



Sustaining momentum: Building on a decade of global surgery progress

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Global Surgery has had an eventful decade as a discipline within global health and a movement towards universal health coverage. Nepogodiev and colleagues provide a timely appraisal of progress and gaps since the 2015 Lancet Commission on Global Surgery (LCoGS)^{1,2}. The documentation of policy advancements in National Surgical, Obstetric, and Anaesthesia Plans (NSOAPs), recognition of surgery in World Health Organisation resolutions, and acknowledgement of persisting gaps in the monitoring of six indicators offer a foundation for future interventional focuses. The article's emphasis on vertical integration, environmental sustainability, and gender-equitable leadership is important to the global surgery agenda.

While substantial progress has been made in agenda-setting and advocacy, surgical care research remains limited by poor implementation, with many proven interventions failing to translate into routine practice, particularly in resource-constrained settings³. One example is the continued low utilisation of the Surgical Safety Checklist in many low- and middle-income countries (LMICs) where studies have repeatedly shown reductions in perioperative complications and mortality, yet its sustained use remains low⁴. Here, we propose areas of improvement that go beyond the important recent work by Nepogodiev

and colleagues¹.

First, Global Surgery needs to deepen multidisciplinary leadership and broaden equity beyond gender to include socioeconomic, rural-urban, and other marginalised dimensions. Nepogodiev and colleagues' article expands international authorship, representing 20+ countries, and demonstrates progress in geographic diversity since LCoGS^{1,2}. Nevertheless, further efforts are required to ensure that leadership in global surgery meaningfully includes those most affected by surgical care inequities. Future initiatives might benefit from greater integration of non-clinical experts from epidemiology, economics, and the social sciences, public health, and allied areas; patient and surgical survivor/beneficiary groups; and members of the private sector and civil society across regions, with proven contributions to Global Surgery. Inclusion and interdisciplinarity are essential to addressing complex health system challenges⁵.

Second, Global Surgery needs strategic research priorities. While evidence generation through Randomized Controlled Trials remains a priority, it is essential to prioritize mixed-methods studies that capture the lived experiences and context-specific insights of local surgeons and enhance the relevance and sustainability of policy recommendations⁶. Such studies fit well in the



Implementation research paradigm, which remains central to strengthening surgical systems. Research focusing on how to effectively translate the existing evidence base into practice across contexts could help address the well-documented gap between evidence availability and real-life implementation. More critically, such a change in research priorities will ensure that the global collective agenda closely aligns with local needs and realities.

Third, Global Surgery needs to focus on and support locally developed solutions. While integrating newer technologies would be useful, attention also needs to be given to frugal, indigenous surgical innovations developed and implemented by surgeons and biomedical engineers in LMICs. A few such successfully executed locally developed innovations include the Bogota bag, Ilizarov external fixator, and flutter valve for intercostal drainage⁷. These context-appropriate innovations may offer sustainable solutions to address workforce and capacity gaps while aligning with both resource constraints and environmental considerations⁸. However, LMIC innovators often face barriers such as limited funding, regulatory hurdles, and a lack of visibility in global academic forums⁹. Supporting LMIC innovators' efforts requires investments and a paradigm shift toward recognising LMIC residents as innovators, rather than mere recipients of innovation. Such frugal innovations could also benefit high-income countries, as they can be more cost-efficient and environmentally sustainable⁷.

Fourth, we must bridge the implementation gap between policy and patient outcomes through robust community engagement and rigorous evaluation. While several countries have developed NSOAPs since LCoGS, a critical implementation gap remains¹⁰. Strengthening community engagement in the design, implementation, and evaluation of policies and programs focusing on surgical care is essential to ensure that interventions are contextually relevant and reliably executed¹¹. Monitoring and evaluation exercises investigating which elements of NSOAPs translate most effectively into improved surgical access and outcomes are needed. More focus must now be on local interest-holders and accountability mechanisms.

A decade after LCoGS, the challenge is no longer inspiration but implementation. The next decade can focus on shifting power to local leadership, investing in contextually appropriate innovation, and embedding accountability across all levels of the surgical systems. Without urgent, equity-centered, locally driven, and sustainable implementation, the promise of Global Surgery will remain unfulfilled for billions.

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