4TH

EAST OF ENGLAND GLOBAL HEALTH CONFERENCE

Building Resilient Healthcare that Empowers People

Colonization And Its Aftermath Reimagining Global Surgery

PRESENTED BY:

Rennie X. Qin[1*], Barnabas Alayande[2,3*], Isioma D. Okolo[4*], Judy Khanyola[6], Desmond T. Jumbam[7], Jonathan Koea[1], Adeline A. Boatin[1,9], Jesse B. Bump[3,10†], Henry M. Lugobe[11†]

[1] The University of Auckland, Auckland, New Zealand, [2] University of Global Health Equity, Kigali, Rwanda, [3] Harvard T.H. Chan School of Public Health, Boston, Massachusetts, USA , [4] NHS Slothian, Edinburgh, United Kingdom , [6] University of Global Health Equity, Kigali, Rwanda, [7] Operation Smile, Virginia Beach, Virginia, USA, [9] Center for Global Health, Massachusetts General Hospital, Boston, Massachusetts, USA, [10] Bergen Center for Ethics and Priority Setting, University of Bergen, Bergen, Norway, [11] Mbarara University of Science and Technology, Mbarara, Uganda.

INTRODUCTION:

Coloniality in global health manifests as systemic, non-merit-based inequalities that benefit one group at the expense of another. Global surgery seeks to insert surgery into the global health agenda; however, it inherits the biases in global health. As a diverse group of global surgery practitioners, we aimed to examine inequities in global surgery.

METHOD: We examined inequities in global surgery using a qualitative, group Delphi consensus-building process drawing on the literature and our lived experiences. We followed a structured, iterative consensus building process commonly used in organising, planning and policy. Discussions occurred through fortnightly virtual meetings. In the initial meeting, group members established the ground rules, which included good faith, confidentiality and disagreeing without being disagreeable. Agreements were reached through overwhelming consensus rather than majority rule. Overwhelming consensus meant that there is more than 90% agreement without any member vetoing.

RESULTS: We identified five categories of non-merit inequalities in global surgery: Western epistemology, geographies of inequity, unequal participation, resource extraction, and asymmetric power and control. We observed that global surgery is dominated by Western biomedicine, characterized by the lack of inter-professional and inter-specialty collaboration, incorporation of Indigenous medical systems, and sociocultural and environmental contexts Global surgery is Western-centric and exclusive, with a unidirectional flow of personnel from the Global North to the Global South. There is unequal participation by location (Global South), gender (female), specialty (obstetrics and anesthesia), and profession (non-specialists, non-clinicians, patients, and communities). Benefits, such as funding, authorship, and education, mostly flow towards the Global North. Institutions in the Global North have disproportionate control over priority setting, knowledge production, funding, and standards creation. This naturalizes inequities and masks upstream resource extraction.

CONCLUSIONS: Shifting global surgery towards equity entails building inclusive, pluralist, polycentric models of surgical care by providers who represent the community, with resources controlled and governance driven by communities in each setting.

We conclude that a truly global form of global surgery should uphold diverse Indigenous efforts around the world rather than masking them. It should allow practitioners in the Global South to form bidirectional regional and global collaborations on their own terms rather than terms set by the Global North while celebrating the uniqueness of each context.

Leaders in the Global South must take charge of designing, funding and delivering surgical services oriented towards the interest of their citizens and populations rather than elite, commercial or international interests.

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Project contact:
DR. HENRY MARK LUGOBE
henrylugobe@must.ac.ug

Cambridge Global Health Partnerships

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