FESTMIH

NEWSLETTER

2026

2ND ISSUE

We are pleased to share a comprehensive new edition of the FESTMIH Newsletter. While our network continues to navigate a rapidly changing global health landscape, this Q3 edition looks firmly forward to the critical epidemiological, environmental, and planetary health milestones of the coming months.

This issue is structured around the United Nations International Days of the third quarter of 2026. Rather than treating ecological shifts and clinical care as separate domains, our contributors show how they are fundamentally interlocked. We invite you on a journey that begins with the expanding footprint of vector-borne zoonoses like West Nile virus right on the European doorstep, moves deep into the intersecting crises of biodiversity loss and systemic health inequities highlighted on the International Day of the World's Indigenous Peoples, and sets sail into the dense, mobile world of cruise tourism to explore the sharp realities of maritime public health. We round out these systemic perspectives with operational field insights from East Africa, focusing on the frontline battle to eliminate rabies through mass canine vaccination.

In this edition, you will also find our "News of the Month" feature. This segment celebrates a pair of historic public health triumphs from May 2026, including the official WHO validation of Tunisia's elimination of trachoma as a public health problem, alongside a vital five-year global partnership renewal to accelerate the elimination of visceral leishmaniasis.

Before you explore these pages, we would like to express our sincere gratitude to the FESTMIH community. Your field notes, rigorous analyses, and shared expertise continue to transform this newsletter into a vibrant space for international health exchange. Looking ahead, we warmly invite you to contribute to future editions with short reflections, case insights, or project updates. If you would like to highlight your work or share a perspective from the field, we would be delighted to hear from you.

Warm regards,

Your FESTMIH Newsletter Team

July 6th
World Zoonoses Day

August 9th
International Day of the World's Indigenous Peoples

September 24th
World Maritime Day

September 28th
World Rabies Day

Mini NEWS OF THE MONTH
NOTM - June 2026

WORLD ZOONOSES DAY

July 6th

Bridging the Gap Between Cardiology and Tropical Medicine

Chagas disease is a neglected tropical disease with profoundly cardiac consequences. In this section, cardiologist Dr. Ana García Álvarez reflects on two decades of clinical work at the intersection of cardiology and tropical medicine - from Barcelona to Bolivia. Her interview is accompanied by a data-driven factsheet drawing on the GBD 2023 estimates and the WHO Global Report on NTDs 2025, highlighting that 10.5 million people remain infected, 70% are undiagnosed, and congenital transmission has emerged as the most relevant route worldwide.

August 9th

INTERNATIONAL DAY OF THE WORLD'S INDIGENOUS PEOPLES

Horses, Birds and Humans: West Nile Virus as a One Health Challenge

Marking Sir David Attenborough's centennial milestone in May 2026 and retracing Douglas Adams' final conservation journeys, this long-form feature provides a profound exploration of our planet's accelerating ecological decline. It provides a critical, data-driven evaluation of the long-standing "80% biodiversity" statistic based on recent Nature findings, alongside an urgent examination of the severe health disparities - including a 5-to-20-year deficit in life expectancy - endured by the very Indigenous communities who serve as the frontline custodians of our planet's remaining intact ecosystems.

WORLD MARITIME DAY

September 24th

Few Ships, Many People: Why Cruise Tourism Needs Maritime Public Health

Moving tens of millions of passengers on less than 0.3% of the global merchant fleet, modern cruise ships represent uniquely dense, mobile public health hubs. Grounded in the spring 2026 Andes hantavirus outbreak on the expedition vessel M/V Hondius - which triggered international contact tracing across 23 nations - Bettina Gau highlights the critical role of syndromic surveillance protocols, the operational necessity of protecting ship crews under the Maritime Labour Convention, and the importance of cross-disciplinary maritime public health literacy in routine travel medicine.

September 28th

WORLD RABIES DAY

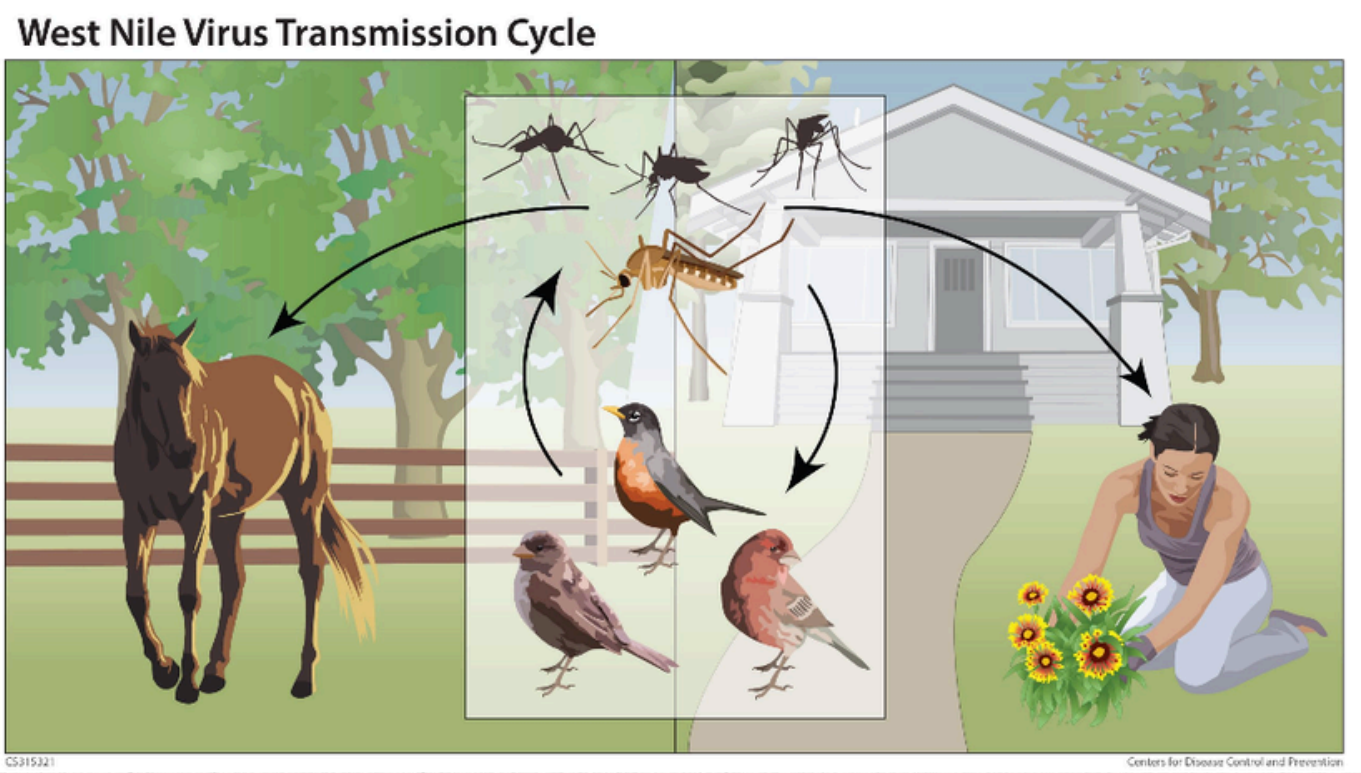
End Rabies Related Deaths by 2030: Mass Vaccination in East Africa

Rabies remains one of the world's deadliest zoonoses, claiming more than 21,000 lives annually in Africa alone, with children bearing the disproportionate brunt of the disease burden. Antonia Braus from Vétérinaires sans Frontières Germany (VSF Germany) outlines the organization's strategic mass canine vaccination campaigns targeting high-risk "red zones" across East Africa. The article showcases the power of community-level health literacy and addresses the persistent funding shortages created because domestic animal protection falls into an institutional gray area between public health, veterinary medicine, and agricultural sectors.

NOTM
JUNE 2026

Updates, Evidence, and Opportunities

This quarter’s positive dispatch highlights major milestones in the global fight against neglected tropical diseases (NTDs). We celebrate the official validation of Tunisia as having eliminated trachoma-the world's leading infectious cause of blindness-using the low-tech, environmental SAFE strategy. This is paired with the five-year global partnership renewal between the WHO and Gilead Sciences through 2030, securing the donation of critical AmBisome vials to sustain the historic 95% reduction of visceral leishmaniasis cases in South-East Asia, balanced with a realistic note of caution regarding recent international aid declines.



WORLD ZOONOSES DAY

Source: Centers for Disease Control and Prevention (CDC). West Nile Virus Transmission Cycle.

Horses, Birds and Humans: West Nile virus as a One Health Challenge

written by Kristin Heenemann

Horses as Dead-End Hosts

Although horses are considered epidemiological dead-end hosts, infection can still result in clinically significant disease. Most infected horses remain asymptomatic or develop only mild nonspecific signs. However, approximately 20–30% of infected horses may show clinical symptoms, including fever, lethargy, muscle fasciculations, ataxia, weakness, or cranial nerve deficits. A smaller proportion develops severe neuroinvasive disease, which may lead to recumbency, long-term neurological sequelae, or death.

Similar to observations in humans, severe neurological disease occurs only in a minority of infections, but represents the most clinically relevant manifestation of WNV infection in horses. The increasing circulation of WNV in Central Europe therefore remains an important concern for both veterinary medicine and public health.

Interestingly, diagnostic approaches for WNV differ considerably between birds, horses, and humans. In wild birds, WNV can frequently be detected directly by reverse transcription polymerase chain reaction (RT-PCR) from blood, swabs, or organ material, reflecting the often substantially higher viral loads compared to horses and humans. In contrast, horses and humans usually develop only a short and low-level viremic phase. As a result, direct viral detection is often limited to a narrow diagnostic window, and serological testing represents the main diagnostic approach in both species. This represents another important parallel between equine and human WNV infections.

Prevention, Vaccination, and One Health Challenges

Currently, no specific antiviral therapy for WNV infection exists in either human or veterinary medicine, and treatment is therefore mainly supportive and symptom-oriented. Prevention therefore focuses primarily on reducing mosquito exposure through measures such as repellents, mosquito control, stable management, and minimizing contact with mosquitoes during peak activity periods.

In veterinary medicine, several vaccines are licensed for horses and represent an important preventive tool in endemic regions. Equine WNV vaccines have also been evaluated experimentally in highly susceptible zoological bird species threatened by severe WNV-associated disease, highlighting innovative One Health approaches for protecting vulnerable animal populations. In contrast, no approved human vaccine against WNV is currently available.

Looking Ahead

As climate change continues to influence vector ecology and transmission dynamics, WNV will likely remain an ongoing challenge for both veterinary and human medicine in Europe. Rising temperatures, changing ecosystems, and the expansion of competent mosquito vectors may further facilitate virus spread into previously unaffected regions.
WNV therefore illustrates how closely animal health, human health, and environmental change are interconnected - and why collaborative One Health approaches will become increasingly important in the future.

📚 Selected References & Further Reading

Peer-Reviewed Articles

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Institutional Surveillance & Public Health Updates

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- *'West Nile Virus Infection'. 23 August 2010. https://www.ecdc.europa.eu/en/west-nile-virus-infection.*
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THE LAST WITNESSES

Written by Maximilian Förster

What David Attenborough's century, Douglas Adams' farewell journey, and the people who were there all along have to do with each other

„He sat in a balcony box on the night of his hundredth birthday and listened to an orchestra play music from his own films. Sixty-six per cent of the planet had been wilderness when he was born. Thirty-five per cent of it remained.“

© BBC Studios/Making Life on Earth

At the Royal Albert Hall on the evening of 8 May 2026, a 100-year-old man sat in a balcony box and listened to an orchestra play music from his own films. Below him, the Icelandic band Sigur Rós performed Hoppípolla - the closing piece of Planet Earth - and the BBC Concert Orchestra worked through scores that had once accompanied images of leopard seals, of coral reefs the size of countries, of fledgling birds-of-paradise flickering through New Guinea forest. Prince William, in the royal box, wished him a happy birthday. Olivia Colman, Dame Judi Dench and, in a short film commissioned by the King and produced by the BBC Natural History Unit, Paddington Bear delivered tributes. At one point David Attenborough took the microphone and said he had thought to mark his hundredth birthday quietly, but it seemed many had other ideas. The other idea - the one the night was really about - was that the broadcaster's life is also a witness statement for the only century in which it became possible to lose the natural world.

This is an article about what Attenborough has seen across that century, what a comedy writer named Douglas Adams documented before his own early death in 2001, and the people for whom the International Day of the World's Indigenous Peoples on 9 August is not a metaphor.

The witness statement

David Attenborough is the most-watched human in history, and he has used the platform to keep a single accountancy. In 1937, when he was a boy turning over stones in Leicestershire, 66 per cent of the planet remained wilderness. In 1979, when his Life on Earth series first put a mountain gorilla in living rooms around the world, the figure stood at 55. By the time of A Life on Our Planet (Netflix, 2020) - his self-described witness statement - it had fallen to 35. The accompanying book opens each chapter with the same three numbers: year, atmospheric carbon in parts per million, and remaining wilderness as a percentage of land area. The cumulative effect is forensic rather than rhetorical. “There was nothing to stop us, unless we stopped ourselves,” is one of the film's most quoted lines.

The chronicle of decline has always needed more than one voice. In 1985 the Observer Magazine sent a 33-year-old comedy writer to Madagascar to find a primate that almost no one outside zoology had heard of. The aye-aye was a nocturnal lemur with the ears of a fennec fox and a tendinous third finger it used to fish grubs from rotten wood. The newspaper's idea was that Douglas Adams - author of The Hitchhiker's Guide to the Galaxy - would write about the animal for general readers. He was paired with a WWF zoologist named Mark Carwardine, and the result was a single piece of journalism that would not let either of them go. The two went back in 1988 and 1989 to assemble the BBC Radio 4 series and the book that became Last Chance to See - a travelogue around the planet's most critically endangered species.

Adams was 36 when the recordings began. He was 49 when he died, suddenly, of a heart attack in a gym in Santa Barbara in May 2001. The book outlived him. Twenty years after the original journey, his friend Stephen Fry stepped into Adams' role for the BBC's television revisit (Last Chance to See, BBC Two, 2009). Mark Carwardine - now in his sixties - has kept returning. He is the only continuous witness across more than thirty years of expeditions to the same handful of species.

© BBC In Search of the aye-aye Exclusive: The 1985 pilot show

Attenborough and Adams never travelled together. They were, in their different registers, doing the same work. Attenborough filmed wilderness for the global living room. Adams, with a comedian's outsider eye, wrote about what the global living room would lose if no one noticed. The closing line of his book - attributed in later editions to Carwardine but originally Adams' - has become the secular gospel of the conservation field: the world would be a poorer, darker, lonelier place without them.

Last Chance to See, re-seen

The bestiary of Last Chance to See is by now a kind of conservation almanac - a fixed list against which the moving numbers of three decades can be measured. The results are not what most readers expect. The book is sometimes invoked, especially since Adams' death, as a record of doomed species. In fact, more of his animals have come back from the brink than have vanished from it.

The mountain gorillas Adams reached in 1988 - in what was then the Parc National des Volcans on the Rwandan side of the Virungas - were the same population Attenborough had filmed for Life on Earth nine years earlier. They were the celebrities of the conservation movement, and they were also, in Adams' account, nearly extinguished by it: rangers walked him past poachers' snare wire and explained that habituation to tourists had created the only paying argument for keeping the forest standing. There were fewer than three hundred individuals left. After the 1994 Rwandan genocide, after the wars in eastern Congo that continue intermittently in 2026, after the still-unsolved murder of the American primatologist Dian Fossey at Karisoke in 1985, the population should by every reasonable expectation have collapsed.

It did the opposite. The 2018 Bwindi–Sarambwe census, coordinated by the Greater Virunga Transboundary Collaboration, recorded 459 mountain gorillas in the Ugandan-Congolese sector, and brought the world total - combined with the 2016 Virunga Massif count of 604 - to 1,063 (Dian Fossey Gorilla Fund, 2018). The sixth Bwindi census, launched in May 2025, is expected to report this year and will almost certainly raise the figure further. The IUCN downgraded the subspecies from critically endangered to endangered in 2018: it is the only great ape population in the world whose numbers are confirmed to be rising. None of this happened because the forest healed itself. It happened because Rwandan, Ugandan and Congolese rangers - many of them killed in the work - protected the gorillas alongside the communities surrounding the parks, with a tourism revenue-sharing model that returns a fixed proportion of every trekking permit to those communities.

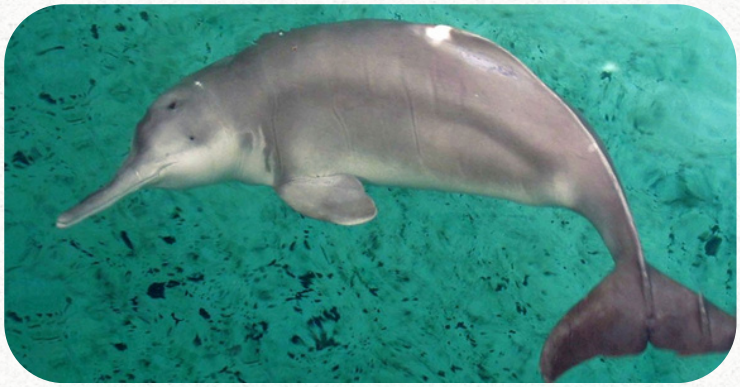
The kakapo of Codfish Island (Whenua Hou), which Adams reached in early 1990 after a flight he described as terrifying, was already a candidate for the most absurd bird on earth: a four-kilogramme nocturnal flightless parrot whose entire male reproductive strategy consisted of digging a bowl in the soil and booming through the night until something showed up. Forty individuals remained. By the time Stephen Fry and Carwardine arrived in 2009 there were 86 - and the kakapo's most famous one, a hand-raised male called Sirocco, climbed onto Carwardine's head and, in a scene since viewed by millions on YouTube, attempted to mate with it. "You are being shagged by a rare parrot," Fry told the camera, narrating in real time. (Sirocco was subsequently appointed New Zealand's official Spokesbird for Conservation.)

As of February 2026, before the breeding season opened, the kakapo population stood at 236 (New Zealand Department of Conservation, 2026). What followed has been the species' biggest year on record: 95 chicks hatched on the predator-free islands off Rakiura and in Fiordland, exceeding the 73 of 2019 (Mongabay, April 2026). The Department of Conservation runs the programme jointly with Ngāi Tahu, the iwi for whom the kakapo is a taonga - a treasure carrying ancestral obligation. The species is now within sight, for the first time since the 1970s, of a population that may exist without round-the-clock individual monitoring of every bird.

The northern white rhinos Adams photographed in 1989 at Garamba National Park in northeastern Zaïre (now the Democratic Republic of the Congo) no longer exist. Garamba was already a battlefield when he arrived - civil war, Sudanese poachers, depleted patrol budgets - and the local population would not survive the next two decades. The subspecies is, in conservation language, functionally extinct: the only two living individuals, a mother named Najin and her daughter Fatu, share a 700-acre paddock under twenty-four-hour armed guard at Ol Pejeta Conservancy in Kenya. Neither can carry a pregnancy. The BioRescue consortium, led from the Leibniz Institute for Zoo and Wildlife Research in Berlin and coordinated by Safari Park Dvůr Králové in the Czech Republic, has since 2019 conducted 21 oocyte collections from Fatu and produced 39 cryopreserved pure northern-white embryos, including one new embryo in early 2026 (Ol Pejeta Conservancy, April 2026). Six embryo transfers into southern white rhino surrogates have so far failed to produce a lasting pregnancy. The team has begun comparing its situation to the early years of human IVF, when more than a hundred attempts preceded the first live birth. It is an open question whether any reader of this newsletter will see a northern white rhino calf in their lifetime.

© Saplakoglu, Yasemin. 'The World Bids Farewell to the Last Male Northern White Rhino'. Scientific American.

The Yangtze river dolphin - the baiji, a near-blind white cetacean whose lineage was older than ours by more than twenty million years - was the only species Adams and Carwardine described as already beyond saving. They were not quite right. In 1990 a few hundred individuals still survived. By 1998 there were thirteen. In 2006 a six-week, full-length expedition along the navigable Yangtze from the Three Gorges Dam to Shanghai, using sonar and visual spotters, did not see a single one. Sam Turvey of the Zoological Society of London, who took part in the search, declared the species functionally extinct. It was the first cetacean and the first large vertebrate driven to extinction by humans in fifty years. The cause was not direct hunting but ambient: bycatch, ship strike, chemical pollution, the noise of a river turned into an industrial corridor.



© 'The Baiji: Why This Extinct River Dolphin Still Matters | Natural History Museum'.

Adams was at Tongling in Anhui province in 1988. He went out on the water with biologists who were trying to catch baijis for a captive breeding pool that, in the event, did not work. The book includes a photograph of him on the bow of the boat looking down into the brown water. It is the last photograph in the public record of a writer in search of a species that, within his daughter's lifetime, would cease to be findable.

The 80 % problem

For more than twenty years the conservation movement has argued, in language so consistent it sounds almost liturgical, that eighty per cent of the world's remaining biodiversity is found on the lands of Indigenous Peoples. The figure appears in UN reports and in World Bank policy documents; it is cited in The Lancet, in PNAS, in Nature itself; it has been quoted, by one count, more than 350 times in published material since around 2002 (Fernández-Llamazares et al., Nature, 2024). It has become the moral grammar of an entire policy field. Almost everyone using it - including, until recently, the present writer - has used it in good faith.

It is also, as it turns out, not supported by the evidence. In a Nature comment in 2024, a multidisciplinary team led by researchers at the Institute of Environmental Science and Technology in Barcelona traced the citation chain back to its origins and showed that the founding source had been misread. A 2002 paper had noted that nearly eighty per cent of the world's terrestrial ecoregions identified as conservation priorities were inhabited by one or more indigenous peoples - which is not the same thing as eighty per cent of biodiversity being located on their lands. By the time the figure had passed through the World Bank, the World Wildlife Fund and a generation of advocacy reports, the qualification had been lost. The number remained.The Nature commentary was not - and this is essential - an argument against the underlying claim. The authors went out of their way to underline that indigenous peoples and their territories are essential to the world's biodiversity. The documented facts are these: indigenous communities hold tenure to roughly a quarter of the Earth's land surface; their territories contain 37 per cent of remaining natural lands and around a third of the planet's intact forest landscapes; rates of biodiversity decline on indigenous lands are demonstrably lower than on otherwise comparable ecosystems, including in zones of armed conflict (CIFOR-ICRAF, January 2026; Mongabay, February 2026). What the Nature commentary tried to do was the opposite of a debunking: to remove an unsupported number before it could be used by opponents to dismiss the whole argument.

This is a methodological story, but not only that. The communities Douglas Adams was passing through - Mbendjele forest-dwellers around the eastern Congolese rainforests where the mountain gorillas live, Antankarana fishermen on the north coast of Madagascar within a day's walk of aye-aye habitat, Ngāi Tahu rangers staffing the kakapo programme on Whenua Hou, Tibetan pastoralists on the headwaters of the Yangtze - were not background characters. They were and are the only continuous human presence in the wildernesses he was documenting. In Attenborough's latest film, Ocean (Silverback Films / National Geographic, 2025), the centenarian narrator names the dynamic he has watched develop across his career in language he had not previously used on screen: industrial fleets from rich countries starving coastal communities of food they have eaten for millennia. "This is modern colonialism at sea," he says.

Custodians and patients

This is also where the story acquires its medical anchor.

The world's roughly 476 million Indigenous Peoples, distributed across more than 90 countries, are by every available metric the most disadvantaged human population on the planet (The Lancet Public Health, 2025). Their life expectancy is, in country after country, between 5 and 20 years shorter than that of the non-indigenous population - the gap is 11 years in New Zealand, 17 in Canada, 20 in Australia and Nepal - and the deficit holds across both high- and low-income settings (UN Permanent Forum on Indigenous Issues; WHO World report on social determinants of health equity, May 2025). Maternal and infant mortality are higher. Rates of type 2 diabetes among indigenous adults over 35 exceed 50 per cent globally. Access to culturally appropriate primary care is, in many regions, structurally absent. In May 2023 the 76th World Health Assembly adopted Resolution 76.16 on the Health of Indigenous Peoples - the first dedicated WHA resolution on the subject. WHO's draft Global Plan of Action, opened for global consultation in mid-2025 and now in revision, sets four priorities: producing evidence on indigenous health; ensuring acceptable, accessible and quality services; participation through indigenous representatives; and recognising indigenous knowledge as part of the evidence base (WHO, 2025). For physicians and health systems working in tropical medicine and international health, this is the relevant institutional moment. It is also where the threads of this article meet. The communities that provide more biodiversity protection per dollar than any formally established conservation institution are the same communities for whom maternal sepsis, drug-resistant tuberculosis, neglected tropical diseases and climate-aggravated food insecurity are present-tense clinical problems. The forests that hold the planet's remaining vertebrate diversity are the same forests in which a Nipah-like spillover, a novel filovirus, or the next zoonotic coronavirus is most likely to begin. The planetary health framework articulated by the Rockefeller Foundation–Lancet Commission a decade ago - and the One Health Joint Plan of Action now coordinated by WHO, FAO, UNEP and the World Organisation for Animal Health - rest on the same operating assumption: that biodiversity loss, climate change and infectious disease emergence are not parallel crises but a single interlocked one (Romañach et al., The Lancet Planetary Health, 2024). The implication for tropical medicine practice is concrete. Investment in indigenous community health is investment in pandemic preparedness. Surveillance for emerging pathogens at the rainforest edge requires the cooperation - and the equity - of the people who live there. The next major filovirus to reach a European intensive-care unit will almost certainly do so from a forest whose continued existence depends on a community whose own clinics are short of insulin.

CODA

© 'Knapton, Sarah. 'Rare Colour Footage of First David Attenborough Expedition Found Hidden in BBC Archives'. The Telegraph, 20 April 2016.

On the night of his hundredth birthday, Attenborough described the world he had inherited and the world he was now leaving as if they were two different planets. The reality the orchestra played him out on was that he had reported on the planet's transformation more thoroughly than any other living human, and that the data series he himself compiled - 66 per cent in 1937, 35 per cent in 2020 - describes a decline he is unlikely to see arrested. Douglas Adams, dead twenty-five years this year, made a similar diagnosis with a different temperature. He framed conservation, in the closing pages of Last Chance to See, not as a problem in biology but as a problem in attention. Why should anyone care, he asked, that a parrot in the Fiordland mountains or a small lemur in Madagascar should continue to exist? His answer is the line that has become the book's secular gospel: the world would be a poorer, darker, lonelier place without them.

In 2026 the question Adams asked has acquired a more specific addressee. The International Day of the World's Indigenous Peoples, observed on 9 August, exists in the UN calendar precisely because the answer to who has cared - for the parrot in Fiordland, the lemur in Madagascar, the gorilla in Virunga, the dolphin in the Yangtze - has disproportionately been one set of communities. They have done this work under conditions of severe health inequity, frequently under armed pressure, and almost always without ownership of the moral grammar - including, until recently, the eighty-per-cent figure itself - that has been used to defend them.

What Attenborough's century has shown, and what Adams' journey foreshadowed, is that the wild and the people who have lived in it are not separate categories. The next century will be decided by whether the medical and conservation communities can stop treating them as if they were.

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World Maritime Day

Bettina Gau
Kieler Schiffsarztlehrgang

Few Ships, Many People: Why Cruise Tourism Needs Maritime Public Health

What the Hondius outbreak reveals about health at sea

Before there was global health, there were ships

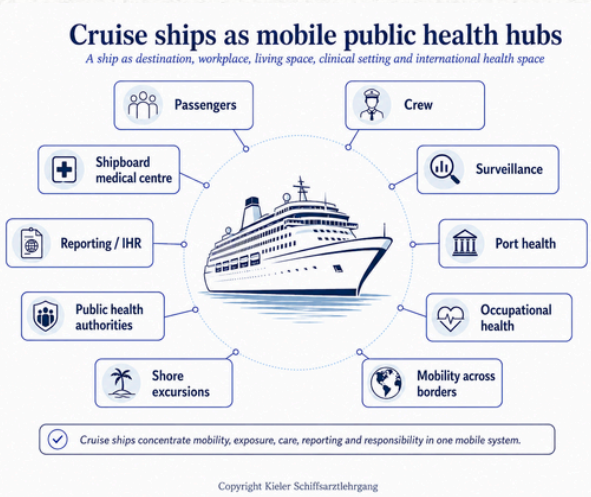
Long before the term global health existed, ships were global health spaces. Along sea routes travelled goods, ideas and people. With them moved food, water, animals, infectious agents and vectors. Ports were never merely places of trade. They were early switchboards of public health: places of surveillance, reporting, control and decision-making.

Some of the central instruments of modern public health have maritime roots. Quarantine, port health services, sanitation certificates and later the International Health Regulations emerged because trade and mobility make health events relevant across borders. From this experience came procedures that still matter today: surveillance, reporting obligations, quarantine measures, Ship Sanitation Certificates and internationally coordinated protective measures.

This history is not over. It has simply acquired different ships.

Few ships, many people

Maritime transport remains the backbone of the global economy. More than 80% of global trade by volume is carried by sea, and at the beginning of 2024 the world fleet comprised around 109,000 seagoing merchant vessels of 100 gross tons and above. Behind this infrastructure are around 1.89 million seafarers. Global supply is therefore not only made of routes, ports and containers. It has people on board. Cruise tourism is numerically small within this world fleet, but dense in public health terms. CLIA reported 34.6 million cruise passengers worldwide in 2024 and 37.2 million in 2025. For 2025, CLIA expected 310 ocean-going cruise ships.7 Compared with around 109,000 vessels of 100 gross tons and above, this represents less than 0.3% of the world fleet.



Less than 0.3% of ships therefore move tens of millions of travellers. Each journey also rests on its own world of work: in 2024, the global cruise sector directly employed an estimated 379,000 people at cruise companies, on board and ashore, and 1.4 million jobs worldwide were attributed to the sector.

This contrast is the key. Cruise ships are not relevant because there are many of them. They are relevant because they concentrate many people, international work, confined spaces, shared infrastructure and routes through numerous ports and states on a small number of vessels.

Cruise ships as mobile public health hubs

Cruise ships are mobile public health hubs. They bring together mobility, exposure, care, reporting and responsibility. They are destinations and workplaces, living spaces and clinical care settings, tourism products and international interfaces of infection control.

This shifts the perspective. Maritime medicine does not belong at the margins of travel medicine and international health. It belongs at their centre. Ships are places where mobility, exposure, clinical care, occupational health and public health meet. Cruise medicine is therefore not merely pre-travel advice and treatment on board. It is medical work in a mobile system, where a clinical signal can rapidly acquire operational, occupational and international significance.

From policy to practice

World Maritime Day, observed annually on the last Thursday in September, carries the 2026 theme “From Policy to Practice: Powering Maritime Excellence”. For maritime health care, this is more than a slogan. It describes the central challenge.

The rules exist. The IHR 2005, the Maritime Declaration of Health and Ship Sanitation Certificates, together with the WHO Guide to Ship Sanitation and the WHO handbook for ship inspection, provide the international framework.1,2,3 Regionally, this framework is complemented by the CDC Vessel Sanitation Program in the United States and EU SHIPSAN / HEALTHY GATEWAYS in Europe.10,11 On this basis, shipping companies develop their own plans, drills and procedures.

This creates a chain from international regulation to the decision made in the shipboard medical centre. On board, it becomes clear whether paper becomes practice: whether a clinical signal is recognised, documented, assessed, reported and translated into protective measures.

Hondius: when a journey becomes a public health event

The M/V Hondius showed how quickly this chain can come under pressure. In spring 2026, an expedition cruise became a multinational public health event. Cases occurred in several countries, and international contact tracing became necessary.

The case is not significant because hantavirus is a typical cruise medicine pathogen. It is not. It is significant because it shows what happens when a rare zoonotic event enters a mobile, closed and medically limited system. Early scientific assessments read the outbreak not as a curiosity, but as a lesson in travelling zoonoses, mobile communities, limited medical resources and international outbreak preparedness.

By 27 May 2026, WHO had reported 13 cases associated with the M/V Hondius, including three deaths. Eleven cases were laboratory-confirmed and two were classified as probable.13 WHO also noted an incubation period of up to six weeks and international contact tracing through International Health Regulations channels. ECDC described the Hondius as a Dutch-flagged expedition cruise ship carrying passengers and crew from 23 countries.

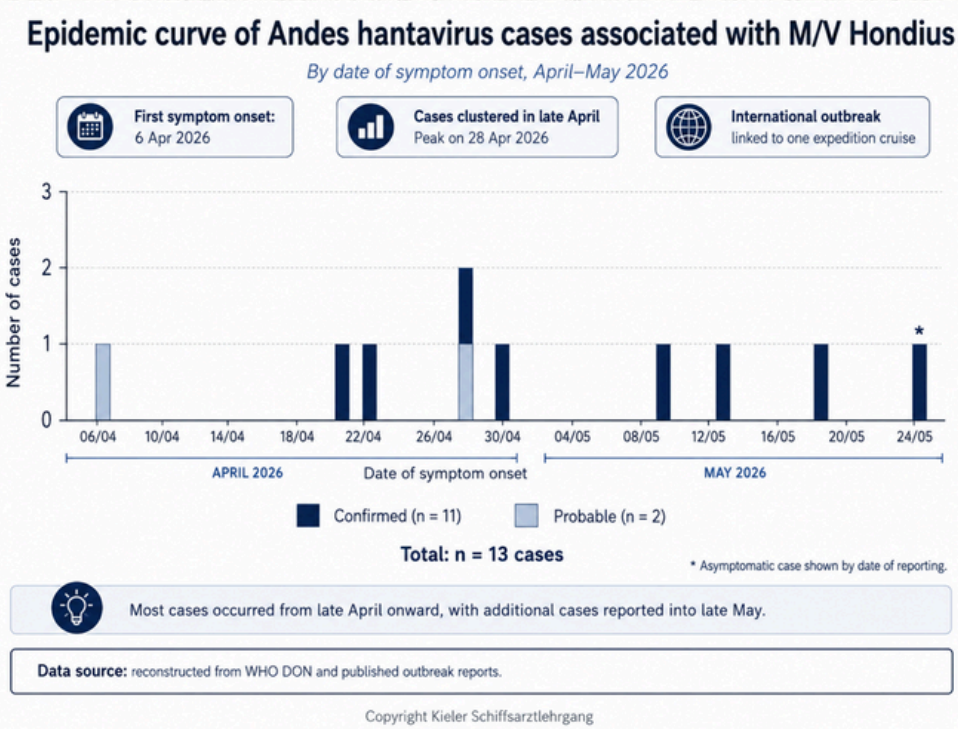
An outbreak on board rarely remains on board.

You do not need to know the pathogen to act

In retrospect, we know that this was Andes hantavirus. At the beginning, however, the name of the pathogen is not the first lever. Public health on board begins with the syndrome.

Surveillance based on syndromic case definitions is designed precisely for this purpose. Gastrointestinal events are captured, for example, through diarrhoea and vomiting. Respiratory events are captured through symptoms such as fever, cough, respiratory symptoms or shortness of breath. Which case definition applies initially depends on the clinical picture, not on the later laboratory result.

A severe respiratory event on board must trigger protective measures: isolation of the ill person, outbreak documentation, a line list, contact management, protection of crew and travellers, further assessment and reporting. Diagnostics may later identify the pathogen. Protocols protect the ship and the people connected to it.



This is one of the central lessons of the Hondius: shipboard physicians must master both clinical medicine and protocols. Medical expertise recognises the clinical signal. Public health competence translates it into surveillance, isolation, contact management and communication. Only together do they make a ship capable of acting.

Protecting the crew protects the system

The system question becomes particularly visible when not only travellers are affected, but also those who carry the system. In the Hondius outbreak, medical and operational key roles were also affected.

The shipboard medical function is the clinical switchboard. The tour guide function connects expedition, passengers, environment and shipboard organisation. When such key roles fall ill, crew health shifts from a matter of care to a question of operational capacity.

Protecting the crew protects the system. The crew is not only exposed. It is part of the intervention. It keeps hygiene, supply, communication, operations and safety functioning. When crew members become ill or are lost as contacts, the ship does not merely lose labour. It loses stability, experiential knowledge and operational capacity.

This idea is already embedded in maritime law and occupational maritime medicine. The Maritime Labour Convention describes medical care, health protection, accommodation, food, working time and rest periods as part of decent work at sea. Behind these terms are concrete realities: months-long contracts, shared cabins, limited privacy, sleep deprivation, work pressure and families far away. Research on seafarers also shows how difficult access to independent health care on board can be.

A person who becomes ill is not simply ill. They are ill at work, in their own living space and in the middle of a system that must continue to function.

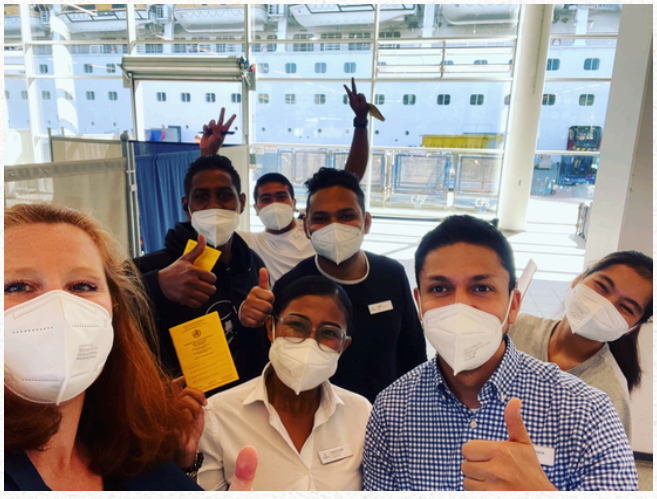
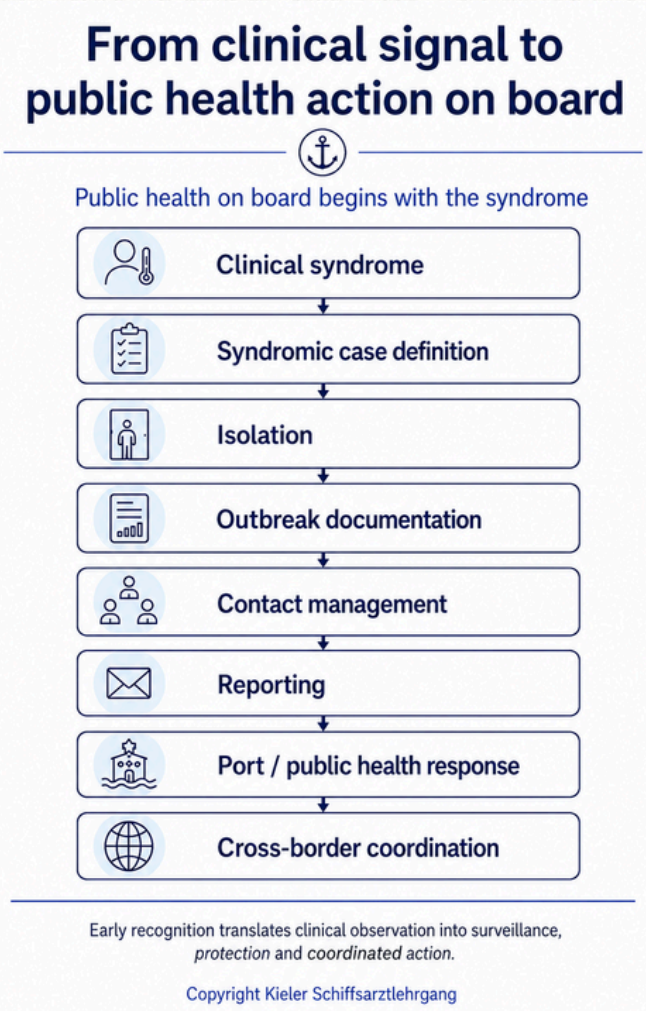


Image: Bettina Gau (left corner)



Crew health is therefore not a marginal issue in cruise medicine. It is where the theme of World Maritime Day becomes concrete: from policy to practice means that occupational safety, care and public health do not remain in regulations, but become operational on board.

Shipboard physicians need a system around them

Precisely for this reason, the role of shipboard physicians becomes larger, not smaller. They are not merely clinicians in a remote setting. They work at a public health hub and at the centre of crew medicine. Their decisions have clinical, operational, occupational, communicative and public health consequences.

Medical resilience on board must not depend on a single person. Precisely because shipboard physicians are key actors, they need a reliable system around them: clear protocols, external advice, functioning reporting pathways, secure documentation and a command structure that understands medical warning signs as safety information.

At the same time, the Hondius showed that international public health can work. WHO, ECDC, national health authorities and international reporting channels interacted; cases were traced across borders, contacts were informed and measures were coordinated. The global community can act together. The crucial point is that this strength must connect to the ship early enough.

Good preparation is therefore not an add-on, but a form of seamanship in medical practice. Shipboard physicians need specific training and experience before they go on board. Clinical competence remains the foundation. It must be complemented by travel medicine, infection control, outbreak management, occupational medicine, crew health, maritime organisation, evacuation logic, telemedicine and risk communication.

Travel medicine has never been only individual protection

Travel medicine can learn from this as well. It has never been only individual protection. In the spirit of yellow fever vaccination, it has always also contributed to protection against international spread. This principle shows that travel medicine protects travellers and the spaces of mobility through which travel takes place.

This is why it is not enough to approach cruises in consultation only as passenger events: itinerary, vaccinations, comorbidities, medication, climate, excursions, seasickness, repatriation. This perspective remains important. But the risk of a journey does not arise from the destination alone. It arises from the form of travel.

A hotel stay, an expedition, a river cruise and an ocean-going cruise ship are not epidemiologically the same. Even within cruising, settings differ substantially. Expedition ships such as the Hondius take small groups into remote regions and special environmental contacts. Large ocean-going cruise ships often bring together several thousand people in a dense, highly organised living and supply system. The 37.2 million ocean cruise passengers reported by CLIA for 2025 are therefore not distributed across a single uniform risk, but across very different maritime settings.

Travel medicine therefore needs maritime public health literacy: the ability to understand ships as workplaces, living spaces, clinical settings and international health spaces.

The lesson is not exceptional. It belongs in routine practice.

The Hondius outbreak was exceptional. What it shows is not. It belongs in the routine of good shipboard medicine: cruise ships are maritime public health hubs. Protecting the crew protects the system. Maritime public health emerges where clinical thinking, surveillance, protocols and communication come together at the right moment.

Understanding cruise ships in this way shifts the idea of protection. Travellers are not protected only once they become patients. They are protected when health on board is read early: in the crew mess, in the shipboard medical centre, during shore excursions, in the logbook, in conversations with command and in timely connection with public health structures ashore.

The protection of travellers therefore begins with the people who carry the ship. It begins with a crew whose health is not treated as a side issue. It begins with shipboard physicians who master both clinical medicine and protocols. And it begins in a travel medicine that sees the ship not merely as a destination, but as a health space.

That is how policy becomes practice: not first in the outbreak, but in the preparation for it. On all levels.

About the author

Bettina Gau is an occupational medicine specialist and owner of the Kieler Schiffsarztlehrgang. Her professional focus lies in maritime medicine, infection control, public health and occupational preventive medicine at sea. She has worked, among other roles, as a port health physician in Hamburg and in the context of international health and disease control structures. Through the Kieler Schiffsarztlehrgang, she trains physicians for the specific clinical, organisational and public health requirements of medical care on board.

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VSF Germany
Member of VSF International

END RABIES RELATED DEATHS BY 2030: PROTECTING LIVES THROUGH MASS VACCINATION IN EAST AFRICA

Every nine minutes, a person dies of rabies worldwide. In Africa alone, more than 21,000 people lose their lives each year, many of them children. Though the number of unreported cases is significantly higher.
Rabies is one of the deadliest infectious diseases known: once symptoms appear, it is fatal. Yet rabies is entirely preventable.

WHO WE ARE:

Vétérinaires sans Frontières Germany (VSF Germany) implements humanitarian aid and development cooperation projects in East Africa.

Following the One Health approach, the organization carries out projects at the local level in six countries: Kenya, Ethiopia, Somalia, Sudan, South Sudan, and Uganda.

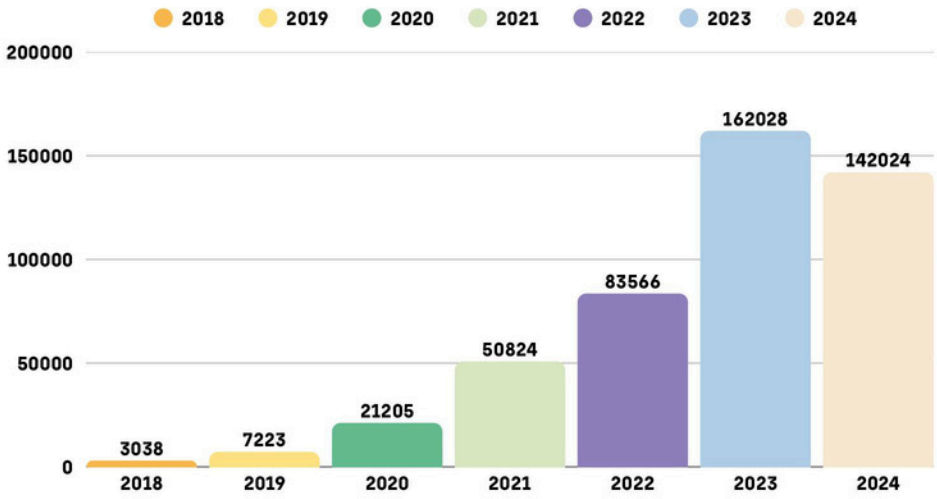
Pastoralist communities are at the center of our work, as their livelihoods depend heavily on their animals. Through our projects, we aim to enable people to live self-determined lives and to protect and strengthen their traditional way of life, which also represents an important economic foundation.

HTTPS://WWW.TOGEV.DE/

Rabies is a viral infection that affects the central nervous system and is one of the deadliest zoonotic diseases. The WHO classifies rabies as a neglected tropical disease (NTDs), a group of poverty-related infectious diseases that primarily affect poorer populations in emerging and developing countries and impose a significant burden of disease.

In over 98% of cases, dogs are the carriers of the virus for humans. More than 15 million people are bitten by rabid dogs every year, 40% of whom are children, as they are particularly at risk of dog bites (WHO, 2021).
Mass vaccination of dogs is therefore the most cost-effective, effective and sustainable preventive measure against rabies infection. A vaccination coverage rate of 70% of the (domestic) dog population can eliminate the risk of rabies for humans, livestock and wildlife within five years.

For over 20 years, we have been actively involved in the fight against rabies through vaccination campaigns. Through our prevention measures, we are helping to achieve the WHO's goal of eliminating human deaths from rabies by 2030. We carry out targeted mass vaccinations – primarily for dogs, but also for other species – in the most severely affected regions to curb rabies in the dog population and prevent transmission to humans. In addition, we raise awareness among the public in public places such as schools, churches, markets and community meetings, as well as through the mass media. Education is crucial to promoting knowledge about disease transmission, safe handling of animals and the importance of vaccination. Only when the public is aware of the risks and prevention options can vaccination campaigns be fully effective and new chains of infection be prevented in the long term.



Number of animals treated and vaccinated by VSF Germany between 2018 and 2024.

Since our first vaccination campaign in the Maasai Mara in Kenya, we have been able to steadily expand our mass vaccination programmes and are now active in four countries in East Africa. We have been vaccinating in Uganda since 2020, in South Sudan since 2021, and in Ethiopia since 2022. Our vaccination activities have increased so significantly in recent years that we are now among the key players in the fight against rabies in the region.

We work in close coordination with local and regional authorities to identify so-called 'red zones' (areas at particularly high risk of rabies) and target them specifically. In these areas, we carry out our vaccination campaigns systematically and repeatedly: we return to the same region three times in succession to ensure the highest possible vaccination coverage and guarantee the long-term protection of both humans and animals.

Despite this progress, due to limited financial and logistical resources, we are not always able to achieve the target vaccination rate of 70% of the dog population, the critical threshold for effectively stopping the circulation of the virus and thus the transmission of rabies. To achieve this goal comprehensively in the future and to secure the successes achieved in the long term, additional support is therefore urgently needed.

Our rabies interventions thus also represent important milestones in achieving the stated goals of the WHO Roadmap for NTDs 2021–2030.

HTTPS://WWW.WHO.INT/PUBLICATIONS/I/ITEM/9789240010352

End Rabies. Protect Animals. Save Human Lives.

THE BIGGEST CHALLENGE: FINANCING

Rabies projects often find themselves in an administrative gray area: dogs (and cats) as pets do not clearly fall within the traditional agricultural sector neither the wildlife sector or public health.

This creates an institutional gap that makes it considerably more difficult to secure funding. This lack of clear responsibility means that rabies prevention and control projects often remain underfunded, despite their high effectiveness and cost-efficiency.

However, investment in rabies control, particularly in mass vaccination and awareness campaigns, is of central importance: it not only prevents human suffering and deaths, but also reduces the long-term costs of healthcare and animal losses. Every dollar invested in rabies prevention can save many times that amount in follow-up costs and contributes to strengthening animal health, public health, and social justice.

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NEWS OF THE MONTH - JUNE 2026

TOPICS

Editors Choice
Vaccine Education in Nigeria

Events
- Good NOTM
- Professional Development & Capacity building
- Events & Campaigns
- Global Health Policy Watch

FESTMIH NOTM

EDITORS CHOICE

Beyond the Script: The Unstandardized Reality of Group Vaccine Education in Nigeria

The Zero-Dose Challenge & Group Dynamics

Routine childhood immunization remains stalled globally, and Nigeria alone contributes 15% of the world's "zero-dose" children. National DTP3 completion rates hover at 60%, but regional divides are stark: southern states like Cross River reach 75%, while northern states like Borno drop to 30%. While high-income nations favor private, one-on-one vaccine counseling, sub-Saharan African clinics rely heavily on group health talks to manage massive patient volumes before immunization sessions begin.

Unmasking Routine Care via "Secret Shoppers"
A 2026 study in Tropical Medicine & International Health evaluated eight clinics across Borno and Cross River to audit what is actually said during these group dynamics. Researchers audio-recorded healthcare workers twice: once when they knew they were monitored, and once unobserved using a "secret shopper" technique. The results exposed a major performance gap:

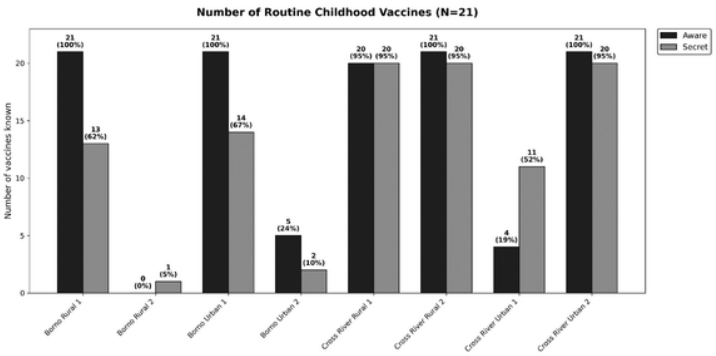

FIGURE | Assessment, while providers were aware they were being recorded. Assessment, while providers were unaware, they were being recorded (secret shopper).

- Content Drifting: Over 37.5% of the talks drifted into non-vaccine topics like family planning, breastfeeding, and general nutrition.
- The Observer Effect: When aware of the recording, workers routinely named 10 or more of the 21 scheduled childhood vaccines. When unobserved, vaccine mentions plummeted-sometimes to zero in rural clinics.
- Missed Core Messages: Critical WHO-vetted information-such as mapping out post-vaccination side effects, fever management, and clarifying that mild illness does not preclude vaccination-was systematically omitted during routine talks.

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FESTMIH NOTM

Driven by Mood, Limited by Training

Interviews with clinic directors revealed that daily topic selection is highly arbitrary. Rather than following a mandated framework, what a mother hears depends on seasonal trends, recent outbreaks, or the healthcare worker's energy levels and mood that morning. This inconsistency is driven by a severe training deficit. Frontline staff receive little to no formal schooling on group communication. Standard communication toolkits from WHO and UNICEF focus almost exclusively on one-on-one consultations or door-to-door community outreach, leaving clinic staff without practical tools to manage large, dense assemblies.

The Parental Experience & Systemic Friction

Mothers generally viewed the sessions as informative and praised workers for breaking down concepts into local dialects. However, their clinic experience was severely strained by systemic friction: long waiting times (often arriving at 9:00 AM for a talk delayed until 11:00 AM), excessive background noise, and a lack of courtesy from overworked staff.

A Blueprint for Scalable Group Communication To streamline group talks and reduce healthcare worker burnout, the study highlights key actionable steps:

- Standardized Mini-Curriculum: Implement a mandatory national curriculum prioritizing core messages like vaccine schedules, side effect management, and card retention.
- Embedded Training: Integrate group-based communication modules directly into existing maternal-child health refreshers and peer-mentorship tracks.
- Pre-Recorded Audio/Visuals: Deploy pre-recorded health talks broadcasted over clinic loudspeakers, supported by large pictorial wall guides. This ensures every family receives consistent, top-tier vaccine education regardless of clinic volume or staff fatigue.

Read full Paper

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BLINDNESS ON THE RETREAT - AND A QUIET WIN AGAINST A DEADLY PARASITE

It has been an unusually bright few weeks for the neglected tropical diseases (NTDs), the cluster of conditions that quietly carry an outsized share of the world's disease burden among the poorest communities. Two pieces of news stand out, and together they tell a hopeful story about what sustained, unglamorous public-health work can achieve.

Tunisia closes the book on trachoma

The headline: on 14 May 2026, the WHO validated Tunisia as having eliminated trachoma as a public health problem - the first NTD the country has ever eliminated. Trachoma is caused by the bacterium Chlamydia trachomatis and is the world's leading infectious cause of blindness; it spreads through close contact, contaminated surfaces, and flies carrying eye and nose discharge, and repeated infections scar the eyelids, turn the lashes inward, and eventually blind the patient if left untreated.

© WHO / Eric Schwab
WHO consultant, Dr Mario L. Tarizzo, prepares to take an eye smear from a school child at Srendi, Djerba. WHO has supported long-standing efforts in Tunisia to eliminate trachoma, a disease of the eye that can cause blindness if left untreated.
Credits

This is not an abstract historical threat: in the early-to-mid 20th century trachoma was endemic across Tunisia, affecting at least half the population, especially in the poorer southern regions. What makes this more than a single national milestone is the momentum behind it. Tunisia caps a genuinely remarkable run in early 2026: WHO validated Libya in February, Algeria on 23 April, and Australia became the 30th country on 29 April, with Tunisia now the 31st country worldwide and the 14th in the WHO Eastern Mediterranean Region to have eliminated at least one NTD. And the trend is global, not just regional - in January, the number of people worldwide requiring interventions against trachoma fell below 100 million for the first time. The approach is refreshingly low-tech, and this is where the One Health framing really lands. Tunisia scaled up the WHO-recommended SAFE strategy: Surgery for advanced cases, Antibiotics to clear infection, Facial cleanliness, and Environmental improvement, above all better access to water and sanitation. In other words, the decisive interventions were not a new drug or a high-tech diagnostic but clean water, hygiene, and the integration of eye care into everyday primary and school health services. This was paired with nationwide screening and treatment campaigns and community hygiene work, and a post-validation surveillance system is now in place to catch any resurgence early. It is a textbook example of how the environmental and human-health dimensions of a disease are inseparable: control the flies and the water, and you control the pathogen.

FESTMIH NOTM

GOOD NOTM

A SECOND FRONT: A FIVE-YEAR BOOST AGAINST VISCERAL LEISHMANIASIS

The trachoma news did not come alone. On 21 May 2026, the WHO and Gilead Sciences renewed their partnership through a new five-year agreement (2026–2030) to support the elimination of visceral leishmaniasis (VL), a life-threatening NTD transmitted by the bite of infected female sand flies. Under the agreement, Gilead will donate 402,941 vials of AmBisome (liposomal amphotericin B) to treat VL in the most affected countries, alongside financial support to improve diagnosis, access to treatment, and WHO-recommended interventions for at-risk populations.

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This matters because the numbers behind it are real and accumulating. Gilead has donated this medicine since 2012, and with the renewal the total contribution since 2011 reaches roughly 1.5 million vials of AmBisome and more than US$ 27 million in financial support. The payoff is measurable: new VL cases in South-East Asia have fallen by more than 95% since the elimination programme began in 2005, and in 2023 Bangladesh was validated by WHO as having eliminated the disease as a public health problem. Here too the One Health logic is explicit - vector control to reduce sand-fly numbers sits alongside treatment access as a core pillar of bringing transmission down.

The bigger picture - and a note of caution

Step back and the trajectory is encouraging. As of early 2026, 58 countries have eliminated at least one NTD, against the WHO roadmap target of 100 countries by 2030, and the number of people requiring NTD interventions has fallen to around 1.4 billion in 2024, a 36% decrease from 2010.

But honesty demands a caveat that belongs in any "good news" piece worth its salt: this progress is hard-won and fragile. NTD aid fell by 41% between 2018 and 2023, and WHO is explicit that the recent gains are now at risk. The lesson from Tunisia and from the leishmaniasis programme is the same - these wins are the product of decades of steady commitment, partnership, and basic investment in water, sanitation, and primary care, not of one-off breakthroughs. They are, as WHO likes to put it, among the most achievable and most equitable goals in global health. The encouraging news of the past month is proof that the strategy works. The open question is whether the funding and political will hold long enough to finish the job.

Sources

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- *WHO news, 21 May 2026 - WHO and Gilead Sciences renew partnership to accelerate visceral leishmaniasis elimination: Sources: ILO, A Call for Safer and Healthier Working Environments (2024); WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury; ILO Global Strategy on OSH 2024–2030; Lloyd's Register Foundation World Risk Poll 2024; UN Global Compact.*
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- *WHO - Leishmaniasis fact sheet: Sources: ILO, A Call for Safer and Healthier Working Environments (2024); WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury; ILO Global Strategy on OSH 2024–2030; Lloyd's Register Foundation World Risk Poll 2024; UN Global Compact.*
- *WHO - World NTD Day 2026 (58 countries / 2030 target / aid decline): Sources: ILO, A Call for Safer and Healthier Working Environments (2024); WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury; ILO Global Strategy on OSH 2024–2030; Lloyd's Register Foundation World Risk Poll 2024; UN Global Compact.*

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PROFESSIONAL DEVELOPMENT & CAPACITY BUILDING

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Advance your technical skillset this summer with two specialized, self-paced programs hosted by the World Bank Group Institute. These courses are engineered specifically for healthcare practitioners, field coordinators, and global health researchers operating in complex environments:

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- Core Focus: Learn to transform complex epidemiological matrices, survey outcomes, and spatial health data into transparent, high-impact graphical narratives.
- Impact: Master the design principles needed to effectively bridge the gap between raw data and decision-makers to drive legislative policy changes.

Enrollment Link

2. MANAGE SUCCESSFUL FIELD RESEARCH (SPRING 2026 EDITION)

- Core Focus: Master advanced logframe logistics, site selections, and budgeting spreadsheet narratives.
- Impact: Build robust operational competencies in ethical clearance frameworks and field-team safety protocols when conducting quantitative or qualitative studies within resource-limited settings.

Enrollment Link

FESTMIH NOTM

EVENTS & CAMPAIGNS

ECTMIH 2027

We are absolutely thrilled to announce that the official landing page for ECTMIH 2027 is officially online! Following a fantastic collaborative effort across our network, the global "Save the Date" campaign kicked off smoothly this week.

Here is a quick breakdown of the essential details:

- Official Launch: The platform and the global "Save the Date" campaign went live on Monday, June 1st, 2026.
- The Partnership: This milestone is spearheaded by the Barcelona Institute for Global Health (ISGlobal) in close coordination with FESTMIH.
- Campaign Rollout: Early dissemination has already begun across international social media channels and major global health newsletters.
- Member Call to Action: All FESTMIH member organizations are warmly encouraged to share the announcement across their institutional networks (especially LinkedIn) to help maximize early global reach.
- Promotional Packages: To make sharing as easy as possible, a dedicated social media toolkit and official high-resolution logo assets are available for all members via internal network channels.

Explore the beautiful new platform, bookmark the page, and stay tuned as we prepare to roll out abstract submissions and registration tracks in the coming months!

Event Page

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WHO RELEASES WORLD HEALTH STATISTICS 2026: A SOBERING COUNTDOWN TO THE 2030 SDG TARGETS

- **The Launch:** The World Health Organization (WHO) has officially published its flagship annual report, World Health Statistics 2026: Monitoring Health for the SDGs. Spearheaded by the Department of Data, Digital Health, Analytics and AI, the report provides a critical baseline assessment with fewer than five years remaining until the 2030 Sustainable Development Goals deadline.
- **The Core Paradox:** The data reveals a starkly fragmented global landscape. Long-term declines continue for several major infectious diseases-notably, new HIV infections fell by 40% between 2010 and 2024, and the global burden of neglected tropical diseases (NTDs) dropped by 36%. However, global malaria incidence has surged by 8.5% since 2015, driving the world further away from the targets outlined in the Global Technical Strategy for Malaria.
- **The COVID-19 Legacy:** The report updates pandemic-related toll models, revealing that an estimated 22.1 million excess deaths occurred globally between 2020 and 2023-roughly three times the 7.0 million officially reported counts. This historic crisis effectively erased nearly a decade of steady progress in global life expectancy and healthy life expectancy (HALE). While female life expectancy partially rebounded to pre-pandemic levels by 2023, male HALE and broader regional recoveries remain severely uneven, with the Region of the Americas experiencing the hardest-hitting deficits.
- **The Health Financing Emergency:** In his opening foreword, WHO Director-General Dr. Tedros Adhanom Ghebreyesus warns of an unprecedented financial contraction. Official development assistance (ODA) for health in 2025 was estimated to be 30% to 40% lower than in 2023. Coupled with soaring national debt burdens, these sudden funding cuts threaten to severely disrupt basic primary care infrastructure, vaccine rollouts, and essential medicine procurement across low- and middle-income nations
- **The Invisible Dead:** Highlighting an ongoing data crisis, the report notes that out of an estimated 61 million global deaths in 2023, only 21 million were reported to the WHO with cause-of-death information. Crucially, only 12 million possessed meaningful International Classification of Diseases (ICD) coding. Currently, only one-third of Member States meet the criteria for high-quality mortality surveillance systems, leaving the vast majority of lower-income environments with critical reporting blind spots.

Full Report

NEWSLETTER

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2ND ISSUE

If you have made it to this page, you have just spent time navigating a landscape of moving borders and shared vulnerabilities. You have read about a virus quietly shifting its range into temperate European summers, a rare zoonotic flashpoint on an expedition ship isolation-tested at sea, and the frontline battle to push a lethal, ancient disease out of East African communities. You have looked at data showing that the very people holding the frontline of our planet's ecological defense face deep, systemic health inequities-and yet, through the unglamorous work of primary care, historic wins against blindness are still being quietly written into reality.

If, somewhere between the rigid matrices of the statistics and the human realities of the science, you felt a flicker of urgency, or a stubborn refusal to accept the status quo, then this edition has done what it set out to do. We find ourselves in a historical moment where the temptation to look inward has rarely been stronger. The headlines of our day speak frequently of retreating multilateralism, shifting geopolitical alignments, and a tightening economic reality marked by a staggering 30% to 40% drop in international health assistance. For those of us operating in global and international health-whether peering through a microscope, managing a high-volume clinic, or coordinating research pipelines-the ground beneath our feet can feel profoundly unstable. It would be entirely understandable to look at this fragmented landscape and feel a sense of powerlessness. But pathogens are a stark, clinical reminder that human health ignores political geometry. A shifting vector does not halt at a national border; a mobile community on a cruise ship links dozens of nations in a single incubation window. In times like these, cross-border cooperation is not an idealistic, diplomatic luxury-it is our absolute baseline infrastructure for survival.

The stories within this issue are essentially quiet acts of defiance against fragmentation. They show us that while the big picture can feel overwhelming, true global health is built from the bottom up. It is found in a maritime physician standardizing crew safety protocols across continents; a field team systematically entering high-risk "red zones" to vaccinate domestic animals; and researchers defending the methodological truth of indigenous stewardship while demanding basic clinical equity for those communities. None of these actors changed the global trajectory alone, but each changed a protocol, a dataset, a conversation, or a patient's life. The world does not ask us to fix everything at once; it asks us to fix the piece we can see. A project of this scope requires immense shared commitment, and we owe a profound debt of gratitude to the voices who brought this quarter to life.

Our warmest thanks go to Bettina Gau, for her outstanding, clear-eyed analysis of maritime medicine, reminding us so beautifully that protecting global transport systems begins with the basic health and equity of the crew on board. We are deeply grateful to Antonia Braus and the relentless team at Vétérinaires sans Frontières Germany, whose vivid field insights showcase the practical, life-saving reality of the One Health approach on the ground. And, as always, a special acknowledgment belongs to Dr. Sophie Schneitler. Her meticulous editorial vision, constant guidance, and unwavering reliability remain the quiet, driving backbone of this entire publication.

As we step into the next quarter, we leave you with an invitation that is also our core conviction: global health solidarity is not something generated in distant summit halls or dictated by funding cycles alone. It is an active choice made in our daily routines. It is the clinical question we ask at the bedside, the rigorous data check we perform at our laptops, the student we take time to mentor, and the difficult conversation we choose to start even when we are exhausted. Ecosystems collapse when their individual nodes give way, but they recover when we strengthen the connections between them. This newsletter exists because you continue to show up for those connections. For your attention, your critique, and your shared expertise, we are deeply grateful.

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

on behalf of the FESTMIH Newsletter Team