and infrastructure, which cannot be supported without targeted financing. Operationalising these commitments will require detailed costing that is grounded in national contexts.[5] However, little public information exists on what implementation will look like for this new agreement, and what it is likely to cost in practice—let alone how these costs will be met.

The need for a clear costing framework is also urgent for the obligations delineated to WHO. The Pandemic Agreement assigns WHO a wide array of new roles; however, in the context of a precarious financial situation[6] and in the absence of earmarked funding for treaty implementation, the ability of WHO to fulfil its expanded mandate under the agreement will be severely constrained, which in turn will have a knock-on effect on the institution's perceived efficiency and legitimacy.

Without a clear picture of the total costs involved, there is a real risk of underestimating the scale of investment needed to enable full and fair participation in the pandemic prevention, preparedness, and response ecosystem. Not addressing this risk early on will limit the ability of the agreement to deliver on its aims to prevent, prepare for, and respond to pandemics in a way that is guided by equity.

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Redefining female leadership by choosing support over rivalry

"Diversity is a fact, inclusion is a choice."[1] This guiding principle echoes in response to *The Lancet*'s recent call for gender justice.[2] In medicine, in which women comprise a growing share of the workforce yet remain under-represented in leadership, solidarity must go beyond symbolic gestures.[3] True support demands intentional, strategic action. Advancement should not be seen as a threat, but as a shared victory.

This advancement includes confronting and addressing internalised hierarchies, such as ageism and lateral competition, that can quietly hinder progress and often manifest as subtle resistance to the success of junior peers. When a junior colleague gains visibility, it should be a moment of shared pride, not comparison. A rising peer does not diminish others; she reflects the strength of those who supported her.

As such, leadership is not a ladder but an ecosystem. Institutions benefit when leadership is shared, mentorship flows in all directions, and sponsorship is practised with intention.[4] Advancement is not about individual triumph but about building inclusive structures in which many can succeed. We must also acknowledge the impact of exclusion, gossip, and coded language; these behaviours disproportionately affect women, especially those who challenge norms.

At a time when reproductive rights, gender equity, and scientific integrity are at risk, leadership in medicine must be grounded in responsibility and courage.[5] Representation alone is not enough. We all must ensure that professional environments are inclusive, affirming, and designed to elevate others.[6] The future of medicine depends on it.

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Early-onset colorectal cancer among Indigenous populations

We read with interest the Editorial on colorectal cancer screening,[1] which discussed the COLONPREV trial,[2] given the disproportionately higher incidence of colorectal cancer and poorer related survival rates among Indigenous peoples compared with their non-Indigenous counterparts globally.[3] We also appreciate the Editorial's attention to the increasing incidence rates of early-onset colorectal cancer. We specifically want to highlight colorectal cancer screening and the concerning rise in early-onset colorectal cancer incidence rates among Indigenous peoples.

The Editorial reported that the absolute risk of colorectal cancer in most adults younger than 50 years remains low. However, in Australia, Indigenous people had 2·6 times the odds of being diagnosed with early-onset colorectal cancer and a lower 5-year survival rate (73% *vs* 77%), compared with their non-Indigenous counterparts.[4]

This disparity is of high concern given the lower global screening participation among Indigenous people younger than 50 years.[3] We strongly agree with the Editorial that increasing participation in colorectal cancer screening is essential, and we emphasise that this need is especially crucial for Indigenous populations. Many colorectal cancer screening programmes around the world, such as those in Australia, use an immunochemical faecal occult blood test.[5] A worldwide review of Indigenous peoples' participation in colorectal cancer screening reported wide variation, with Indigenous rates likely to be lower compared with those of non-Indigenous populations.[4] For instance, in Australia from 2021 to 2022, 40·5% of non-Indigenous Australians participated in colorectal cancer screening, whereas Indigenous participation rates were considerably lower (34·2%). Indigenous Australians also returned a higher screening positivity rate than non-Indigenous Australians (8% *vs* 6%).[5]

We agree with the Editorial that alternative approaches are needed to promote colorectal cancer screening participation among hard-to-reach groups. These approaches should include responding to the cultural needs and logistical barriers that hinder participation in colorectal cancer screening among Indigenous peoples—factors often overlooked by standardised screening programmes. Hence, culturally safe, co-designed approaches to the prevention of early-onset colorectal cancer and screening—supported by trusted health-care professionals who can provide clear guidance and explain screening procedures—are essential to improving participation and outcomes for Indigenous people.[6]

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Ligelizumab use for chronic spontaneous urticaria

In the phase 3 PEARL studies, Marcus Maurer and colleagues[1] investigated the efficacy of ligelizumab for the treatment of moderate-to-severe H1-antihistamine refractory chronic spontaneous urticaria (CSU) among individuals aged 12 years and older. Their findings indicated that ligelizumab was more effective than placebo, with no superiority over omalizumab. Although these findings are encouraging, it is important to consider them in the context of specific limitations inherent to the study.

Aspects of the exclusion criteria might reduce the generalisability of the findings to individuals with autoimmune and psychiatric conditions.[1] The prevalence of autoimmune diseases in individuals with CSU is 28%,[2] yet individuals with clinically significant autoimmune diseases were not included in the study. Furthermore, individuals were excluded if they had clinically significant psychiatric disease.[1] The prevalence of psychiatric disorders in CSU is 32%,[3] although other estimates have reported the prevalence to be as high as 60%.[4] Thus, the results of the study might not apply to these populations.