

An Occasional Rural Miscellany

July 2016



I have had a great response to Seamus O'Rourke's poem "Rescued Time". Special thanks to Jim Rourke's message from Canada

Thank you for posting the poem "Rescued Time" by Seamus O'Rourke in your June Rural Miscellany. It took me right back to my childhood riding on the tractor with my father on our small family farm. One of my favourite songwriter/singers is the great Canadian balladeer Stan Rogers. Many of his songs tell a rural story. This is a link to his 1981 song "The field behind the plough" which still resonates with me.

<https://music.apple.com/ca/album/the-field-behind-the-plow/1799361435?i=1799361859>

On the same theme, I would add a song by the American musician, Adrienne Young and her band Little Sadie, "Plow to the End of the Row" The song blends traditional Appalachian folk with contemporary themes of resilience, hard work, and agrarian life. The lyrics to the first verse are:

"Wake up in the morning in the moonlight grey

We got dirt to break, we got a note to pay

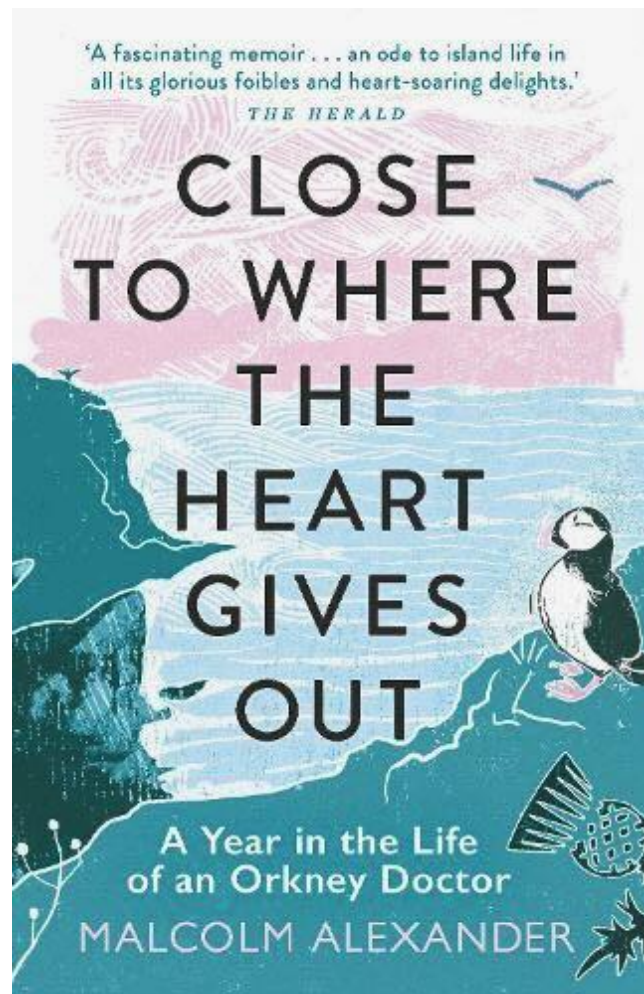
I'm gonna plow, plow to the end of the row

I'm gonna wake up in the morning and plow to the end of the row [1]

The song continues with verses detailing the daily struggles of farm life, including fixing breakfast, working in the fields, and managing the harvest. It highlights the physical demands of labour and the uncertainty of farming, featuring the recurring, determined chorus to "plow to the end of the row"

Finally, I was fortunate to hear the Dalai Lama speak at Glastonbury in 2015. It was a moving experience for us all. At the end of his inspiring address a little boy asked him what he would have wanted to be if he had not been the Dalai Lama. He responded “*I would like to have been able to drive a tractor*”

I have just returned from a trip to the Orkney Islands which lie 8 miles off the Northern tip of the UK. They are very beautiful and sparsely populated, especially the smaller islands. I picked up this book by Malcolm Alexander about the trials and tribulations he experienced leaving a very urban practice in Glasgow and moving to the tiny island of Eday with his wife and 4 children in the late 1980s.



If any of you have a book about rural doctors, please let me know and we can feature and share them across the world.

Thailand's Universal Healthcare



You're probably thinking— universal healthcare starts with government policy. But in Thailand, it started with something else. Doctors. In the 1960s, many left for better opportunities abroad. Those who stayed were sent to rural areas. And what they saw there— changed them. Patients weren't just getting sick. They were losing everything. Land. Savings. Dignity. All just to afford treatment. So these doctors did more than heal.

They organized the RURAL DOCTORS MOVEMENT which became a voice for the rural poor, pushing for reforms, building systems, and fighting for access to care. It took decades. But in 2002, Thailand achieved Universal Health Coverage.

Today, millions benefit from it. In 2024, the Movement received the Ramon Magsaysay Award for showing that real change doesn't come from looking away. It comes from choosing to stay and fight for those left behind.

A group of dedicated Thai physicians who has championed universal health coverage, significantly improving rural healthcare access and quality through relentless activism and advocacy

- Thailand's universal health coverage, implemented in 2002 after decades of advocacy by visionary Thai physicians, now provides largely free medical care to citizens, especially benefiting the rural poor.
- The RURAL DOCTORS MOVEMENT (RDM), consisting of the Rural Doctor Society (RDS) and the Rural Doctor Foundation (RDF), emerged as a unified force of Thai doctors advocating for healthcare in rural areas; the RDS operates informally, while the RDF is a formal NGO of doctors in public hospitals.
- The RDM arose from societal changes, including a brain drain of medical professionals to the U.S. in the 1960s, which led the Thai government to require

compulsory rural service for doctors; this, coupled with the pro-democracy movement of the early 1970s, inspired many doctors to address rural healthcare inequities and support student-led initiatives in impoverished areas.

- RDS doctors advocate for policy reforms, while the RDF implements progressive healthcare programs through formal channels and collaborates with other NGOs and international agencies, demonstrating the lasting impact of rural doctors on Thai society in promoting healthcare, social justice, and democratic change.
- The RMAF board of trustees recognizes their historic and continuing contribution to their people's health—and perhaps just as importantly, to their recognition and fulfilment as citizens with basic rights. By championing the rural poor, the movement made sure to leave no one behind as the nation marches forward to greater economic prosperity and modernization.

Conferences and Events

A message from our Chair, Dr Pratyush Kumar:



Dear Rural WONCA Members,

I am delighted to share some wonderful news with our Rural WONCA community.

Tourism New Zealand and Business Events Wellington have published an official case study and video showcasing the success and lasting legacy of Rural WONCA 2026 in Wellington.

This is a significant recognition, as only a select number of conferences are chosen to be featured as case studies highlighting their international impact and contribution.

This recognition reflects far more than a successful conference—it celebrates the strength of our global rural health community and the collective efforts of everyone who contributed to making Rural WONCA 2026 such a memorable and impactful event.

The case study highlights how bringing together rural health professionals, researchers, educators, policymakers, and advocates from across the world fostered meaningful collaboration, strengthened partnerships, and advanced our shared commitment to improving rural healthcare globally.

I encourage you to take a few moments to explore these resources:

Case Study:

<https://businessevents.newzealand.com/news-and-success-stories/case-study-wonca-delivers-a-rural-health-legacy-in-wellington/>

Conference Highlights Video:

<https://youtu.be/5glcd4s9qjg>

If you feel they may be of interest, you are welcome to share them through your usual channels or with colleagues and networks who might appreciate them.

On behalf of Rural WONCA, I extend my sincere gratitude to all our members, delegates, speakers, volunteers, partners, sponsors, Board members, Council, Te Rōpū, and everyone whose dedication made this conference such an outstanding success.

Thank you for your continued commitment to Rural WONCA and for helping us share this remarkable story with the world.

With warm regards,

Regards,

Dr. Pratyush Kumar



Bayanihan for Health Equity: Co-Creating Social Innovations for Responsive & Resilient Health Systems

Henry Sy Sr. Medical Sciences Building, University of the Philippines Manila

August 4-7, 2026

<https://tufh2026.com>

Network and Learn from Leaders in the Field

TUFH 2026 will be an international, intersectoral, and intergenerational in-person and virtual conference that brings together academic organizations and global health providers into a single event. We strongly recommend attending in person, but for those unable to travel, we will provide the opportunity for virtual

15th EURIPA

Rural Health Forum

1-3 October 2026 • Cartagena, Spain

The 15th EURIPA Rural Health Forum will be held in Cartagena, Spain, from October 1–3, 2026. Themed "Embracing Rural Diversity", this major healthcare event brings together professionals, researchers, and community leaders to address the specific healthcare and wellbeing challenges faced by rural populations.

Event Details and Registration

- **Location:** El Batel Congress Centre, Cartagena, Spain [[1](#)]
- **Dates:** October 1–3, 2026 [[1](#)]
- **Registration:** Early bird rates apply until August 20, 2026, with fees set at €50 for students and €175 for young doctors and other healthcare professionals. You can secure your spot via the [EURIPA Forum Registration](#)

The title of our Forum this year is: Embracing Rural Diversity

So, what do we mean by 'Diversity'?

There is rural diversity across Europe and within our communities: cultural, geographic, demographic, economic. There is also diversity in approaches to delivering rural primary care.

Not only do different countries have different health systems, the approach to delivering care in rural areas varies enormously.

The two sub themes this year are:

Rural diversity across Europe and within communities

Diverse approaches to delivering rural primary care

In EURIPA Forums, the attendees are from across Europe, from very different contexts (sometimes even within the same country) but all have an interest in 'rural health and rural practice'. The golden thread is 'rural' and each Forum provides an opportunity to compare and contrast your experiences and learn from each other, from your research, education and policy. The excitement comes from the interaction and the collaboration from these diverse contexts.

What's new in 2026?

The big news is that this year, as well as the EURIPA Bursary for four students and young clinicians, we are also piloting the opportunity for four students and young clinicians to participate in a Pre-Forum Rural Exchange Programme. Participating students / young clinicians will be invited to give a presentation of their research and experiences of the Exchange in an international 'Rural Café'.

As in previous years we welcome abstracts for oral presentation, posters, and workshops. As in 2025 we are again encouraging abstracts for "One slide/five minutes" presentations. These presentations are for people wanting to explore new areas for research, explore a research problem or invite potential collaborators to engage with them.

Our local host in Cartagena is SEMFYC, the Spanish Society of Family and Community Medicine. The rural group of SEMFYC is holding its annual conference at the same time as EURIPA and we are delighted to be offering joint discussion panels as a part of our programme, that will reflect our sub-themes. We will also be sharing a social programme. The Forum web site will be live in mid-April when you will be able to access all the information

that you will need to plan your trip and to submit your abstract. Watch out for social media posts and emails to announce the new web site.

The deadline for abstract submission: 14 June 2026

<https://www.euripa.org/news/view/first-newsreel-for-the-15th-euripa-rural-health-forum%21>

<https://www.euripa.org/>

9th World One Health Congress



September 4-7, 2026, Lisbon, Portugal

Organized by the Global One Health Community, the 9th World One Health Congress will bring together a global community of experts dedicated to advancing One Health science and policy. Over the course of four days, the Congress will feature a dynamic and forward-thinking agenda, with parallel tracks covering One Health science, antimicrobial agents and resistance, and the science-policy interface, among other critical topics. This leading international forum will foster discussions on major One Health challenges, facilitate the exchange of cutting-edge research, and highlight policy developments shaping the future of health for humans, animals, and the environment. <https://globalohc.org/9WOHC>

<https://globalohc.org/9WOHC>

Greetings CLIC Community!

We invite you to consider hosting the CLIC conference in 2027. Please see the request for proposal attached.

Interested programs and/or institutions, individually or in collaboration, should **submit their applications on or before Monday, August 3, 2026.**

The selected applicant(s) will be expected to market their event at the upcoming CLIC Conference in Calgary, Alberta Canada September 17-20, 2026.

Respond with completed RFP to Bernadette M. Duperron: duperron@uw.edu

Questions? Contact: Jay Erickson jerick@uw.edu, Katie Webb webbk11@cardiff.ac.uk or Myles Nickolich mnickolich@pennstatehealth.psu.edu

More details about the CLIC Calgary conference in September can be found here:
Clicmeded.org

Thank you!

Roger Strasser

Bernadette Duperron

International Consortium of Longitudinal Integrated Clerkships (CLIC)

Request for Proposals (RFP) to host the 2027 CLIC International Meeting.

Background to CLIC is

“Characterized by being the central element of clinical education whereby medical students: (1) participate in the comprehensive care of patients over time, (2) participate in continuing learning relationships with these patients clinicians, and (3) meet the majority of the year’s core clinical competencies, across multiple disciplines simultaneously through these experiences (International Consortium on Longitudinal Integrated Clerkships, 2007).” (Med Teach. 2012; 34:548–554).

CLIC is

The international Consortium of Longitudinal Integrated Clerkships—an organization of educators, clinicians,

administrative leaders, and researchers dedicated to “meaningful transformation of clinical education to meet a range of goals: to improve clinical education through innovation at science or research-oriented, workforce-oriented and rural-oriented schools; to study and describe LICs in order to encourage research in medical education; to foster improved recruitment and retention of doctors in underserved areas; to advance the social accountability and community engagement of medical education; to enhance humanism and patient-centredness in medical education; to explore the potential of workplace learning, and to challenge orthodoxies that inhibit the transformation of medical education.” (Med Educ. 2011; 45:436–437).

Determination of conference site arises from CLIC core values

- Value of the movement - its vision, history, and progressive educational nature
- Value of community - inclusive, supportive, mission-driven
- Value of engaging in discussion, deliberation, and sharing ideas openly

- Value of developing, supporting, and advancing new and existing programs

Other Conferences:

[IX Congreso Iberoamericano de Medicina Familiar y Comunitaria](#)

Asunción, Paraguay

Dates: 22 - 25 July

[9th WONCA Africa Region Conference](#)

Gaborone, Botswana

Dates: 10 – 11 September 2026.

Submit your abstract by 28 February 2026.

[East Mediterranean Region Conference](#)

Cairo, Egypt

Dates: 29 - 31 October 2026.

WONCA WORLD CONFERENCE 2027

Cape Town, South Africa

Dates: 3 - 7 November 2027

Education, Webinars, Videos and Podcasts



Welcome to The Race Equation, a new season of the “Intention to Treat” podcast that explores the many critical issues facing medicine today. In a new 8-week series, The Race Equation confronts harmful assumptions about race in clinical medicine—from diagnostic

algorithms to clinical guidelines—exploring how these practices took hold, why they endure, and what it will take to change them.

Listen to The Race Equation and follow “Intention to Treat” on Apple Podcasts or wherever you get your podcasts.

The Myth of Race and Genetics

https://store.nejm.org/signup/nejm/intention-to-treat?query=itt&utm_source=nejm&utm_medium=en&utm_campaign=itts2&cid=DM2452953_NEJM_Non_Subscriber&bid=-753257671

The Lancet Voice

Paul Spiegel: rethinking the humanitarian response to conflict and forced displacement

Do we need to rethink our response to conflict and forced displacement? A new Lancet Commission radically rethinks policy, funding, and practical approaches to humanitarian crises. Chair Professor Paul Spiegel joins Niall Boyce from the Lancet to discuss the aims and recommendations of this Commission on one of the most pressing health issues of the 21st century.

<https://www.thelancet.com/audio-do/paul-spiegel-rethinking-humanitarian-response-conflict-and-forced-displacement>

What happened when cannabis was legalised in the US?

While cannabis remains illegal at the federal level, almost half of the states of the US have now legalised it for recreational use. But what effect has this had on health, and how are researchers monitoring the situation?

Niall Boyce and Mariam Sabin from the Lancet chat with Professor Deborah Hasin, Professor of Clinical Epidemiology at Columbia University.

https://www.thelancet.com/audio-do/happened-cannabis-legalised-us?dgcid=hubspot_update_feature_tlv_lancet&utm_campaign=update-lancet&utm_medium=email&hsenc=p2ANqtz-8PJvbidXwZz4i5r6PhcgF6OD1HjR4zOkZ3xa6hLfbO9-zafH7Kf1O43BjAB8PbQsEYf4RH0KTNBmzcBM9CmqGFFjoBKw&hsmi=423743419&utm_content=423510207&utm_source=hs_email

Why has the UK government banned social media for under-16s?

The UK Government has just announced a ban on social media for under 16-year-olds. Why? Why now? And will it actually improve young people's health and wellbeing? Lancet Editor Niall Boyce is joined by Esther Lau, Editor-in-Chief of The Lancet Child and Adolescent Health, to discuss the key issues and likely consequences.

https://www.thelancet.com/audio-do/why-has-uk-government-banned-social-media-under-16s?dgcid=hubspot_update_feature_tlv_lancet&utm_campaign=update-lancet&utm_medium=email&hsenc=p2ANqtz-8t9usJiaLZdfbSmZwovMTDYffzuuWfa7SJ2tEo2cFV4_sYqiA46sRy_x0mLNT08iAeMXGaGoqI5HFBCQWIBEY_A2rVug&hsmi=427005402&utm_content=426817909&utm_source=hs_email

Bioethics flashpoints of the next decade

Bioethics are a matter of practical, everyday concern for physicians, and other health care providers, especially as medical science continues to advance, opening up new therapeutic

possibilities. In this episode of The Lancet Voice, the bioethicist and oncologist, Ezekiel Emanuel, talks about applying bioethics to some of today's most pressing health problems, globally.

https://www.thelancet.com/audio-do/bioethics-flashpoints-next-decade?dgcid=hubspot_update_feature_tlv_lancet&utm_campaign=update-lancet&utm_medium=email&hsenc=p2ANqtz--S8JTtfAeQqcFoCnNzzXJ8EBOxoflukNcXHHOzujuOdUtXkAyDbQUKaerWxxPHNBJoMu35UvX6CI9Qx3-6RwWGJgWiGA&hsmi=425950365&utm_content=425710422&utm_source=hs_email

Nature Podcasts

Your phone can use tiny skin-colour changes to measure your heart rate

Passive heart-rate monitoring during regular phone use could provide early warning of health issues — plus, testing Richard Feynman's solution to the 'restaurant dilemma' problem.

https://www.nature.com/articles/d41586-026-01793-1?utm_source=Live+Audience&utm_campaign=b1934c07ab-nature-briefing-weekly-20260605&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Togetherness: How cooperation built the world

Science journalist Rowan Hooper joins us to talk about symbiosis and the importance of organisms working together.

https://www.nature.com/articles/d41586-026-02067-6?utm_source=Live+Audience&utm_campaign=391cc28626-nature-briefing-weekly-20260703&utm_medium=email&utm_term=0_-33f35e09ea-50521540

DNA from hunter-gatherer teeth reveals secrets of ancient plague

Analysis shows evidence of deadly outbreaks 5,500 years ago — plus, a prototype dark-matter detector.

https://www.nature.com/articles/d41586-026-01941-7?utm_source=Live+Audience&utm_campaign=37188488c5-nature-briefing-daily-20260619&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Rural Road to Health Podcast

Martin Robertson & Faye Watson - Farmers & Dementia (Mind Our Farmers)

Martin Robertson, a lived experience expert and **Faye Watson**, a Public and Community Engagement Consultant, speak about the project they are leading to start conversations about dementia in farming communities in Scotland.

<https://266bc421-ca82-421e-a797-509482316cde.libsyn.com/martin-robertson-faye-watson-farmers-dementia-mind-our-farmers>

Matt Paneitz- Long Way Home: Education & Community Transformation

The work of Long Way Home started in San Juan Comalapa, a Maya Kaqchikel (indigenous) community in Guatemala.

Long Way Home is a non-profit organization which is integrating sustainable rural development, education and addressing poverty.

Built the first city park and they wanted to charge an entry fee, the entrance fee became a plastic bottle filled with trash.

There was no system for trash management, there was nowhere to put it, so they decided to use trash as a building material.

At their school the tuition fee is one plastic bottle filled with trash. One family will send 3 or 4 children to the school and they will clean up the trash in their environment. This then helps to clean the neighbourhood.

They were experimenting with alternative material such as trash to bring down the cost of building materials.

San Juan Comalapa is in the western highland of Guatemala, the area has volcanoes, it is 60km west of Guatemala city. The people are mostly farmers, growing maize.

They opened the first high school in the town. There is a lack of money going into education. Not all of the children had a space in public school. Only 30% of children were enrolling in middle school as there is 87% unemployment locally.

The availability of a secondary school with low tuition fees enabled more young women to go to school. This is also improving their chances of going to university. Members of the community are not becoming professionals with better employment opportunities.

There were many obstacles to building the school. It was important to know the right people in the community who could help.

Building relationships and trust was important, it meant never asking others to do something they would not do themselves.

The school includes a Kaqchikel class where they learn about their language and culture.

The school campus uses a variety of materials, they experimented with different building methods including tyres, earth bags, cob, and bamboo. There are 22 different buildings which have integrated conventional and unconventional materials.

They used this experience to build further infrastructure with the wider community.

They have shared their experiences with other organizations around the world. They have also shared their expertise in building with alternative materials and documented the process to create a profile for the different types of buildings.

<https://sites.libsyn.com/457074/matt-paneitz-long-way-home-education-community-transformation>



New articles published in Rural and Remote Health

10792 - Asia - Decentralised clinical training affects retention but not recruitment: a case study in East Nusa Tenggara, Indonesia

The low recruitment and retention of doctors in rural areas is a significant barrier to achieving equitable health services globally. Various cross-country studies have shown that long-term clinical placements in rural areas through decentralised clinical training (DCT) – in which the location and model of clinical education is restructured into networks of health service facilities outside the primary teaching hospital – increase the probability of graduates practising in rural locations. This Original Research study investigates the influence of DCT duration on rural doctor recruitment and retention in East Nusa Tenggara, Indonesia.

10393 - Australasia - The association between medical student selection and a fit-for-purpose medical workforce in low- and middle-income countries in the Asia–Pacific region: a scoping review

For decades, medical schools have debated appropriate ways to select the future workforce. Empirical research and reviews on selection of medical students mostly originate from high-income countries, which might not lead to training the health workforce to meet the needs and priorities of communities in low- and middle-income countries (LMICs). This Review explores approaches that medical schools in LMICs in the Asia–Pacific region could utilize in their selection strategies.

Papers from other journals

WHO: Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo continues to evolve rapidly, with sustained transmission and increasing numbers of reported cases. As of 17 June, a cumulative of 896 confirmed cases, including 232 deaths, have been reported from the Democratic Republic of the Congo. As of 18 June, Uganda has reported 19 confirmed cases including two deaths, as well as one probable case who has died. In Uganda, the outbreak remains epidemiologically linked to transmission originating in the Democratic Republic of the Congo, with evidence of both imported infections and secondary transmission among contacts and healthcare workers. Uganda has not reported any new cases since 5 June 2026. National authorities in the two affected countries, in collaboration with WHO and partners, are implementing an extensive set of response measures. A regional preparedness and prioritization framework continues to guide readiness activities across the African Region.

Since the last [Disease Outbreak News](#) was published on 13 June 2026, the number of confirmed cases and deaths have increased rapidly in the Democratic Republic of the Congo. In total, 915 confirmed cases; 896 from the Democratic Republic of the Congo and 19 from Uganda; and 234 deaths including two from Uganda, have been reported. At least 88 patients have recovered from the disease; 78 patients from the Democratic Republic of the Congo and 10 patients from Uganda.

<https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON608>

Lancet Editorial: Key facts about the Bundibugyo virus outbreak

On May 15, 2026, an outbreak of Ebola virus disease (EVD) was declared in DRC and Uganda, with WHO designating it a Public Health Emergency of International Concern on May 17. The outbreak is due to Bundibugyo virus—one of three species of Ebola virus

causing haemorrhagic fever outbreaks in humans. The other two species, Zaire and Sudan, have been responsible for several large EVD outbreaks in Africa over the past two decades. By contrast, Bundibugyo virus outbreaks have been rare and relatively small. The [first](#), in 2007–08, led to the identification of Bundibugyo as a new species of Ebola virus. It began in Bundibugyo district in western Uganda and was associated with 56 laboratory-confirmed cases and 37 deaths. The [second](#) and last occurred in the Isiro Health Zone in DRC in 2012, with 36 laboratory-confirmed cases and 34 deaths. The current outbreak of Bundibugyo virus is already significantly larger than the previous two, with around 900 suspected cases and 220 suspected deaths as of May 25. These numbers include seven confirmed cases and one death in Uganda. Early cases were reported in health-care workers and in cities in DRC far from the outbreak's epicentre (Ituri province), suggesting the virus may have been circulating for some time before it was detected.

Why did the outbreak grow so large before detection? Multiple factors likely contributed. Although DRC has extensive experience responding to EVD outbreaks, persistent insecurity, case remoteness, population movement, and weak health infrastructure make timely detection and response extremely challenging. Early illness was also difficult to recognise as EVD because initial symptoms are non-specific. Recognition was further delayed because the GeneXpert test being used in the field was looking for the Zaire strain. Only after samples were sent to a central laboratory for PCR testing was it confirmed that the outbreak of EVD in DRC was due to Bundibugyo virus, a relatively unknown Ebola species. When Bundibugyo virus was first identified in 2007–08, [sequencing](#) revealed its genome differed from those of the Zaire and Sudan viruses by roughly 30%. The authors of the report noted that such sequence divergence could “have important implications for design of future diagnostic assays [...] and ongoing efforts to develop effective antivirals and vaccines”. Nearly two decades later, the world remains inadequately prepared to detect and respond to an outbreak of Bundibugyo virus.

[https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(26\)00293-8/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(26)00293-8/fulltext?dgcid=raven_jbs_etoc_email)

The Telegraph: Witchcraft and WhatsApp: The fight to contain Ebola misinformation

Huge groups on messaging apps, where many share voice notes because many cannot read, are a major conduit for information about the outbreak

While Julienne Anoko's colleagues work in treatment wards and labs to stop the spread of Ebola, she takes on WhatsApp groups with tens of thousands of members, where distrust and rumours are rife.

Medics treat the virus tearing through this corner of north eastern Congo as she navigates the local fear and suspicion which make their job harder.

The past six weeks have seen her deal with beliefs that the outbreak is caused by witchcraft, by magic coffins, or is a pretext by outsiders to control local gold mines.

Step-by-step, she and her team have tried to persuade the population that the virus is real and that precautions and strict burial arrangements are necessary for their safety.

The tide is turning, she told the Telegraph in a phone interview this week, but even as the population comes to believe the virus is real, there is now widespread impatience and fear at the lack of government help.

She said: “What I saw at first was that people were afraid. They didn't believe that Ebola existed. They thought it was witchcraft, sorcery and poisoning.

“Now they are scared. They understand that Ebola is real and it's killing them.”

Six weeks into the outbreak in the Democratic Republic of Congo (DRC), [the rare Bundibugyo strain of Ebola](#) is still outpacing the international response to stop it and is continuing to spread.

<https://www.telegraph.co.uk/global-health/science-and-disease/health-workers-fight-to-contain-ebola-misinformation-drc/>

The Lancet Editorial: Whose evidence counts? Strengthening African health systems

Amid external funding constraints, there is growing consensus for re-imagining the future of domestically funded yet resilient health systems across Africa. To realise this aspiration, evidence-based policy making, which is standard practice across governments and global health agencies, is more critical than ever. Unfortunately, for too long, much of the evidence that guides policy and investment decisions has been, and is still, generated [outside Africa](#). Consequently, there is a wide gap in context-specific data and locally grounded research evidence that threatens efforts to effectively strengthen African health systems. At the recent [World Health Summit Regional Meeting](#), convened in partnership by the WHO, Africa CDC and Kenya's Ministry of Health, this was echoed in an urgent call for context-specific evidence to inform the strengthening of health system equity and resilience.

Health policy discussions in Africa are often informed by donor priorities, multi-country models, and studies from high-income settings. Although the value of international evidence is undisputed, transferability to African contexts is usually assumed rather than demonstrated; this poses a risk for adoption of policies or programs that are ineffective and unsustainable in African settings because of lack of consideration of contextual realities. For example, assumptions underpinning [insecticide-treated bednet](#) design and distribution strategies for malaria prevention did not fully align with local housing structures, sleeping arrangements, and ventilation realities, which reduced uptake and sustained use. Hand washing campaigns that assumed reliable water access were difficult to operationalise in [informal settlements](#) that rely on communal taps and therefore prioritise water for drinking and cooking water over hygiene practices. Immunisation campaigns for COVID-19, polio, and measles that required refrigerated vaccine supply chains and uninterrupted power supply were ineffective in [remote regions](#) across the Sahel and Central Africa due to frequent power outages and poor transport infrastructure. These examples highlight the need for the production and interpretation of local data that are anchored in contextual intelligence and local realities.

Building African evidence ecosystems can reveal subnational disparities, identify underserved populations, and therefore support more responsive policy decisions. National averages, which initially suggested broad progress in maternal and child health in Ethiopia, masked district-level disparities that later showed that [pastoralist](#) and geographically isolated communities continued to experience substantially poorer outcomes. These local data informed targeted policy responses involving deployment of mobile health teams, expansion of community-based maternal services, strengthening of referral pathways, and tailoring of health education strategies to local cultural and linguistic contexts.

Other than HIV, tuberculosis, and malaria, Africa has a dearth of data not only in clinical research, but also in implementation science and health economics evidence across a spectrum of health topics. On one hand, implementation research is essential for understanding how well programmes would work within existing, routine settings that are often overburdened and resource-constrained. On the other hand, health economics evaluations demonstrating robust data on cost-effectiveness, return-on-investment analyses, affordability and scalability, are much needed to help finance ministries to prioritise the allocation of scarce resources. The [Friendship Bench](#) mental health intervention in Zimbabwe is a great success story because it is not only grounded in African contexts, but it demonstrated real-world delivery feasibility with measurable outcomes. It was shown to be low cost, highly scalable, and well integrated into primary care. Without these forms of locally relevant evidence, the strengthening of African health systems will remain a distant aspiration.

[https://www.thelancet.com/journals/lanaf/article/PIIS3050-5011\(26\)00069-6/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/lanaf/article/PIIS3050-5011(26)00069-6/fulltext?dgcid=raven_jbs_etoc_email)

Science: Doctors vs. Algorithms: Physicians, too, struggle to learn from evidence that contradicts AI suggestions

Despite their widespread adoption, Artificial Intelligence-based Patient Classification Systems sometimes rely on incorrect, outdated, or incomplete data, which can lead to inaccurate outputs. Nevertheless, health professionals are expected to override these errors, at least when they have access to critical information. To test this, we conducted two experiments in which professional physicians interacted with an Artificial Intelligence system that incorrectly classified fictitious patients as either highly or lowly sensitive to a treatment. The physicians administered the treatment to a series of fictitious patients and received feedback that was useful for learning that the patient classification was incorrect and that all patients were equally sensitive to the treatment. We ran two experiments: in Experiment 1, the medicine showed medium effectiveness for both types of patients, while in Experiment 2, the treatment was completely ineffective for both types of patients. The results showed that, in the two experiments, physicians generally trusted the AI-based patient classification and struggled to learn from the evidence. Furthermore, in Experiment 2, they failed to realize that the treatment was ineffective. Our findings have important implications for healthcare professionals and patients, underscoring the need to critically evaluate Patient Classification Systems.

Artificial Intelligence (AI) is now widely used in various fields, including clinical practice, where AI systems assist in classifying patients for diagnosis and treatment. However, these AI-based patient classification systems can sometimes use incorrect, outdated, or incomplete data, leading to errors. In such cases, health professionals are expected to catch and correct these errors. Earlier studies found that the general population often do not sufficiently detect and fix AI's mistakes. We wanted to see if professional physicians would act differently so that they would notice and correct these errors. To find out, we conducted two experiments in which participants had to decide whether to administer a fictitious treatment to patients who were incorrectly classified by an AI as being more or less sensitive. In the first experiment, the treatment worked moderately (and equally) well for both groups. In the second, the treatment did not work at all for either group. In both experiments, physicians trusted the AI's classifications and did not use the available information to override the erroneous classification. What is more, in the second experiment, they did not even realize that the treatment was completely ineffective.

<https://journals.plos.org/digitalhealth/article?id=10.1371/journal.pdig.0001490&et rid=1169729274&et cid=6007130>

European Journal of General Practice: Impact of nurse practitioners in primary care on patients with chronic diseases in rural and underserved areas: A systematic review

Ageing, multimorbidity, and workforce shortages increasingly limit access to primary healthcare, especially in rural and underserved areas.

To document impact of nurse practitioners (NPs) in primary care on patients with chronic diseases.

Searches were conducted in Medline, EMBASE, CINAHL, and CENTRAL (March 1978–October 2023). This systematic review followed MECIR and PRISMA guidelines (PRISMA 2020 checklist: EQUATOR Network) with SWiM used as a PRISMA extension due to the lack of meta-analysis. The focus was on NPs' roles in chronic disease management and

primary care in underserved or remote areas, excluding mental health, cancer, and dental care.

Among 3,684 citations, 25 studies were selected, including 10 RCT. NPs may improve access to primary care and chronic disease management, particularly in underserved areas. Although not all studies directly compared NPs to traditional models, they were most often assessed against General Practitioners (GPs) alone. Seven studies also evaluated collaborative NP-GP models versus GP-only care. Patient satisfaction was generally higher with NPs, possibly due to longer consultations and greater patient education. Clinical and biological outcomes were often comparable between NPs and GPs, with the best results in collaborative models, which were also associated with higher costs.

NPs may enhance access to care, particularly for vulnerable populations. Higher patient satisfaction may be linked to longer consultations and patient education. While clinical outcomes were comparable to those of GPs, collaborative models yielded the best results, though potentially at a higher cost.

<https://www.tandfonline.com/doi/full/10.1080/13814788.2026.2613495#abstract>

The Lancet: Medical Aid for Palestinians: Gaza facing a health-care catastrophe

The recent UN Final Gaza Rapid Damage and Needs Assessment,¹ published in collaboration with the EU and the World Bank, concludes that Gaza's human development has been set back by an estimated 77 years since October, 2023. Nowhere is this regression more catastrophic than in health. The assessment identifies US\$10 billion of recovery and reconstruction needs in the health-care system and the loss of approximately 14% of Gaza's health-care workforce.¹

These numbers are in line with the experiences and findings of the Medical Aid for Palestinians (MAP) medical and humanitarian personnel working in Gaza. Gaza's health system was fragile long before October, 2023, degraded by years of the Israeli authorities' illegal closure and blockade of goods and aid entry and repeated Israeli military assaults.² Since October, 2023, Israel's military campaign has systematically accelerated the destruction of health-care infrastructure. At least 1700 Palestinian health-care workers have been killed as of Oct 7, 2025,³ and every hospital has been damaged, attacked, or rendered non-functional.⁴ Medical services have been repeatedly targeted in clear violation of international humanitarian law, as evidenced by a UN Commission of Inquiry,⁵ which found that Israeli forces' systematic destruction of reproductive health care and resulting denial of access to such services constitute genocidal acts and the crime against humanity of extermination. This targeted destruction of the health-care system has left it in ruins and struggling to respond, let alone recover.⁶

9 months after the announcement of a ceasefire in October, 2025,⁷ conditions for patients have not meaningfully improved. Israeli authorities' ongoing restrictions on humanitarian access continue to prevent the entry of essential medicines, equipment, fuel, and personnel at the scale required to sustain life. As of April, 2026, around half of all essential medicines in Gaza are unavailable and hospitals are facing power cuts and severely limited service provision.⁸ Every day, MAP's local staff and partners are distressed to be unable to provide the treatments that patients need due to shortages of medicines, equipment, and power. The UN Office for the Coordination of Humanitarian Affairs reports that more than 18 500 critical patients, including 4000 children, require medical evacuation;³ these evacuations are routinely delayed or denied.^{2,8} Israeli military forces continue to kill Palestinians on an almost daily basis.⁹

The health consequences are predictable and devastating: preventable deaths, untreated chronic illness, the collapse of maternal and neonatal care, and a generation facing long-term

disability and trauma. Gaza's health-care system cannot recover under siege, nor can it be rebuilt when violence and obstruction persist.

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(26\)01013-5/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)01013-5/fulltext?dgcid=raven_jbs_aip_email)

Journal of Family Medicine and Primary Care: What motivates young European doctors for rural work? European Rural and Isolated Practitioners Association-Motivating young European doctors for rural Work study

Rural general practitioners (GPs) play a vital role in providing healthcare to populations in remote areas, yet there is a significant shortage of doctors willing to work in these regions. Despite the critical need, a strong preference for urban practices persists among young GPs in Europe, exacerbating the lack of healthcare providers in rural settings. Understanding the motivation factors influencing young GPs' decisions to work in rural areas is essential to address this workforce distribution problem.

This study aims to identify the main motivating factors that drive young GPs to work in rural areas across four European countries. Additionally, the study seeks to propose strategies to enhance recruitment of young GPs in rural healthcare settings.

A key informant survey was conducted across four member countries of the European Rural and Isolated Practitioners Association (EURIPA). The EURIPA Motivating young European Doctors for rural Work (MEADOW) study utilized a semi-structured questionnaire. The survey targeted young GPs in Denmark, Norway, Turkey, and the Czech Republic, collecting data from 350 respondents.

Our survey revealed that 64.14% of young GPs expressed an interest in rural practice, with major motivating factors including accessibility of schooling for their children, income profitability, and employment opportunities for partners.

The study highlights that financial incentives alone are insufficient to motivate young GPs to work in rural areas. Instead, a comprehensive approach that includes improving rural medical education, ensuring access to quality schools for children, and providing employment opportunities for partners is crucial. Addressing these multifaceted needs can enhance rural recruitment and retention efforts across Europe.

https://journals.lww.com/jfmnp/fulltext/2026/04000/what_motivates_young_european_doctors_for_rural.22.aspx

The Lancet primary Care: Rethinking primary care redesign through community coordination hubs for interprofessional care

We read with great interest the Viewpoint by Michael A Peters and colleagues published in The Lancet Primary Care,¹ in which the authors propose four core functions of primary health care (PHC): serving first-choice health needs, detecting illnesses and risks, providing high-quality care over time, and linking people with advanced care and social services. We share the authors' emphasis on continuity, coordination, longitudinal information, and team-based practice.¹ Building on this vision, we offer a complementary perspective on how organisational, digital, and operational assets might advance a community-centred PHC ecosystem.

Despite longstanding commitments to integrated, person-centred care, PHC often remains fragmented. PHC physicians, community pharmacists, nurses, psychologists, dietitians, social workers, public health professionals, and other community-based practitioners frequently work in parallel, with only limited opportunities for communication or collective decision making.²

In our view, the framework proposed by Peters and colleagues could be strengthened through community coordination hubs embedded within PHC. Such hubs do not require physical co-

location but functional interoperability through networks linking professionals who are serving the same communities. Through shared information, care priorities, and referrals, professionals could move from parallel practice towards coordinated action for each patient–citizen.

In terms of capacity, these community coordination hubs extend beyond conventional multidisciplinary models. Through interdisciplinary and transdisciplinary conceptualisation, they can generate synergies exceeding the contributions of individual professional roles.³ Under the coordinating stewardship of PHC physicians and while acting as a bridge to specialist and hospital services, such hubs could create opportunities for professionals to proactively discuss emerging risks, care priorities, and intervention strategies for individuals and communities using shared information environments. By integrating clinical, behavioural, social, medication-related, and environmental information, these hubs could strengthen prevention, health promotion, risk stratification, and personalised interventions.⁴ [https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143\(26\)00081-6/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143(26)00081-6/fulltext?dgcid=raven_jbs_aip_email)

BBC: Australia confirms first case of H5N1 bird flu as virus reaches every continent

The H5N1 strain of bird flu has for the first time been found in Australia, the country's agriculture ministry confirmed. It means the highly contagious variant has now reached every continent.

The disease was found in a migratory seabird, a brown skua, in remote Western Australia, Agriculture Minister Julie Collins said on Saturday.

The bird was found on a beach at the Cape Le Grand National Park near the town of Esperance, about 700km (434 mi) south-east of Perth, according to local media.

Australia was previously the only continent where the H5N1 bird flu strain had not been found.

The strain can spread quickly among poultry and wild bird populations. Human cases tied to the disease remain uncommon.

"We all knew we couldn't be bird flu-free forever," Collins told a press conference.

Collins added that there was a second suspected case of bird flu - a southern petrel that was found exhausted on an Esperance beach, though she added that there was no "evidence of mass mortalities at this time".

Threatened Species Commissioner Fiona Fraser said authorities would know "within a few days" if the virus was present in any other animal populations in Australia, according to a report by the national broadcaster, the ABC.

The report also quoted the country's Chief Veterinary Officer Beth Cookson who said authorities had been "preparing for this event for a long time" and that the committee for emergency animal disease had convened on Saturday.

The H5N1 strain of bird flu was detected on the remote Australian territories of Heard and McDonald Islands in October last year - located in the southern Indian Ocean.

A study released this week estimated that around 13,000 baby seals from a group of 17,000 on Heard Island were killed by the H5N1 strain of bird flu since last August, more than 75% of the entire group. They also found higher than expected deaths in penguin populations. Scientists believe bird flu was likely introduced to the islands last August from migrating birds from the French-owned Crozet Islands, about 1,800 km away.

https://www.bbc.co.uk/news/articles/c4gykxklv15o?utm_source=Live+Audience&utm_campaign=6d0033ed27-nature-briefing-daily-20260622&utm_medium=email&utm_term=0_-33f35e09ea-50521540

FAO: The economic case for One Health in agrifood systems:

Why prevention pays

As global food systems face mounting pressures from climate change, emerging diseases, and antimicrobial resistance, a prevention focused One Health approach offers compelling economic advantages that could refocus agricultural investment priorities. The numbers tell a clear story: reactive disease management costs far more than prevention.

The true cost of disease

The economic toll of disease outbreaks in agrifood systems either directly or indirectly is staggering. COVID-19 alone generated cumulative output [losses projected at USD 13.8 trillion](#) through 2024, while H5N1 avian influenza outbreaks have exceeded [USD 20 billion](#) in direct costs since 2003. Beyond pandemics, more than [1 billion cases of zoonotic disease](#) are recorded annually, with most originating at the human-animal-environment interface where food is produced.

By 2050, AMR could kill as many as [10 million people](#), with global costs estimated to reach USD 100 trillion, resulting in a 3.8 percent drop in global GDP, with livestock production systems serving as critical reservoirs for resistant pathogens and genes. Meanwhile, foodborne illnesses affect 600 million people annually, imposing massive healthcare costs and trade disruptions that disproportionately impact smallholder farmers and food-insecure populations.

Recent analyses confirm that infectious disease outbreak frequency has continued to increase significantly since 1980, with the most [comprehensive 2024 studies](#) showing this acceleration persists, particularly for zoonotic and vector-borne pathogens.

One Health represents a fundamental shift from reactive disease management to proactive prevention across the agrifood chain. Most pathogens infectious to humans are zoonotic, moving bidirectionally between animals and people within interconnected food production systems where pathogens can evolve and spread across species barriers. By addressing root causes rather than symptoms, a One Health approach offers superior cost-effectiveness to derisk agricultural investments.

<https://www.fao.org/one-health/highlights/the-economic-case-for-one-health/en>

The Lancet: Ensuring the clinical impact of medical artificial intelligence

Randomised controlled trials (RCTs) testing artificial intelligence (AI) approaches in health care (AI-RCTs) mostly use measures of processes rather than measures of health outcomes. Measures of processes refer to indicators that assess the performance of a tool or an intervention, rather than their actual results. These measures include diagnostic accuracy, detection rate, specificity, time-to-test results, and workflow-related efficiency. In contrast, measures of health outcomes reflect the actual effects on patient's health. Notably, clinical outcomes, such as mortality, survival, morbidity, and quality of life, are often considered the primary measures of health outcomes. Although process improvements can suggest potential benefits, they do not necessarily guarantee patient benefit, as other factors, such as overdiagnosis, overtreatment, lack of resources, lack of effective treatment, or poor patient compliance, might also substantially influence a patient's health.

A 2024 systematic review of published RCTs first identified this trend.¹ More than half of the trials analysed (46 [54%] of 86) focused on endpoints related to diagnostic yield or performance, including detection rates or mean absolute error. The remaining endpoints were categorised into care management (18 [21%] of 86), patient behaviours and symptoms (15 [17%]), and clinical decision making (7 [8%]). These varied metrics have the potential to show how AI systems can improve clinical practice and patient health.¹

Preliminary data of ongoing and planned trials show that this trend is not only confirmed but also reinforced. Based on evidence from a preprint paper, 71 (55.91%) of 127 ongoing and

planned AI-RCTs, registered on [ClinicalTrials.gov](https://www.clinicaltrials.gov), use measures of processes, whereas the remaining 56 (44.09%) focus on measures of health outcomes.² These data² about ongoing and planned AI-RCTs suggests a stable preference for measures of processes. A possible explanation for this preference is that process-related endpoints are quicker to measure than measures of health outcomes and thus allow for shorter trials, enabling sponsors to hit the market earlier. Overemphasis on measures of processes can also stem from the fact that a majority of such trials test diagnostic deep learning systems for medical imaging, which are typically assessed in terms of predictive accuracy.

[https://www.thelancet.com/journals/landig/article/PIIS2589-7500\(26\)00053-1/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/landig/article/PIIS2589-7500(26)00053-1/fulltext?dgcid=raven_jbs_aip_email)

Nature: Europe's record heatwave: does the continent have a new climate?

As the second unprecedented heatwave in Europe this year smashes temperature records, many people are asking the same questions: is this the new normal? Has Europe's climate fundamentally changed?

Scientists who spoke to Nature say that a European heatwave lasting four or five days, with London approaching 40 °C, is an anomaly. "It's nothing short of phenomenal," notes Sarah Perkins-Kirkpatrick, a climate scientist at the Australian National University in Canberra. But researchers also say that Europeans can expect to see more of these events in the future as global warming continues.

"Heatwaves are here to stay, until we turn the tap off to global emissions," says Samantha Burgess, deputy director of the Copernicus Climate Change Service at the European Centre for Medium-Range Weather Forecasts in Reading, UK. "They're more frequent, they're more intense and they're lasting longer."

The risks are severe. In France — which recorded its hottest day ever this week, reaching 44.3 °C in the town of Pissos — at least 54 people have died from the heat or from drowning in waterways while trying to cool off.

What researchers don't necessarily agree on is how quickly Europe's climate shifted from one of cool, pleasant summers, during which residents could leave their windows open, to one dominated by extreme heat and questions about whether to buy an air conditioner.

An analysis released on 26 June¹ examined temperatures in 854 cities across Europe — home to 30% of the population — and found that nearly half of them broke or will break their all-time heat-stress records this month (see 'Epic heatwave'). Every city examined in the Czech Republic, Lithuania and Luxembourg has seen unprecedented highs according to the study, which was conducted by the World Weather Attribution group, an international organization that studies extreme weather events.

https://www.nature.com/articles/d41586-026-02046-x?utm_source=Live+Audience&utm_campaign=b339d16fce-nature-briefing-anthropocene-20260626&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet Public Health: Ebola: lessons from the past

On May 17, 2026, WHO declared the Ebola outbreak caused by the Bundibugyo virus affecting DR Congo and Uganda a [Public Health Emergency of International Concern](#) (PHEIC). WHO's decision reflected the evidence of cross-border transmission, uncertainty about the scale of the outbreak, the absence of licensed vaccines or treatments for the rare Bundibugyo Ebola strain, and the need for urgent international action. As of July 1, 2026, WHO reported a total of [1460 confirmed cases](#) and 452 deaths in DR Congo. Uganda reported 20 confirmed cases, including two deaths. The outbreak in DR Congo continues to evolve rapidly, with sustained transmission and increasing numbers of reported cases. On June 24, France reported the [first imported case](#) of Ebola virus disease in Europe linked to the

current outbreak. The case was a doctor who had recently returned from DR Congo. Although the risk of Ebola spreading globally is low, imported cases highlight the importance of maintaining robust surveillance.

To curb the outbreak, on June 5, WHO and the Africa Centres for Disease Control and Prevention (CDC) launched a US\$518 million preparedness and [response plan](#). The 6-month (June–November, 2026) strategy complements the national plans of DR Congo and Uganda and focuses on surveillance, laboratory testing, infection prevention and control, clinical care, community engagement, logistics, research, and maintenance of essential health services. However, Africa CDC reported on June 25 that the estimated funding requirement had risen from \$518 million to \$1·4 billion because of the rapidly worsening outbreak and humanitarian crisis in eastern DR Congo, where ongoing conflict has displaced millions of people, forcing many into overcrowded camps while others remain on the move. This situation substantially complicates outbreak control.

Previous Ebola outbreaks show that rapid financing, community trust, and sustained support are key elements for control. The 2014–16 west African epidemic, the largest Ebola outbreak ever recorded, transformed Ebola from a neglected disease into a major global health priority. The US alone provided about \$5·4 billion in emergency Ebola funding, including for treatment centres, surveillance, vaccine development, and preparedness. Most of the funds supported international response activities, particularly in affected countries. The 2026 Bundibugyo outbreak has again mobilised substantial funding. The EU announced €493 million in support, while governments and international organisations have pledged around \$910 million. Although clinical trials of candidate therapeutics for the Bundibugyo strain have started, candidate vaccine trials are months away. If any prove successful, they must be made readily available and accessible to affected populations. For now, implementing the WHO–Africa CDC plan and public health measures—including surveillance, case isolation, contact tracing, infection prevention and control, and safe and dignified burials—is paramount. However, Africa CDC has reported that, across all international donors, disbursements have lagged far behind pledges, with less than \$90 million of the \$910 million pledged globally actually received as of mid-June. Given the agency's revised funding figure, this situation is extremely concerning. Disbursing funds swiftly is essential for the careful coordination and rapid implementation of the WHO–Africa CDC plan.

[https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(26\)00147-7/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(26)00147-7/fulltext?dgcid=raven_jbs_aip_email)

NEJM: Global Cholera-Control Efforts — Progress and Remaining Challenges

The current cholera pandemic — the seventh in recorded history — began 65 years ago, in 1961. There is little evidence that it will end anytime soon. Indeed, the number of new cases and the magnitude of outbreaks continue to increase. Cholera is currently endemic in nearly 50 countries, causing millions of cases and tens of thousands of deaths each year. The disease primarily affects the world's poorest people, especially those who lack access to safe water and adequate sanitation and hygiene facilities. Displaced populations and refugees are often at particular risk, and severe weather events and disasters can precipitate outbreaks and epidemics.

Before the massive cholera outbreak in Haiti in 2010, global cholera-control efforts largely focused on advancing global access to safe water and adequate sanitation (WASH — water, sanitation, and hygiene), timely identification of outbreaks, rapid response, and treatment of the sick. Unfortunately, this approach failed to keep the global cholera burden from increasing or catastrophic outbreaks from causing thousands of deaths. Although long-term control of cholera and other diarrheal diseases can only be achieved through WASH, the World Health Organization (WHO) estimates that at least 2 billion people lack access to

safely managed drinking water, more than 3 billion do not have safely managed sanitation, and more than 350 million defecate in the open each day. The World Bank estimates that investments of \$1.4 trillion — six times the current investment level — would be required to meet WHO Sustainable Development Goals for water and sanitation by 2030.¹

Over the next half-century, the global human population could increase from 8 billion to 10 billion, with much of that growth occurring in African and Asian countries where cholera is endemic. Many of these people will live in informal settlement areas with limited water and sanitary options, which further compound the risk of cholera. Even a conservative estimate that at least 2 billion humans will need new access to safe water over the next few decades would necessitate adding access for 100,000 more people each day, every day for the next 50-plus years — an unlikely scenario.

<https://www.nejm.org/doi/full/10.1056/NEJMp2600873?query=TOC>

The Lancet: Update on the Ebola virus outbreak in DR Congo

As of June 8, 2026, authorities in DR Congo are struggling to contain an outbreak of Ebola virus disease due to Bundibugyo virus, with 598 confirmed cases and 115 deaths. Talha Burki reports.

As The Lancet Infectious Diseases went to press, experts were still struggling to define the extent of the Ebola virus disease (EVD) outbreak in Democratic Republic of the Congo (DRC) and Uganda. WHO declared a Public Health Emergency of International Concern on May 17, 2026, after dozens of cases of EVD caused by Bundibugyo virus were reported in eastern DRC. But there are indications that the virus has been in circulation since at least the beginning of March.

There are no approved vaccines or antivirals against Bundibugyo virus. The supply of diagnostics for the virus is limited and health-care facilities in the affected parts of DRC are working under serious constraints. As of June 8, there had been 598 confirmed cases and 115 deaths in DRC and 19 confirmed cases and two deaths in Uganda.

The affected provinces in DRC are Ituri, where cases are concentrated, North Kivu, and South Kivu. They are collectively home to over 5 million internally displaced people. Dozens of militias are active in the three provinces. Fighting has intensified in Ituri this year, leaving 100 000 people displaced. The capital of North Kivu has been captured by rebel forces. Conflict has forced families to abandon farmland, leaving them destitute. Food security is a major problem—the weakened state of many children in the region leaves them vulnerable to infectious diseases.

Daniel Bausch is Professor of Tropical Medicine and Global Health at the London School of Hygiene & Tropical Medicine (London, UK). He has responded to several EVD outbreaks, including the 2018–20 one in North Kivu and Ituri. “It is an incredibly difficult region to work in”, he said. “There is a lot of insecurity and population movement. Ebola did not just happen to break out in this place where it is really difficult to manage. Ebola broke out because the public health systems have been worn down from the violence and insecurity over the years.”

Suspicion from the community exacerbates matters. Treatment centres in Ituri have been attacked and set alight by residents angry at being denied permission to retrieve the bodies of patients who have died. The provincial authorities have banned traditional funerals, which involve handling the body. WHO Director-General Tedros Adhanom Ghebreyesus visited DRC in early June. He subsequently revealed that community leaders had told him that Ebola was not real.

[https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(26\)00311-7/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(26)00311-7/fulltext?dgcid=raven_jbs_aip_email)

WHO: A one health priority research agenda for antimicrobial resistance

The Quadripartite organizations have developed the One Health Priority Research Agenda for AMR report, this is a joint initiative to assist in directing and catalysing scientific interest and financial investments for the priority research agenda across sectors for countries and funding bodies. The research agenda also serves as a guide to mitigate One Health AMR that will help policymakers, researchers, and a multidisciplinary scientific community work together on solutions to prevent and mitigate AMR within the One Health approach.

The research agenda focus on five pillars:

- Transmission
- Integrated Surveillance
- Interventions
- Behavioural insights and change
- Economics and policy

Implementing this research agenda will support priority-setting and development of policy and practice-relevant evidence for countries to simultaneously address the threat of AMR and support national action plan (NAP) implementation and achievement of the SDGs for 2030.

WHO TEAM: Antimicrobial Resistance Division (AMR)

EDITORS: The Quadripartite organizations (the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the World Health Organization (WHO) AMR Division and the World Organisation for Animal Health (WOAH, founded as OIE))

<https://www.who.int/publications/i/item/9789240075924>

Academia Medicine and Health: Medicine and health: a necessary reunion

Medicine has always known, on some level, that it is not enough. The physician who treats the wound but ignores the conditions that produced it has done something—but not everything. The scientist who maps the pathogen but not the poverty in which it thrives has answered one question while leaving the larger one unasked. This tension—between medicine as it is practised and health as it might be understood—is as old as the discipline itself. What has changed, across the past century, is that the world has progressively formalised its understanding of what health actually requires. It is a tension this journal has decided, with the addition of a single word, to formally acknowledge.

The World Health Organization's Constitution of 1948 made the first and most consequential move: defining health not as the absence of disease but as a state of complete physical, mental, and social well-being [1]. Revolutionary for its time, the definition was also deliberately ambitious—its authors understood that aspiration precedes achievement. It drew immediate criticism for its breadth, its apparent utopianism, and its resistance to measurement. Those criticisms were not wrong. But the definition's enduring power lies precisely in what it refused: the reduction of health to a clinical transaction.

A progressive widening of that refusal followed. The Alma-Ata Declaration of 1978 embedded health in social and economic development, named peace as its active prerequisite, and demanded that communities—not only health systems—be its agents [2]. The Ottawa Charter of 1986 went further still, identifying peace, shelter, education, food, income, a stable ecosystem, and social justice as health's fundamental conditions [3]. Global Health, emerging as a field in the late twentieth century, extended the frame beyond national borders, insisting that health inequity anywhere was a concern everywhere. And One Health—perhaps the most radical expansion yet—dissolved the boundary between human, animal, and environmental health entirely, recognising that the well-being of each is inseparable from the well-being of all.

These were not merely definitional refinements. Each represented a shift in who counts, what counts, and who bears responsibility. Each made health more inclusive, more ecological, more political, and more human. Together they describe a concept that has been moving, consistently and deliberately, away from the clinic and toward the world.

And yet the story of health's conceptual expansion is inseparable from the story of its practical resistance. For every step the idea of health took toward greater inclusivity, there was a countervailing force pulling medicine back toward the manageable, the measurable, and the profitable.

The Declaration of Alma-Ata represented the most ambitious attempt to translate the expanding concept of health into institutional reality [2]. What followed was a systematic dismantling. Within a year, a paper in the New England Journal of Medicine, presented at a Rockefeller- and Ford Foundation-sponsored conference, introduced "selective primary health care," redirecting attention toward discrete, disease-centred interventions [4]. Comprehensive, community-centred care was displaced by cost-effectiveness logic and privatisation incentives. Health was being converted, quietly and deliberately, into a commodity [5]. This retreat of medicine from its social foundations was not an accident. It was a political and economic project [6, 7].

Nowhere is that logic more legible—or its cost more measurable—than in surgical care.

<https://www.academia.edu/3070-3530/3/2/10.20935/AcadMedHealth8277>

Family Medicine & Primary Care Review: The nature and range of motivators for future doctors in the context of medical deserts

Many countries worldwide are currently struggling with medical workforce shortages and unequal distribution of healthcare workers between urban and rural areas. Medical deserts are defined as areas with insufficient access to healthcare services due to a shortage of qualified professionals. The emergence of medical deserts is attributed to physicians' lower willingness to work in rural areas due to factors such as overburdened work conditions, lack of recognition, insufficient financial aspects, professional isolation, and socio-demographic factors like finding jobs for spouses or ensuring quality education for children. To address this issue effectively, understanding the motivations and decisions of future doctors is crucial. The choice of physicians' specialization is complex and influenced by factors such as work conditions, prestige, economic conditions, personal interests, and psychological aspects. Altruism, curiosity, and a desire for prestige often drive a career in medicine, but these motivations are tempered by financial considerations, job market competition, and the availability of specialized training opportunities. The choice of medical specialization is further shaped by personality traits, research interests, and the demand for specific expertise in the healthcare system. Additionally, family influence, mentorship, and socialization play critical roles in shaping career trajectories, with parents' professions and teachers' attitudes often steering students toward particular fields. Addressing medical deserts requires a multi-faceted approach that understands these factors and develops policies and strategies encouraging future doctors to work in underserved regions.

<https://www.termedia.pl/The-nature-and-range-of-motivators-for-future-doctors-in-the-context-of-medical-deserts,95,57994,0,1.html>

The Lancet: The general practice workforce crisis in Europe: scale of the challenge and available policy responses

General practice across the European region faces a systemic workforce crisis that threatens patient access to health services as well as the coordination, continuity, and equity of care within European health systems. In this Health Policy paper, we use an analysis of the WHO/Europe-Eurostat-Organisation for Economic Co-operation and Development (OECD)

Joint Questionnaire on Non-Monetary Health Care Statistics dataset for 43 countries, evidence from a dedicated research collection, and a rapid review of policy interventions to assess the scale, drivers, and solutions to general practitioner (GP) shortages. Although headcounts have increased since 2010, GP density has stagnated, and effective full-time equivalent capacity has declined due to ageing, early retirement, part-time work, migration, administrative burden, and private-sector competition. We argue that incremental responses are insufficient and propose a coordinated, lifecycle-based strategy spanning training, recruitment, retention, and late-career roles. Key actions include expanded training pathways, improved employment conditions, rural and return-migration incentives, expanded multidisciplinary teams, reduced administrative workload, and full-time equivalent-sensitive workforce monitoring linked to modernised funding and contracting. Tailored national implementation within a shared European framework will be essential to rebuild sustainable GP capacity.

Across Europe, general practice and family medicine are facing a profound and escalating workforce crisis. Although longstanding challenges in recruiting and retaining general practitioners (GPs) have been documented for decades,¹ the situation has intensified in the aftermath of the COVID-19 pandemic. Health systems in almost every European country now report worsening shortages of primary care physicians, longer waiting times, and growing political alarm over the financial sustainability of comprehensive primary care. WHO analyses warn that the European region is experiencing a multilayered, slow-burning primary care crisis, marked by simultaneous pressures on demand, supply, and health system governance.²

[https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143\(26\)00062-2/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143(26)00062-2/fulltext?dgcid=raven_jbs_etoc_email)

Education for Health: Conceptualizing accreditation through the humanities: what is the bigger picture of medical education?

Introduction: Accreditation in Canadian undergraduate medical education is often viewed as a procedural mechanism for verifying compliance with national standards. Yet, the standards and elements of the Committee on Accreditation of Canadian Medical Schools (CACMS) articulate a deeper ethical framework, one that embeds dignity, equity and relational responsibility within the foundations of medical education which literature has yet to capture. This study analyzes CACMS elements through a humanistic lens to illuminate how accreditation functions as a commitment to sustaining humanity within medical training.

Methods: All CACMS elements were examined using qualitative thematic analysis and organized into three themes: (1) Individual humanity and institutional integrity, (2) Humanity in medical knowledge and competence and (3) Broader humanity in medicine. This approach enabled interpretation of accreditation standards as ethical texts rather than solely regulatory directives.

Results: Findings show that CACMS standards do far more than codify technical requirements. Elements addressing learner wellness, mistreatment, diversity, cultural safety, ethics, social accountability and curricular responsiveness explicitly embed humanistic values into accreditation expectations. Across domains, standards affirm that medical education is a moral and relational enterprise grounded in respect for persons and social justice.

Discussion: Governance, resources, assessment and feedback are positioned not only as administrative obligations but as ethical responsibilities essential to supporting human dignity. By framing accreditation as both a technical and moral instrument, this analysis argues that accrediting a medical school is an affirmation of its duty to cultivate physicians who are clinically competent and socially responsive stewards of humanity.

<https://educationforhealthjournal.org/index.php/efh/article/view/536>

Issues: Merton Redux: Re-Confronting the Norms of Science in Democracy

When the second Trump administration took office in January 2025, the executive branch moved forcefully to slash federal funding for science. It posed challenge after challenge to the long-standing precedent of federal support for research: an [existential threat](#) to planetary science at NASA, [shattering](#) cuts to biomedical research at the National Institutes of Health (NIH), and many others. Many months later, when Congress passed its budget for fiscal year 2026, its decision to maintain an apparent continuity in funding for NASA and NIH [seemed to many](#) observers a rejection of the administration's efforts to cut federal investment in these research areas. Yet the threat has not passed. Although public attention remains focused on funding, the decimation of the democratic institutional processes that undergird state-sponsored scientific research is far more consequential.

In this chaotic time, Vannevar Bush's *Science, the Endless Frontier* has emerged as a symbolically meaningful text among scientists, who frequently point to it as the basis for the government's long-running support of university research. Certainly, Bush marked a call for a new industrial policy in the United States that would make the nation a global leader in the new world order. He would later be credited as the architect of the so-called [social contract of science](#), whereby federal funding is allocated primarily to university researchers in pursuit of free inquiry that might later yield some economic or social benefit. But this mythologized rendering of the innovation system overlooks other key ideas, like those expressed by sociologist Robert K. Merton, that described how the United States should govern science democratically based on lessons learned from the Second World War. Rereading Merton now, even more than revisiting Bush, better exposes the vulnerabilities driving us, as social scientists, to defend a vision of science as—and for—democracy in our own era.

A major figure in American sociology and a professor at Columbia University from 1941 until 1979, Merton casts a long shadow over contemporary sociology of science. As a structural-functionalist, his sociological approach assumed that the way institutions are structured strongly influences the social orders that allow them to serve different vital functions in society. Most enduring is his [work from the 1940s](#) addressing what he called “the normative structure of science,” which is still taught as “the norms” of science: communalism (science as communal property), universalism (participation without prejudice), disinterestedness (against ideology), and organized skepticism (deliberative, not dogmatic). These conditions, which Merton claimed are distinct to free scientific inquiry, allow science to thrive as an institutional form.

https://issues.org/merton-redux-aviles-vertesi/?utm_source=Live+Audience&utm_campaign=5363efeb1f-nature-briefing-daily-20260608&utm_medium=email&utm_term=0_-33f35e09ea-50521540

New Scientist: Vaping after quitting smoking is linked to lung cancer

A study of 4.5 million people suggests that ex-smokers who take up vaping are more at risk of dying from lung cancer than people who quit without the use of e-cigarettes. Smokers who give up cigarettes but still [vape](#) have more than a 50 per cent higher chance of developing lung cancer than those who stop altogether, according to a study of more than 4.5 million people. But the research also emphasises that using e-cigarettes to help you quit is safer than continuing to smoke.

“The study adds to the rapidly growing body of evidence that e-cigarettes are absolutely not as low-risk as initially claimed,” says [Becky Freeman](#) at the University of Sydney, Australia, who wasn't involved in the work. “[It's] important that people who are trying to quit smoking try other safer [but] effective methods first, and only use e-cigarettes after exhausting other methods if they are unable to quit.”

https://www.newscientist.com/article/2529853-vaping-after-quitting-smoking-is-linked-to-lung-cancer/?utm_source=Live+Audience&utm_campaign=d53010ac60-nature-briefing-daily-20260615&utm_medium=email&utm_term=0_-33f35e09ea-50521540

Science: British ‘First Fleet’ brought smallpox to Australia—and may have killed millions

Two papers pin the deadly disease’s introduction on British colonists and suggest the continent held far more people than previously believed

On a hot summer day in January 1788, 11 ships filled with British convicts and sailors landed in Australia’s Sydney Harbor. There, naval Captain Arthur Phillip raised the Union Jack and claimed the continent for the British crown.

The arrival of this so-called First Fleet preceded a catastrophe that befell the continent’s Indigenous people. More than a year after the first landing, “there are a significant number of Aboriginal people perishing in horrible, ghastly circumstances from what sounds like smallpox,” says Lynette Russell, a historian at Monash University. “By 1789, a horrendous depopulation has occurred.”

Historians have long wondered whether the deadly disease arrived with those first ships or took some other route. A study in press, which was [released last year as a preprint](#), tracks how it spread to argue the First Fleet was the only possible source. A [related preprint](#) suggests the toll of smallpox and other impacts of colonization was far greater than believed. It argues that Phillip and his shipmates set foot on a continent that was home to millions more Aboriginal people than previous scholars had estimated. “It’s a very rigorous, careful analysis,” says Australian National University historian Ann McGrath, who was not part of the research team.

It also undercuts a popular narrative holding that the British colonized a land whose few inhabitants quickly vanished after early colonists arrived. “The smallpox story was a way that the British could say that there were no more of us in those early times, that everybody was wiped out,” says molecular biologist Shane Ingrey, whose Indigenous ancestors, the Dharawal, lived around Sydney Harbor and might have been watching as the First Fleet landed. A co-author on both papers, Ingrey is the research manager for a Dharawal cultural organization called the Gajaga Foundation. “We want to undo the myth” of an empty continent, he says.

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https://www.science.org/content/article/british-first-fleet-brought-smallpox-australia-and-may-have-killed-millions?utm_source=Live+Audience&utm_campaign=369c4c0d3b-nature-briefing-daily-20260707&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet Editorial: How we imagine the future matters

Those working to address major societal challenges such as climate change, ecological collapse, and persistent poverty and inequality face a deep tension between the scale of these problems and our apparent capacity to respond. In short, today’s political and economic norms—the ‘Overton Window’ of currently acceptable policy options—can seem nowhere near equal to the scale of these challenges. This mismatch creates a kind of cognitive

dissonance. Judged against prevailing socio-economic and political norms, which shapes people's sense of what futures are feasible, the changes required can seem so radical as to appear highly improbable. Yet from an understanding of the risks and harms; seven of nine planetary boundaries have already been [transgressed](#), while the basic needs of many people still go [unmet](#). It seems absurd to claim that meaningful action is too radical. To foresee such harms and still fail to act for lack of political imagination, will, or capacity, is a profound societal failing. This disconnect between the recognition of problems and available solutions is sharply satirised in the film 'Don't Look Up', which captures how those who grasp the scale of a crisis can be alienated and helpless in the face of vested interests and political inertia. A worse future can then seem grimly inevitable; this is also fertile ground for nostalgia for an imagined past that is helping to fuel support for right wing authoritarian politics.

The point here is not to suggest that any future outcome is truly inevitable, but rather to recognise that how we understand and think about the future is foundational to how we interpret planetary health evidence and formulate policy responses.

It is perhaps a feature of all political projects that they make claims (often implicitly) about how the future can or should look. Neoliberalism, the dominant social-political ideology since the late 1970s, has for many become the, rather than just a, lens with which to view and tackle societal challenges. As a result, what people view as practical and readily implementable has tended to align with neoliberal logics. That is the logic of growth, market incentives, efficiency, cost savings, and technological solutions. As Margeret Thatcher often repeated "there is no alternative", and like many often-reinforced messages it has grown to feel true for many. There is, however, a major problem with this logic. Neoliberal ideas and policies have been thoroughly tried, they have dominated for over 40 years, yet as we approach the deadline for the sustainable development goals in 2030, it seems clear that most are likely to go unmet. The gap between known challenges and meaningful responses remains gaping large.

[https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(26\)00066-5/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00066-5/fulltext?dgcid=raven_jbs_etoc_email)

Science: How did the cruise ship hantavirus outbreak start? Scientists are investigating new scenarios: Understanding how the first patient became infected may shed new light on Andes virus' transmission patterns and incubation period

When news broke of a deadly outbreak of a rodent-borne hantavirus aboard the cruise ship MV Hondius last month, it took only hours for wild conspiracy theories to start to circulate about how it might have started. Was this a side effect of COVID-19 vaccines? Did the virus leak from a lab in Australia?

A more prosaic and plausible origin story also took hold quickly: The first patient, a 70-year-old Dutch man who died on board the ship on 11 April, could have come into contact with rodents carrying hantavirus while he and his wife were birdwatching at a landfill in Ushuaia, the city on Argentina's southern tip where the cruise started on 1 April. (His wife died 2 weeks later on her way back to the Netherlands.)

But even that story "never made much sense," says Gustavo Palacios, a virologist at the Icahn School of Medicine at Mount Sinai. No hantaviruses have ever been reported around Ushuaia, and the region has never seen cases of the disease they cause, hantavirus pulmonary syndrome. Palacios and a large group of other researchers are now investigating several other possible scenarios, including some that would revise scientists' knowledge of where the virus circulates or its incubation period.

The investigation promises fresh insights into the little-studied Andes virus, the species that caused this outbreak and the only hantavirus documented to transmit from person to person.

(Other strains infect people only through contact with rodents, such as breathing in dried rodent feces or being bitten.) “We don’t yet understand whether this virus is more transmissible in some regions than in others” because of genetic differences between strains, says Nicole Tischler, a virologist at the Science and Life Foundation and San Sebastián University. Finding out where different Andes strains circulate, under which circumstances they jump to humans, and how easily they spread is key to “strengthening surveillance, prevention, and response strategies for similar future events,” Argentina’s minister of health, Mario Lugones, wrote in a statement to Science.

https://www.science.org/content/article/how-did-cruise-ship-hantavirus-outbreak-start-scientists-are-investigating-new?utm_source=Live+Audience&utm_campaign=ce082d3cdc-nature-briefing-daily-20260612&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The lancet: Estimating the Potential Burden of Clinically Significant Hantavirus Cases in Argentina

Cruise ships represent semi-closed environments characterised by relatively high population density, shared communal spaces, and prolonged interpersonal contacts, providing ideal settings for outbreak clusters of human-to-human-transmissible viruses to occur.¹ We note that the recent hantavirus outbreak on the cruise ship MV Hondius resulted in fatalities or severe clinical signs among early cases,² providing a unique statistical signal to estimate the true burden of hantavirus cases presenting severe clinical conditions (hereafter defined as ‘clinically significant hantavirus cases’) in the area in which the index case acquired infection.

By leveraging the statistical signal from the outbreak aboard MV Hondius alongside tourism statistics (non-resident cruise passenger counts, cruise duration, and inland travel duration), population census figures, and the time from exposure to clinical detection, we can estimate the probability of an infected non-resident cruise passenger being detected during the cruise journey and, based on this probability, the true burden of clinically significant hantavirus cases in the assumed at-risk resident population. We also note that the main hantavirus transmission season substantially overlaps with the cruise season, making our approach highly relevant from an epidemiological perspective³; during the 12-month period from May 2025 through April 2026, 84.9% (90 out of 106) of the reported hantavirus cases occurred during the cruise season from September 2025 through April 2026.³ Our approach builds upon prior research estimating the number of pandemic H1N1 influenza infections in Mexico and the number of symptomatic COVID-19 cases in Wuhan City, China. Our methodology, data, and the underlying assumptions are detailed in [Supplementary Information](#) and [Supplementary File 1](#).

We explored baseline and alternative scenarios regarding the at-risk population, average duration of inland travel, cruise passenger totals, and the proportion of cruise passengers travelling inland prior to embarkation ([Table 1](#)). Under the baseline scenario, for the 2025–2026 cruise season from September through April, we estimated 292 (95% CI: 17–1285) clinically significant hantavirus cases among dispersed rural residents in Argentine provinces with officially reported cases since July 2019. This central estimate was 3.2 times higher (95% CI: 0.81 times lower to 14 times higher) than 90 cases reported from September 2025 through April 2026. Central estimates from the explored alternative scenarios were all greater than the reported number, despite wide confidence intervals encompassing the reported number

[https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762\(26\)00158-4/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762(26)00158-4/fulltext?dgcid=raven_jbs_aip_email)

Nature: White House proposes vast overhaul of US science funding: what you need to know

The Trump administration's proposal aims to improve transparency in federal funding, but critics fear the proposed rules would politicize research

Scientists are raising the alarm about [a far-reaching White House proposal](#) that could fundamentally recast federally funded science. The proposed rules would put [political appointees in control](#) of all federal grants; de-emphasize peer review; place more restrictions on meeting attendance for grant holders; limit [collaborations between federally funded US scientists and overseas colleagues](#); and restrict federal financial support for the publication of US scientists' results in scientific journals.

The 412-page proposal, issued by the White House Office of Management and Budget (OMB) on 29 May, applies to all federal agencies, including the National Institutes of Health (NIH) — [the world's largest funder of biomedical research](#)— and [the National Science Foundation](#) (NSF). The OMB says that it aims to “improve transparency, accountability, and oversight” of federal funds. In a statement, an OMB spokesperson said that “federal grants were already politicized to promote a far-left agenda”. The administration of US President Donald Trump plans to implement the proposal on 1 October.

Just four days after it was posted, the proposal had drawn more than 3,500 comments from the public. Comments reviewed by Nature were almost all critical, although some agreed that reform was needed. Many comments were from prominent researchers, such as leading oceanographer [Dawn Wright](#), chief scientist of Esri, a global company specializing in geographic information system software, in Redlands, California, who wrote that the proposal “is dangerous and absolutely politicizes science”. Suzanne Segerstrom, a biostatistician at Oregon State University in Corvallis, wrote: “This regulation harms taxpayers, harms Americans' health, and contravenes federal policy. I am in strong opposition.”

On 2 June, some 2,000 people attended an emergency virtual meeting to mobilize opposition to the proposal. A variety of speakers at the meeting, which was organized by the advocacy group Stand Up for Science (SUFS), implored attendees to submit comments against the rule.

The proposal is a “brazen power grab by the Director of the Office of Management and Budget and will make future discoveries less likely”, said Sudip Parikh, the chief executive officer of scientific society American Association for the Advancement of Science, in a statement. The American Society for Cell Biology described it as a “massive threat to American science”.

https://www.nature.com/articles/d41586-026-01779-z?utm_source=Live+Audience&utm_campaign=da2c1b150a-nature-briefing-daily-20260604&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: The general practice workforce crisis in Europe: scale of the challenge and available policy responses

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administrative burden, and private-sector competition. We argue that incremental responses are insufficient and propose a coordinated, lifecycle-based strategy spanning training, recruitment, retention, and late-career roles. Key actions include expanded training pathways, improved employment conditions, rural and return-migration incentives, expanded multidisciplinary teams, reduced administrative workload, and full-time equivalent-sensitive workforce monitoring linked to modernised funding and contracting. Tailored national implementation within a shared European framework will be essential to rebuild sustainable GP capacity.

Across Europe, general practice and family medicine are facing a profound and escalating workforce crisis. Although longstanding challenges in recruiting and retaining general practitioners (GPs) have been documented for decades,¹ the situation has intensified in the aftermath of the COVID-19 pandemic. Health systems in almost every European country now report worsening shortages of primary care physicians, longer waiting times, and growing political alarm over the financial sustainability of comprehensive primary care. WHO analyses warn that the European region is experiencing a multilayered, slow-burning primary care crisis, marked by simultaneous pressures on demand, supply, and health system governance.²

Media reports have amplified these concerns. Politico has asked why Europe is running out of doctors, particularly for countries like France, Germany, and the UK.³ In the UK, evidence given to a parliamentary committee described general practice as being at breaking point, with patients struggling to obtain timely appointments and GPs reporting untenable workloads and burnout.⁴ Professional organisations echo these concerns: the Standing Committee of European Doctors, the World Organization of Family Doctors (WONCA) Europe, and the European Junior Doctors Association report that up to 43% of doctors experience symptoms of burnout, with excessive workloads and unsafe staffing among the most commonly cited drivers.⁵ A WHO Europe study on health workers' mental health in the EU found that one in three doctors and nurses report symptoms of depression or anxiety.⁶ [https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143\(26\)00062-2/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143(26)00062-2/fulltext?dgcid=raven_jbs_aip_email)

European Journal of General Practice: Primary health care policy advocacy in Europe: A cross-sectional study of family medicine associations

Policy advocacy (PA) in European healthcare has a strong tradition promoting evidence-based policies. Key organisations, including the European Observatory on Health Systems and Policies, the WHO's Evidence-Informed Policy Network, and the OECD play pivotal roles in integrating research into policymaking.

To assess the involvement of European Family Medicine (FM) Associations in PA, identify key issues, and explore interactions with governmental and institutional bodies related to Primary Health Care (PHC)—defined as first-contact, continuous, comprehensive, and coordinated care provided by general practitioners/family doctors (GPs), in line with the WHO Alma-Ata and Astana declarations—and perceived challenges in PHC advocacy.

An exploratory descriptive, cross-sectional study was conducted among WONCA Europe Member Organisations and GPs involved in PA. Data collected between November 2023 and February 2024. Content analysis was performed to identify themes related to advocacy priorities.

Responses were received from 12 member organisations across 12 countries and 37 participants from 17 countries. Key concerns included workforce shortages, high workloads, inadequate infrastructure, and insufficient financial compensation. Public visibility, gender equality, and the integration of FM into university curricula were also highlighted. Eleven respondents reported active engagement with national governments in policy discussions.

Respondents highlighted the need for a more unified strategy to address common PHC challenges across Europe. WONCA Europe's Working Party on PA supports national efforts through exchange of best practices, research support, and promoting FM at national and European levels. Continued research and advocacy were viewed as essential for sustaining effective and equitable PHC in Europe.

<https://www.tandfonline.com/doi/full/10.1080/13814788.2026.2625572#abstract>

The Lancet: Safety of the Dengue Vaccine TAK-003 and Factors Associated with Adverse Events in Travellers from Non-Endemic Areas: A Real-World Prospective Multicentre Pharmacovigilance Cohort Study in Spain

TAK-003 is the first dengue vaccine licensed for endemic and non-endemic regions, but real-world safety data in non-endemic travel settings are scarce, particularly for older adults, people with comorbidities, and concomitant vaccinations.

We conducted a prospective multicentre pharmacovigilance study in eight Spanish travel clinics, enrolling travellers aged ≥ 4 years who received TAK-003 (January–December 2024). Participants were followed for adverse events (AEs) after each dose. Logistic regression models assessed associations of age, sex, comorbidities, prior flaviviral infection or vaccination history, and concomitant vaccination with risks of any, systemic, or local AEs. Among 1028 participants (1851 TAK-003 doses), 998 (97.1%) completed ≥ 1 follow-up assessments; 587/998 (58.8%, 95% CI 55.7–61.8) reported AEs. After the first dose, 470/998 (47.1%, 44.0–50.2) reported AEs, most often injection site pain and swelling, headache, or malaise, declining to 235/679 (34.6%, 31.1–38.3) after the second dose. No serious AEs, anaphylaxis, or deaths occurred. Female sex was associated with any AEs (adjusted OR 1.83, 95% CI 1.42–2.37) and local AEs (1.89, 1.44–2.48). Prior dengue was associated with any (1.51, 1.07–2.14) and systemic AEs (1.73, 1.22–2.43). Concomitant flaviviral vaccination was associated with higher odds of systemic AEs (1.64, 1.18–2.28). Age ≥ 60 years and comorbidities were not associated with increased reactogenicity.

TAK-003 was well tolerated in travellers from non-endemic regions, with no serious AEs reported. Female sex, prior DENV infection, and flaviviral vaccine co-administration were associated with increased reactogenicity; older age, comorbidities, and non-flaviviral vaccine co-administration were not. These findings provide real-world evidence on tolerability of TAK-003 in travellers from non-endemic regions. Larger studies with extended follow-up are needed to better characterise uncommon and longer-term AEs.

[https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762\(26\)00139-0/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762(26)00139-0/fulltext?dgcid=raven_jbs_aip_email)

npj | artificial intelligence: Human-AI teaming in healthcare: 1 + 1 > 2?

While humans and AI-powered machines are expected to complement each other—for example, leveraging human creativity alongside AI's computational power to achieve synergy (“1 + 1 > 2”)—the extent to which human-machine teaming (HMT) realizes this potential remains uncertain. We investigated this issue through reliability analysis of data from 52 empirical studies in clinical settings.

Results show that medical AI can augment clinician performance, yet HMT rarely achieves full complementarity. Two factors matter: (1) teaming mode, with the simultaneous mode (clinicians review diagnostic cases and AI outputs concurrently) yielding greater benefits than the sequential mode (clinicians make initial judgments before reviewing AI outputs); and (2) clinician expertise, with

juniors benefiting more than seniors. We also addressed two practical questions for medical AI deployment: how to predict or explain HMT reliability, and how to achieve clinically

significant improvements. These findings advance understanding of human–AI collaboration in safety-critical domains.

Artificial intelligence (AI) systems are transforming professional domains, ranging from medical diagnosis and surgery to driving and piloting^{1,2}. These AI-powered machines sometimes surpass human capabilities in computational and analytical efficiency, accuracy, consistency, and scalability. We focus on their role in healthcare, where AI is poised to address critical challenges, such as clinician errors—a major contributor to medical accidents and patient harm³. Powerful AI machines like predictive analytics and surgical robots are expected to reduce clinician errors and enhance patient safety, thereby revolutionizing healthcare delivery worldwide^{4,5}. In fact, clinicians have utilized computer-based clinical decision support systems (CDSS) since the 1970s. Recent technological breakthroughs in machine learning, deep learning, and multimodal large language models^{6,7,8} have expanded these machines' capacity to process diverse medical data, including images, text, and phenotypic information.

<https://www.nature.com/articles/s44387-025-00052-4>

The lancet: Severe droughts and the tuberculosis and HIV care cascade in the Brazilian Amazon: a Bayesian, structural, interrupted time-series analysis of 24 years of surveillance data

In river-dependent regions such as the Brazilian Amazon, severe droughts can disrupt care continuity by isolating municipalities and fragmenting supply chains. We assessed how four major droughts affected tuberculosis and HIV care cascades in Amazonas state.

We analysed monthly data (Jan 1, 2001, to Dec 31, 2024) from all 62 municipalities of the Amazonas state, Brazil, grouped into nine river basins and stratified by sex when available. Droughts were defined by the relative maximum cumulative water deficit value being below -2.0 or river discharge at or below the fifth historical percentile. We prespecified four major drought episodes affecting Amazonas at a monthly resolution: May to June, 2005; May to June, 2010; August, 2015, to April, 2016; and October, 2023, to February, 2024. Outcomes were primary-care consultations, tuberculosis and HIV notifications, treatment interruption, and disease-specific mortality. Additionally, we did a prespecified subgroup analysis stratified by sex for both diseases' indicators to assess whether drought-associated deviations differed systematically between men and women. We fitted Bayesian hierarchical negative binomial models to estimate counterfactual trajectories and summarised effects as incidence rate ratios (IRRs) and excess events per 100 000 population.

The 2015–16 drought coincided with widespread consultation deficits (statewide peak IRR 0.78 [95% credible interval 0.68–0.89]) and pronounced increases in HIV treatment interruption across all basins (statewide peak IRR 6.01 [2.12–15.33]), particularly among men (Rio Negro peak IRR 5.57 [3.02–9.78]). By contrast, the 2023–24 drought coincided with increased care consultations statewide (peak IRR 1.63 [1.25–2.11]) but persistent treatment interruption and mortality signals, including female-predominant increases in HIV treatment interruption in Rio Negro (peak IRR 2.87 [1.27–5.63]) and female mortality statewide (1.97 [1.05–3.39]), with additional basin-level mortality increases in Alto Solimões, Baixo Amazonas, and Médio Amazonas. Tuberculosis notifications increased mainly in 2023–24 in specific basins, especially in Baixo Amazonas (peak IRR 2.09 [1.54–2.76]), Médio Amazonas (1.74 [1.30–2.28]), and Baixo Solimões (1.60 [1.24–2.07]). Severe droughts were associated with basin-specific disruptions in tuberculosis and HIV care cascades in the Brazilian Amazon, with clearer signals in adherence-dependent and downstream outcomes than in case detection. Strengthening resilience will require anticipatory, continuity-focused strategies that safeguard treatment access during climate-related transport constraints.

[https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(26\)00032-X/fulltext?dgcid=raven_jbs_aip_email](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(26)00032-X/fulltext?dgcid=raven_jbs_aip_email)

Nature: This mysterious lung disease affects millions of people — but a drug tested in mice shows promise

The therapy activates a protein that could stop pulmonary fibrosis from progressing.

A mysterious lung disease that affects millions of people worldwide and for which there is no cure has been treated in mice using a drug that targets a previously unknown mechanism¹.

Idiopathic pulmonary fibrosis (IPF) is a life-threatening disease in which lung tissue becomes scarred, making it hard to breathe, eventually leading to death for many people. Two drugs are currently used to slow down disease progression but have not been shown to improve symptoms. The biological mechanisms that trigger IPF are mainly unknown.

In a study published in Science Translational Medicine¹, Stavros Garantziotis, a clinician-researcher at the National Institute of Environmental Health Sciences in Durham, North Carolina, and his team show that mice with a mutation to a gene called toll-like receptor 5 (Tlr5) are more susceptible to IPF than are mice without the mutation. The gene encodes a receptor that recognizes bacteria, triggering an immune response to infection. With a mutated gene, the receptors do not work properly, making the body more susceptible to infections. Garantziotis says the study is the first to identify a genetic link between the lung microbiome and IPF. They found that TLR5 receptors in airway cells is activated in response to lung injury and stops the overgrowth of harmful types of bacterium. IPF develops following injuries to the lung, caused by smoking, repeat infections and environmental exposures. But not everyone who experiences these injuries go on to develop IPF, and a person's genetics and the types of bacterium that cause the infections could play a part, says Brian Oliver, a respiration and pollution researcher at the University of Technology Sydney in Australia.

Oliver says the latest findings are exciting because they show a new pathway connected to the development of IPF. "It's a very novel idea" to look at the TLR5 receptor, he adds, because it is not something many people would associate with a fibrotic lung disease. Targeting the protein with drugs could prevent the disease from progressing, Garantziotis says.

https://www.nature.com/articles/d41586-026-01789-x?utm_source=Live+Audience&utm_campaign=da2c1b150a-nature-briefing-daily-20260604&utm_medium=email&utm_term=0_-33f35e09ea-50521540

BMJ: Generative AI and the changing dynamics of clinical consultations

David Fraile Navarro and colleagues consider how generative AI can be safely integrated into clinical consultations to ensure patient centred decision making and accountability and introduce the concept of triadic care

Generative artificial intelligence (AI) has moved rapidly from experiment to everyday use in clinical encounters. Powered by large language models (LLMs), generative AI systems generate novel content in response to prompts rather than following scripted rules. Clinicians and patients commonly access generative AI through conversational interfaces such as ChatGPT that respond in natural language, while specialised applications such as AI powered medical scribes are being increasingly adopted for clinical documentation. Generative AI's fluent but only partially verifiable reasoning changes how clinical knowledge is formed, communicated, and tested within the doctor-patient relationship, shifting consultations from exchanging facts to co-producing explanations.

The consultation is therefore becoming a three way conversation in which explanations are shaped by doctor, patient, and AI, creating what we call triadic care. As part of this shift it is

important to record use of AI so that healthcare systems, researchers, clinicians, and patients can learn and improve practice. Openness also clarifies how AI influenced clinical decision making and supports patient understanding and trust. When AI use is not explicitly discussed, it becomes harder to assess its effect on clinical judgment, patient autonomy, and the therapeutic relationship.

The challenge for clinicians is to integrate AI in ways that preserve the benefits while managing potential risks. This article, part of a BMJ series on use of generative AI (www.bmj.com/collections/gen-AI), focuses on consultation based care, especially primary care, where generative AI most directly affects communication and decision making. Other articles in the series will consider the patient experience and the competencies that clinicians need to use AI transparently and effectively within the clinical encounter.¹²

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Nature: Why are so many young people getting cancer? What researchers do and don't know

Candidates for the trend are emerging, but are likely to vary from one type of tumor to another.

Researchers around the world are grappling with a vexing problem: why are so many [young people developing cancers](#) once considered the purview of old age?

The question was prominent at two of the world's largest cancer meetings this year, and hypotheses abounded. [Ultra-processed foods](#), [obesity](#), [microbial toxins](#) and agricultural chemicals were all considered. But a clear answer remained elusive.

“Multiple cancers are increasing in incidence globally among individuals under the age of 50,” oncologist Kimmie Ng told the audience at the American Society of Clinical Oncology meeting in Chicago, Illinois, last week. “The vast majority are considered sporadic, with unknown cause.”

Worldwide, more than 9,000 cases of cancer are diagnosed in adults under the age of 50 each day, epidemiologist Hyuna Sung told the American Association for Cancer Research (AACR) annual meeting in San Diego, California, in April. But lumping these diagnoses together could obscure clues as to their cause, she cautioned. “Rising incidence of cancers among young adults does not reflect a single story,” said Sung, who works at the American Cancer Society in Atlanta, Georgia.

Clues to each story lie in the data. If [diagnoses of a particular cancer](#) increase suddenly and across all age groups, for example, the culprit might be a change in how that cancer is detected or classified. In the early 2010s, for example, the definition of [pancreatic cancer](#) was expanded to include pancreatic neuroendocrine tumours, which form in the pancreas's insulin-making regions. Pancreatic cancer diagnoses had been slowly rising in the years before that change, but after it, the increase accelerated, including in people under the age of 50.

https://www.nature.com/articles/d41586-026-01780-6?utm_source=Live+Audience&utm_campaign=5363efeb1f-nature-briefing-daily-20260608&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Lancet: Towards clean air and health for all in the Andes

In Andean countries, including Colombia, Ecuador, Peru, Bolivia, and Chile, air pollution represents one of the most pressing threats to public health and environmental sustainability. Rapid urban growth, expansion of vehicle fleets, continued dependence on fossil fuels, and limited industrial regulation have collectively contributed to a high burden of atmospheric pollutants.¹ This convergence has positioned the region as a critical setting where socioenvironmental inequalities intersect with emerging health risks.

Over 90% of the Andean population is exposed to levels of fine particulate matter (PM_{2.5}), nitrogen dioxide (NO₂), and tropospheric ozone exceeding World Health Organization (WHO) guideline limits of 5 µg/m³ (annual), 10 µg/m³ (daily), and 60 µg/m³ (seasonal peak), respectively.^{2–5} Air pollution ranks among the seven leading combined causes of mortality and disability, contributing to major chronic health conditions, such as ischemic heart disease, stroke, and lung cancer. Reducing current PM_{2.5} concentrations to WHO-recommended levels could increase life expectancy approximately 1.9–2.7 years, with Bolivia, Peru, and Chile experiencing the greatest gains, underscoring the urgency of strengthening air quality control policies across the region.⁴

In the Andean region, geographic, social, and political factors further amplify vulnerability.^{1,5–7} Mountainous topography restricts pollutant dispersion, enclosed valleys trap emissions, and high altitude may increase cardiopulmonary susceptibility to the effects of air pollutants. These environmental constraints are compounded by social determinants, such as unplanned urbanization, informal settlement growth, and unequal access to public transport, which disproportionately expose low-income communities. From a governance perspective, environmental decentralization processes remain incipient, and weak intermunicipal coordination hampers the uniform enforcement of air quality standards.

[https://www.thelancet.com/journals/lanam/article/PIIS2667-193X\(26\)00126-2/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(26)00126-2/fulltext?dgcid=raven_jbs_etoc_email)

Nature: I advise the Vatican and the UN on AI — don't dismiss the Pope's message as theology: The papal letter goes beyond a religious document and diagnoses a failure in AI governance that the scientific community should heed.

On 15 May, Pope Leo XIV signed his first encyclical letter, titled *Magnifica humanitas* ('magnificent humanity' in Latin). In it, he chose to warn society about artificial intelligence.

The encyclical — an official format once used to address Roman Catholic bishops but now intended as a moral statement for all — is a diagnosis of who governs AI and on whose behalf (see go.nature.com/3qxctvc). Leo XIV maps the unprecedented ways in which AI is concentrating power. He raises concerns that a handful of private actors are making crucial decisions about the values encoded in systems used by billions of people without democratic mandate and beyond national regulatory frameworks.

The document discusses autonomous weapons, the destabilization of democratic discourse and the displacement of professions through AI use. It highlights the risk of 'algocracy' — a system of governance in which algorithms make decisions that were previously made by humans. For example, [predictive algorithms](#) are used in some jurisdictions to inform policing strategies and sentencing decisions.

Magnifica humanitas deserves serious attention from the scientific community. This is not because the Pope has legal or regulatory authority over AI development — he doesn't — but because the document flags a structural problem that continues to be understated. The capacity to shape how AI systems reason, what they optimize for and whose values they embed is a political issue. Deferring to self-regulation of AI — the prevailing approach in the United States, for example, which relies mainly on voluntary ethics commitments rather than on enforceable regulations — is more an abdication of responsibility than governance. Some scientists, by maintaining their studied neutrality, are complicit in this.

https://www.nature.com/articles/d41586-026-01876-z?utm_source=Live+Audience&utm_campaign=ce082d3cdc-nature-briefing-daily-20260612&utm_medium=email&utm_term=0_-33f35e09ea-50521540

The Colorado Sun: Federal judge blocks breakup of NCAR in Boulder while blasting Trump for enacting political revenge on Colorado

federal judge in Denver on Monday blocked federal officials from breaking up Boulder's National Center for Atmospheric Research by handing over a renowned supercomputing center to the University of Wyoming, in a 38-page injunction raking the Trump administration for enacting political revenge on Colorado.

Senior U.S. District Judge R. Brooke Jackson issued an injunction because the National Science Foundation divesting the supercomputing center was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," according to the ruling. Jackson said his injunction was necessary because the lawsuit filed in March by the [University Corporation for Atmospheric Research](#), or UCAR, was likely to succeed, and that too much damage had already been done to the supercomputing center's operations.

The NCAR-Wyoming Supercomputing Center has "already lost significant number of experts in supercomputing, for example, with the chance of losing many more," the judge wrote.

The National Science Foundation declined comment on the injunction late Monday, through head of media affairs Mike England.

UCAR, a consortium of more than 100 universities and the contracted manager of NCAR operations, "has made a showing of irreparable harm through the significant 'brain drain' that it is already experiencing as a direct result" of the National Science Foundation's attempted transfer, the judge wrote. "It will also continue to lose critical employees — including scientists, engineers, and systems administrators — that are essential to the continuous and proper functioning of the NWSC."

The original lawsuit and the injunction say the supercomputing center is a "pillar" of the nation's atmospheric research. Judge Jackson agreed with the UCAR lawsuit's claim that breaking off parts of NCAR, dismantling projects and potentially firing thousands of employees was intended by Trump and agency officials as direct political revenge.

https://coloradosun.com/2026/06/01/federal-judge-denver-injunction-ncar-breakup/?utm_source=Live+Audience&utm_campaign=e8b6af7dc9-nature-briefing-anthropocene-20260612&utm_medium=email&utm_term=0_-33f35e09ea-50521540

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