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Global Urology, Urolink, and the *BJUI*

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Interest in the provision of solutions for access to safe and essential surgical care has increased dramatically over the last 30 years, with the term ‘global surgery’ now commonplace amongst surgical and allied healthcare specialties. This has been matched by a 10-fold increase in the number of publications relevant to the topic between 1987 and 2017 [1], an exponential growth since 2004, with at least 50% of papers being provided on an open-access basis. Despite 1623 articles being published about policy, clinical activity, or disease management in low- or low-middle-income countries (LMICs) only 35 papers were identified that could be attributed to Urology [1] and the *BJUI* was responsible for at least two-thirds of the relevant manuscripts prior to 2004.

The period of the Sgrò *et al.* [1] bibliometric review pretty much encompassed the establishment of Urolink, the BAUS committee for international co-operation [2], and the era during which it became active in sub-Saharan Africa. Urolink’s founding principals were to develop durable relationships between countries, organisations and individuals so that training, education and equipment could be provided, and disseminated, in a collaborative manner based on the needs of the host LMIC. In 2002, soon after Urolink’s inception, the *BJUI* published a supplement of introductory topics about working with colleagues in LMICs and disease conditions relevant to linked centres [3]. That supplement antedated the explosion in literature about global surgery, which culminated in an all-embracing report outlining a vision for the future in the *Lancet* in 2015 [4]. However, that report, like others emphasising the multiplicity of more dominant healthcare issues in the most deprived countries in the world [5], has virtually no lens onto the type of urological pathology that is encountered in those situations, or its prevalence. Equally, those major works [4, 5] have given no indication of how high-income countries (HICs) clinical management practices may be relevant to the urological needs of a resource-poor environment, and how this may be delivered practically in a situation with less access to technology than is the norm in the more-developed world.

Since 2002, the *BJUI* has continued to support the development of the concept of ‘global urology’ by publishing topics relevant to Urolink’s activity as well as altruistically supporting, via its associated charity, the development of urological services in Hawassa, Ethiopia. Now 20 years after the initial *BJUI* supplement it seems appropriate to consider how things have progressed and the evidence that now exists to indicate how global urology may meet the needs of host countries in an ethical, co-operative, and sustainable way. We are grateful to the Editorial Board of the *BJUI* who have given us this chance to summarise the learning, development, and changes in the concepts of collaboration between urologists in HICs and colleagues in less privileged parts of the world. We thank them for the opportunity.

During 2022 we will provide monthly articles that will focus on one of four areas in global urology in a series of joint-authored commentaries. These are from the viewpoint of UK urologists, who have been working in LMICs over the last 20 years, together with the perspective of their local hosts and colleagues. The first three articles concentrate on the recognition of the urological needs of LMICs, the development of sustainable healthcare systems, and an understanding of the logistical issues of service delivery consequent upon cultural, religious, and financial issues in the host country. The second tranche of papers address how teaching and training for sustainable benefit has become Urolink’s most important function, especially during the travel limitations that followed the coronavirus disease 2019 (COVID-19) pandemic in 2020–2021. The next four articles, therefore, tackle the challenges of virtual learning, and operative mentoring, in an environment with variable access to basic amenities such as electricity and water. The commentaries also address the applicability of simulation training in a LMIC environment and the pros and cons of different models of disseminating surgical experience. In the last part of this programme, we concentrate on four of the most clinically important urological challenges to our colleagues in more deprived settings; urethral stricture disease, paediatric urology, the management of stone disease, and uro-gynaecology. Finally, we turn our attention to quality assurance, examining how a valid collegiate structure, and examination process, can ensure perpetuation of standards of practice across a large and diverse region.

We hope you will enjoy reading these articles, and maybe you will join us in promoting global urology. There is an undeniable need for help across the world, and there are so many personal benefits to be had from an involvement in humanitarian work [6].

Disclosure of Interest

None declared.

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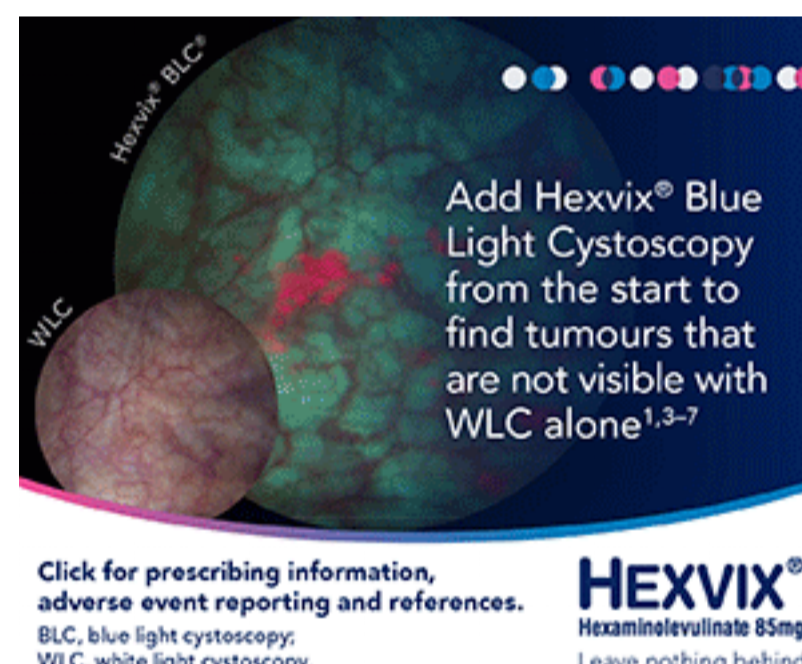
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