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Beyond evacuation: building epidemic-resilient global surgery partnerships in an era of recurrent Ebola outbreaks

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SUMMARY BOX

⇒ Global surgery partnerships have expanded over the past two decades, improving workforce development, research capacity and access to safe surgery.
⇒ Recurrent epidemics expose a structural weakness in travel-dependent collaborations.
⇒ During outbreaks, international partners often suspend activities, evacuate personnel and postpone exchanges.
⇒ Partnerships should shift from episodic, travel-dependent models to epidemic-resilient ecosystems grounded in local leadership and shared risk.
⇒ Epidemic resilience should become a core metric for designing and evaluating partnerships.

Global surgery has emerged as a major domain within global health, with partnerships between high-income countries (HICs) and low-income and middle-income countries (LMICs) supporting workforce development, research collaborations, educational exchanges and infrastructure investments. These efforts are central to addressing the estimated five billion people worldwide who lack access to safe, affordable and timely surgical care.[1–3] However, the growth of global surgery has largely been built on architectures that assume mobility and stability. Recurrent Ebola outbreaks in Uganda and the DRC reveal how fragile these architectures can be when confronted with sustained crises.

Epidemics expose the structural dependence of many global surgery partnerships on international travel. When outbreaks arise, numerous HIC institutions rapidly suspend activities and evacuate their personnel. Visiting faculty return home, trainee exchanges are cancelled, research projects are paused and planned surgical missions are postponed indefinitely. Universities institute travel bans, insurers withdraw coverage and collaborative activities enter hibernation until normalcy returns. Meanwhile, Ugandan and Congolese institutions remain on the front lines of care. This asymmetry exposes an uncomfortable truth: many global surgery partnerships are designed for periods of stability rather than adversity. Partnerships that disappear when health systems are under the greatest strain cannot reasonably be described as resilient.[4]

Uganda and eastern DRC have become emblematic of twenty-first-century epidemic vulnerability. Their shared borders facilitate extensive movement of traders, refugees, healthcare workers and families. At the same time, conflict, displacement and fragile health systems create ideal conditions for recurrent outbreaks. Over the past decade, Ebola outbreaks have repeatedly crossed, or threatened to cross, national boundaries, demanding sustained vigilance and regional cooperation. These outbreaks occur in settings already burdened by severe shortages of surgeons, anaesthesiologists, obstetricians, nurses, biomedical engineers and critical care personnel. Humanitarian agencies have documented Ebola transmission extending into internally displaced persons' camps, where overcrowding and poor sanitation complicate containment efforts. Global surgery partnerships have not kept pace with this reality.[5–8]

The paradox of support receding when it is most needed is not new. The West African Ebola epidemic of 2014–2016 disrupted numerous academic collaborations, and the COVID-19 pandemic similarly exposed the fragility of mobility-dependent global health programmes. Institutions have a clear obligation to protect their personnel, and states have a clear obligation to protect their citizens. *We do not suggest that international staff should ignore legitimate infection risk, security concerns or institutional liability. The problem is not evacuation itself; the problem arises when evacuation becomes synonymous with disengagement. Physical absence should not translate into relational absence.* When partnerships lack preplanned mechanisms for remote continuity, protective withdrawal

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of personnel can unintentionally become abandonment of local institutions.[9–13]

Historically, global surgery has relied on movement. Expertise circulates through visiting professorships, short-term surgical missions, conferences and trainee exchanges. This model has yielded important gains, yet it creates structural vulnerabilities: when international mobility stops, collaboration often stops as well. This architecture inadvertently reinforces colonial dynamics, in which expertise is perceived as external and transient rather than locally embedded. Epidemics expose this imbalance by revealing whose presence is deemed indispensable and whose absence is tolerated. When international experts can leave and programmes pause, while local clinicians and patients cannot step out of harm's way, risk is effectively externalised to the very communities global surgery seeks to serve. An alternative partnership architecture would treat epidemic resilience as a core design principle, not an afterthought. Such partnerships would be organised around continuity rather than colocation, ensuring that collaboration persists when usual patterns of travel are disrupted.[2 11 14–16]

Recurrent Ebola outbreaks in Uganda and the DRC provide a natural experiment for testing and refining these principles. They show that shocks are not rare anomalies but recurring features of health systems, especially in conflict-affected and politically fragile regions. While this editorial focuses on Ebola, similar vulnerabilities are evident during other acute shocks, including COVID-19, conflict-related displacement and climate-related disasters. Designing partnerships that evaporate under stress is not only impractical; it is ethically untenable. If epidemic resilience is to become a core metric, evaluation frameworks must change. Funders, universities and ministries of health routinely assess global surgery partnerships using indicators such as numbers of visiting teams, operations performed, trainees exchanged or publications produced. These metrics capture productive activity in stable periods but say little about performance under strain. Alternative indicators might include continuity of emergency and essential surgical services, including caesarean delivery, trauma care and emergency abdominal surgery during outbreaks; the ability to maintain or adapt surgical and anaesthesia training; preservation of local decision-making authority; and the extent to which partnerships support, rather than compete with, national emergency responses. Practical examples include Sierra Leone's CapaCare programme, which trained associate clinicians to perform essential emergency surgical and obstetric procedures in district hospitals, and Connaught Hospital's Ebola Holding Unit, which combined screening, isolation, testing and referral to maintain vital services. Uganda's Kyabirwa Surgical Center shows how locally led care, simulation, connectivity and tele-mentoring can sustain surgical capacity when international travel is restricted.[17–19]

This shift in evaluation has implications for how success stories in global surgery are narrated. Celebrating volume metrics or high-profile missions without examining what happens during crises risks reinforcing models that are impressive in stable times yet fragile in emergencies. By contrast, partnerships that maintain essential surgical and anaesthesia services during outbreaks through remote supervision, task-sharing, simulation and local leadership should be recognised as exemplars of ethical and effective global surgery. Their success should be judged not only by the number of visiting teams, operations or publications, but also by whether local clinicians can continue safe caesarean delivery, trauma care, emergency abdominal surgery and postoperative management when external travel is interrupted.[20 21]

Decolonising global health requires more than critical discourse; it demands re-engineering the material and institutional arrangements of partnership. Epidemic-resilient global surgery partnerships would embed authority, resources and expertise within local institutions, such that international withdrawal does not translate into system collapse. However, the extent of corruption in some unstable settings can make decentralisation and the transfer of resources exceptionally challenging, underscoring the need for strong accountability mechanisms, transparent governance and context-specific safeguards. Uganda and the DRC should no longer be regarded as temporary sites of intervention but as equal partners at the centre of global surgery systems that are prepared for epidemic crises. Their recurrent Ebola outbreaks are not pathologies at the margins of an otherwise stable world; they are harbingers of a future in which health emergencies will be increasingly frequent. Information technology should form part of this re-engineered global surgery model. Tele-mentoring, virtual simulation, recorded surgical demonstrations, online case conferences and competency-based e-learning can sustain surgical and anaesthesia training when travel is restricted. Teleconsultation, digital imaging, pathology, ultrasound interpretation and secure laboratory transmission can extend specialist support while preserving local leadership. Digital protocols, outbreak dashboards, surgical registries and remote equipment troubleshooting can strengthen triage, referral, operative decision-making and postoperative continuity.[22] These tools should complement, not replace, locally led clinical care. Success should therefore be measured through diagnostic accuracy, surgical quality, workforce capability, continuity of essential surgical services and epidemic resilience.

CONCLUSION

Global surgery was founded on principles of equity, solidarity and shared responsibility. Repeated cycles of withdrawal and re-engagement risk undermining these very foundations. The future of global surgery depends on a simple but transformative shift: partnerships must no longer be evaluated solely on their performance during periods of stability, but on their capacity to withstand

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and adapt to disruption. If global surgery is to be truly global, its partnerships must be designed to be epidemic-resilient. The time to redesign them is now.

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