

An exciting new chapter for chronic respiratory diseases

SUMMARY

Chronic respiratory diseases affect more than half a billion people worldwide yet remain insufficiently prioritised within global health agendas. Recent developments, including the first World Health Assembly resolution on lung health and the integration of chronic respiratory diseases into United Nations frameworks, represent important progress. Major gaps persist, particularly limited access to spirometry, essential inhaled medicines, and protection from tobacco smoke and air

pollution, especially in resource-limited settings. Coordinated action is needed to strengthen national strategies, expand care, improve air quality, and advance cross-sector research. The launch of *IJTLD CRD* is a catalyst for change, helping to democratise knowledge, and accelerate the flow of evidence to reshape policy and improve clinical care.

KEY WORDS: asthma; COPD; smoking; air pollution; lung health; pulmonary rehabilitation

The year 2026 opens a new chapter for chronic respiratory diseases (CRDs). Slowly but surely, lung health is rising to the top of global health agendas. In 2025, the World Health Assembly (WHA) passed its first-ever resolution on lung health; the United Nations (UN) High-Level Meeting wove CRDs into its political framework on noncommunicable diseases; the UN Economic and Social Council gave respiratory health new standing within the development agenda.^{1,2} Together, these events trace the outlines of a new trajectory: one shaped by science, driven by policy, and long overdue. *IJTLD CRD* launches into this climate as a catalyst. It brings a long-awaited space to a field ready for expansion: a journal to showcase the full spectrum of respiratory research, built with a global mindset.

CRDs live in plain sight and yet often remain unseen. They affect more than half a billion people worldwide, showing up in daily life, not dramatic headlines: incremental loss, not sudden catastrophe. CRDs start in kitchens, on sidewalks, in schoolyards.³ Breath changes gradually. Work becomes harder. Nights stretch longer. Why the invisibility? Because unlike infectious epidemics, CRDs do not generate a sense of urgency and fear. CRDs do not fit neatly into vertical funding streams. They cross sectors, from environment to industrial policy to clinical care. They lack the advocacy networks and dedicated budget lines that HIV or TB commanded decades ago. And so, the result is systemic undervaluation, despite lives altered and economies impacted.

BARRIERS TO EARLY DIAGNOSIS AND EFFECTIVE CARE

Why do so many people living with CRDs fail to receive a timely diagnosis and effective care? Diagnosing and treating CRDs is possible, but the gap between what is known and what is delivered is wide. Respiratory diseases are especially prevalent in communities experiencing rapid change: ageing populations, dense

urban growth, shifting labour conditions, and environmental strain. These intersecting dynamics create a perfect storm of exposure and vulnerability. Primary care plays a critical role in providing accessible, person-centred care, yet essential technologies, such as spirometry and medicines, are often unavailable. WHO is currently updating guidelines for the diagnosis and treatment of asthma and chronic obstructive pulmonary disease (COPD) in primary care. But real impact requires widespread dissemination and uptake.

Access to inhaled medicines (relievers, controllers, and combination therapies) can be sporadic, unaffordable, or absent altogether. Supply chains break down. Formularies omit key drugs. Health financing models favour short-term episodes of care over chronic management. For patients, this results in delayed intervention and irreversible lung damage. Symptoms worsen gradually until crisis strikes. Quality of life diminishes long before care begins. For health systems, the cost of delay is steep. Emergency visits and hospitalisations increase. Opportunities for prevention are lost because of gaps in coordination, investment, and political will.

An effective response to CRDs does not require revolutionary technologies, we simply need to deliver what already exists and bring consistency, affordability and trust into the spaces where people seek care.

OUR BREATHED ENVIRONMENT

If we look at upstream causes of CRDs, two risk factors dominate: tobacco and air pollution. Tobacco remains a potent driver, taking more than 7 million lives each year.³ Trends show deaths growing by more than 25% since 1990, even as some age-standardised rates decline. Air pollution is a silent amplifier. Over 99% of the global population breathes air that exceeds the WHO guideline for particulate matter exposure.⁴ In all corners of the world, exposure to indoor biomass fuels, traffic-related emissions, industrial pollutants, and urban dust places heavy burdens, especially on

children, women and low-income households. These exposures not only cause CRDs, they also determine when and how they unfold. Wildfire smoke, unprecedented dust storms, elevated pollen seasons, and increased heat stress, all attack the lungs, triggering exacerbations and eroding resilience.

The risks posed by our breathed environment present a pervasive injustice. For individuals in lower-income contexts, choices are limited: cooking fuels, occupational exposures, proximity to traffic or industry. Lung damage becomes a marker of inequity. A recent projection estimated that by 2050 nearly 592 million people will live with COPD, with the largest growth in low- and middle-income countries (LMICs) and among women.⁵ Care for CRDs must take account of climate health, occupational medicine, environmental policy and urban planning. It is no longer purely the domain of the pulmonologist. Primary care, public health, city design, housing and transport all matter.

A MANDATE FOR GLOBAL ACTION: THE FIVE ACTIONS NEEDED

We now stand poised for change. Policy windows are opening, attention is turning, but momentum alone does not bring transformation. The WHA resolution ‘Promoting and prioritizing an integrated lung health approach’ calls for a whole-of-government and whole-of-society response.¹ The following five actions, reflecting priorities highlighted by WHO’s Global Alliance against Chronic Respiratory Diseases (GARD),⁶ are critical to reshape how the world responds to CRDs:

1. *Elevate CRDs in national strategies and budgets:* Visibility determines viability. Without explicit inclusion in national health plans, CRDs are left out of training curricula, procurement lists, and data systems. When countries embed respiratory conditions in policy frameworks, as they have with HIV or maternal health, funding and implementation follow.
2. *Close the diagnostic and treatment gap:* It is unacceptable that in many regions, patients are only diagnosed at the point of crisis. We need spirometry in primary care, affordable access to inhalers, and evidence-based protocols to catch and treat disease early.
3. *Reinforce tobacco regulation to meet modern threats:* The battle against tobacco is far from over. Combustible cigarettes remain widely available, while new products create confusion and open new markets, especially among youth. Regulation must stay ahead of industry tactics and reflect current consumption patterns.
4. *Make clean air a non-negotiable policy objective:* Air quality is not an environmental add-on; it is a health determinant. Clean-air legislation, fuel transitions,

transport policies, and industrial standards must all reflect the reality that every breath taken in polluted air is a policy failure.

5. *Invest in research networks that span borders and silos:* Researchers, policy designers, clinicians, urban planners, economists, and community leaders must collaborate to maximize impact. The agenda needs both upstream investigation and downstream implementation. It also needs funding models that promote LMIC-led research.

Delivering these five elements requires political will, strategic allocation, and mechanisms for accountability. *IJTLD CRD* will help us to assess progress, helping to identify what is working, the spotlight on what still lags, and the archive of progress as it unfolds. It is a journal for evidence, but also for ambition. For closing the space between what we know and what we do.

A journal with a new vision

Too often, studies on CRDs from high-income contexts dominate, whereas the most affected communities remain footnotes in the evidence base. *IJTLD CRD* is designed to rebalance this. The journal offers more than open access, it offers access with intent: to democratise knowledge, to accelerate the flow of evidence from field to clinic to policy chamber. CRDs do not occur in isolation, and neither should the research. Building on the approach used by *IJTLD* and *IJTLD Open* for a range of CRDs,^{7–10} *IJTLD CRD* will embrace an interdisciplinary lens: epidemiology, clinical trials, health systems research, environmental exposure science, implementation economics, occupational health, behavioural science, and urban policy. The whole picture is needed if we are to understand and address these conditions in context. But breadth without focus achieves little. That is why the journal sets a high bar: contributions must go beyond mere description of disparities. They must offer insights that shift agendas, build systems, and prepare the respiratory landscape for the challenges ahead. Whether the topic is inhaler affordability in rural clinics, or how environmental regulation reduces hospital admissions, the thread that connects it all is relevance: locally grounded, globally resonant.

IJTLD CRD provides a platform to move evidence out of silos and into action. A home for researchers whose work has long deserved greater visibility. A space where science speaks to strategy, and local insight informs global thinking. Only together, can we shift the arc of respiratory health: from delay to prevention, from exclusion to investment, from vulnerability to agency. The story of CRDs unfolds in kitchens where stoves pollute, in cities choked with smog, and in clinics where healthcare workers are overstretched and inhalers unavailable. It is shaped by decisions: about infrastructure, regulation, access, and research. In that

sense, CRD prevention, diagnosis and care is a measure of how seriously we take fairness in health.

Let this be a new chapter, where lungs matter, breath is protected, and health systems rise to meet the needs of every life they serve.

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IJTLD CRD welcomes the submission of research articles on all aspects of TB and respiratory diseases such as asthma, bronchiectasis, COVID-19, COPD, child lung health and the hazards of tobacco and air pollution.

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