



We Must Not Lie to Ourselves: A Reckoning for Global Surgery

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Cite as: Bhangu, A. We Must Not Lie to Ourselves: A Reckoning for Global Surgery. *Impact Surgery*, 2(6), 183-184. <https://doi.org/10.62463/surgery.263>

We must not lie to ourselves about the state of global surgery research funding. Global Surgery itself is entering a fragile period and after a period of confident expansion, it will now contract and quiet face uncertainty.

A recent *Lancet* modelling analysis issued a stark warning that reductions in global health funding will now be significant and sustained¹. It is highly likely that surgical systems will be amongst the most vulnerable². The downturns in the USA's USAID and the UK's NIHR Global Health Research funding are huge blows to the Global Surgery research community³. Foundation and large donors are inundated and are now closing doors to new approaches; surgery is nowhere to be seen in manifestos from the Gates or Bloomsburg Foundations. This seems to be a major political reset rather than a slowdown, hastened on by political action but possibly an inevitable consequence of expansion over the last decade.

Given this environment, we should prepare for three forms of erosion. Research erosion will lead to a downturn in funding for multicountry surgical trials, longitudinal cohort studies, and embedded systems-building. Without predictable support, collaborations will be hit by cumulative attrition with job losses. Some countries may gain governmental support for surgical researchers, especially those where governments may want to fill the political gaps left over, although there is no certainty. Industry funding, in the wake of significant tariff disruption and the lure of robotic surgery, also appears too fragile to play a major role.

The second is advocacy erosion. Over the past decade, Global Surgery found its voice through strong community, policy engagement, and society presence. Journals elevated arguments for access to surgical care, documenting innovations, and amplifying surgical equity. An advocacy downturn is deepened by the World Health Organisation's structural downsizing. As part of its emergency reorganisation, programme divisions at its Geneva headquarters will shrink from ten to four, departments from about sixty to thirty-four, and senior leadership from twelve to seven⁴. These changes coincide with reports suggesting up to 40% staff reductions in Geneva, though exact figures remain unclear. Importantly, surgery and perioperative care are not visible in the revised architecture. When the organisation that anchors global health realigns without including surgery, it sends us the message of diminishing institutional priority.

The third is service erosion. This is perhaps the most consequential and immediate. In fragile, rural, conflict-affected, or disaster-prone regions, surgical care depends on continuity. As external funding recedes, surgical backlogs will grow, workforce retention weakens, and access becomes harder. Existing surgical capacity will thus remain vital and should be fiercely protected, with non-governmental organisations picking up an important volume of care. *Impact Surgery* has published EMERGENCY's fifteen-year surgical initiative in Afghanistan, which is a programme that sustained free surgical and obstetric services through conflict and disruption⁵. These organisations, also exemplified



by Mercy Ships and KIDS OR, continue to deliver, adapt, and persist in challenging environments⁶. Their endurance and financial independence is no accident but the consequence of grounded, community-responsive models.

In response to these pressures, Global Surgery will be forced to re-position. Equity alone and repeating the arguments of the last decade will now fall on deaf or even absent ears, but repeated they must be, perhaps with some adaptations as suggested below.

It seems apparent that governments around the world will spend the next decade focussed on health security, which is where surgery may need to re-frame. This probably must include surgical responses in conflict zones (of which there are more than ever⁷), surgical care for refugee populations, and injury response in the wake of major natural disasters. Reframing surgical systems as infrastructure that will help return people to local economic activity, with alliances from rehabilitation and social workers, may be appealing to governments as a measurable way to reduce unwanted economic and health-related migration.

Looking ahead to a lean five years, the critical question is now not who will expand but who can endure this period. Some government funded consortia will slow and even falter. Meanwhile, mission-driven NGOs or flexible, locally embedded entities are better placed to adapt. Strategic preservation of essential research capability, essential advocacy, platforms like *Impact Surgery*, and frontline NGOs will be essential to preserving the message in preparation for a future resurgence.

Global Surgery must now undergo a hard and immediate triage, choosing topics and approaches that will entice governments of tomorrow, not each other^{8,9}. We must not lie to ourselves, but we can endure and we can prepare.

Funding and competing interests: No funding was received for this article. The author declares no competing interests.

GAIT statement¹⁰ for Generative AI use: Generative AI was used for language editing in this manuscript. No content generation, data analysis, or substantive rewriting was performed. The author takes full responsibility for the accuracy and integrity of the work.

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RESEARCH *for* GREENER SURGERY

17TH December 2025

CONFERENCE AGENDA

08:30-09:30	Pre-conference session - Behaviour Change (James Glasbey, Sivesh Kamarajah, Laura Kudrna) <i>Implementing local sustainability research and change in the NHS</i>
08:30-09:30	Pre-conference session - Developing a new carbon model (Virginia Ledda, Elizabeth Li) <i>How to develop a carbon model for an ongoing trial</i>
08:30-10:00	Registration, coffee and posters
	Opening session (Aneel Bhangu, TBC)
10:00-10:10	<i>Welcome from the University of Birmingham Aims for the day Update on national efforts to tackle climate change</i>
10:10-11:10	Update on Current Studies (Virginia Ledda, Clifford Shelton, James Glasbey, Cortland Linder) <i>Update on ongoing green surgery studies – Dragon Noble Waste Energy Global prioritisation</i>
11:10-11:30	Coffee, posters and networking
	Cross cutting methodology for greener surgery (Laura Kudrna, Dmitri Nepogodiev, Elizabeth Li)
11:30-12:30	<i>Presenting findings from pre-conference session Lessons from behaviour change research Lessons from modelling carbon and costs in trials</i>
12:30-13:30	Lunch, posters and networking
	Robotic surgery and climate change (Aneel Bhangu, Deena Harji, Mike Bahrami-Hessari)
13:30-14:40	<i>Future of robotic surgery in the NHS How can robotic surgery be sustainable Communicating robotic surgery and sustainability with patients</i>
14:40-15:10	Coffee, posters and networking
	Building sustainable health systems using Large Language Models (LLMs) (James Glasbey, TBC)
15:10-15:55	<i>Can LLMs help prioritise sustainable solutions in the NHS How do LLMs contribute to carbon emissions</i>
15:55-16:00	Prize giving
16:00-16:15	Closing remarks: Aneel Bhangu
16:15	Drinks and networking

