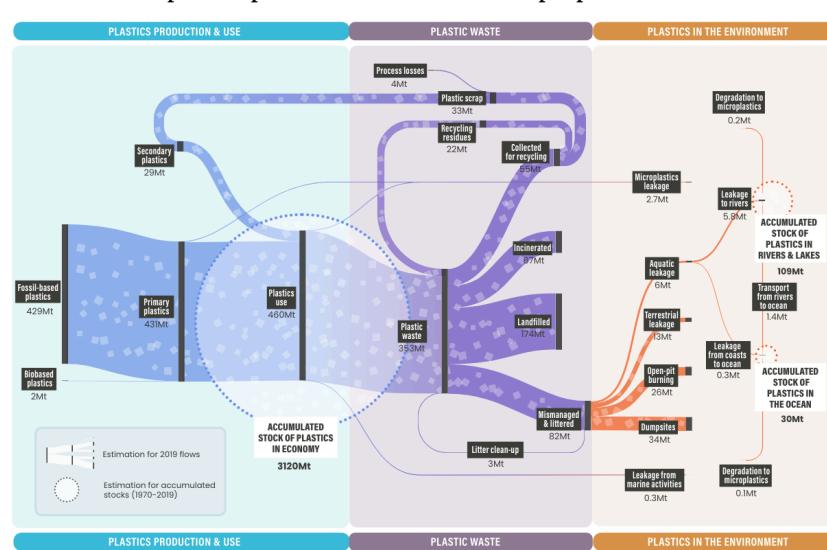


Climate Inequality

- The richest 1 percent emit 76 tons CO₂ per person per year
- The poorest 50 percent emit 0.7 tons CO₂ per person per year
- Both groups have the same annual carbon budget (2.1 tons per capita)
- The richest 1 percent exhaust their yearly budget in 10 days
- The poorest 50 percent would need 1022 days

‘Climate Change’ - WHC

Only 33 million tonnes (Mt), or 9% of the 353 Mt of plastic waste, was recycled in 2019
OECD, 'Global Plastics Outlook'.



Neglected Diseases Spreading with the Climate

Tropical diseases were once “neglected” by wealthy countries - presumed to only afflict distant developing regions. That notion is quickly evaporating. “As Earth warms, the creatures that spread neglected tropical diseases are gaining a foothold in Europe. Wealthy countries must prepare for more cases,” warns a *Nature Outlook* report. Indeed, mosquito-borne illnesses like dengue, chikungunya, Zika and West Nile virus are climbing northward as temperatures rise and summers grow longer. In 2010, mainland Europe recorded its first local dengue fever cases; now these outbreaks are no longer rare. France, Spain, and Italy have all experienced homegrown dengue transmission in recent summers. In 2022, France saw 65 locally transmitted dengue cases, and Italy recorded 82 local cases in 2023. The past year (2024) marked an alarming milestone, with over 300 combined autochthonous dengue infections across Europe.

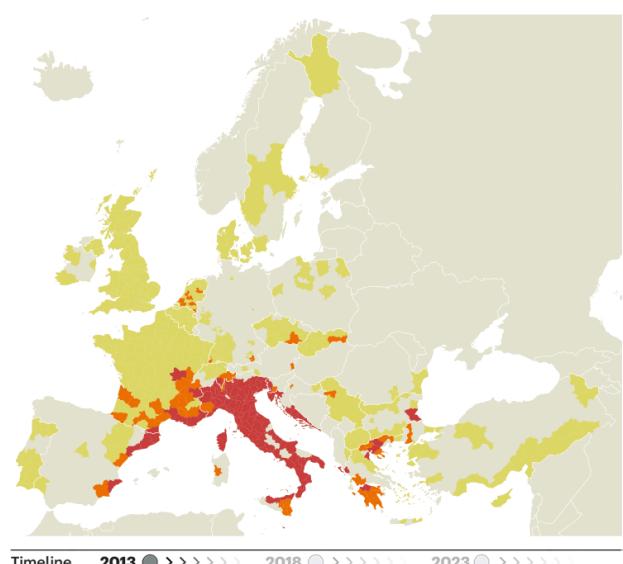
Similarly, chikungunya outbreaks have hit Italy and France in the past decade, and malaria - long eliminated in Europe - has resurfaced in isolated instances (e.g. locally acquired cases in Greece and Italy) as *Anopheles* mosquitoes find new suitable habitats. Neglected tropical diseases (NTDs) like leishmaniasis and schistosomiasis are also expanding their range or appearing in new host populations. All these trends point to a reality where climate change anywhere can ignite health threats everywhere. Populations with no immunity or preparedness for “tropical” diseases are now at risk, placing new strain on public health systems. This convergence underscores a simple truth: in an era of climate disruption, diseases do not respect borders - and global health security depends on tackling climate change as a root cause.

MOSQUITOES MOVE NORTH

Over the past decade, *Aedes albopictus*, or the Asian tiger mosquito, has made its home at increasingly higher latitudes, thanks in part to climate change. *Aedes albopictus* is a vector of chikungunya and dengue viruses, and is suspected to also carry other pathogens, including Japanese encephalitis and West Nile viruses.

Status

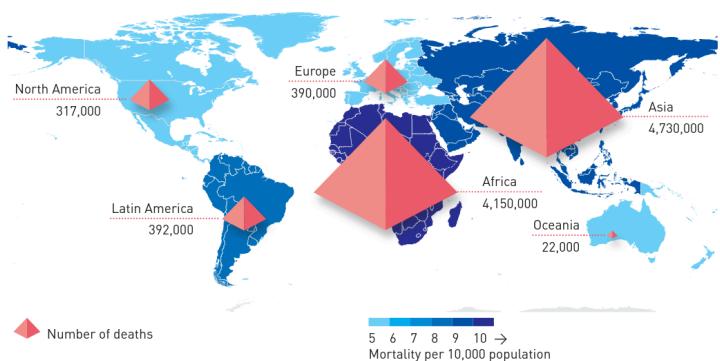
■ Established ■ Introduced ■ Absent ■ Unknown or no data*



Timeline 2013 >>>>> 2018 >>>>> 2023 >>>>>

*Established, an established population has been observed in at least one municipality; Introduced, the species has been detected, but establishment unconfirmed; Absent, species not detected in field surveys or studies. Source: ECDC.

Nature publications remain neutral with regard to contested jurisdictional claims in published maps.

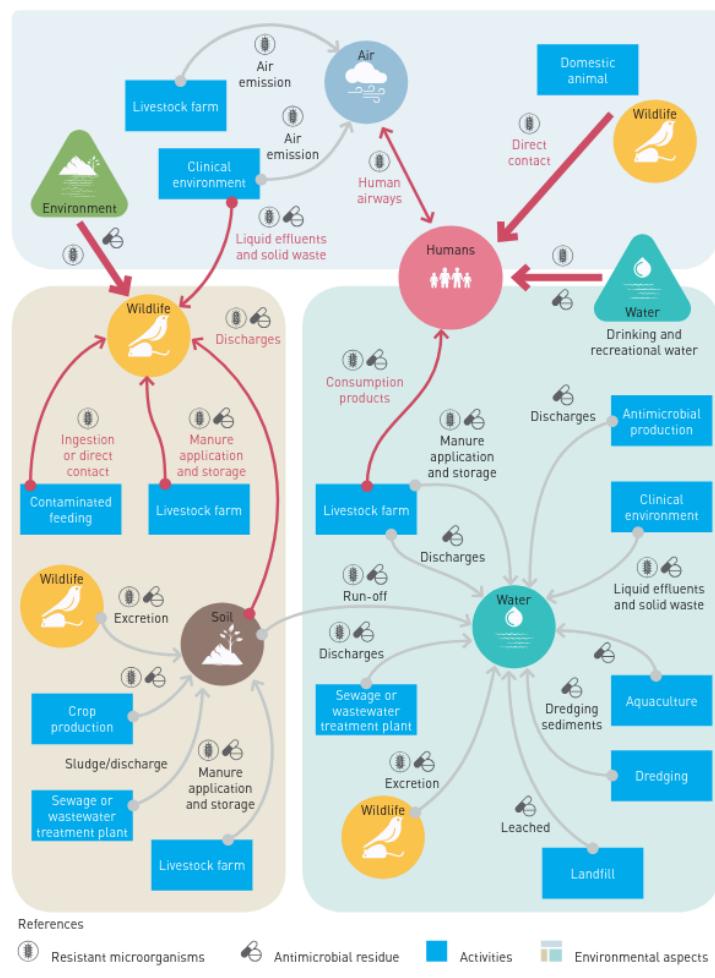


The silent Threat of Antimicrobial Resistance

Not all global health threats make headlines: some, like antimicrobial resistance, spread insidiously under the radar. AMR is often called the “silent pandemic”: bacteria and other microbes are evolving to withstand the drugs we rely on, partly due to overuse of antibiotics. But environmental factors are a huge and overlooked driver of AMR.

Pollution from pharmaceutical factories, hospital waste, agriculture, and poor sanitation is seeding the environment with antibiotics and resistant germs. These pollutants create ideal conditions for superbugs to emerge and spread. A recent UN report warns that pollution, climate change and biodiversity loss are tightly interlinked with AMR. For example, runoff from farms and wastewater can carry antibiotic residues and resistant bacteria into rivers and soil, propagating resistance. Air pollution is now also implicated: a study in *Lancet Planetary Health* found that increases in fine particulate pollution (PM2.5) correlate with rising antibiotic resistance across countries. Particles in polluted air can actually carry antibiotic-resistant bacteria and genes and transport them long distances. This means smoggy, polluted cities could inadvertently help superbugs travel or develop.

Climate change exacerbates the problem - higher temperatures have been associated with increased bacterial growth and gene exchange, accelerating resistance. The human cost of AMR is already catastrophic: an estimated 1.27 million deaths per year are directly caused by drug-resistant infections (as of 2019), more than malaria or HIV. If trends continue, up to 10 million lives per year could be claimed by AMR by 2050 - a death toll on par with the global cancer burden. This would hit developing regions hardest, where healthcare resources to combat resistant bugs are limited. AMR is a quintessential One Health issue, spanning humans, animals, and the environment. Tackling it requires cutting pollution (especially pharmaceutical and agricultural waste), improving sanitation, and global surveillance for resistant strains. Every plastic dump, untreated sewage outlet, or coal plant belching smoke can indirectly fuel the rise of untreatable infections. In essence, keeping our environment clean is key to keeping our medicine effective.



Environmental Drivers of AMR: How Resistance Spreads Across Ecosystems

The figure illustrates how antimicrobial resistance (AMR) emerges and circulates across interconnected environmental, agricultural and human pathways. When antimicrobials and contaminated waste enter soil, water, air or wildlife habitats, they create selective pressure that allows resistant microorganisms to thrive. In these environments, resistance can further develop through mutations or the exchange of genetic material between bacteria.

Wastewater, livestock operations, aquaculture, crop production, wildlife and clinical environments all contribute to a shared resistome, where antimicrobial resistance genes accumulate and move between ecological niches. Rivers, lakes and coastal waters play a particularly important role, as they collect inputs from multiple sources, creating ideal conditions for selection, co selection and horizontal gene transfer.

The diagram highlights that AMR is not confined to hospitals or farms, but is shaped by a wide network of environmental processes, making coordinated One Health action essential.

Environment, 'Bracing for Superbugs'.

Be Part of the Next FESTMIH Newsletter!

Celebrate global health by contributing to our Q1 2026 Edition!

Choose a UN Day topic in Q2 and send articles, project summaries, or inspiring stories to our E-Mail.

Deadline: 30.1.2026



A CALL TO ACTION: CLEAN ENERGY AND ZERO WASTE FOR GLOBAL HEALTH

The intertwined crises of climate change, pollution, and emerging diseases highlight our global interdependence. No country, rich or poor, can insulate itself from these threats. However, those with greater resources and historical responsibility have a moral imperative to lead. The UN's International Day of Clean Energy (January 26) and International Day of Zero Waste (March 30) serve as rallying points for the changes we need:

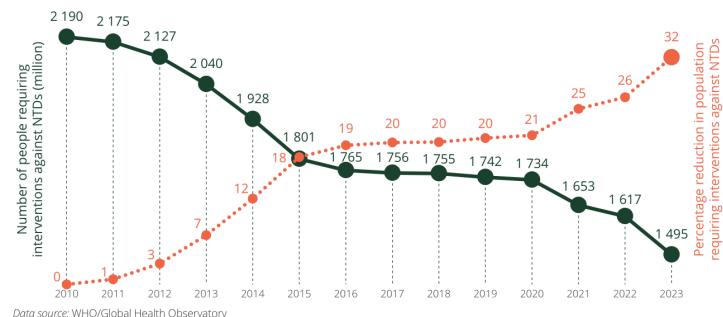
- **Accelerate the Clean Energy Transition:** Phasing out fossil fuels in favor of clean, renewable energy isn't just about meeting climate targets - it will save lives. Cleaner energy means less air pollution (already the single largest environmental health risk) and fewer climate disasters. Achieving the Paris Agreement's 1.5°C goal could prevent millions of heat-related illnesses, climate-driven malnutrition, and infectious disease cases. It also embodies climate justice: wealthy nations must drastically cut emissions and invest in affordable clean energy access for LMICs, so that developing communities can grow sustainably without compromising health. From solar panels in rural clinics to climate-resilient hospitals, the health sector itself can lead by example (the healthcare industry, if it were a country, would be the 5th largest emitter!). Every bit of carbon we keep out of the atmosphere reduces future disease risk - truly, clean energy is an investment in public health.
- **Embrace Zero Waste and a Circular Economy:** We must move from a throwaway culture to a circular one - where products are reused, recycled, or composted rather than dumped. Reducing plastic and chemical pollution will yield direct health benefits: cleaner air, safer drinking water, and less toxic exposure for all. It will also curb breeding grounds for disease vectors (improperly discarded trash and plastics can collect water and breed mosquitoes, linking waste management to dengue control!). High-income countries need to slash single-use plastics and stop exporting hazardous waste, while supporting waste management infrastructure in LMICs. Innovations - from biodegradable materials to improved medical waste treatment - are part of the solution. But at its core, the zero waste ethos calls for rethinking our consumption patterns. By cutting waste, we reduce pollution and greenhouse emissions from production and disposal. We also diminish the environmental pressures that drive AMR and other health threats. A world with less waste is a world with fewer toxins, less habitat destruction, and ultimately healthier communities.

Global responsibility means recognizing these connections and acting collectively. International frameworks like the Paris Climate Agreement, the Kigali Amendment on HFCs, and the impending Global Plastics Treaty are steps in the right direction. But agreements only matter if implemented with urgency and ambition. High-emitting countries must uphold their climate finance commitments to help vulnerable nations adapt and build resilience (for instance, funding early warning systems for climate-related disease outbreaks, or strengthening healthcare in climate hotspots). Similarly, a global plastic treaty should ensure big manufacturers take responsibility for product waste, and guarantee support for waste reduction in the Global South. We also need a One Health approach ingrained in policy - bringing together environmental, veterinary, and human health sectors to address problems like AMR, zoonoses, and pollution holistically. The challenges are undeniable, but so is our ability to overcome them. The world mobilized to tackle COVID-19, showing how science, political will, and community action can save lives on a massive scale. The climate and pollution crises demand a similar all-hands-on-deck approach. There is no vaccine for climate change, no quick fix for microplastics or superbugs - the only cure is prevention, through sustainable development and cooperation.

WORLD NTD DAY

Neglected tropical diseases (NTDs) are often described as the diseases of people who are last in line for health care: they affect communities living in poverty, in remote rural areas, informal settlements and conflict zones, and they quietly reinforce cycles of ill-health and social exclusion. Yet the latest Global report on neglected tropical diseases 2025 from WHO shows that, despite crises and constrained resources, the global response to NTDs has become one of the most substantial – if still under-recognized – public health success stories of the past two decades.

At their core, NTD programmes aim to do two things: prevent people from acquiring infections, and ensure that those who are already affected receive diagnosis, treatment and long-term care. In 2023, an estimated 1.495 billion people still required interventions against at least one NTD – but this is 122 million fewer people than in 2022, and represents a 32 % reduction compared with the 2010 baseline. The number of people affected by NTDs has also fallen over the longer term, from 1.9 billion in 1990 to just over 1 billion in 2021. Importantly, as the world's population has grown from around 7 billion in 2010 to 8 billion in 2023, the share of the global population needing NTD interventions has dropped from 31.2 % to 18.5 %.



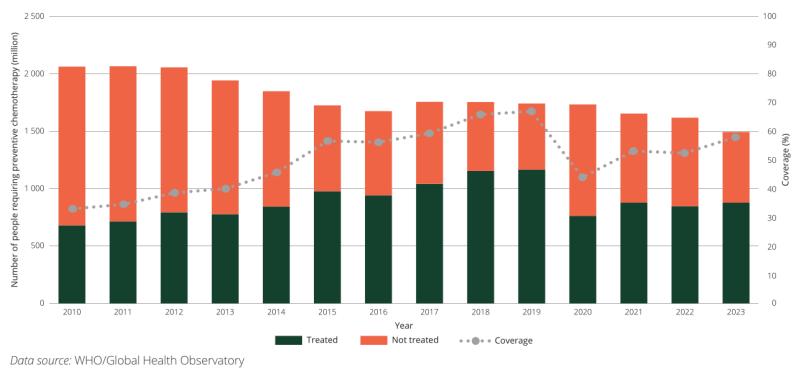
Number of people requiring interventions against NTDs in 2010–2023 and percentage reduction since 2010

Between 2010 and 2023, this has translated into a shrinking footprint of NTD risk, even as populations grow.

At the same time, treatment delivery has become more efficient. In 2023, 867.1 million people were treated for at least one NTD, and 99 % of them received preventive chemotherapy (mass or targeted administration of medicines). Looking specifically at preventive chemotherapy, 864.6 million people received treatment against one or more NTDs in 67 countries, representing a coverage of 57.9 %, up from 52.4 % in 2022, even though the absolute number of people requiring treatment has declined.

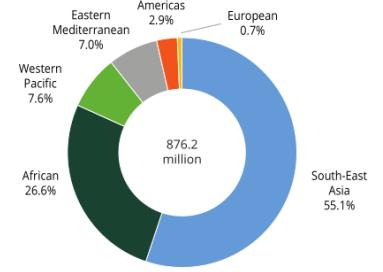
A decade of measurable progress – fewer people at risk, more people reached

The reduction in people needing NTD interventions is not only a function of better case management; it reflects real epidemiological gains. Mapping of endemic areas, scale-up of mass drug administration and improved access to water and sanitation have allowed many countries to move entire populations from “requiring” to “no longer requiring” interventions.



Number of people requiring preventive chemotherapy for at least one disease and coverage achieved, 2010–2023

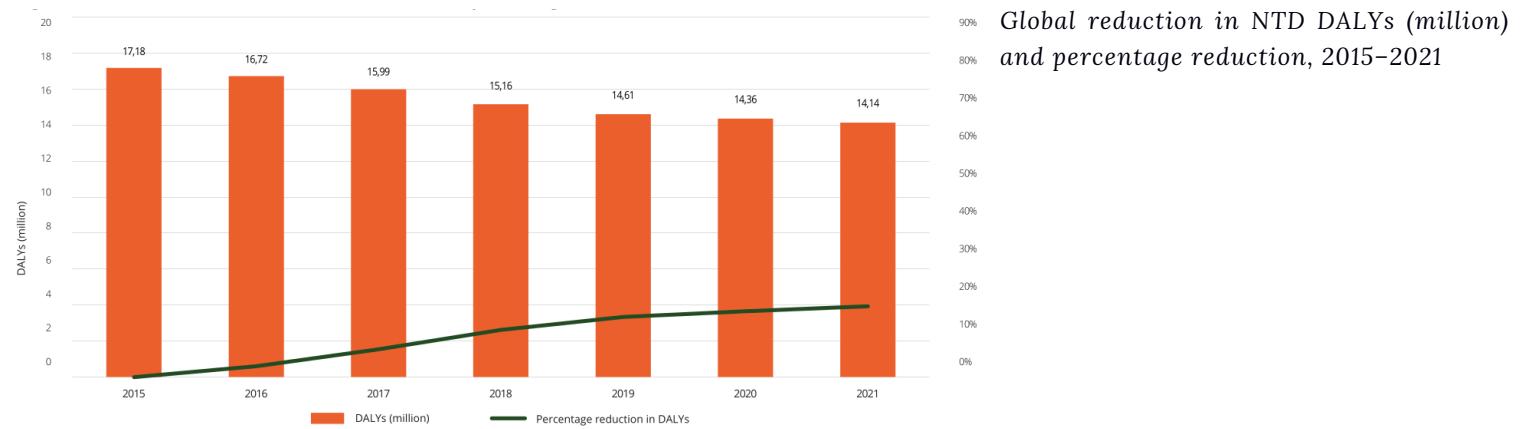
Number of people requiring preventive chemotherapy for soil-transmitted helminthiases by WHO region, 2023



Falling burden of disease – but momentum has slowed

Beyond coverage, the WHO report looks at disability-adjusted life years (DALYs) to capture the combined impact of premature death and long-term disability due to NTDs. Between 2015 and 2021, NTD DALYs fell from 17.18 million to 14.14 million, an 18 % reduction, with most gains driven by reductions in premature mortality: years of life lost decreased by around 20 %, while years lived with disability fell by about 15.7 %.

However, this progress has not been linear. The average annual reduction in DALYs between 2015 and 2021 was about 0.51 million per year (3.33 % annually), but the pace slowed markedly after 2019 – coinciding with the disruption of health services during the COVID-19 pandemic. This is a central message of the 2025 report: NTD programmes have demonstrated resilience and recovery, but their momentum remains vulnerable to broader system shocks.

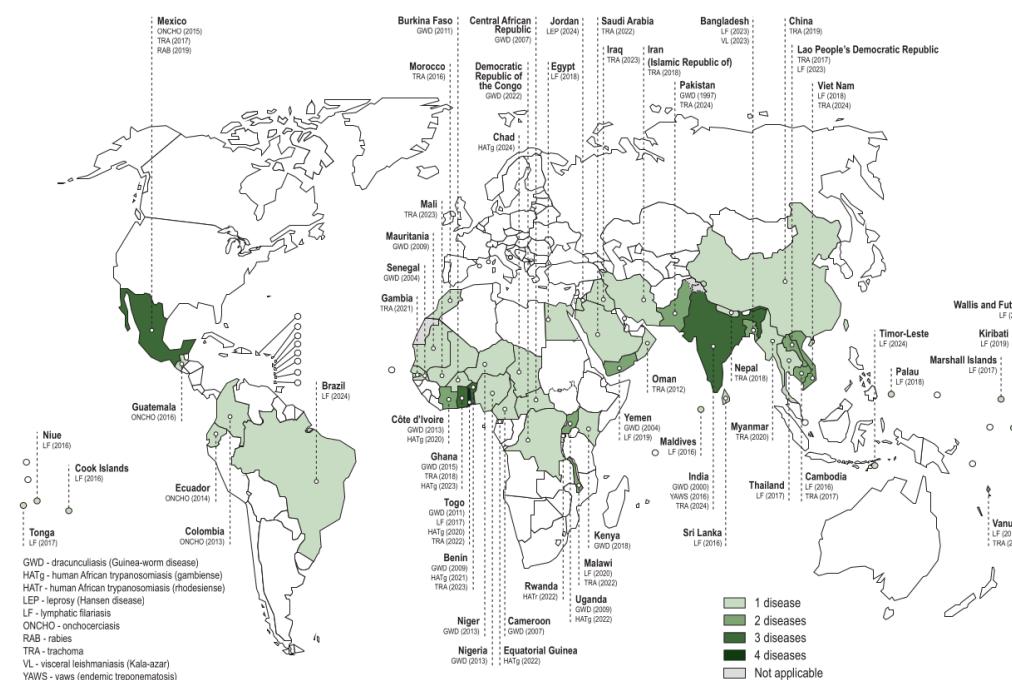


Data source: WHO/Global Health Estimates

Countries leading the way - elimination as a reality, not just a target

One of the most striking signals of progress is the growing number of countries that have eliminated NTDs. In 2024 alone, WHO acknowledged seven countries for eliminating at least one NTD – Brazil and Timor-Leste for lymphatic filariasis; Chad for the gambiense form of human African trypanosomiasis; India, Pakistan and Viet Nam for trachoma; and Jordan for leprosy.

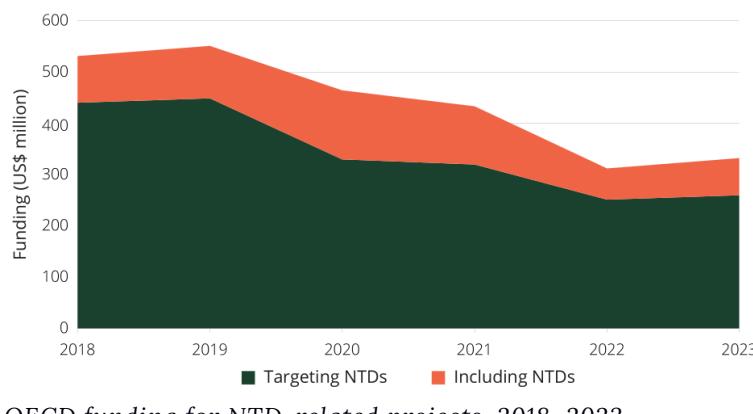
This brings the total to 54 countries that have eliminated at least one NTD, corresponding to 75 completed elimination acknowledgement processes. It means that millions of people now live in areas where transmission has been interrupted or disease is no longer a public health problem – and where programmes have transitioned to post-treatment or post-elimination surveillance.



Distribution of countries that have eliminated at least one NTD (54 as of December 2024)

The backbone of progress – donated medicines, logistics and innovation

Behind these numbers lies a massive operational effort. Interventions against NTDs are supported by one of the largest medicine donation programmes in global health. As of the end of 2024, 19 different types of medicines were being donated by 12 manufacturers to support NTD interventions. Between 2011 and 2024, almost 30 billion tablets and vials were delivered to countries, with 1.8 billion doses donated and delivered in 2024 alone, about half of which were managed directly by WHO. At the same time, new tools and guidance continue to emerge. In recent years WHO has prequalified additional NTD medicines and diagnostics, and issued new guidelines – for example on human African trypanosomiasis, strongyloidiasis, and on monitoring and evaluation for schistosomiasis and soil-transmitted helminthiases – as well as target product profiles for diagnostics and snakebite antivenoms. To tackle persistent supply-chain bottlenecks, the Global Coordination and Stewardship Committee (GCSC) was established in 2024 to improve management and stewardship of donated NTD medicines, and a Supply Chain Technical Support Mechanism is being piloted in eight high-burden African countries.



OECD funding for NTD-related projects, 2018–2023

A success at risk – shrinking resources and persistent neglect

Despite these achievements, the 2025 report is clear that NTDs remain under-recognized and under-funded. Surveillance and reporting systems are often weak; many NTDs require specialized diagnostics that are not widely available; and in many settings, people with NTDs seek care from informal or traditional providers, leaving cases invisible to national health information systems.

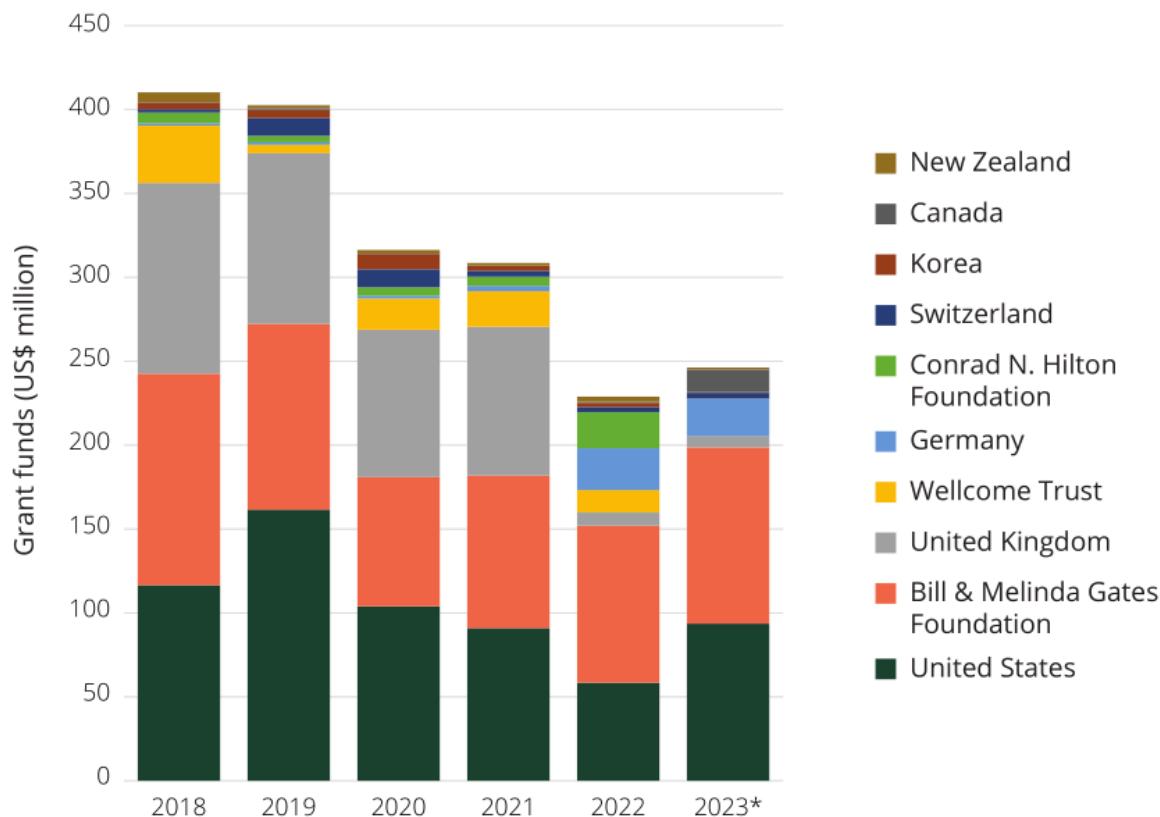
Financially, NTD programmes are operating in an increasingly constrained environment. Analysis of official development assistance (ODA) shows that funding for projects primarily targeting NTDs fell from US\$ 440 million in 2018 to US\$ 260 million in 2023 – a 41 % decrease over just five years. At the same time, the report notes that progress has slowed or stagnated in several cross-cutting areas: reducing deaths from vector-borne diseases, expanding access to water, sanitation and hygiene (WASH), protecting populations from catastrophic out-of-pocket health expenditures, and achieving complete, gender-disaggregated reporting for all NTDs.

In other words, NTDs are becoming less visible in the financing landscape just as programmes reach a critical, more complex phase – where integrated, people-centred and system-strengthening approaches are needed to consolidate gains and reach the “last mile”.

Why this matters for our community

Taken together, the 2025 WHO report paints a picture of NTDs at a crossroads. On one side, there is undeniable progress: fewer people at risk, fewer deaths and disabilities, more countries reaching elimination, and an unprecedented scale of medicine donations and technical innovation. On the other, there are clear warning signs – slowing momentum in burden reduction, persistent data gaps, and a sharp decline in dedicated funding.

For a network like ours, this combination is both a challenge and an invitation. It means that contributions from clinicians, researchers, public health practitioners, policy-makers and communities remain essential – to keep NTDs on the agenda, to generate and share data, to advocate for equitable financing, and to ensure that the gains of the past decade are not only protected but extended to those who have still not been reached.



Top donors funding NTD-related projects (reported to CRS, 2018–2023)

WORLD NTD DAY 2026 – UNCOVER HOPE

On January 30 is World NTD Day. To raise awareness for Neglected Tropical Diseases (NTDs), the Working Group for NTDs (AG NTD) of the German Society for Tropical Medicine, Travel Medicine and Global Health e.V. (DTG) has partnered up with the Ethiopian NTD Youth Initiative Alert Gursha and Ethiopian artist Solomon Kifle. Together, they have created an Art Project comprising an Art Competition and a mural on NTDs as well as contributions to a vernissage on World NTD Day. The Project is supported by FESTMIH.

Art Competition:

Until December 10, artists and/or individuals interested in or affected by NTDs could send in their artwork on the topic of “Bandage the Pain. Uncover the Hope”. The participants were asked to reflect on an infographic designed by Solomon Kifle, which depicts a hand and forearm covered with a bandage. The infographic could be used either as a template for the submission, or as inspiration for an independent piece of art.

The winners will be announced in January 2026 and will receive price money (300, 200 and 100 € for the 1st, 2nd and 3rd price, respectively). They will get the chance to exhibit their artwork on NTDs at a vernissage for World NTD Day in Hamburg. The Art Competition is funded by the Andreas Ruppel Fund.

Vernissage:

The vernissage will take place in Hamburg Speicherstadt and is part of the World NTD Day Celebration organised by the Bernhard-Nocht Institute for Tropical Medicine (BNITM) in Hamburg, Germany, in cooperation with the German Center for Infection Research (DZIF). The event will comprise a panel discussion with experts on the field of NTDs. The vernissage is funded by the DZIF.

Mural:

The mural will be done on the compound of ALERT Comprehensive Specialized Hospital in Addis Ababa, Ethiopia. At ALERT, individuals with NTDs such as leishmaniasis and leprosy receive diagnostics and treatment. The mural will be under the motto of 'Unite. Act. Eliminate.' and will focus on skin NTDs. The process of doing the mural is planned to be recorded on video, to be shown in time for the World NTD Day 2026 celebrations. On January 30, 2026, the mural will be revealed to the public and people affected by, interested in or working on NTDs are invited to attend the event. The mural will be finalized by the visitors themselves, who can share their thoughts and experiences directly on the mural. Everyone is welcome to participate!

Meet the artist: Solomon Kifle



I am Solomon Kifle, a visual artist, public art curator, gallery owner, and entrepreneur based in Addis Ababa, Ethiopia. I am the founder of Addis Street Art, an organization that has been promoting street art in Ethiopia for the past eight years. Recently, I opened the first urban art gallery in Ethiopia, which aims to showcase and promote African urban art, with a current focus on Ethiopia.

Three Questions to Solomon Kifle:

- 1. What fascinates you about art that made you decide to become an artist?** Art fascinates me because it is part of who I am. I have been doing it all my life, and it has shaped me. Through art, I can share feelings and ideas that are difficult to say with words, and connect with people in a way nothing else can.
- 2. In your exhibitions, you often use interactive elements, e.g. allowing visitors to write their experiences on your artwork. In your view, how does this influence how the visitors perceive your art, and how in turn does it shape your artwork?** Ideas don't usually belong to the artist alone. When you make your work interactive, people start to notice things they were not giving attention to before. They become part of the art and give it new meaning. Their contributions also shape my work, showing me new perspectives and making the artwork grow beyond my own vision.
- 3. How do you think art can raise awareness for NTDs, even if the viewers might not be familiar with the topic?** People are often tired of information, and they quickly replace it with something new. That's why another approach, like public art or other art forms, can be more effective. Art can stay with people for a long time without disturbing their emotions, and it can make them feel, notice, and remember things that words alone often cannot.





Information on the Vernissage:

Address:
1000 Satellites,
Hamburg Speicherstadt,
Am Sandtorkai 25-27

Date and time:
January 30, 6 pm

No pre-registration necessary



World NTD Day Art Contest: Cast Your Vote

Creativity is a powerful tool for advocacy. As part of this year's World Neglected Tropical Diseases Day, the NTD Art Contest highlights artistic perspectives on NTDs, equity, and global health. We warmly invite you to support the participants by casting your vote. Every vote helps amplify awareness and gives visibility to voices engaging with NTDs beyond the scientific sphere.

Vote for your favourite contributions using the links below.



INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE

Women and Girls in Science: Perspectives from the Charité

On the occasion of the International Day of Women and Girls in Science, this edition features insights from two experts at Charité Universitätsmedizin Berlin who work at the intersection of science, leadership culture and structural equality.

Dr. Christine Kurmeyer **CK** is the Central Equal Opportunities Commissioner at Charité. In this role, she has been instrumental in shaping institutional strategies to promote gender equality, fair career development and inclusive leadership across one of Europe's largest university hospitals. Her work focuses on translating equality concepts from formal requirements into everyday academic and clinical practice, addressing questions of power structures, career pathways and accountability within scientific institutions.



Dr. Ingar Abels **IA** works in the field of mentoring, coaching and organizational development at Charité, with a particular focus on supporting early career researchers. Her work engages with the lived realities of women in science, including structural barriers, informal exclusion mechanisms and the often unspoken challenges of navigating academic careers. Through mentoring programmes and systemic coaching approaches, she contributes to strengthening individual agency while also reflecting on the limits of individual solutions within unequal systems.



Together, their perspectives highlight that promoting women and girls in science requires more than symbolic commitment. It demands sustained structural change, critical reflection on leadership cultures and concrete support mechanisms that address both institutional frameworks and everyday experiences in research and medicine.

Note: This interview was originally conducted in German and was subsequently translated into English by the editorial team.

INTERVIEW

INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE

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The "Paper Tiger" Check (Equality Concepts)

"I'd like to start with a reality check on structural changes. Dr. Kurmeyer, back in 2015, you introduced a requirement for every new professor to submit a written concept on how they intend to promote equality. Hand on heart, after ten years of practice: Are these often just 'copy-paste' documents for the files?"

CK

"Quite honestly? This relatively small measure has indeed led to a gradual, but lasting change. Perhaps not as directly or immediately as one might expect, but cultural change does not always occur in a revolutionary way.

To begin with the origins: resistance within the organization to introducing this instrument was minimal. Its implementation did not involve any costs, and previous experience from appointment committee meetings had shown that the so called "gender question" was an excellent test of the candidates' alertness and reflective capacity.

Very formally, the appointments office now sends, together with the invitation to give a lecture, a request to submit a written concept for the promotion of early career researchers, with particular consideration of female early career scientists. This document is then not only forwarded to the Women's and Equal Opportunities Officer, but officially becomes part of the application materials. At the same time, candidates are informed that the Women's and Equal Opportunities Officer is available for follow up questions. This invitation has already led to some very interesting telephone conversations and video calls.

During the lecture event, I can then, through carefully graded evaluative comments, draw the attention of the members of the appointment committee to the fact that it is particularly worthwhile to read the submitted concept, or perhaps not quite so worthwhile. In this way, all members of the committee potentially also receive impulses for their own equality practice through these concepts.

One year after taking up their position, the individuals selected through the procedure are informed of an upcoming visit by the Women's and Equal Opportunities Officer. Naturally, this visit serves to critically revisit the concept that is brought back into focus at that point: What has been achieved? Where are there still gaps in implementation? And also, where can the Women's and Equal Opportunities Officer provide further support?

The written concept is therefore far more than the piece of paper it is written on. It is the lived encounters and personal interactions that can truly foster cultural change. For this reason, I cannot entirely agree with the notion that this instrument is merely a "paper tiger".

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The "Paper Tiger" Check (Equality Concepts)

"And Dr. Abels, from your sociological perspective: Do you observe that the leadership culture in these departments has genuinely changed because of this mandate, or is the 'old guard' mentality still dominant despite the paperwork?"

INTERVIEW

INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE

IA

"A changed leadership culture encompasses far more than the mere fulfillment of formal requirements. Of course, momentum is created as soon as more women or, more generally, more diverse individuals become visible in leadership positions. But what is decisive is how leadership is practiced.

I observe that genuine cultural change becomes tangible where people with strong social skills take on responsibility, meaning individuals who are willing to learn, to further develop themselves, and who actively seek support through coaching or supervision when conflicts arise. Especially among younger women and men in leadership positions, I often see a heightened awareness of how crucial employee well being is for the success of a team. They increasingly understand that good leadership also means supporting and developing people according to their interests and talents.

In addition, many of them have internalized the idea that, as a leader, one does not have to solve everything alone. Seeking support, whether through coaching, intervision, or other forms of reflection, has become much more self evident today.

And not least, we as Women's and Equal Opportunities Officers are, of course, also available as points of contact. Especially when dealing with challenging situations, we can offer guidance and contribute to the further establishment of a contemporary, learning oriented, and constructive leadership culture."

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The Economic Argument vs. "Social Fluff"

"Dr. Kurmeyer, you have argued in the past that we need to prove to the economy that diversity drives profit. Has this argument finally won the day at Charité? Is equality viewed as a hard economic success factor by the board today?"

CK

"This discussion is, of course, far from being concluded. I continue to be convinced that mixed teams perform better, but this requires investing more time in these teams beforehand. For them to work well together, they need to speak the same language and overcome potential hierarchical barriers.

At the same time, given the currently tense budgetary situation in the state of Berlin, all employees at Charite are under enormous pressure. In such circumstances, there is often little time to engage in dialogue about how we want to work together and how we can do so effectively. Nevertheless, the Charite Executive Board is more convinced than ever that we must pursue new paths in order to remain productive and innovative in research, while staying humane in patient care.

Together, we share the goal of making medicine and nursing a little better every day. The recognition of the opportunities inherent in the lived diversity at Charite is well underway."

INTERVIEW

INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE



The Economic Argument vs. "Social Fluff"

"Dr. Abels, looking at it from the research side: Does the pressure to be 'economically efficient' sometimes clash with the goal of creating a diverse, healthy work environment? Is equality still seen as a 'social nice-to-have' that costs money, rather than an asset?"

IA

"Of course, academic medicine is under considerable economic pressure, and it is not always easy to argue for stronger support of diversity when, at the same time, key senior physician positions cannot be made permanent, even though they are urgently needed for patient care. At the same time, a large body of research shows this very clearly: diversity and equal opportunity are not social nice to haves, but real organizational advantages. Teams that are diverse and in which people feel safe work more innovatively, make better decisions, and are more productive in the long term. This is a decisive factor, especially in times of skilled workforce shortages."



Operating While Pregnant

"The topic of 'Operating while Pregnant' was a major discussion point back in 2017. Dr. Kurmeyer, is it standard practice at Charité today for a pregnant surgeon to remain active in the OR from a regulatory standpoint? But also, beyond the regulations: Do the women actually feel safe doing it? Or are your female doctors still battling the fear of stigma or being seen as 'difficult' if they insist on their rights?"

CK

"This touches directly on the core weakness of these regulations. If we were to define "operating during pregnancy" as a standard, any refusal by a woman to do so would become, at the very least, problematic. We tried this once.

A senior physician insisted on continuing to operate during an advanced stage of pregnancy, provided that all safety measures were observed. As a result, she encountered considerable resistance. Due to the increased staffing requirements, meaning that a substitute always had to be available while she was operating, and the mandatory testing of patients for infectious diseases because of potential transmission risks to the unborn child, tensions within the team rose significantly.

Her conclusion after this trial phase was telling: "If I had not already been a senior physician, I would have given in under the pressure from my colleagues."

Without changing the existing structures, any systemic change is therefore carried on the backs of the individuals directly involved. Nevertheless, work on precisely this change is continuing. In many surgical departments at Charité, operating theatre conditions are currently being reviewed with regard to whether they are suitable for pregnant staff or not.

We must ensure that it remains a voluntary decision for every woman whether she feels safe and has no concerns regarding the health of the fetus, or whether she prefers to refrain from operating. It is important to us to accommodate all legitimate interests while keeping the well-being of women firmly in focus."

INTERVIEW

INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE

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Culture Change: Lone Wolf vs. Team Player

"It has been emphasized that medicine needs to move away from pure competition toward more cooperation. Dr. Kurmeyer, when you look at the appointments of young Chief Physicians today: Are we actually hiring team players?"

CK

"You raise very interesting questions, thank you very much for that. The selection criteria for early career researchers in academic medicine have traditionally been highly stereotypical: publication output and success in acquiring third party funding. The idea that innovative and modern science is a team outcome, and that it emerges through coordinated cooperation between as many diverse perspectives as possible, is still relatively young.

As a result, traditional criteria remain deeply embedded in the mindset of most members of appointment and selection committees. Of course, this should gradually change, but the economic pressure on academic medicine tends to stifle such efforts immediately.

This makes us all the more appreciative of developments such as those being advanced by the QUEST Center at the Berlin Institute of Health (BIH)

Here, new ways are being explored to highlight  originality and innovativeness of a research idea and to identify funding potential beyond validation through prior reviews in the so called peer review process.

So, in short: do we primarily recruit team players? No, this is still not a defining criterion when appointing senior scientists. Perhaps this would also require a parallel re examination of the concept of excellence itself, which for centuries has been shaped almost exclusively by men who had no experience with maternity protection or parental leave.

Engaging in an open dialogue about how these requirements and needs could be adapted to modern realities would be truly worthwhile, especially if we do not want to lose the competition for the best minds."

?

Culture Change: Lone Wolf vs. Team Player

"And Dr. Abels, regarding the men in the system: Is the Charité system reproducing the classic 'lone wolf' mentality through its hierarchy, or do you see a genuine shift in how young male doctors define their role and masculinity today?"

IA

"From a sociological perspective, we observe a slight shift at the societal level away from traditional norms of masculinity, moving from the classic "lone wolf" ideal toward more cooperative and relationship oriented forms of masculinity. In the 2024 Shell Youth Study, for example, young people more frequently than in previous years express a desire for a more egalitarian distribution of childcare responsibilities. The key question, of course, is whether this shift actually reaches academic medicine. My experience is clearly ambivalent. On the one hand, I see many younger men who no longer want to be stigmatized when they wish to take parental leave, and who actively approach us as Women's and Equal Opportunities Officers to discuss how to further develop their departments in a more equality oriented way.

On the other hand, there are still men who have deeply internalized very rigid norms of masculinity and who reproduce these norms in their leadership behavior.

In such moments, I am always reminded that a large body of scientific research shows that these traditional, strongly competitive ideals of masculinity are not only organizationally counterproductive, but also harmful to men's own health. Research on men's health increasingly describes men as the "ill" or sometimes even the truly vulnerable gender. Men have a significantly lower life expectancy, but also a lower quality of life, and they report feelings of loneliness more frequently.

The motivation to further develop workplace culture, particularly in academic medicine, should therefore also be strong for men themselves."

IA



Mental Health & Gender

"Dr. Abels, you research 'Gender-Sensitive Psychiatry.' Do we currently see a significant difference in how male and female medical staff at Charité experience burnout?"

IA

"First of all, it is important to emphasize that burnout is not a medical diagnosis, but rather an umbrella term for different states of exhaustion. Behind these states of exhaustion, however, there are sometimes clearly defined diagnoses, and in these, marked gender differences become apparent.

Men, for example, develop substance use disorders more frequently and have a higher risk of suicide. At the same time, depression often remains undetected in men because symptoms such as withdrawal or addictive behavior are less readily interpreted as signs of psychological distress. Women, by contrast, tend to seek help earlier due to their socialization, speak more openly about psychological strain, and therefore more often receive an accurate diagnosis, such as depression.

When it comes to the assessment of vulnerability, I would argue that there are also differences. When women in leadership positions address exhaustion, this is more often interpreted as a personal deficit, with stereotypical assumptions about lower resilience clearly continuing to have an effect. In men, openness is less frequently problematized and is sometimes even viewed positively, for example as a sign of responsibility or willingness to perform.

But let us not deceive ourselves. Particularly in certain disciplinary cultures within medicine, very rigid gender norms still prevail. In such contexts, even men cannot simply say that they can no longer cope, let alone admit to having a mental illness."



Mental Health & Gender

"And Dr. Kurmeyer, does the system punish women more for showing this vulnerability? If a female leader admits to exhaustion, is it treated differently than if a male leader does?"

INTERVIEW

INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE

CK

"Male leaders are often unwilling to admit that they are not up to a task. One reason for this is that they see themselves, and are also seen by others, as the "breadwinner of the family". The so called system does in fact respond very differently to expressions of vulnerability by different members of the group.

The system does not penalize women to the same extent as men when they experience setbacks, because it is assumed that women will, in any case, respond to family needs with a higher sense of responsibility than men. This is both a blessing and a curse. Women tend to place greater emphasis on family relationships and thus provide the social glue that holds society together. At the same time, they are also held responsible when connections between different groups fail to function.

Men, by contrast, are assigned and attributed responsibility for the financial security of the family. This is certainly no small responsibility, but it is not associated with the same degree of dependency as the status assigned to women.

So, once again: when men fail to live up to the ideal of the family breadwinner model, external circumstances are blamed. When women break under the same model, it is interpreted as their personal inability to meet the expectations of a system shaped by male norms. In other words, different standards are applied to the same situation.

Is that justice?"



The "Leaky Pipeline" & Structural Blind Spots

"I want to look at where we lose talent. Dr. Abels, in your role leading the Mentoring Center: Is the 'Rush Hour of Life' (kids + career) still the main exit point, or are the reasons changing?"

IA

"Yes, the so called rush hour of life remains the central point at which we lose talent. The combination of high family responsibilities and fixed term contracts creates a strong need for security during this phase of life. If this security, particularly with regard to career predictability, is not provided within a system dominated by endlessly renewed temporary contracts, many people decide to leave academic medicine. This applies above all to highly qualified women, but sometimes also to men."



The "Leaky Pipeline" & Structural Blind Spots

"Dr. Kurmeyer, you have the unique advantage of having started as a nurse. When you look at these structural problems alongside Dr. Abels' sociological analysis: what is the one structural blind spot that classic medical doctors simply fail to see, but which is driving women out of the hospital?"

INTERVIEW

INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE

CK

"Perhaps I should try to answer this in two parts. Women tend to leave regular hospitals when they have ambitions for advancement and no longer wish to accept the still dominant hierarchy between medical and nursing staff. At the same time, the hospital workplace remains attractive to many women, because healthcare provision carries a relatively high level of social status and offers long term income security.

Academic medicine, such as at Charite, however, presents women with a very different set of obstacles. Career pathways in medicine are particularly insecure and difficult to plan. Fixed term positions in externally funded projects, unclear promotion criteria, the triple burden of research, teaching, and patient care, the mandatory period abroad, and the prohibition of internal appointments continue to affect women in the family planning phase differently than their male colleagues.

In addition, pregnancy and parental leave are still not viewed as positive events by hospital management, but rather as a potential total loss of capacity. As a result, women of childbearing age are not supported and challenged equally in all settings, because an absence or departure linked to childbirth is assumed. Many early career researchers still vainly hope for part time or job sharing options.

This becomes a serious problem at the latest when the more than 65 percent of new medical students who are now women decide against a career in academic medicine for precisely these reasons. At that point, the shortage of skilled professionals will take on entirely new dimensions."



Political Rollback

"Finally, a look at the political climate. Dr. Kurmeyer, in 2017, you warned quite starkly about a looming 'rollback' to the 1950s. Looking at the election results of the past few years: Has this societal pressure seeped into the daily reality of the clinic?"

CK

"Unfortunately, the trend that was already becoming apparent at the time has been confirmed and solidified in a dramatic way. The broader social and political climate has shifted toward a traditionalist and even reactionary stance. As a result, many emancipatory achievements are suddenly being called into question once again.

Women are being attacked with all available means and at all levels, pushed out of leadership positions, or prevented from entering them in the first place. That said, this development is not reflected to the same extent in academic medicine. Even before, conditions there were difficult for women. For now, however, most universities still maintain a self understanding of themselves as spaces for innovation and progress.

This is where new ideas and concepts are born, experimentally tested, and further developed, including what some might consider daring constructs such as equality and equal opportunity. We will work to preserve this space of freedom for as long as possible."

INTERVIEW

INTERNATIONAL DAY OF WOMEN AND GIRLS IN SCIENCE



Political Rollback

“Dr. Abels, do you find that you have to defend equality gains today, intellectually and scientifically, that you previously considered secure against this political backdrop?”

IA

“At Charite, and also within research on gender sensitive psychiatry itself, I have so far felt relatively little of this pressure. At the level of society as a whole, however, we clearly see that scientific knowledge and questions of diversity are increasingly coming under attack, particularly from politically authoritarian directions. Many things that were long considered self evident now have to be defended again scientifically and intellectually. To be honest, that does give one a few grey hairs.”

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Celebrate global health by contributing to our Q1 2026 Edition!

Choose a [UN Day topic](#) in Q2 and send articles, project summaries, or inspiring stories to our [E-Mail](#).

Deadline: 30.1.2026



WORLD TUBERCULOSIS DAY

MARCH 24TH

Tuberculosis at the Crossroads: Insights from the Epicenter of the Epidemic

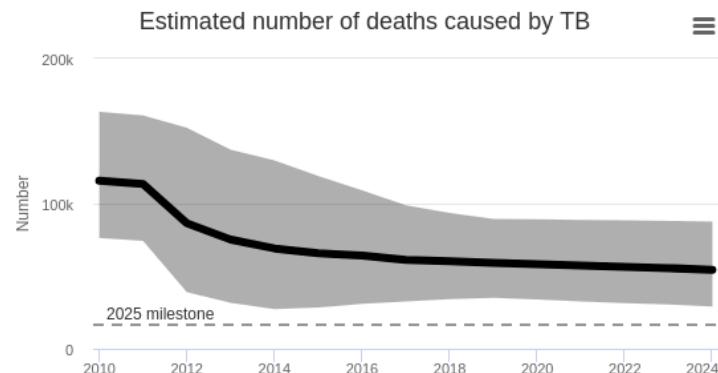
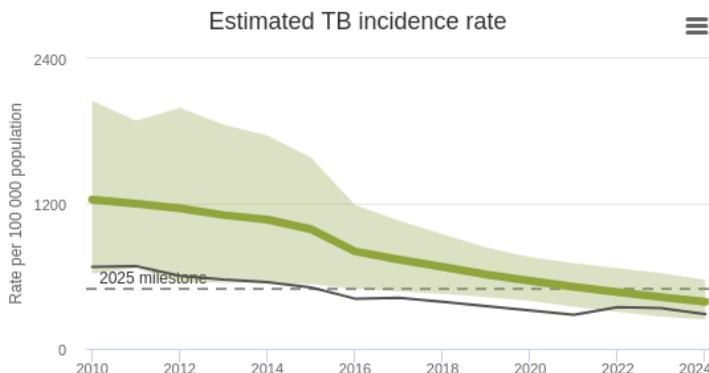
An Introduction to the Status Quo of Global TB Control and the Reality on the Ground in South Africa

Tuberculosis (TB) remains one of the global health architecture's most pressing and, simultaneously, most paradoxical challenges. While science has celebrated historic breakthroughs in recent years regarding the development of new drug regimens and potential vaccines, implementation on the ground continues to struggle with systemic hurdles, funding gaps, and the relentless adaptability of the pathogen *Mycobacterium tuberculosis*.

The current Global Tuberculosis Report by the World Health Organization (WHO), released in November 2025, paints a sobering picture: In 2024, 1.23 million people worldwide still died from this preventable and curable disease. With this figure, tuberculosis defends its tragic status as the world's leading cause of death from a single infectious agent. The persistence of the disease in high-burden countries is particularly alarming: with an estimated 10.7 million new cases in 2024 and a massive gap in care for multidrug-resistant tuberculosis (MDR-TB), health systems worldwide remain under immense pressure. Nowhere do the fault lines of this battle become clearer than in Southern Africa. South Africa—and specifically the Cape Town metropolitan area—has served for decades as a global "living laboratory" for tuberculosis research. Here, world-leading scientific innovation meets a complex epidemiological reality characterized by high rates of HIV co-infection, rapid urbanization, and profound socioeconomic inequality. The following interview with two leading researchers from this region not only highlights local challenges but serves as a magnifying glass for the issues currently occupying the global TB community.

The Epidemiological Burden: HIV and the "Missing Millions"

To understand the urgency of this conversation, one must look at the nexus between HIV and TB, which remains particularly severe in Southern Africa. According to the WHO, the African Region continues to bear the highest burden of HIV-associated tuberculosis. People living with HIV are 12 times more likely to fall ill with active TB. In 2024, approximately 150,000 deaths worldwide were still attributed to this lethal synergy. Although nearly 10 million lives have been saved since 2005 through the scale-up of antiretroviral therapies (ART) and TB treatments, only 61% of HIV-positive TB patients globally received ART in 2024.



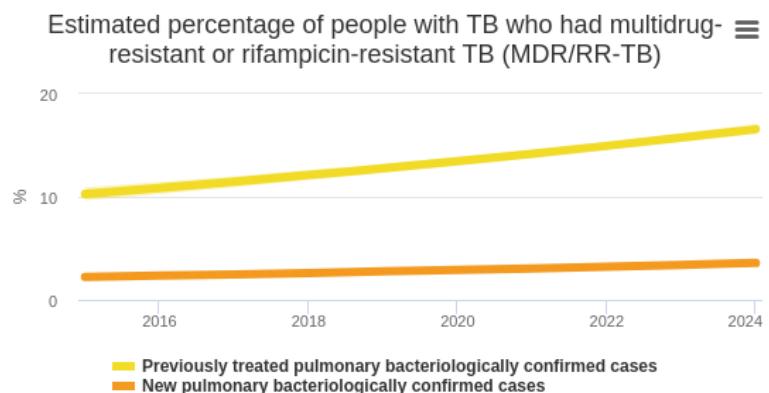
However, an even greater obstacle to eliminating the disease is the phenomenon of asymptomatic transmission. For a long time, the global screening model was based on the assumption that TB patients are symptomatic—coughing, fever, night sweats, and weight loss were considered the cardinal signs. The first National TB Prevalence Survey in South Africa shattered this dogma: It revealed that nearly 58% of bacteriologically confirmed cases showed no or only minimal symptoms. These "Missing Millions"—people who fall through the traditional diagnostic net and unknowingly transmit the infection—are forcing programmes in Cape Town and elsewhere to radically rethink their search strategies. The question of whether health systems can continue to reactively wait for sick patients or must proactively enter communities is a central component of the following dialogue.

The Therapeutic Revolution: BPaL and the Resistance Crisis

A glimmer of hope in the grim statistics is the modernization of treatment for drug-resistant tuberculosis (DR-TB). Multidrug-resistant tuberculosis (MDR-TB), where standard drugs like Rifampicin and Isoniazid fail, has been classified by the WHO as a "public health crisis" and a threat to global health security. Only about two out of five affected individuals received adequate treatment in 2024.

South Africa has taken a pioneering role by being one of the first countries globally to adopt the shortened, fully oral BPaL/BPaLM regimen (Bedaquiline, Pretomanid, Linezolid, and optionally Moxifloxacin) as the standard of care. This six-month regimen replaces earlier therapies that lasted up to two years and often involved toxic injections and severe side effects. The WHO data confirms the global trend: In 2024, approximately 34,000 patients worldwide started these new short-course therapies—a massive increase compared to just 1,744 patients in 2022.

However, this progress is fragile. The interview critically examines whether the reality in clinics can keep up with the promises of clinical trials. Side effects such as neuropathies caused by Linezolid continue to pose challenges for treatment adherence. Even more concerning is the potential emergence of resistance to new core drugs like Bedaquiline. The worry that *M. tuberculosis* is adapting faster than the pharmaceutical pipeline can supply new solutions hangs like the sword of Damocles over treatment programmes.



Financing in the Shadow of Geopolitics

No health programme operates in a vacuum. Funding for TB control is chronically insufficient. To achieve global targets by 2027, the UN High-Level Meeting estimated that US\$ 22 billion would be needed annually. The reality is starkly different: investments are stagnating, and the funding gap for research is particularly glaring, with only US\$ 1.2 billion available against a target of US\$ 5 billion.

For countries like South Africa, the situation is doubly precarious. While South Africa—alongside Brazil, China, India, and Russia—funds a large portion of its TB expenditure domestically (64% of domestic funding in low- and middle-income countries comes from these five nations), the country remains heavily reliant on international donors like the Global Fund and, crucially, PEPFAR (U.S. President's Emergency Plan for AIDS Relief). Current political uncertainty in the US regarding the long-term reauthorization of PEPFAR is causing anxiety. The interviewees are asked to describe from their perspective whether this uncertainty is already having operational consequences in the townships—for example, through hiring freezes or reduced testing capacities.

Looking to the Future: Vaccines and Long-Term Consequences

Beyond acute treatment, research is focused on preventive measures. The vaccine candidate M72/AS01E, currently undergoing Phase 3 trials in South Africa, is considered the first real hope since the 100-year-old BCG vaccine. Yet experts warn against over-optimism: Is M72 a true "game-changer," or do we risk relying on a future solution while neglecting today's tools?

At the same time, there is growing awareness that "cured" does not always mean "healthy." Cape Town records high rates of recurrent TB. Many patients suffer from chronic lung damage ("Post-TB Lung Disease") even after microbiological cure. The interview sheds light on the often-overlooked necessity of pulmonary rehabilitation and the question of whether we are producing a generation of young people with permanent respiratory impairments for whom no structured follow-up programmes exist.

Social Determinants: Climate, Migration, and Housing

Finally, it must not be forgotten: Tuberculosis is, at its core, a social disease. Transmission dynamics are significantly determined by living conditions. In Southern Africa, climate change and economic pressure are intensifying internal migration, leading to the expansion of informal settlements. In these extremely dense living conditions, the bacterium finds ideal grounds to spread. The question of how TB programmes must adapt to these new patterns of mobility and urbanization is crucial for the future success of control efforts.

The Interview

Against this backdrop, caught between groundbreaking medical innovations and the harsh reality of underfunded health systems, we speak with two experts who work daily on the frontlines in Cape Town. They offer us an unvarnished look at the successes, the fears, and the necessary next steps in the fight against humanity's oldest pandemic.

INTERVIEW

For this edition, we spoke with Janet Scott  and Roland Croxford , two clinicians with long standing experience in tuberculosis and HIV care in the Western Cape, South Africa. Both work in public sector facilities that serve populations heavily affected by TB, HIV and the social determinants that shape these diseases. Their daily clinical work places them at the interface between national policy decisions, international funding dynamics and the realities of patient care on the ground.

Janet Scott is based at DP Marais Hospital and has been closely involved in inpatient TB and HIV care, as well as in drug resistant TB surveillance and programme implementation. Her perspective combines clinical practice with insight into national monitoring systems and the impact of recent funding shifts on routine services. Roland Croxford has worked in TB and HIV care since the early 1990s across hospital, hospice and outpatient settings and has witnessed profound changes in the clinical presentation and management of these diseases over several decades.

Together, their reflections offer a grounded view of how global developments translate into everyday clinical challenges and opportunities. The interview brings together complementary perspectives from two clinicians who have navigated periods of crisis, innovation and recovery within TB and HIV care.

INTERVIEW: WORLD TUBERCULOSIS DAY



PEPFAR, Global Fund and funding insecurity

Over the past two decades, South Africa's TB response has been deeply intertwined with HIV funding, especially through PEPFAR and the Global Fund. Now there is political uncertainty around long-term PEPFAR reauthorization in the US, and at the same time pressure on countries to mobilise more domestic resources. From your vantage point in Cape Town, are you already sensing any tightening of resources or anxiety on the ground; for example around testing capacity, community outreach staff, or TB/HIV integration, or is this more of a "future worry" than a present reality?

JS

At DP Marais Hospital, we have not felt the effects of the USAID withdrawal of funding to date. Our hospital is fully funded by the National Department of Health, and we operate within this budget, which has not been affected. In addition, the supply of TB and HIV drugs remains fully available and is funded by the Department of Health.

That said, South Africa as a whole was significantly affected by the US funding cuts in 2025, and the impact on TB services across the country is a present reality. TB research groups nationwide were also heavily affected by funding restrictions, as many South African researchers had long standing and well established collaborations with research groups in the United States. A major consequence of the sudden international funding withdrawal has been its impact on routine care services within the TB and HIV programme. Community Health Workers across the Cape Metro were informed, almost overnight, to stop their usual activities because they would no longer be paid for their services. Community Health Workers are essential for providing psychosocial and adherence support for TB patients throughout their treatment journeys. They also conduct household contact assessments for people exposed to newly diagnosed TB patients and link newly diagnosed patients to clinic care following hospital discharge.

In addition, satellite clinics staffed by NGOs and NPOs that provided treatment to patients in rural areas were closed. As a result, many patients are now required to travel long distances to access treatment. Since the withdrawal of international funding, the South African government has committed hundreds of millions of rand to support provincial health programmes and research initiatives. It has also pledged financial support over the next two years for researchers who were affected by the loss of funding.

Furthermore, the national electronic drug resistant TB treatment register, EDRWeb, was entirely dependent on external funding and would have ceased to exist without emergency interventions by the National Department of Health to secure funds for continued patient registration, monitoring and evaluation.

Despite these efforts, a substantial funding gap remains. This gap has not been filled and has had a severe impact on the TB and HIV programme for the reasons outlined above.

INTERVIEW: WORLD TUBERCULOSIS DAY

RC

PEPFAR funding has been fundamental to our initial TB and HIV response with inputs ranging from the provision of fluconazole and ART to research funding and community support programs. I now work in a Western Cape Government TB and HIV facility in a much more mature service provision environment and have not (as yet) experienced a significant direct service reduction. Our systems are generally resource stressed however, and I am aware that loss of funding and services in any area of the service pool will feed through as an additional stress in the larger environment. Areas of concern are drug availability coupled with a pipeline of new drugs and research. I am keenly aware that the future of multiple active and future research programs is doubtful given the disruption of the prior funding and support programs. Future vaccine availability would be a major concern given the current ethical and practical constraints in US funding programs. I am especially concerned that the funding and support withdrawal will be devastating to other African countries and services with severely compromised programs across regions, and with potential cross regional infectious disease resurgence and regional stress.

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Emerging resistance to Bedaquiline and other new drugs

After a long struggle to replace toxic injectable regimens, drugs like Bedaquiline, Linezolid and Pretomanid are now at the core of modern DR-TB treatment. At the same time, we are starting to see emerging resistance to Bedaquiline and related drugs in several high-burden settings. How worried are you that *Mycobacterium tuberculosis* is adapting faster than our current drug pipeline can keep up? And in your own wards or programmes, are you already seeing cases of primary Bedaquiline resistance - patients infected with resistant strains from the start - or is resistance still mostly something you observe after previous, poorly functioning regimens?

JS

M. tuberculosis has always adapted faster than the current drug pipeline can keep up. This is largely because the drug development pipeline has been relatively neglected and is inadequate for the scale of this disease, rather than due to any intrinsic change in the ability of the mycobacterium to adapt.

The introduction of new TB drugs in isolation, meaning not in combination or as part of new multidrug regimens, into national treatment programmes is likely to lead to cases of acquired drug resistance over time. This may occur for several reasons, including sub optimal drug dosing, inadequate treatment regimens for TB with undetected resistance patterns, intermittent interruptions in drug supply, and both individual and systemic adherence challenges. In addition, naturally resistant wild type strains may already exist within the population even before the widespread introduction of new drugs.

Thanks to the foresight of the South African National Department of Health and the National Institute for Communicable Diseases, routine surveillance for emerging drug resistance was implemented alongside the introduction of bedaquiline, delamanid and pretomanid, each introduced individually, within the national TB treatment programme. This approach has enabled the National TB Programme to detect and monitor the emergence of resistance to bedaquiline, linezolid and pretomanid over recent years.

While the number of bedaquiline resistant rifampicin resistant TB cases remains relatively small at a national level, these numbers appear to have increased in the Western Cape over the past two to three years. A paper published by Ismail et al. in *The Lancet Infectious Diseases* in 2022 reported the results of an epidemiological analysis of national surveillance data collected between 2015 and 2019. The study showed that bedaquiline resistance was acquired during treatment in 2.3 percent of isolates, while resistance was detected at treatment baseline in 3.8 percent of isolates.

These findings indicate that bedaquiline resistant strains are being transmitted between individuals in the community, leading to primary bedaquiline resistant rifampicin resistant TB, and that resistance is also being acquired in isolates from patients receiving inadequate or sub optimal treatment for rifampicin resistant TB.

RC

JS

I currently work in a TB referral hospital and therefore manage a selected group of patients that does not necessarily reflect the broader population treated in the community. Our hospital is primarily focused on drug sensitive TB, and as a result we have limited experience with bedaquiline and related statistical data.

I am, however, clearly concerned about the emergence of bedaquiline resistance in general, and consequently about primary transmission of resistant *Mycobacterium tuberculosis*. This concern is heightened by the extremely long half life of bedaquiline and the risk of prolonged functional monotherapy in patients who are poorly adherent to balanced multidrug TB regimens.

Similar concerns apply to many of our key drugs, including rifampicin, isoniazid, levofloxacin, linezolid, dolutegravir and others. My impression is that rifampicin and isoniazid resistance often emerges in chronically poorly adherent patients, particularly those with structural lung disease where *M. tuberculosis* populations may be sequestered. However, resistance is most commonly transmitted as primary resistant infection.

Over the past 20 to 30 years, we have witnessed remarkable advances in TB and HIV treatment, with regimens becoming shorter, more effective and better tolerated, both symptomatically and metabolically. I believe that our research and clinical management colleagues have largely been able to stay ahead of the infectious challenges posed by TB and HIV, and I am confident this will continue.

At the same time, I recognise that more can be done to improve treatment adherence and limit the development of drug resistance. Many of these challenges, however, are rooted in socio economic and real life circumstances that are difficult to address through medical interventions alone.

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Climate change, migration, informal settlements and TB transmission

TB is, at its core, a social disease. In Southern Africa, climate change – together with economic and social pressures; is contributing to internal migration and rapid urbanisation. This often means expansion of informal settlements and very dense living conditions, including in and around Cape Town. In your experience, do you see a link between these newer, denser settlement patterns and the TB transmission clusters you treat for example, in terms of where your patients come from, how they live, or how often they move? And do you feel TB programmes are already adapting to these climate- and migration-related shifts, or are we still organised around an older picture of where TB transmission happens?

INTERVIEW: WORLD TUBERCULOSIS DAY

JS

It is true that climate change may influence the transmission of TB and significantly challenge efforts to control the epidemic. Extreme weather events can force people to move between rural and urban areas and may lead to overcrowding in poorly ventilated shelters, which increases the risk of TB transmission. In rural settings, such events may further limit practical access to healthcare facilities, while in urban areas overcrowding places additional strain on already stretched healthcare resources. Climate change can also affect agricultural production and lead to rising food prices, thereby exacerbating poverty and food insecurity. These factors are associated with an increased risk of TB, as inadequate nutrition weakens immune defences.

Although many regions of South Africa are frequently affected by severe weather conditions, which appear to be worsening over time and are likely linked to climate change, the expansion of informal settlements and dense living conditions has been a public health challenge for decades. Internal migration between rural areas and major urban centres has occurred for many years, largely driven by historical factors such as the forced separation of populations under the apartheid system. It is therefore unlikely that climate change alone is responsible for ongoing internal migration and the growth of informal settlements, as these trends are also shaped by social, economic and political factors.

Because internal migration and overcrowded living conditions have challenged healthcare delivery for such a long time, TB services in the Western Cape and other provinces have already adapted and have long been organised around these realities. I am not in a position to determine whether recent changes in TB transmission can be directly attributed to climate change. Given the long latency period of TB, it is difficult to demonstrate a clear correlation between specific climate events and changes in TB incidence.

The major drivers remain urban densification and overcrowding, with many families living in single room dwellings, as well as financial constraints and unemployment. It is also worth noting that the national incidence of TB in South Africa has gradually declined over the past 15 years, excluding the post Covid spike from which the programme is slowly recovering. Any potential increase in transmission linked to climate change may therefore have been mitigated by sustained TB control efforts.

RC

This is an area I feel ill equipped to comment on formally, as I have limited insight into the available statistical data. Anecdotally, however, anyone living and working in the local areas, and listening to patients' stories, is keenly aware of the socio economic challenges faced by many of our patients. These include overcrowded and remote living conditions, often with poor access to basic sanitation, significant unemployment, financial stressors and food insecurity.

Additional challenges include crime and gang related violence, which can compromise access to medical facilities and lead to property loss. It is clear that there is ongoing urban densification and population growth in both formal and informal housing settings. This is visible through continuous expansion of housing construction across these areas.

We receive TB patient referrals directly from clinics and hospitals serving these communities, and as such I am confident that transmission is increased in these densely populated environments. TB service provision is adapting to these changes, with multiple new facilities now serving these populations directly, although the nature of service delivery itself is likely similar to that of previous years.

New drug regimens have facilitated decentralised outpatient treatment programmes, and current efforts are focused on strengthening community based services and support. These aim to improve linkage to care and retention in treatment programmes, with some success observed to date.

RC



How the typical TB inpatient has changed over time

The Changing Face of the Patient: Epidemiology, NCDs, and the "Post-COVID" Effect You have witnessed the evolution of the epidemic first-hand. If we look back 15 or 20 years, TB wards in South Africa were largely defined by the HIV crisis. Today, we have widespread ARV coverage, but we are also seeing a rising burden of non-communicable diseases like diabetes. How has the "typical" TB inpatient on your ward changed in this new era?

- Demographics & Co-morbidities: Are you seeing a shift from younger, HIV-driven cases to older patients with complex co-morbidities like diabetes or hypertension?
- The "Shadow of COVID": Furthermore, do you feel the aftershocks of the COVID-19 pandemic in your daily admissions? Specifically, are patients arriving later and with more advanced lung destruction today because they were "missed" during the pandemic years, reversing some of the gains made in earlier detection?

JS

The expansion of antiretroviral therapy coverage over the past two decades has been both remarkable and rewarding, and the profile of our TB and HIV patients has changed accordingly. While we have always admitted patients with advanced disease, the age profile has shifted over time from a predominantly younger population to one that increasingly includes older patients.

With this change, we are now managing patients with additional comorbidities, including structural lung disease and bronchiectasis, as well as complex HIV associated opportunistic infections. The majority of our patients have interrupted antiretroviral therapy, and therefore we do not commonly see the healthier, virally suppressed HIV patient with weight gain and associated metabolic comorbidities. That said, after discussion with a Groote Schuur Hospital specialist, this is clearly a pattern being observed in Groote Schuur outpatient clinics.

The Covid pandemic severely disrupted our TB and HIV programme. Clinics were closed, follow up appointments and contact tracing were halted, and health seeking behaviour declined. As a result, patients often presented to healthcare facilities with very advanced TB and HIV disease. There was a clear increase in TB transmission during this period. However, according to colleagues at Groote Schuur Hospital, the programme is now slowly recovering.

RC

I have experienced a profound change in the presentation and complexity of TB patients over the past 35 years of my clinical work in the Cape Town area. The emergence of the HIV epidemic in the 1990s, and its subsequent expansion, has fundamentally altered the presentation, diagnostics, progression and management of TB in patients who are HIV co-infected.

The addition of HIV associated opportunistic infections, the broader and often atypical clinical presentations of TB, and the persistent challenge of immune reconstitution inflammatory syndrome have added multiple layers of complexity to TB and HIV management. Nowadays, it is not uncommon to manage multiple comorbidities, sometimes ten or more, in a single patient. These patients are often treated with numerous medications for different conditions, creating significant challenges related to polypharmacy, drug interactions and competing metabolic effects, all of which affect tolerability and long term treatment adherence.

In the past, it was uncommon to admit older patients with TB and HIV. However, with improved service provision and antiretroviral therapy regimens, we are now seeing an increasing number of patients in their sixties or older. As a result, there is a higher prevalence of chronic conditions such as hypertension and diabetes. This pattern is more evident in outpatient settings among relatively well patients, but it also affects those who are acutely ill.

The immediate Covid and post Covid periods further complicated patient diagnosis and care, although I have not observed major ongoing disruptions over the past two to three years. A continuing major challenge remains structural lung damage related to prior TB, particularly in patients with high levels of inhaled recreational drug use.

RC



Beyond pills and guidelines - what really helps patients complete treatment?

Clinical guidelines tell us which regimen to use and for how long, but your day-to-day work is with real people whose lives are often very complicated. In your experience, what makes the biggest difference for a patient with drug-sensitive TB to actually complete treatment successfully, beyond prescribing the right drugs? For example, is it family support, mental health care, addressing alcohol or substance use, food support, good communication with the team, or something else? And if you could change one or two small things in the health system or in your hospital to make completion of treatment easier for your patients, what would those be?

JS

There are several reasons why patients interrupt their treatment after discharge from hospital. These include:

- The vast majority of admitted patients have a history of polysubstance drug use. This commonly includes combinations of cannabis, mandrax, crystal methamphetamine, heroin and, occasionally, cocaine. Substance use is a major contributor to poor adherence and treatment interruption in the outpatient setting.
- Another important factor is that many patients begin to feel better after two to three months of TB treatment and therefore stop taking their medication, believing that treatment is complete.
- Pill burden plays a significant role in adherence. Most patients take more than seven tablets each morning, including TB medication, antiretroviral therapy, vitamin B6 and co trimoxazole. Patients with HIV associated comorbidities or opportunistic infections may take more than fifteen tablets per day, for example antiepileptics for seizures related to TB meningitis or tuberculoma, steroids, or high dose co trimoxazole for toxoplasmosis.
- Food insecurity.
- Work commitments and the need to take an entire day off work to queue at clinics for medication collection.

Taking these factors into account, DP Marais Hospital employs a multidisciplinary team to address adherence challenges.

This includes harm reduction programmes targeting substance use, education sessions focused on TB and HIV and treatment duration, counselling, family meetings to ensure post discharge support, referral to community based services, and assistance with disability grant applications while patients are unfit to work.

Following hospital discharge, the Western Cape Department of Health and Wellness and the City of Cape Town Health services have also made substantial efforts over the past decade to strengthen psychosocial support for outpatients with TB. These efforts include formalised training of Community Health Workers to deliver structured TB education, adherence counselling and motivational interviewing, supported by tools such as counselling flip charts and information leaflets on adherence strategies including pill boxes and reminder techniques. Additional measures include improved referral pathways to substance use support services, facilitation of weekly or monthly TB medication supplies from primary care clinics, access to disability grants, increased awareness of mental health issues among TB patients, and education of employed patients regarding their occupational health rights.

Further changes that could improve treatment adherence include the provision of food and nutritional support to TB patients and their families, delivery of TB treatment at locations most accessible to individual patients rather than requiring frequent clinic visits during working hours, and the reinstatement and funding of clinics that have closed as a result of the withdrawal of international funding.

RC

JS

While I may have described a dauntingly complex clinical environment and disease profile for our patients, it is also important to highlight the remarkable therapeutic advances that have accompanied and complemented these management challenges. TB diagnostics and imaging have improved immensely over the years. Rapid turnaround molecular TB diagnostics, urine LAM testing, point of care diagnostics, formal ultrasound, CT imaging and interventional radiology have all increased the accuracy and effectiveness of identifying pathology.

Substantial improvements in drug resistant TB and antiretroviral therapy regimens have enhanced the efficacy, tolerability and safety of our therapeutic options. Improved regimen tolerability has significantly increased the likelihood that patients remain on therapy, which was previously sometimes almost impossible due to severe symptomatic side effects, such as those associated with older multidrug resistant TB regimens, protease inhibitors and earlier nucleoside reverse transcriptase inhibitors with mitochondrial toxicity.

Despite these advances, TB remains a disease closely linked to poverty and overcrowding. As such, the main frontier in controlling the epidemic continues to involve improving housing conditions, expanding substance use counselling and support groups, and strengthening broader community support through NGOs, community based initiatives, education and stigma reduction.

Within the hospital setting, we do our best through patient counselling, social work input and family involvement during admission. However, a truly holistic solution requires coordinated and sustained engagement across all levels of the community and the healthcare system. While moments of frustration are inevitable, the overall evolution and progress in TB and HIV management during my career have been remarkable and have enabled many meaningful successes despite ongoing challenges.

A NOTE OF GRATITUDE AND LOOKING AHEAD

Dear FESTMIH Community,

As this winter edition of the FESTMIH Newsletter reaches you between December and February, we would like to take a moment to pause and say thank you.

This is a deliberately extensive issue. After a shorter previous edition, we wanted to create space again for longer reads, deeper reflection, and voices from the field. We hope this newsletter accompanies you well through the quieter days of the winter months, offering time to engage with the themes that shape our work in global health.

This edition follows the United Nations International Days of the first quarter of 2026 and brings together a wide range of perspectives on topics such as Women and Girls in Science, antimicrobial resistance, tuberculosis, neglected tropical diseases, and the environmental dimensions of health. It is filled with interviews, commentaries, and background pieces that reflect how closely science, clinical practice, policy, and social context are intertwined.

Before you turn the page, we would like to express our sincere gratitude to everyone who contributed to this issue. This newsletter exists only because colleagues across the FESTMIH community are willing to share their time, expertise, and experiences.

We are especially grateful to **Dr Christine Kurmeyer** and **Dr Ingar Abels** for their thoughtful and candid interview contributions. Their reflections on leadership culture, equality, structural barriers, and cultural change in academic medicine bring honesty and depth to discussions that are often reduced to formal policies or abstract concepts. Their voices remind us that meaningful change is shaped by everyday practices, institutional realities, and sustained dialogue.

We also warmly thank **Dr Janet Scott** and **Dr Roland Croxford**, two clinicians with long standing experience in tuberculosis in South Africa. Their interview offers a grounded, practice oriented perspective from public sector settings deeply affected by TB, HIV, and the social determinants that shape these diseases. Drawing on decades of clinical work, their reflections connect national policy decisions, international funding dynamics, and the realities of patient care on the ground. Together, they provide a valuable and nuanced view of how global developments translate into everyday clinical challenges and opportunities.

In addition, we would like to thank **Solomon Kifle** for sharing his perspective in the interview. His reflections on art as a form of connection, participation, and memory highlight how creative approaches can raise awareness for neglected tropical diseases beyond traditional information channels. By emphasizing emotion, interaction, and shared experience, his contribution adds an important cultural dimension to this issue and underscores the role of art in global health advocacy.

A special thank you goes to **Dr Sophie Schneitler**, whose continuous editorial engagement, reliability, and constructive input have been central to the development of this newsletter and the News of the Month. Together with many dedicated contributors, she has helped ensure that this edition is both coherent and accessible. We would also like to thank all FESTMIH members, readers, and interested colleagues who continue to engage with this publication. Your interest, feedback, and willingness to contribute are what keep this newsletter alive and relevant.

Looking ahead, we warmly invite you to contribute to future editions. Short reflections, case insights, project updates, photo essays, and commentaries are always welcome. If you would like to highlight your work, introduce your team, or share perspectives from the field, we would be delighted to hear from you.

Wishing you calm winter days, time to reflect, and a healthy start into the year ahead.

Warm regards,
Maximilian Förster
on behalf of the FESTMIH Newsletter Team

A Quarterly Commitment to Connection

We are excited to **continue** this journey **with you**. The FESTMIH Newsletter is a **quarterly publication**, and each issue is carefully **curated around** the **United Nations International Days**, celebrating their relevance to global health and cooperation. We aim to foster a **platform** where our **community** can **share, learn, and inspire** action.

Do you have a story, project, or initiative to share? Or perhaps you know an inspiring individual or organization that deserves the spotlight? We would **love to hear from you!** The next edition will focus on the **UN International Days of Q2**.

To explore the **full list** of upcoming observances, visit the [**UN International Days page**](#). If you're ready to contribute, send your ideas, articles, or summaries to our team at this [**E-Mail**](#).

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