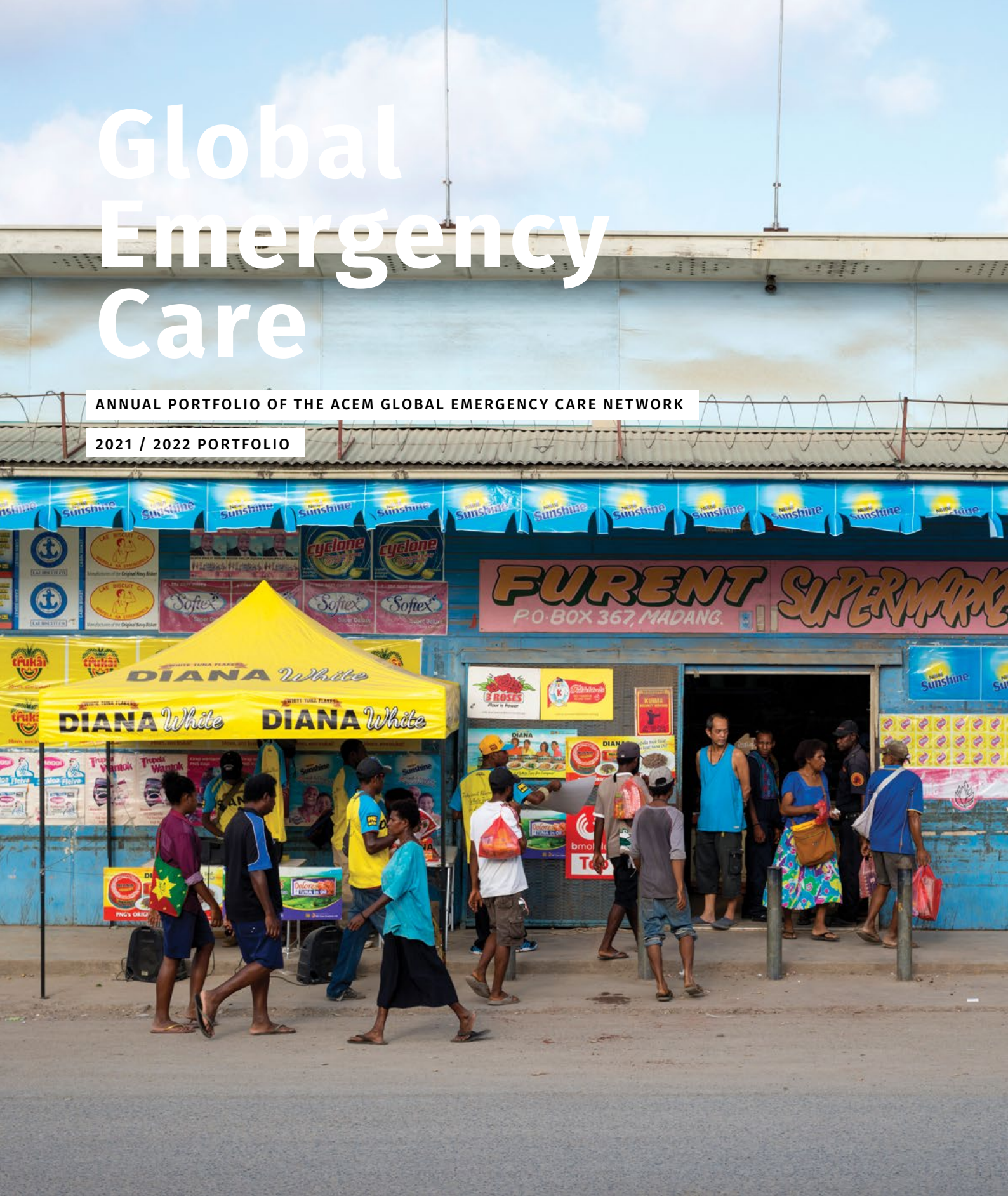
Global Emergency Care

ANNUAL PORTFOLIO OF THE ACEM GLOBAL EMERGENCY CARE NETWORK

2021 / 2022 PORTFOLIO



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This page: Bara people in the southern part of the central plateau of Madagascar.
Stock photo ID: Leamus 957769460
Cover: People coming and going at a supermarket in Madang, Papua New Guinea (PNG).
To learn more about ACEM supported projects in PNG please see page 18.
Stock photo ID: Joel Carillet 1130783619

Global Emergency Care Portfolio

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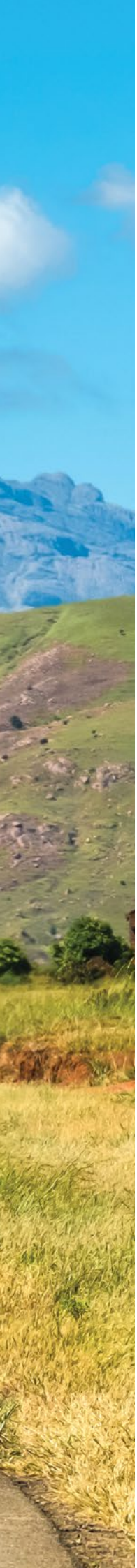


The Australasian College for Emergency Medicine (ACEM) acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

‘A GLOBAL EMERGENCY COMMUNITY CREATING BETTER CARE FOR A BETTER WORLD’

Dr Megan Cox
Chair of the Global Emergency Care Committee (GECCo)

As an emergency care worker in Australia, I have always known our health system could not operate effectively without us. The COVID-19 pandemic management throughout 2021 has highlighted our importance in surveillance, triage and clinical care to the communities we serve.

As a Fellow of the Australasian College for Emergency Medicine (FACEM), I recognise the diversity of our emergency care health care workers (HCWs) and the importance of multidisciplinary teams every day. We all know that our patients get better care when we all work together. Multiple new healthcare partnerships and resources formed in this pandemic have many teams working better together, frequently with emergency care leaders in the foreground.

Sadly, these things are not always standard with our regional neighbours. Our emergency care colleagues in the Indo-Pacific region are stretched with the COVID-19 response on top of regular surge events and the ongoing impact of climate change. Many of them work with weak triage or emergency care systems, sparse emergency care equipment and medications in small overcrowded emergency departments (EDs). Their fragile emergency care systems struggle to surge due to high rates of staff comorbidities, absenteeism and inadequate training increasing burnout, illness and exacerbation of the mismatch between supply and demand for care. The need for emergency care leadership and advocacy for our regional neighbours has never been more urgent.

GECCo members have continued to reach out to our Indo-Pacific emergency care colleagues to mentor,

Triage being performed at ANGAU Memorial Provincial hospital, Lae, PNG. Photo JP Miller/ACEM

assist and advocate over the last year. In fact, I feel the pandemic has brought us closer together than ever. As the GECCo Chair, it has been a privilege to host the ACEM supported COVID-19 support forums, with the 27th forum on May 31st, 2022. Over 500 emergency care colleagues in over 25 countries have participated and the forum has transitioned to Pacific emergency care leadership and co-hosting, in a South-to-South network arrangement. COVID-19 Management Guidelines for Low and Middle-Income Countries (LMICs), developed by Global Emergency Care (GEC) Network members have been translated into three different languages for the Pacific. A HCW safety guide discussed in these forums and written by local nursing leaders continues to assist many LMIC staff working with personal protective equipment (PPE). Research about these forums will soon be published in a regional journal, increasing the voice, leadership and advocacy of Pacific emergency care HCWs.

I feel these COVID-19 support forums are an example of the best-practice volunteering, capacity-building and international development research that GEC promotes. GEC aims to collaborate with leading global health organisations and academic institutions to advocate and promote unified recommendations for emergency care system development, preparedness and resilience. In the year ahead GEC also plans to attain Australian Council for International Development (ACFID) membership, which will be a further step towards our commitment to best practice.

In March 2021, GECCo endorsed the establishment of a multi-disciplinary GEC Community of Practice (GECCoP) to facilitate effective communication and partnership between the many individuals and organisations engaged in GEC development across the Indo-Pacific region. GECCoP will provide a forum for resource sharing, networking and mutual learning among the entire GEC community. In recognition of this, GEC's Annual Portfolio this year contains content from all our GEC partners, not just FACEMs. I also hope that GECCoP will enable and support the participation of many LMIC colleagues' at ACEM supported GEC events, to build networks and strengthen relationships.

This Annual Portfolio will be released at our first face-to-face international ACEM event in over two years, the International Conference on Emergency Medicine (ICEM) 2022 in Melbourne. The conference theme 'Better care for a better world' could not be more relevant at this time. GEC plans to be prominent at ICEM, with ACEM supporting and sponsoring the GEC Scholars attending in person from Botswana, Cook Islands, Fiji, Solomon Islands, Tonga, and Vanuatu. I thank the ACEM Foundation for this scholarship's long-awaited return, and the opportunity to be with our emergency care colleagues and support them as they tell their stories and discuss the complex issues of our region. I know that their presence, alongside many other LMIC emergency care colleagues at ICEM, will inspire us with their leadership and resilience, to learn from and be reminded of the challenges in our region, and in emergency care globally.

Another exciting development for 2022 is the recommencement of our Visiting Emergency Medicine Registrar Program (VEMRP) in partnership with the Australian Volunteers Program in Solomon Islands, Vanuatu and Papua New Guinea. This Program provides another opportunity to reconnect and be part of our GEC community as well as a great place to learn from our regional emergency care colleagues. If you are interested, please reach out to any GEC team member at the GEC Desk to discuss these challenging opportunities. Thank you for your continued support for GEC through this last year, and I look forward to continuing our journey together into 2023.

Stories from *Your ED*

This Annual Portfolio features a collection of GEC stories published in *Your ED* magazine between 2021-2022, highlighting ACEM Supported Projects across the Indo-Pacific region. This range of content facilitates readers to develop a sense of the challenges and rewards that come with working in resource-limited environments. You can read the full stories and further references at: **acem.org.au/Content-Sources/About/Publications/Your-ED**.

THE ACEM GLOBAL EMERGENCY CARE COMMITTEE

Formed in 2015, the Global Emergency Care Committee (GECCo) has been integral to the establishment of Global Emergency Care (GEC) as a key pillar of ACEM's body of work. The committee's primary objectives are to: Advance ACEM as a leading expert body in providing expertise in and progressing sustainable and ethical GEC capacity development and GEC volunteering for development; respond to requests from Low and Middle-Income Countries (LMICs) to support locally-led capacity development to deliver safe and effective emergency care at both the systems policy and health service planning level; advocate for emergency care as a core component for the attainment of health equity in universal health coverage and contribute to the body of accessible GEC research and build capacity of LMICs to lead GEC research

Dr Megan Cox – Chair

Megan has over 20 years of GEC experience, mostly in sub-Saharan Africa with non-governmental organisations (NGOs) and faith-based organisations, and then six years spent working full-time in Botswana. She helped graduate their first doctors, the first Emergency Medicine (EM) specialists and continues to mentor staff and students as an Adjunct Associate Professor at the University of Botswana. Back in Sydney, Megan works both part-time for NSW Health and NSW Ambulance, and as an academic at the University of Sydney running courses in humanitarian emergencies, resource-limited critical care, as well as supervising students undertaking international placements in the Asia-Pacific region.

Dr Rob Mitchell – Deputy Chair

Rob is an Emergency Physician based at the Alfred Hospital Emergency and Trauma Centre in Melbourne. He has been a member of GECCo since 2018 and is the current deputy chair as well as the inaugural medical chair of the GECCoP. Through his PhD and ACEM GEC activities, Rob is currently involved in several emergency care projects in the Pacific, including Papua New Guinea (PNG), Solomon Islands and Vanuatu, focussing on emergency care systems, triage implementation and data registries. In addition, Rob contributes to the ACEM GEC COVID-19 online support forums for emergency care clinicians in the Indo-Pacific region and the resultant research activities. Rob is actively involved in the organisation of other key GEC events including the annual GEC Conference and this year's ICEM22.

Dr Colin Banks

Colin, based in Townsville, has been part of the GECCo since its inauguration in 2015, including a stint as chair. His GEC experience is predominantly in PNG where he has been supporting the emergency physician training program since 2009. More recently Colin has also become involved with system improvements in PNG, including triage implementation.

Dr Claire E Brolan

Claire is a health equity, health rights and sustainable development academic specialist based at the University of Queensland's School of Public Health. Her current advisory roles include: Honorary Advisor and Thematic Expert for Sustainable Development Goal (SDG) three (Good Health and Wellbeing), the Legal Economic and Empowerment Global Network's specialist international multidisciplinary advisory group to promote rights-based approaches to SDG implementation to United Nations (UN) agencies and among UN Member States; Queensland Red Cross' International Humanitarian Law Committee's Medical Sector Representative; and member of Queensland Human Rights Commission's Academic Advisory Committee.

Dr Ngaire Caruso

Ngaire is an Emergency Physician at Fiona Stanley Hospital in Perth, Senior Lecturer in Emergency Medicine at the University of Western Australia (UWA) and adjunct Senior Lecturer in Emergency Medicine at the University of Botswana. Ngaire's experience in global emergency care includes volunteering with Médecins Sans Frontières (MSF) in Uganda, Ethiopia and on the Thai-Burmese Border. Ngaire worked for the University of Botswana Medical School from 2010 to 2012 and again in 2019 to 2020. Ngaire and her colleagues introduced and developed Emergency Medicine Specialist Training in Botswana. After leaving Botswana in 2020, Ngaire established and coordinated a weekly remote learning program for the Botswana registrars and continues to contribute regularly. Ngaire also has a Master of Public Health (International Health) from Monash University.

Dr Anne Creaton

Anne studied medicine in the United Kingdom (UK) before moving to Australia in 1999. She was awarded FACEM in 2007 and completed a Master of Public Health (LSHTM) in 2020. Anne's interests include education, pre-hospital and retrieval, disaster medicine and emergency care systems. Anne was involved in

capacity building with Thai emergency physicians from 2006 to 2008. She also has GEC experience in Fiji, where she developed the Diploma and Master of Emergency Medicine (2013) and the Certificate in Pre-Hospital Care (2018) with Fiji National University. Anne is currently based in Melbourne.

Dr Jennifer Jamieson

Jennifer is based at the Royal Hobart Hospital and has previously worked with Médecins Sans Frontières (MSF) in Afghanistan as an emergency and intensive care doctor and in a medical education role in Dar es Salaam, Tanzania. She is involved in a number of GEC projects, and assists with the GEC content for *Your ED* magazine.

Associate Professor Anthony Joseph

Anthony has a long involvement in teaching both locally and internationally on EM and trauma topics. Over the years he has participated in educational sessions in India, Myanmar, Vietnam, Hong Kong, Brazil and Egypt. He is the current chair of the International Federation for Emergency Medicine (IFEM) Trauma Special Interest Group. He has been involved in delivering educational sessions on trauma-related topics in collaboration with the World Health Organization (WHO) to doctors in conflict zones in the Middle East. He has also recently assisted with the provision of trauma education for doctors in the current conflict in Ukraine.

Dr Emma Lawrey

Emma grew up in Canada, with Aotearoa New Zealand (NZ) ex-pat parents, and studied medicine at the University of Auckland. She has transitioned through a number of subspecialty interests, including postgrads in clinical education and toxicology, but for the last eight years has focused on humanitarian health and disaster response, having worked as the clinical director of the NZ Government Field Hospital (NZMAT) and for the Emergency Medical Teams (EMT) Secretariat of WHO assisting governments and medical teams with disaster preparedness. She currently works for Auckland Hospital and as the Clinical Operations Lead at the NZ Northern Region Health Coordination Centre. Her most recent outbreak related deployments include PNG (COVID-19 coordination and clinical care, 2021), Cook Islands (vaccine rollout support, 2021) and Samoa (measles response, 2019). Emma's previous deployments were focused on sudden onset disaster in the Pacific region.

Dr Alex Markwell – CAPP representative

Alex is an Emergency Physician at the Royal Brisbane and Women's Hospital and Immediate Past Chair of the Queensland Clinical Senate. She is a Senior Lecturer with the University of Queensland and member of ACEM's Council of Advocacy, Practice and Partnerships (CAPP). Alex is passionate about health care workers' health, wellbeing, and work-life flexibility and is founding member of Wellness Resilience and Performance in Emergency Medicine (www.wrapem.org). She is also a Past President of Australian Medial Association (AMA) Queensland.

Dr Donna Mills

Donna is an Australian FACEM with a strong interest in emergency care development including post-graduate medical training, tropical medicine and public health in the Pacific region.
She has lived and worked in Solomon Islands and Fiji, assisting the with development of emergency care systems and Diploma and Masters programs for emergency medicine. She has also been involved with COVID-19 preparedness and response in PNG and Vanuatu. She is currently studying the Gorgas Diploma of Tropical Medicine and Global Health. Donna's other passions include ocean swimming, spending time with her pet parrot, Jack, and enjoying a good glass of wine with her husband and friends.

Associate Professor Gerard O'Reilly

Gerard is Head of Global Programs at the Alfred Hospital Emergency and Trauma Centre.
Gerard's key roles and activities include: Chair of Alfred-Monash GEC Workshop and Conference; PhD supervisor at Monash School of Public Health and Preventive Medicine; Monash WHO Collaborating Centre representative in WHO Global Alliance for the Care of the Injured; partnering with WHO in emergency and trauma care system development activities in Iran and Myanmar; leading multiple emergency response and emergency capacity-development programs across Afghanistan, Kenya, Indonesia, Sri Lanka, India, Vietnam and Myanmar for over 20 years.

Dr Georgina Phillips

Georgina, based at St. Vincent's Hospital, Melbourne, has been involved in the development of EM in the Asia-Pacific region since volunteering as an emergency doctor in Kiribati in 1996.
Georgina's current roles and activities include: visiting EM specialist at Fiji National University and the University of Papua New Guinea; Honorary Professor at the University of Medicine, Yangon, Myanmar; ACEM Country Liaison Representative for Solomon Islands and the Pacific Region; EMA journal's Global EC section editor; PhD candidate exploring the impact of emergency care capacity development in low resource environments. Over the last two years Georgina has collaborated with GEC colleagues to research the COVID-19 experience across the Indo-Pacific region, as well as been a member of the local organising committee to deliver the ICEM22 in Melbourne this June.

Dr Aruna Shivam – Trainee Representative
Aruna is a recent FACEM graduate at the Royal Darwin Hospital and is currently acting as clinical director at Katherine Hospital Emergency Department (ED). She trained through St Vincent's Hospital, Sydney, and holds a Master of International Public Health. Aruna is passionate about delivery of high-level emergency and critical care to patients in resource poor and austere settings within Australia and internationally, having spent time in India, Nepal and Solomon Islands. She enjoys medical education, opportunistically teaching and learning wherever she can. Aruna is also parent to T. Rex, her adopted puppy from Gizo, Solomon Islands where she lived and worked for four months.

Dr Nick Taylor
Nick is co-Director of Emergency Medicine Training (DEMT) at the Canberra Hospital and an Associate Dean at the Australian National University (ANU) Medical School. During 2015-16, Nick worked in Galle, Sri Lanka, where he was involved in clinical care, education and assisting with the new EM specialist training program. Since returning, he has ongoing involvement in teaching and support of Sri Lankan emergency care providers both locally and within Australia; and created the first Sri Lankan critical care online education platform.

Dr Alan Tankel
Alan has a Scottish science degree, an English medical degree and an Australasian fellowship. He has lived in Australia for 30 years and has worked in Queensland, Western Australia, Victoria, and New South Wales. He is passionate about developing the specialty of EM and improving the quality of health care around the world.

Dr Gina Watkins
Gina graduated in London and undertook her EM training in Sydney. She is passionate about enhancing emergency care for those most in need and has combined her career in Australia with pursuit of her interests in education and international development through the GEC Network and the ACEM Foundation. This has led to on-site involvement with the development of EM in Botswana, Nepal and Vanuatu. Gina is also an advocate for better coordination of research within the College, becoming the inaugural Chair of the Clinical Trials Network.

ACEM Foundation

The ACEM Foundation supports emergency medicine in three key areas through sponsorship, grants, awards and scholarships.

It fosters emergency medicine research, encourages and supports Aboriginal, Torres Strait Islander and Māori doctors in undertaking emergency medicine training and builds the capacity of emergency care programs in developing countries.

How can I donate to the ACEM Foundation?

There are three ways you can support the ACEM Foundation:

1. **Donate online**
2. **Bequest in your Will**
3. **Make an In Memory gift**

All donations made by Australian and Aotearoa New Zealand residents are tax deductible.

www.acem.org.au/foundation
twitter.com/acemonline
foundation@acemfoundation.org.au
61 3 9320 0444

THE ACEM GLOBAL EMERGENCY CARE DESK

The Global Emergency Care (GEC) Desk the key focal point for Fellows and trainees interested in learning more about or getting involved in GEC. The team manages the portfolio of ACEM Supported Projects in GEC and is responsible for establishing partnerships that support locally-led, capacity development of emergency care in Low and Middle-Income Countries (LMICs). The GEC Desk is growing to become a repository of resources and guidance for those interested in engaging responsibly in GEC capacity development and volunteering. If you would like to learn more about GEC or ACEM's GEC activities and projects please email: **gecnetwork@acem.org.au**

Sarah Körver

Sarah is a public health and development professional and Manager of GEC at ACEM. She has more than a decade of experience working closely with governments, development partners and civil society, establishing global health programs, policies and coordination of humanitarian surge response. She has previously worked with the World Health Organization and the Joint United Nations Programme on HIV/AIDS and across the Western Pacific and South Asia regions extensively.
Since joining ACEM in 2019 she has led the establishment of the GEC Desk and facilitated the College's commitment to building an extensive partnerships network that supports locally-led capacity development of emergency care in LMICs. In conjunction with GECCo she has steered ACEM into a leading role in sustainable and ethical GEC capacity development and volunteering for development that adheres to evidence-informed practice.
With the growth of the team and GEC project portfolio, Sarah will be guiding regional engagement and strategic direction in alignment with the GECCo 2022-2024 Strategic Plan.
Sarah is deeply passionate about advocating for increased investment in emergency care systems and is proud of the College's continued commitment to the sector. She has a keen interest in development ethics, healthcare workforce capacity development and health system strengthening with numerous peer-reviewed publications in these areas.

Sally Reid

Sally is ACEM's GEC Coordinator, previously having worked in the College's Continuing Professional Development (CPD) Unit as a CPD Officer.
Sally is an experienced administrator and project manager who has worked across the health, agriculture and community services sectors. Her early career as a scientist and a dietitian has been subsequently combined with working in research, research and development management, administration, advocacy, policy and project management. Sally has worked with a number of not-for-profits, community and membership organisations, including Dairy Australia and the National Heart Foundation.
This role enables Sally to fulfil a long-term goal of working in the global health sector and be involved in the improvement of healthcare and healthcare access in LMICs.
Sally plays an integral role supporting the recruitment and technical vetting for our Visiting Emergency Medicine Registrar Program (VEMRP) offering GEC placements across the Indo Pacific region.

Juliette Mundy

Juliette is the newly appointed Grants Coordinator joining ACEM's GEC team.
Juliette is a public health professional with significant experience in the Aboriginal Community-Controlled Health Sector (ACCHS), including project management and program development. Juliette has recently moved to Melbourne from the Northern Territory, where she has most recently been working on a health systems-strengthening project in Timor-Leste.
Juliette is looking forward to supporting organisational growth through new initiatives for GECCo and the GEC Desk.

Inga Vennell

Inga is an experienced editor and publications specialist with a background in communications, journalism and a demonstrated history of working in the non-profit sector.
Inga has been with ACEM for four years and a part of the GEC Desk since its inception.
She is the Editor of *Your ED* – the ACEM Magazine, Editor of the GEC Annual Portfolio and supports production of of the Emergency Medicine Australasia (EMA) Journal.
She has a special interest in global emergency care and is honoured to be the custodian of your stories.

Jesse Dean

Jesse is General Manager, Policy and Regional Engagement, overseeing ACEM's work in public policy and advocacy, faculty engagement and global emergency care. Jesse comes to the role with broad experience, including policy and government relations, international development, program management and media relations. Jesse spent four years working in East Africa and has a strong interest in building public health capacity in LMICs.

ACEM looks forward to welcoming a newly appointed GEC Project Manager to the GEC team in June 2022.

MAPPING GLOBAL EMERGENCY CARE AT ACEM

This map features ACEM's 2021-2022 portfolio of work in Global Emergency Care (GEC).

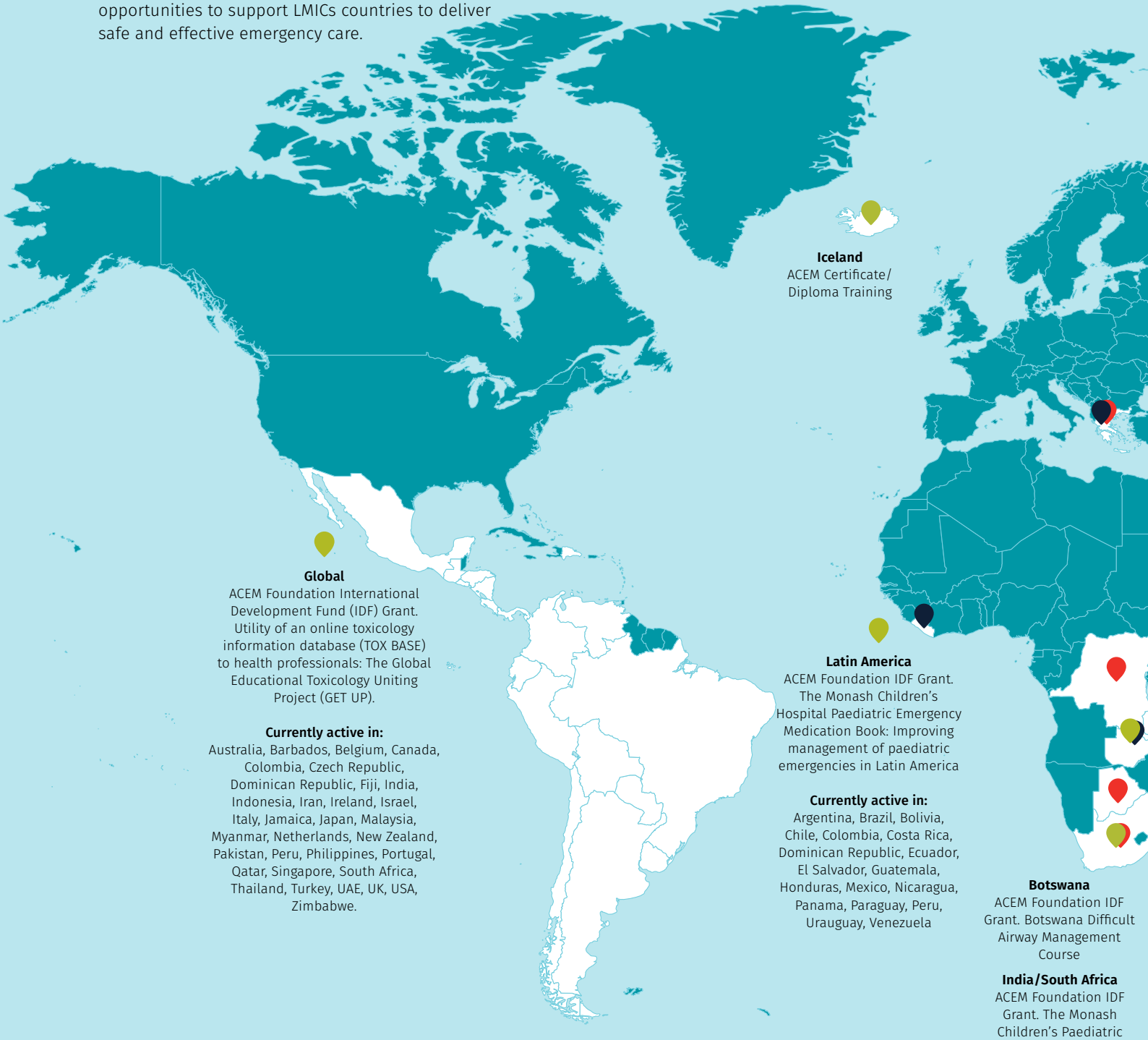
ACEM supported activities and projects are a body of work managed by ACEM's GEC Desk focused on building capacity in emergency care in Low and Middle Income Countries (LMICs). This work supports locally-led development and adheres to best-practice in volunteering for development.

GECCo's 35 Country Liaison Representatives (CLRs) are in 32 locations and act as a point of linkage between local providers of EC and ACEM to facilitate discussions and opportunities to support LMICs countries to deliver safe and effective emergency care.

Fellows in the field (FIFs)/ trainees in the field (TIFs) are individuals supporting GEC activities independently of the College. We link in with our FIFs and TIFs and share information via our GEC Network.

If you are a FIF or TIF and do not see the geographical location of your work reflected on this map please reach out the GEC Desk at **GECNetwork@acem.org.au**.

We would love to hear about your work in GEC.



Iceland
ACEM Certificate/ Diploma Training

Global
ACEM Foundation International Development Fund (IDF) Grant. Utility of an online toxicology information database (TOX BASE) to health professionals: The Global Educational Toxicology Uniting Project (GET UP).

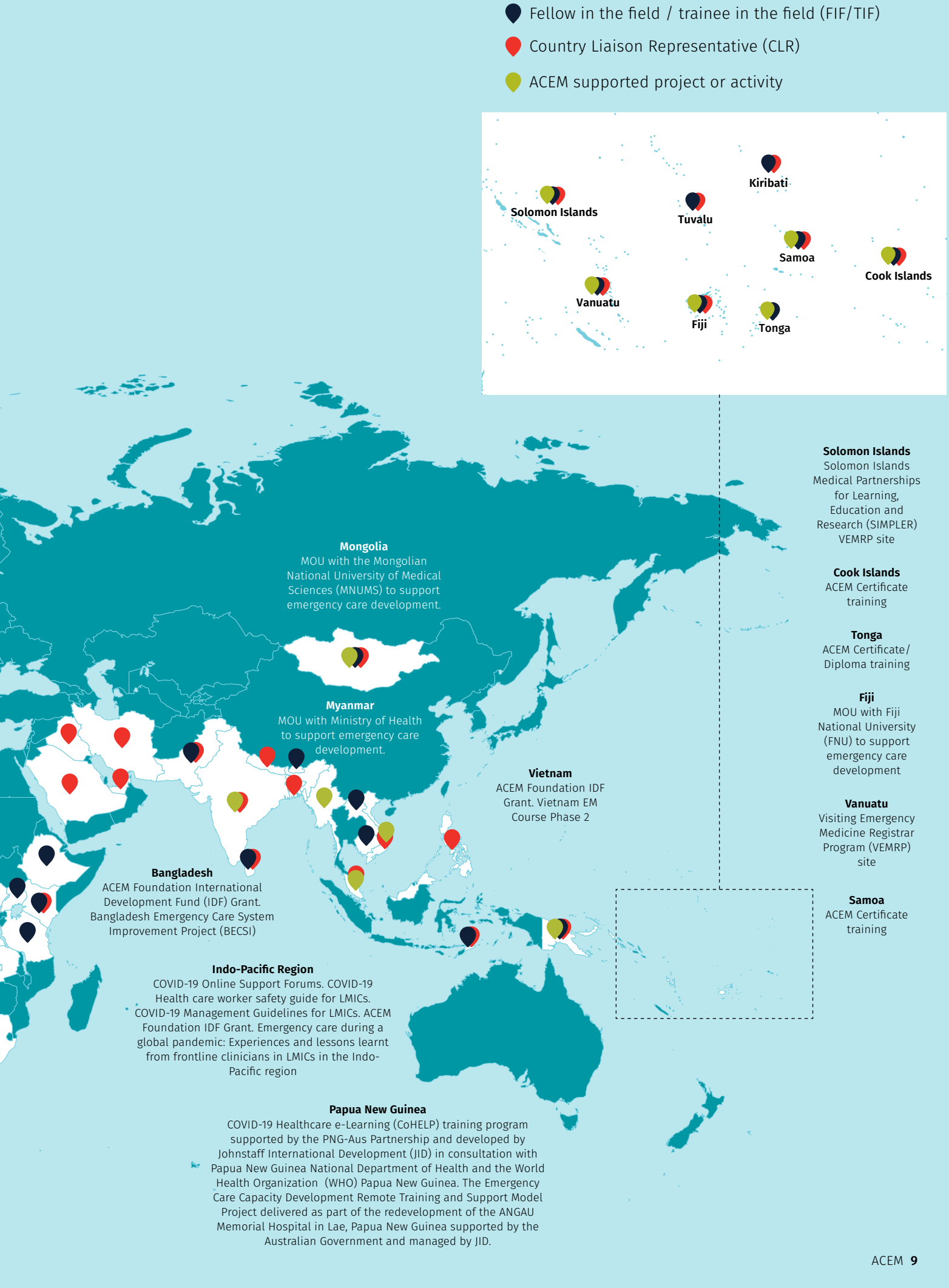
Currently active in:
Australia, Barbados, Belgium, Canada, Colombia, Czech Republic, Dominican Republic, Fiji, India, Indonesia, Iran, Ireland, Israel, Italy, Jamaica, Japan, Malaysia, Myanmar, Netherlands, New Zealand, Pakistan, Peru, Philippines, Portugal, Qatar, Singapore, South Africa, Thailand, Turkey, UAE, UK, USA, Zimbabwe.

Latin America
ACEM Foundation IDF Grant. The Monash Children's Hospital Paediatric Emergency Medication Book: Improving management of paediatric emergencies in Latin America

Currently active in:
Argentina, Brazil, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Urauguay, Venezuela

Botswana
ACEM Foundation IDF Grant. Botswana Difficult Airway Management Course

India/South Africa
ACEM Foundation IDF Grant. The Monash Children's Paediatric Emergency Medication Book: Developing resources for LMICs


Fellow in the field / trainee in the field (FIF/TIF)
Country Liaison Representative (CLR)
ACEM supported project or activity
Kiribati
Solomon Islands
Tuvalu
Samoa
Cook Islands
Vanuatu
Fiji
Tonga
Mongolia
MOU with the Mongolian National University of Medical Sciences (MNUMS) to support emergency care development.
Myanmar
MOU with Ministry of Health to support emergency care development.
Vietnam
ACEM Foundation IDF Grant. Vietnam EM Course Phase 2
Bangladesh
ACEM Foundation International Development Fund (IDF) Grant. Bangladesh Emergency Care System Improvement Project (BECSI)
Indo-Pacific Region
COVID-19 Online Support Forums. COVID-19 Health care worker safety guide for LMICs. COVID-19 Management Guidelines for LMICs. ACEM Foundation IDF Grant. Emergency care during a global pandemic: Experiences and lessons learnt from frontline clinicians in LMICs in the Indo-Pacific region
Papua New Guinea
COVID-19 Healthcare e-Learning (CoHELP) training program supported by the PNG-Aus Partnership and developed by Johnstaff International Development (JID) in consultation with Papua New Guinea National Department of Health and the World Health Organization (WHO) Papua New Guinea. The Emergency Care Capacity Development Remote Training and Support Model Project delivered as part of the redevelopment of the ANGAU Memorial Hospital in Lae, Papua New Guinea supported by the Australian Government and managed by JID.
Solomon Islands
Solomon Islands Medical Partnerships for Learning, Education and Research (SIMPLER) VEMRP site
Cook Islands
ACEM Certificate training
Tonga
ACEM Certificate/ Diploma training
Fiji
MOU with Fiji National University (FNU) to support emergency care development
Vanuatu
Visiting Emergency Medicine Registrar Program (VEMRP) site
Samoa
ACEM Certificate training

iStock.com/mtcurado

PROTECTING EMERGENCY HEALTHCARE PERSONNEL IN CONFLICT ZONES DURING THE COVID-19 PANDEMIC

Dr Claire E Brolan and Bailey Meyers

Centre for Policy Futures, The University of Queensland, Brisbane, Australia.

Larry Maybee

Australian Red Cross, Legal Adviser – International Humanitarian Law, Humanitarian & Health Sectors, Brisbane Australia.

The COVID-19 global health emergency adds another layer of complexity to healthcare systems, services and resource allocation around the world. In fragile and conflict-affected countries where health systems and infrastructure have already been ravaged by civil unrest, neglect and war, COVID-19 poses an added threat.

In such countries, health information and disease surveillance systems are usually weak or have altogether collapsed. People uprooted by conflict live in close proximity. Life-saving resources like clean water, soap, food, essential medicine, and trained healthcare personnel in personal protective equipment (PPE) to combat infectious disease transmission (and its impacts), are in short supply.

Local communities in conflict zones may have low levels of health literacy for effective COVID-19 preventative healthcare or receive misinformation spread through social media. Use of modern communication technology has created new digital forms of aggression and challenge for humanitarian actors, in negotiating safe, timely healthcare access, to affected and at-risk populations and in negotiating the security of their own health or medical staff.

Emergency healthcare workers, who courageously work in complex and dangerous settings, are owed a number of protections under International Humanitarian Law (IHL), the international legal framework that governs armed conflict. Such protections are owed whether the healthcare worker is from the local population and reports to the Ministry of Health, or belongs to international humanitarian, nongovernmental, military or peace-keeping organisations.

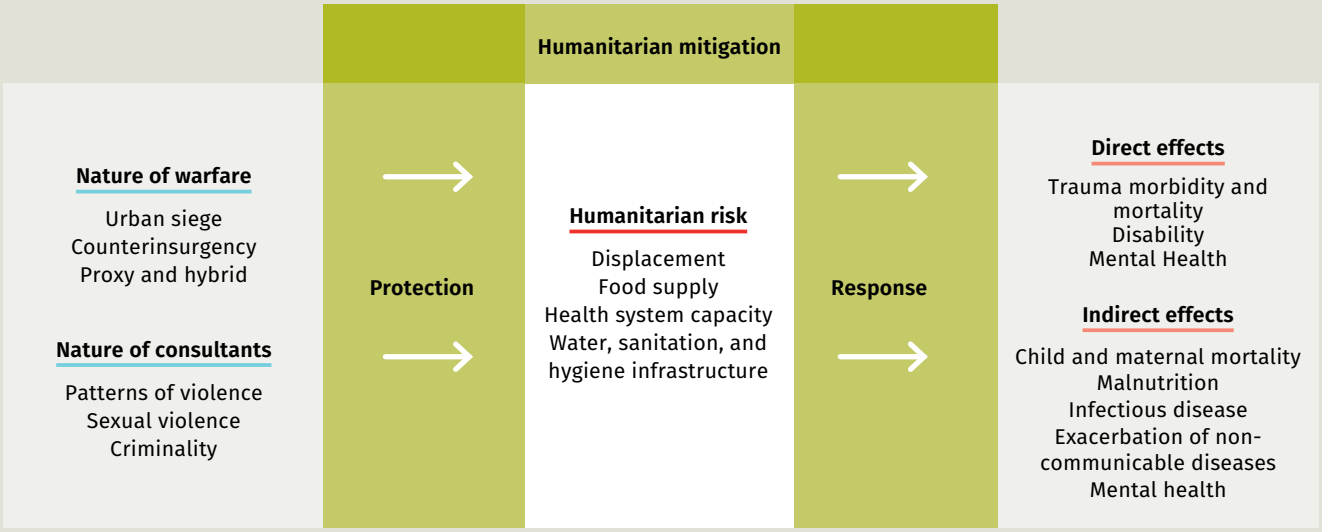
Conflict and the COVID-19 pandemic

Healthcare workers are at the frontline of all kinds of emergencies. As first responders, emergency care personnel provide crucial medical support to the sick, injured and wounded in armed conflict and civil unrest, as well as during floods, earthquakes and other natural and human-made disasters.

In addition to the clinical care role paramedics and emergency health workers have played in the pandemic response, they have also played a significant role in collaborating with governments and multi-stakeholders to develop timely, cost-effective, localised public health emergency policy and planning solutions to contain and prevent the spread of COVID-19 at both the health systems and service level.

Yet even with vaccines, diseases are often hardest to eradicate in conflict zones. In certain locations COVID-19 and conflict appear to have a symbiotic or bi-directional relationship. Evidence is emerging that circumstances associated with armed conflicts may give rise to greater spread of COVID-19 within and across borders. In turn, COVID-19 can create conditions for the exacerbation of

Figure 1. Humanitarian mitigation of adverse health outcomes in areas of armed conflict.[4]



What is International Humanitarian Law according to the Australian Red Cross[20]

'International Humanitarian Law (IHL) is a set of international laws that set out what can and cannot be done during an armed conflict.

- Their main purpose is to maintain some sort of humanity in armed conflicts, saving lives and reducing suffering.
- To do that, IHL regulates how wars are fought, balancing two aspects: to weaken the enemy and limit the suffering.
- The rules of war are universal. The Geneva Conventions (which are the core elements of IHL) have been ratified by 196 countries. Very few international treaties have this level of support.
- Everyone fighting a war needs to respect IHL, both governmental forces and non-stated armed groups.
- There are consequences if the rules of war are broken. War crimes are documented and investigated by States and international courts. Individuals can be prosecuted for war crimes.

In short, the laws of war mean:

You do not torture people. You do not attack civilians. You limit as much as you can the impact of your warfare on women and children. You treat detainees humanely.'

Key points on what the laws of war do (or ought to do).

12 key points in the context of protecting and promoting human health and wellbeing, health service provision, and promotion of the underlying determinants of health.

1. Protect those who are not fighting, such as civilians, medical personnel or aid workers.
2. Protect those who are no longer able to fight, like an injured soldier or a prisoner.
3. Prohibit targeting civilians and medical personnel. Doing so is a war crime.
4. Recognise the right of civilians to be protected from the dangers of war, as well as receive the help they need (including equitable, non-discriminatory access to health services). Every possible care must be taken to avoid harming civilians, their houses or destroying their means of survival and underlying determinants of health, such as water sources, crops or livestock.
5. Mandate that the sick and wounded have a right to be cared for, regardless of whose side they are on. This is also part of everyone's human right to health (and to access health services) without discrimination.
6. Specify that medical workers, medical vehicles and hospitals dedicated to humanitarian work cannot be attacked.
7. Prohibit torture and degrading treatment of prisoners.
8. Specify that detainees must receive adequate food, water and shelter (critical underlying determinants of health) as well as be allowed to communicate with their loved ones.
9. Limit the weapons and tactics that can be used in wars, to avoid unnecessary suffering.
10. Explicitly forbid rape or other forms of sexual violence in the context of armed conflict.
11. Protect historic buildings, monuments, works of art and other cultural treasures.
12. Not only must medical personnel and the healthcare services they provide be respected and protected, but they must also receive such support and assistance that they require in order to fulfil their medical mission. This includes access to any place in which their services are essential, subject to such supervisory and safety measures deemed necessary by the party to the conflict that is in control of the area.

Adapted from the 11 points on 'what the law of wars do' outlined by the Australian Red Cross [20]

poverty, social tension, displacement and violence. These conditions leave citizens and displaced persons exposed to COVID-19 and have been reported as constituting an indirect method of warfare.

Harm to healthcare workers responding to COVID-19

Armed conflicts are intensely dynamic and contextual. The protection of healthcare workers and non-combatants for the safe provision of health and humanitarian services must continually flex and adapt. This creates new challenges for health service access and equity, medical supply chains, healthcare worker security and, ultimately, direct and indirect health (morbidity and mortality) outcomes in local populations (Figure 1).

Violence against healthcare workers and facilities has been widely reported on and documented extensively. A Declaration condemning increasing incidents of such attacks was issued in May 2020 by medical and humanitarian organisations, with signatories including the International Committee of the Red Cross (ICRC).

Sadly, the experience of harm and violence against healthcare workers at the hands of state and non-state operatives during infectious disease outbreaks is not a COVID-19 phenomenon. Ten years ago, the ICRC and Red Crescent Movement launched the Health Care in Danger (HCiD) initiative to respond to growing incidences of violence against health workers, patients, health facilities and vehicles, and to promote safe access to and delivery of healthcare in armed conflict and other emergencies.

Despite the HCiD initiative's intensive efforts, more recent attacks against healthcare workers responding to Ebola virus outbreaks in West Africa have been reported.

The laws of war and the special protection of healthcare workers

IHL is also known as the law of armed conflict or law of war. The main body of IHL is primarily found in the 1949 Geneva Conventions and their 1977 Additional Protocols, as well as in several international treaties.

IHL provides a comprehensive framework of rules aimed to regulate how wars are fought and protect those who are wounded, sick or injured (civilians and military combatants) and in need of medical treatment. Box 1 sets out what the laws of war are and why they exist. Box 2 expands on how the laws of war specifically protect and promote access to safe health service provision and underlying determinants of health.

IHL provides special status and protections to healthcare workers in armed conflicts, and to hospitals, clinics, ambulances and other medical infrastructure. IHL protects emergency care workers from attack and the effects of fighting, and their ability to provide healthcare without fear of punishment or reprisal.

Individuals who violate IHL and target healthcare workers or those in their care face prosecution for war crimes. Attacks against medical personnel, wounded and sick combatants and/or medical infrastructure, by either side during an armed conflict, is the most serious kind of violation of the laws of war. Attacks against medical personnel, attract universal jurisdiction under IHL and may be investigated and prosecuted by any State as a war crime, regardless of where the violation occurred.

Central to IHL is the rule that wounded, sick and injured combatants must be protected and cared for,

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without discrimination or adverse distinction. This means emergency care workers must provide treatment to the wounded and sick based solely on their medical and healthcare needs, regardless of which side the patient is fighting on or may be loyal to.

Under IHL, if healthcare workers are captured and detained by an adverse power during an armed conflict, they must be allowed to continue their professional work wherever possible.

Finally, armed conflicts can present a demanding context for the application of medical ethics by healthcare workers. For instance, healthcare workers may struggle to protect patient confidentiality in armed conflict zones vis-à-vis COVID-19 contact tracing and compulsory infectious disease reporting under the International Health Regulations.

IHL recognises the importance of medical ethics and protects the independence of medical personnel in two ways: (1) by prohibiting the punishment of persons for carrying out medical activities, so long as the activities are being carried out in accordance with medical ethics; and (2) by ensuring that medical personnel are not compelled to act, or refrain from acting, contrary to medical ethics.

IHL also gives legal mandate or force to medical personnel to determine issues of healthcare prioritisation and resource allocation based on clinical need and medical grounds. IHL seeks to ensure that medical personnel are free from pressure to participate in acts of torture or other ill-treatment of the sick and wounded or detainees.

Healthcare workers cannot and should not be punished for disobeying an unlawful or medically unethical order. In circumstances where healthcare workers are punished or harmed, in violation of IHL, both the perpetrators and their superiors will be accountable and may face prosecution for war crimes. For more information on the practice of medical ethics in conflicts, see the World Medical Assembly (WMA) Regulations in Times of Armed Conflict and Other Situations of Violence of 1956 (revised latest by the 63rd WMA General Assembly in 2012).

In light of new strains of COVID-19 emerging, demand for healthcare workers who are skilled in emergency medicine will continue. Scientists warn that zoonotic disease pandemics like COVID-19 are on the rise due to ecological, behavioural or socioeconomic change, combined with global climate change. Climate change will also continue to impact the ferocity and frequency of natural disasters that can exacerbate armed conflicts and disease outbreaks and transmission.

As emergency health events like COVID-19 and different types of conflict sadly continue to arise in our world (or remain protracted), it is crucial that emergency healthcare workers have an overview of the protections they are owed under IHL when working in dangerous conflict zones, including during the COVID-19 pandemic.

The Australian Red Cross offers training and support to organisations that deploy personnel in conflict-affected regions, including from defence, government, and the humanitarian and health sectors.

@ To read more about the role ACEM is playing in advocating for the protection of healthcare workers in Myanmar please turn to **Page 22**.

ACEM SUPPORTED PROJECTS

ACEM supported activities and projects are a discreet body of work managed by ACEM's Global Emergency Care Desk, committed to improving the capacity of Low and Middle-Income Countries (LMICs) to deliver safe and effective emergency care, with a focus on training, education, and research.

The following stories provide an insight into how ACEM works with our partners to progress locally-led emergency care development objectives in a manner that promotes reciprocity, sustainability and mutually beneficial partnerships; ensures accountability and value learning and; adheres to best-practice in volunteering for development.

LESSONS FROM THE FRONTLINE:

DOCUMENTING THE EXPERIENCES OF PACIFIC EMERGENCY CARE CLINICIANS RESPONDING TO THE COVID-19 PANDEMIC

This article is an adapted extract from the report Cox, M., Phillips, P., Mitchell, M., Körver, S., Herron, LM., Sharma, D., Brolan, CE., Kendino, M., Masilaca, O., Gerard O'Reilly, G. Poloniati, P., Kafoa, B. 2021. 'The Ethics of Public Health Emergency Preparedness and Response: Experiences and lessons learnt from frontline clinicians in low- and middle-income countries in the Indo-Pacific region during the COVID-19 pandemic' Research Report 2021, Melbourne, Australia: Australasian College for Emergency Medicine.

LMICs across the Pacific region have been severely impacted by the COVID-19 pandemic, and our colleagues in emergency care have been on the frontline of response efforts.

Emergency care clinicians have been involved significantly in everything from triage and clinical management of patients with COVID-19 to health system leadership and coordination, exposing them to a range of ethical and operational challenges. From the beginning of the COVID-19 crisis right through to now, ACEM's Global Emergency Care Committee (GECCo) continues to provide technical assistance and support. This includes collaborative development of practical resources and coordinating online support forums for emergency care providers across the Indo-Pacific region to discuss COVID-19 preparedness and response. ACEM has partnered with the World Health Organization (WHO) and the Pacific Community (SPC), an intergovernmental scientific organisation mandated with providing scientific and technical functions for its 26-member Pacific states and territories. The forums have been pivotal in facilitating South-to-South cooperation and learning. In addition, they provide a valuable platform for care providers in LMICs to share knowledge, innovations and adaptive behaviours, and problem solve and professionally support each other during this stressful and complex time. In the course of these forums, participants have identified localised and shared ethical challenges. Key themes have emerged, such as the challenges emergency departments (EDs) face as unique frontline response areas, required to respond to COVID-19 as well as maintain 'business as usual'. There have been numerous stories of a 'mismatch' between donated equipment and what was required to meet local needs, and what could be utilised given in-country infrastructure and resources, particularly staff capacity: 'The mismatch came when we got four ventilators and then realised we don't have enough staff to run those ventilators.' In the forums, we have seen emergency care clinicians as experienced innovators in disaster response and triage, showing flexibility and vision under pressure, when faced with the significant ethical challenges of clinical decision-making in resource-limited environments. As the webinars have progressed, GECCo members have noted that, although guidance has been generated for healthcare worker protection and the allocation of scarce resources during public health emergencies, it is not easily translated to the LMIC context. The webinars have consistently highlighted lessons for all countries from the adaptive, innovative and pragmatic responses to COVID-19 implemented in

LMICs, especially in relation to the ethical and operational challenges faced by frontline clinicians. We decided to examine these issues in-depth for the current COVID-19 response and use the outcomes to improve resilience and readiness for future communicable disease outbreaks.

Courtesy of co-funding from WHO and the ACEM Foundation, ACEM, in partnership with SPC, initiated a rapid, prospective, qualitative research project to explore the experiences of emergency care clinicians and other key stakeholders in Pacific LMICs responding to the pandemic. The study was conducted as a collaboration between Australian and Pacific researchers affiliated with ACEM and SPC, and employed rapid, prospective, qualitative research methods aiming to explore the lived experience of participants from their perspectives. We deliberately used strengths-based, appreciative inquiry as a fundamental underpinning of our qualitative data collection, to counter the ubiquitous deficit narrative that commonly accompanies research about LMICs. Data collection and analysis methods were informed by WHO health system building blocks, adapted for the Pacific emergency care context. These building blocks reflect the importance of human resources (such as trained clinicians), infrastructure (such as infection prevention and control-compliant resuscitation areas), and processes (such as triage) to effective emergency care, and have been endorsed through regional consensus involving clinicians across multiple Pacific Island Countries and Territories (PICT). Data were gathered from emergency care clinicians and other relevant stakeholders across Pacific LMICs in three phases: via online regional emergency care support forums (Phase 1), in-depth interviews with key informants (Phase 2), and focus group discussions (Phase 3). Phase 1 and 2 of our data collection and analysis is complete and we are currently analysing and triangulating data for Phase 3. The third phase involved data collection via focus group discussions with emergency care stakeholders from recognised geographical regions of the Pacific: Micronesia (encompassing the Federated States of Micronesia, Kiribati, Marshall Islands, Palau and the northern Pacific states); Polynesia (Cook Islands, Samoa, Tokelau, Tonga, Tuvalu and other small island states); and Melanesia (Fiji, Papua New Guinea, Solomon Islands, Vanuatu and Timor–Leste). Our study aims to capture the rich and diverse voices of emergency care clinicians in the Pacific region, and document lessons learned to inform recommendations for improved health system preparedness in future public health emergencies. To the best of our knowledge, it is the most in-depth qualitative study bringing to light the voices and lived experiences of emergency care clinicians in the Pacific region as they respond to the COVID-19 crisis. We anticipate the findings will fill important knowledge gaps on COVID-19 and the responsibilities of emergency care clinicians and contribute to greater understanding of the ethical tensions implicit in public health emergencies affecting the Indo-Pacific region. Importantly, this work will help facilitate context-specific ethical guidance that builds on existing COVID-19 resources and frameworks. Study results, to be published in subsequent papers, will inform efforts to improve health system preparedness for future public health emergencies. Importantly, the findings will strengthen emergency care system capacity to provide timely, quality and accessible care during routine operations as well as surge events. Although a significant amount of technical guidance has been generated during the pandemic, much of it has focused on high-income settings with advanced public health and clinical care capacity. Given the wide variation in health system responses to COVID-19 across the globe, all countries stand to benefit from structured analysis of the innovative and pragmatic solutions implemented in LMICs.

Acknowledgments

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More Information

The Ethics of Public Health Emergency Preparedness and Response https://ace.mn/nnb

A RECIPE TO PRIORITISE EMERGENCY CARE ON A TROPICAL ISLAND

John Foley and Libby White

John Foley is a Critical Care Registered Nurse currently working at Royal North Shore Hospital in Sydney.
Libby White is a Critical Care Registered Nurse working at Alfred Health in Melbourne.

For this recipe to succeed, firstly you need to prepare one professional body with a long-term vision and motivated members. Then fold in logistics and support provided by a volunteer organisation. Add a sprinkle of enthusiasm, a pinch of excitement, and simmer for a couple of months. When everything is steaming, whisk in two emergency nurses and put in a warm place for six months. Ensure they are mixed well with the local leaders to form a cohesive dish. As coconuts are plentiful and the sun is shining, sprinkle with some learning and laughter, then place in a ground oven, for best results.

The recipe being referred to here is the ACEM partnership with Vila Central Hospital (VCH) and Australian Volunteers Program. It is unique because it's a collaboration of many parties working together to achieve a common goal, which, sadly, is not common enough when supporting Low and Middle-Income Countries (LMICs).

This long-term vision has been created by the ACEM Global Emergency Care (GEC) Vanuatu team, who visited VCH in the archipelago nation of Vanuatu and, through a needs assessment, identified a plan of support to improve emergency care. The GEC Vanuatu team organised a string of nurses and doctors to work at VCH alongside the local team, to achieve a series of goals.

We were lucky enough to be selected to travel to Vanuatu in December 2020. VCH is the national referral hospital for the country and patients are flown in from all of the islands to receive specialised healthcare. The hospital is nestled into a hillside, looking out over a lagoon, and is surrounded by tropical bushland. There are 156 beds making up the medical, surgical, obstetrics and gynaecology, maternity, and paediatric wards.

On our arrival at VCH, we were warmly welcomed. We were tasked with teaching and supporting the implementation of a triage system at VCH. We had six months to achieve this goal, with regular support from ACEM.

We worked clinically with our colleagues and learned so much, as the scope of nurses is very different in Vanuatu. Medical staff are even more scarce than nurses, so the nursing staff often assess, treat and discharge patients independently. Slowly, this is changing as doctors from neighbouring Melanesian countries come to support the developing healthcare workforce. ACEM are providing support through their Visiting Emergency Medicine Registrar Program (VEMRP), also in partnership with Australian Volunteers Program .

The exchange of knowledge was incredible as we learnt about the large burden of non-communicable diseases (NCDs), and kastom (traditional) medicine.

The weekly presentation of diabetic foot sepsis, destined for amputation, was confronting. We saw record-breaking blood pressure readings every day in young Ni-Vanuatu men and women. The number of young women with breast and cervical cancer, for whom there is no treatment or palliative care service, was overwhelming. The ED staff took care of these patients and did their best to provide adequate pain relief and explanations to families. John and I shared our critical care knowledge and did our best to role model emergency nursing as we knew it, blending in local needs.

We encouraged more than one set of observations to be recorded for a critically unwell patient and advocated for nurses to document the care they had given. We continued advocating for asthma patients to use a metered-dose inhaler (MDI) instead of a nebuliser, a project started by our predecessors. We supported the nurses in caring for patients and we provided clinical teaching, such as explaining electrocardiograms (ECGs) and trauma patient care.

There was one patient had a blood pressure of 235/120 and he wanted to try kastom medicine before taking prescription medication. The emergency department (ED) staff encouraged him to come back in two weeks to re-check his blood pressure. When he returned, his blood pressure had not reduced so he agreed to try prescription medication. This is a great example of holistic care by Ni-Vanuatu healthcare professionals.

Throughout our time in Vanuatu, we had fortnightly meetings with the ACEM team in Australia and Aotearoa New Zealand to update them on our progress and discuss plans. We submitted budgets for triage training and prioritised what we could achieve.

After much planning and preparation, we delivered the triage training, which was well received by the nurses and doctors within the hospital. Hospital managers, nursing interns, and nurses from the Vanuatu College of Nursing Education attended. The Integrated Interagency Triage Tool

John and Libby teaching hospital leaders about performance appraisals.

Celebrating after completing triage training – there's always much laughter in Vanuatu!

(IITT) was developed by the World Health Organization (WHO) with input from the Red Cross and Médecins Sans Frontières (MSF). IITT has been given a Pacific twist by the ACEM team, to make it specific for the conditions and the people using it.

Staff came from all departments to understand how the new triage system would work and how it would impact the hospital. Some staff highlighted that triage could be used in their workplaces as well. For example, the nurses from the Children's Outpatients Department identified that a triage system would help them to formally organise their workload. The nurses in maternity who received all new referrals on Mondays believed that it would be useful in their area too. Staff were thinking outside of the ED about how to improve their own departments using the available resources.

We ran several days of training which were all well attended and we finished up each day of training by accessing the hospital computer lab, to ensure every nurse was logged on to Tembo training to continue their learning. Tembo is a free training platform developed by MSF that teaches the WHO triage system. The ED nurses have access to a computer, thanks to the "recipe to prioritise emergency care", through ACEM's vision and a grant from Australian Volunteers Program. Another beautiful example of how collaboration is working at VCH.

After the training, while we were out buying supplies to support the new triage system, the nurses started triaging on their own, using the knowledge and resources available to them. It was exciting to see them implement it without any input from us. This felt incredibly rewarding and we left Vanuatu with smiles on our faces, hoping the Ni-Vanuatu nurses got as much out of our time there as we did.

As mentioned above, this recipe to prioritise emergency care will continue to ferment and grow in the warm climate of Vanuatu. With ongoing support from ACEM and Australian Volunteers Program, another ED registrar has just landed in Vanuatu and will continue building on knowledge and skills to improve emergency care. All that is needed now is a few more nurses.

Dr Vincent Atua, ED Consultant at VCH explains, 'There have been huge changes to the way we do things in ED, including processes and staff morale. The nursing staff have been used to having visiting doctors from Australia or other developed countries, but never a nurse who could stand shoulder to shoulder with them.

Get involved in a small project if you can – leave a footprint when you go that we can cherish long after you've gone.'

Acknowledgements

Support for John and Libby's placements is provided by ACEM in partnership with the Australian Volunteers Program, an Australian Government-funded initiative managed by AVI in a consortium with Cardno and Alinea Whitelum.

More Information

Please contact the ACEM Global Emergency Care Desk at gecnetwork@acem.org.au if you are interested in working in Vanuatu.

WE LIVE IN A DIGITAL WORLD: INCREASING EMERGENCY CARE CAPACITY IN PAPUA NEW GUINEA

Dr Donna Piamnok, Sr Wilma Sebby and Sarah Bornstein

Dr Donna Piamnok is a Senior Emergency Physician at ANGAU Memorial Provincial Hospital (AMPH), Papua New Guinea (PNG).

Sr Wilma Sebby is an Emergency Nurse Specialist and Nurse Unit Manager (NUM) at AMPH.

Sarah Bornstein is an Emergency Nurse Specialist and the Project Lead for the PNG Emergency Care Capacity Development Remote Training and Support Model Project.

'We haven't used online learning before. We've just been doing our own in-house trainings here with the local team', said Sister Wilma Sebby, NUM at AMPH Emergency Department (ED) in Lae, PNG.

'I think on our own we wouldn't know where to begin really. It would have been like being thrown in the middle of the Pacific Ocean and asked to swim', added Dr Piamnok, AMPH ED physician.

There are two things you can't help but notice in Lae – the weather is wet, and the potholes are big and many. With the city's reputation as 'rainy Lae', the gardens are tropical, the grass is green, the weather is sticky, and power outages are common. Lae is PNG's second largest city, located in Morobe Province. It is a port and industrial city, and a gateway to the Highlands Region. AMPH is PNG's second largest hospital, and was built in 1964. In 2016 the redevelopment of AMPH, including the commissioning of a new ED, commenced. The project is a joint effort between the Papua New Guinean and Australian governments, including strong relationships with the PNG National Department of Health and the Provincial Health Authority.

In preparation for transition to the new ED, in late 2020 a team from ACEM began working with Johnstaff International Development (JID) and alongside PNG emergency care colleagues at AMPH to remotely support the development and implementation of an evidence-based model of care. At the forefront of the team at AMPH ED were Dr Donna Piamnok and Sister Wilma Sebby. Dr Piamnok is a Senior Emergency Physician at AMPH with extensive medical experience in the public and private sectors in PNG and has been a Senior Medical Officer at AMPH ED since 2019. Sr Sebby is an Emergency Nurse Specialist and has been the NUM of AMPH ED since 2000. They both have over 30 years of clinical experience and they are both pawa meris: powerful, strong women and experts in their chosen fields. Dr Piamnok and Sr Sebby led the AMPH ED Technical Advisory Group for the commissioning of the new department.

Together, we designed a model of care that would be fit for purpose in the new ED and included triage, patient flow and data management. We then set out to develop and deliver a PNG-specific training program encompassing each aspect of this model of care using entirely digital methods. The concept of introducing a new model of care, new assessment skills and new processes, via a new learning platform, with a team that was based across two countries (PNG, Australia) and four cities (Lae, Melbourne, Sydney, and Townsville) was bold to say the least. But these are unprecedented times...

When asked to reflect on triage processes used at AMPH before the project, Dr Piamnok smiled, 'I know in an emergency department it's supposed to be organised chaos, but I really would say it was quite chaotic and very stressful for our staff' The Integrated Interagency Triage Tool (IITT) was chosen as the preferred triage system for implementation in the ED. The IITT was developed collaboratively by the World Health Organisation (WHO), International Committee of the Red Cross (ICRC) and Médecins Sans Frontières (MSF), and is a novel, three-tier system purpose designed for developing EC settings. In partnership with local clinicians, ACEM has previously supported the successful implementation of the IITT in two other EDs in PNG and it has been well received by staff in those locations. In 2019, Dr Piamnok and Sr Sebby visited one of the sites, Mount Hagen Provincial Hospital. They observed the education program about triage and patient flow, followed by implementation of the IITT. Sr Sebby recalled, 'We were practising triage previously, but it wasn't really organised, and having a sneak peek of it when I went to Hagen. I saw that it was really organised, so we wanted to implement it here'.

Dr Piamnok conducting handover at the newly created patient tracking board. Photo: JP Miller/ACEM

Sr Wilma Sebby cutting cake at KHS Graduation. Photo: ACEM

Planning for training and implementation of the new model of care was affected by COVID-19 from the outset, with international border restrictions limiting travel. But, of course, a global pandemic wasn't going to deter the devoted AMPH ED team. Dr Piamnok said, 'We had no idea of course when COVID first hit our doorstep but like in any other emergency department you've just got to throw yourself into it and just plough and keep ploughing'. The project team were forced to be adaptable and innovative and embrace digital media. For 16 months, the teams from Australia and PNG have met weekly via Zoom to collaboratively create a digital learning program suitable for delivery in PNG. 'Neither I nor Sr Sebby had any experience with Zoom conferencing… honestly, I didn't think it would work at first… but that's the thing, as a team we found ways and means to make things happen, and we've had really great support', Dr Piamnok said.

The online program developed was named the Essential Emergency Care Systems Training Program and comprised 10 courses addressing triage, patient flow, the IITT, data and documentation, as well as a recap of essential emergency care skills, IPC and ED equipment. The program was launched on a digital learning platform named Kumul Helt Skul (KHS) – kumul being the Tok Pisin word for bird of paradise and emphasising a locally led and designed program.

With the support of a design team from Catalpa, the digital learning provider, we were able to customise the learning platform to suit the needs of emergency care staff in PNG. Many of the training participants did not readily have computer access or stable internet, so a smartphone-friendly platform was designed with offline capability and downloadable resources that would update once a connection was restored, and images and videos were low-bandwidth friendly. There was limited time for teaching and no dedicated work hours for self-directed learning, so the courses were designed with a micro-learning approach that used short lessons and courses to make up the program. Learning content previously available was rarely contextualised to the Pacific context, so a graphic designer was used to develop Melanesian-specific imagery and animations, with examples taken from the PNG setting, using voiceovers recorded by local clinicians. 'All of us were keen to try something new, it was a huge learning experience for us' Dr Piamnok said.

With coordination by the Project Delivery Office (managed by JID), live seminars were planned that would be delivered via Zoom to provide a 'face-to-face' component to the training and an opportunity to discuss the material and answer questions. We designed flowcharts and posters to be hung around the ED, as well as a quick reference guide containing all the information required to understand the new system, so that participants had their own resources to use for the training program, and for use after implementation. 'I think the bulk of us use pictures and diagrams and colour coding and all of that. The tools that were used, I think they greatly helped our team', said Dr Piamnok.

In early 2021, during the development phase of the project, a third wave of COVID-19 hit PNG and had a dramatic effect on the community, hospitals, and their front-line care providers. Meetings were interrupted by internet and power outages, COVID-19 outbreaks in the ED, nursing strikes and community protests, but the dedication of the team at AMPH ED was unwavering throughout. Balancing the coordination of a busy regional ED during a global pandemic as well as the commitments of family and community is impressive enough, but to add on an extra workload in designing and developing a novel training program to benefit EC staff across PNG is truly exceptional. Triumphantly, KHS launched at AMPH in July 2021 and was then expanded to the ED at Port Moresby General Hospital, PNG's largest hospital, in

the country's capital. This resulted in over 130 EC staff registering across both sites to participate in the online training whilst concurrently responding to the country-wide pandemic, and both EDs committing to implementation of the new model of care.

The already fragile health system in PNG faced significant pressure with recurrent COVID-19 surges, limited testing capacity, stretched resources and insufficient COVID-19 isolation areas. Business as usual emergency care systems had to be modified to accommodate surge support. This stretched already limited resources and impacted both patients and staff. Noting the challenges both facilities were facing in the wake of COVID-19, the Australian Government supported a team of clinicians, including six emergency nurse specialists to deploy to PNG from Australia to provide rapid training and COVID-19 system development support. This meant that in addition to the online training from KHS, Australian clinicians were available to concurrently provide face-to-face training opportunities and support ED staff with preparations for and implementation of the new model of care during their 'go live' weeks.

Many participants were excited to try online learning for the first time and while there were plenty of challenges, having Australian clinicians in-country meant there was support for access and troubleshooting, and the Zoom seminars could be delivered in-person for a combined approach that maximised participation. Donna explained, 'Having face-to-face training was very good because we had immediate responses to questions and demonstrations at the bedside. Different people have different ways of learning, some are classroom-oriented people… others of us, we would like to diversify things'. Following completion of the online training, the team supported preparation for the new model of care in ED including clinical redesign, minor infrastructure improvements and data support for the new, custom-designed data management system.

The night before the launch of the new model of care, an eager Sr Sebby slept in ED to get an early start on preparations, and there was excitement in the air for ED staff. We separated each ED into dedicated areas to align with the IITT and applied coloured tape and signs to make each area clear to staff and patients. Each ED has triage, resuscitation, acute, fast track, and respiratory areas. The local staff then used the knowledge they had gained from the KHS training, including case studies and triage scenarios, in the real world. 'It has brought a lot of clarity to us, seeing how we can manage patients according to the type of problems that they present with at the ED, especially attending to the very sick ones quickly', Sr Sebby said. Dr Piamnok added, 'It gives us a tool not only to help us quickly identify emergencies, but it forms a basis for us to be able to explain to our presenting population what constitutes an emergency, and why we can't see everybody

Summary of Monitoring and Evaluation Data from AMPH

Training delivery

100%

of *EC staff agreed or strongly agreed that the Kumul Helt Skul (KHS) learning platform was easy to access, use and navigate

100%

of EC staff agreed or strongly agreed that the digital teaching methods were appropriate for their learning needs

100%

of EC staff agreed or strongly agreed that the learning content was interesting and engaging

100%

of EC staff agreed or strongly agreed that the learning content made it easy to understand new triage and flow processes

Triage and flow process

100%

of EC staff agreed or strongly agreed that the triage and flow system has improved patient flow in the ED

100%

of EC staff agreed or strongly agreed that implementation of the triage and flow system has improved their job satisfaction

5%

under-triage rate for the 3 months following triage implementation **(target <10%)**

41%

over-triage rate for the 3 months following triage implementation **(target <60%)**

at the same time. It helps the public understand and cooperate with us.'

The COVID-19 pandemic affected every phase throughout the project period. Respiratory screening and isolation areas were incorporated into the IITT and new patient flow processes, though limited resources meant that access block and staffing difficulties were dominant during the introduction of the new model of care. These conditions were not ideal for the introduction of new systems and processes, but the commitment of local staff and the leadership of Dr Piamnok and Sr Sebby have seen use of the IITT continue. 'You either sink with the ship or you keep it afloat, knowing there are innocent lives on the ship with you... so I think it's the instinct to survive that's really kept us going', Dr Piamnok said.

Despite ongoing challenges, Dr Piamnok and Sr Sebby both have an optimistic outlook for the future. Sr Sebby explained, 'online training and the new model of care implementation has given us a lot of help in how we can manage patients in the ED. Going forward it's not only the Kumul Helt Skul that we'll be continuing, but we can also do refresher courses and if we need some more Zoom training we know that our counterparts from Australia will always be there to support us and they will help us out through future online trainings'. Donna agreed, adding, 'it's definitely my hope and my belief that the ED will not be where it is right now, it will improve greatly. In the new ED I can see that we will have much better control of patient flow, and I can see that the space will be huge, so our current problems with space will be pretty much eliminated. Our challenge is those factors that are out of our control - the pharmaceutical challenges, staffing problems, administration problems - those are pretty big-ticket items which we have no control over. If we can correct all those constraints, it will definitely be a really nice hospital for the Morobe people, the Highlands people, the Southern region people, and even the Islands people.'

Acknowledgements

The PNG Clinical Support Program (CSP) is funded by the Australian Government and managed by Johnstaff International Development (JID).

Donna, Wilma and Sarah would like to thank Dr Colin Banks and Dr Rob Mitchell for their ongoing commitment to this project and more broadly to emergency care development in PNG. We thank emergency care advisor deployees Leigh Elton, JP Miller, Travis Cole, Angie Gittus and Bronwen Griffiths for their valuable contribution in 2021. Finally, many thanks to Sarah Körver for overseeing the project.

We would also like to acknowledge all healthcare workers in PNG and the Pacific who are working tirelessly in challenging environments during the COVID-19 pandemic.

Implementation process

100%

of EC staff registered for the Essential Emergency Care Systems Training Program (EECSTP)

81%

of EC staff completed one or more courses

63%

of EC staff have completed the core courses of the training program (courses 1-7)

94%

of EC staff attended one or more live training sessions

100%

of EC staff agreed or strongly agreed that they felt confident to carry out all key components of the IITT at the end of the EECSTP

14%

increase in EC staff knowledge scores between pre and post training quizzes*

PNGAus Partnership

* emergency care (EC)

* further increase anticipated following refresher training (in a post-COVID environment)

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STANDING IN SOLIDARITY WITH OUR MYANMAR COLLEAGUES

Dr Rose Skalicky-Klein and Dr Georgina Phillips

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Dr Georgina Phillips is an Emergency Medicine Specialist, based at St. Vincent's Hospital, Melbourne and Professor (Hon.) at UM1, Yangon.

Like every other country around the globe, 2020 was the year that COVID-19 dominated the actions of the government and the people in Myanmar. Health resources were increased to cope with the national pandemic response and essential healthcare workers unified, working towards the common goal of beating COVID-19. Despite the mental, physical and emotional exhaustion that battling this unseen enemy formed, health workers and Myanmar citizens alike expected some respite and hope in 2021.

For emergency medicine (EM) there was a sense of success – the academic program had continued, and all exams completed, despite the complex challenge of ongoing service provision during the pandemic. COVID-19 cases were starting to decrease, and healthcare staff were on the frontline of the vaccination program. However, this hope shattered in a moment of greed and power.

In the early morning of 1 February 2021, the Myanmar military staged a coup to detain key leaders of the democratically elected government immediately before the first sitting of the new parliament. In response to the subsequent declaration of military rule, the citizens of Myanmar took to the airwaves, the web and the streets, to peacefully protest their outrage and unreserved rejection of this unlawful and anti-democratic act. Within days, emergency doctors and other health workers around the nation were leading peaceful resistance through the Civil Disobedience Movement (CDM). On 8 February, when Professor Zaw Wai Soe made his speech closing the UM1, Yangon, in support of CDM, all other medical and nursing universities quickly followed, and all government hospitals closed their doors to clinical service, leading to a health system suddenly in crisis.

The threat to the nation of Myanmar and civil society function is overwhelming. Fifty years of previous military rule failed to develop the health system and instead enshrined poverty, inequality and inadequate medical care. Until recently, government spending on health was amongst the lowest in the world, and decades of neglect, isolation and armed conflict resulted in poor health outcomes and a high rate of catastrophic individual health out-of-pocket expenditure. Emergency care systems have been established in recent years as an essential, but previously absent, component of a universal healthcare response. A return to this preceding situation is no longer acceptable.

EM doctors and all healthcare staff are now bearing a heavy emotional toll for their decisions of protest. Duty of care for patients is a doctor's first priority, but how can this be done under an unlawful, undemocratic and oppressive military system? Yet how can a service be withdrawn – particularly for civilian patients? Limiting access to life-saving interventions presents an acute and complex ethical challenge, notwithstanding the significant risks to the public.

With government hospitals closed, EM and civil healthcare workers turned to charity and private hospitals, returned to their clinics, opened new clinics and worked on the streets amongst the protesters. Many EM doctors have returned to their hometowns to provide healthcare for protesters, as retaliation against protesters has expanded

into even the most remote areas of the country. However, these small or private facilities have neither capacity nor finances for comprehensive care.

EM specialists have led the clinical COVID-19 response in Myanmar. Until recently, the government emergency departments (EDs) were performing screening, testing and early critical care for COVID-19-positive patients. In collaboration with global health partners, systems were robust and resource stewardship sound. An immunisation program had commenced, prioritising first-line responders. Since the military takeover, the COVID-19 response has stalled; testing is minimal, clinical care restricted, and immunisations have paused.

Mass public rallies and protests are serving a critical function for resistance and unity, but are also likely to be super spreader events for virus transmission. Without adequate testing, public compliance and goodwill for isolation, access to acute clinical care, and continued immunisations, the implications for COVID-19 spread, morbidity and mortality are substantial. Within this dreadful context, senior EM doctors, specifically, have ensured that government hospitals were prepared and ready to respond to mass casualty incidents, checking drugs and equipment daily. Graduates of the EM program are on the streets coordinating transport and preparing the public for mass events of violence that have increased in frequency and severity over recent weeks.

Sadly, this has been the case over multiple days the past few months, with an ever-growing number of deaths. On one bloody day, Yangon EM doctors saw over a hundred gunshot wound (GSW) casualties with close to 40 deaths. Our colleagues report:

'... More and more violence in Myanmar. Yesterday was a very sad day: Yangon General Hospital (YGH) Emergency Department (ED), 39 GSW and today another 15. Total deaths 13. Today I'm recording post-mortems and collecting bullets. I will never forget that scene.'

Our colleagues are united in their courage and care:

'What I liked about EM was the unity of EM doctors in this response. Many of them (who) live close to the hospital came back quickly to care for the patients.'

As the civil protest continues and grows, so do the retaliatory actions of the military regime, legalising their acts of violence through law changes that allow the arbitrary removal and detention of protesters and those they see as a threat to the military regime. Contrary to international humanitarian law, healthcare workers are now targeted for peaceful protesting when they are treating patients on streets and even inside hospitals.

There have been videos shown of ambulance personnel being dragged out of their ambulance and beaten. Hospitals have been shot at while patients are being treated inside, and hospital access has been blocked. Healthcare workers have been arrested and others forced to flee their homes. Hundreds of doctors and medical students have now been arrested, with many still detained.

Most shocking to the global EM community has been the arrest of Professor Maw Maw Oo, Head of EM at UM1 and on 12 April. He was taken from his office, while on duty, at YGH ED. Over the past months, he had been coordinating care of all people, including the victims of violence, and was instrumental in negotiating the release of many healthcare workers. He is President of the Myanmar Emergency Medicine Society, and a key leader in the past and future development of EM and disaster preparedness and response in Myanmar. Professor Zaw Wai Soe, past Rector of UM1, 'Father' of EM in Myanmar, and leader of medical education reform, is now in hiding. Emergency Nurse Kaung Myat Htun was arrested and is yet to be released.

Myanmar's government health system has effectively collapsed. Recent work over the last decade to address inequality of access and outcome, and to build a modern health education, clinical services and public health system are under threat. In the short term, we are seeing national pre-hospital, triage and ED systems falter from lack of personnel and resources.

With increasing harassment and arrest, the workforce is being critically reduced. Reversion to military rule and subsequent expected financial neglect, coupled with global isolation and sanctions, are likely to result in critical deterioration of both public health measures and clinical services. Access to essential medicines and supplies may be restricted, and global partnerships for research, education and capacity development will falter.

ACEM had a formal, meaningful partnership with the Myanmar Ministry of Health and Sports for development of EM over the last decade and continues to have a strong bilateral partnership with the Myanmar EM Society, with many member affiliates of ACEM. Despite the apparent disintegration of emergency care in the government system, we can be encouraged that EM doctors and nurses are still using their training and skills daily for the good of their community. Our colleagues are training, coordinating, and assisting at pre-hospital, village and rural clinic levels in ways that will only help future emergency care development. The lessons learnt through almost a year of battling COVID-19 – teamwork, perseverance, solidarity, courage – are now standing them in good stead as they face a long battle ahead.

Our College has been at the forefront globally, advocating for Myanmar EM and other health colleagues, and will continue to do so. We all have a part to play now and into the future. For now, Members should call out the inhumane treatment of fellow health workers in Myanmar – this is unacceptable. For the future, we should be prepared to comprehensively assist our colleagues as they rebuild their emergency care system at every level.

Our colleagues plead to us, **'Do not forget us'**.

More information

1. Joint Statement – calling for urgent release of Professor Maw Maw Oo **https://ace.mn/ijr**
2. President of Myanmar Emergency Medicine Society speaks out **https://ace.mn/wji**
3. ACEM stands in solidarity with our Myanmar colleagues **https://ace.mn/wmk**
4. ACEM urges safe release of medical professionals detained in Myanmar **https://ace.mn/rz**

ACROSS THE GLOBE

The following stories have been submitted by emergency care personnel working in-country. Unlike ACEM Supported Projects, these opportunities have been independently sourced. We are delighted to share these impactful stories from our colleagues working globally.

NURSING ADVENTURE IN TANZANIA

Marwa Obogo and Libby White

This article is dedicated to the memory of Upendo George (1981-2020) – one of the first female emergency specialists in Tanzania. A pioneer, champion, legend and amazing friend who lived every day of her life to the fullest.

Muhimbili National Hospital (MNH) is in Tanzania's capital of Dar es Salaam. This tropical seaside city is home to over five million people and the dusty streets are vibrant with colour and life during the daytime. Buses spewing black smoke are crammed full of people, while motorbike taxi drivers zip in and out of the busy traffic, honking their horns, not wearing helmets. There are always people walking along the roads, carrying babies while balancing buckets of shopping on their heads or trying to sell goods through open car windows at the lights. Police shut down roads at a moment's notice to allow dignitaries clear passage, causing even more chaos on the congested roads.

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A stone's throw from the ocean, MNH proudly offers healthcare to all Tanzanian citizens, who are often referred from far-flung locations for specialist care.

The first fully equipped emergency department (ED) in Tanzania was set up in 2010 by taking a multi-faceted approach to creating change within the public hospital system. This included an in-country international nurse and doctor support team, hand-picked local leaders, and a constant rotation of international visiting emergency medicine specialists and nurses to lead education and development of clinical skills.

Support from MNH's nursing management was vital in creating change, by minimising the movement of skilled nurses out of the ED, and by providing a much larger number of nurses to work in the ED than were historically on the wards.

The local nursing leader, Sister Angelina Sepeku was in the first group of three nurses to complete a Master of Critical Care and Trauma. Along with her strong work ethic and nurturing personality, she spent many long days and nights in the ED. She developed equipment and supplies processes, billing methods, and protocols of how the ED would fit within the hospital structure, as well as upskilling around 80 nurses and health attendants. An electronic medical record (EMR) was used from the beginning, but for most staff, who had never even turned on a computer, training them to utilise this technology was a feat in itself.

I was offered an opportunity to work at MNH for one year (I happily stretched it to three) as a Clinical Emergency Nurse Educator, to support the nursing team. I had travelled to Africa before and vowed to return one day – that day arrived in September 2016. Sister Sepeku welcomed me with a huge embrace and I just knew this was going to be an amazing adventure. She introduced me to Marwa Obogo, the current Nurse Manager of the ED and, together, they helped me settle into Tanzanian life and work.

Listening to Sister Sepeku and Marwa's stories of those early days, it was incredible to see how far they had come. I spent time working in all areas of the ED to build relationships with the nurses and understand their workflow. The nurses' training was in English so I could communicate with them, but most patients only spoke the national language, Swahili, so I had to quickly get to work learning another language.

The MNH ED had been part of an African Federation for Emergency Medicine (AFEM) pilot program and set up a group of specialised nurses, called Clinical Nurse Trainers (CNTs), to be the educational leaders in the ED. These nurses ran daily teaching sessions.

The CNTs also taught at the university and initiated emergency care in the nursing curriculum. This led to development of a more locally delivered emergency care course, as we noticed that patients being transferred to MNH from the peripheral hospitals were not receiving adequate care. I worked with the CNTs to develop a teaching program for regional hospitals as EDs began to open around the country. The CNTs travelled to these hospitals and delivered teaching specifically developed for nurses, however, doctors often attended as well. The program was delivered through didactics and hands-on workshops to ensure knowledge translated into practice, as there are no specific clinical educators in the Tanzanian nursing system.

The CNTs are pioneering emergency nursing in Tanzania. They take it all in their stride and are very humble. Every day, I was amazed at their achievements and motivation to ensure all Tanzanians have access to quality healthcare. The CNTs understand the importance of testing every patient's blood sugar levels, as many of them are hypoglycaemic, and life-saving glucose can be administered urgently. Patients would often present in diabetic ketoacidosis (DKA) and be so acidotic it was hard to believe they were still awake and talking. Clinical protocols guide nursing actions in treating patients, which is vital as there is only a small medical team, while the resus rooms are overflowing with patients.

As emergency clinicians, we are exposed to many confronting situations but one of the most emotionally upsetting group of patients are little children with burns. Tanzanians cook mostly over a fire with wood and charcoal or sometimes a hob attached to a gas bottle. Put these cooking devices in a small, busy home with many children running around and may result in severe burns to these tiny humans. The nurses skilfully use ketamine to provide analgesia before dressing the kids' burns, which works well.

As in many Low and Middle-Income Countries, noncommunicable diseases are prevalent and many patients present with hypertension, renal failure and diabetes-related complications. Often they are very young. Patients who have been involved in trauma commonly present with severe head injuries after being struck by vehicles or being involved in motorbike accidents. Shortly after I arrived in Tanzania, small sachets of alcohol were banned from being sold at local shops. This is a great public health measure for reducing alcohol-related accidents.

The ED at MNH is an incredible example of how emergency care can be developed and help improve the healthcare standards of the community. We believe one of the key factors to development of a successful EMD is to bring the nurses along with the doctors. In Tanzania, nurses make up the majority of healthcare professionals. The World Bank reports there are 0.584 nurses per 1,000 people (2017) compared to 0.014 doctors per 1,000 people (2016). It makes sense to involve nurses in emergency care training from the beginning, to ensure they have access to knowledge and skills. But more than that, it helps to build team spirit and improve the culture of working relationships.

The ED at MNH is leading the country in providing emergency care. We feel extremely privileged to have been able to support the staff there in a small way to continue the amazing work they are doing.

‘WHERE ACTUALLY IS KIRIBATI ON A MAP?’

Angie Gittus and Bronwen Griffiths

Angie Gittus and Bronwen Griffiths are both Clinical Nurse Specialists with a Master in Public Health and currently employed by NSW Health.

This was the question that followed our spontaneous decision to offer the nursing support that Fellow of the Australasian College for Emergency Medicine (FACEM) Dr Brady Tassicker pitched at the 2015 Global Emergency Care (GEC) Conference, ahead of his ACEM supported medical training program in Tarawa. Often out of the public gaze, finding the small atoll of Kiribati on a map was our first challenge.

This was the beginning of a journey that has seen us increasingly invested in support and collaboration with our frontline nursing colleagues across the region. These colleagues are remarkably the providers of more than 90% of regional health care, and it can rightly be said that they hold the health of the Pacific in their hands.

A practical, hands-on, structured assessment and communication program was developed at the behest of senior I-Kiribati colleagues in the wake of that first trip. The program has been described by their Nurse Unit Manager (NUM) at a shared presentation, as ‘taking the fear away’ from their everyday practice.

Since that first experience we have had the privilege (thanks to New Zealand Foreign Affairs and Trade | Manatū Aorere) of delivering the Pacific Emergency Nurse Training course, not only in Kiribati, but also Tuvalu and twice in Vanuatu. There are also plans to bring the course, plus its phase two Train-the-Trainer component, to Samoa and returning to Vanuatu in the coming months.

In each area, the program has been met overwhelmingly with relief – the tools it provides helping to increase confidence and reduce fear – as well as with huge enthusiasm for stepping into the growing space of the global emergency care community. This sense of collegiality is particularly important for those nurses who work in the isolated clinic settings common across the region.

Disappointingly, for many senior nurses this has been the first postgraduate training of their entire career. Although nurses provide the vast bulk of healthcare in the Pacific, they have not traditionally had a strong political voice, and this has unfortunately been reflected in their conditions and access to training.

It has been an enormous privilege to witness the increase in each participant’s confidence as they complete the program, and to know that these skills equate to safer care for their communities, as well as pride in joining a multidisciplinary GEC movement.

Tuvalu nurses with Moana

Highlights of our Pacific journey thus far have been; co-presenting with our I-Kiribati colleague Teitinana Ribanti at the South Pacific Nurses Forum in Rarotonga, witnessing the impressive trajectory of emergency care in Vanuatu under the leadership of Dr Vincent Atua and collaborating via the excellent ACEM Global Emergency Care Committee (GECCo) Pacific COVID-19 Support Forum. This support from regional clinicians has assisted in the development of a relevant and usable staff COVID-19 safety poster, now translated into Tuvaluan, Bislama and I-Kiribati. These collaborations have fostered a sense of mutual collegiality and respect for shared areas of expertise, while offering a window into the blossoming community of emergency clinicians across this diverse but strongly connected region.

Despite the lockdown in 2021, we were fortunate enough to join a multidisciplinary initiative assisting ED clinicians in PNG to introduce a triage system and supported an online emergency care program, on the threshold of a catastrophic COVID-19 outbreak. Once again, the resilience of the local clinicians, their ability to think laterally, and their commitment to providing the best possible care for their communities, was both inspiring and motivating.

We are passionate about the need for frontline clinicians to have such structured systems tools at their disposal, especially in the remote clinics where there is little else. The extraordinary, unflagging commitment of Pacific health workers to provide best practice care for their communities, is one that should be supported in every way possible.

In our own clinical practice, it is a reminder that all the gadgets in the world do not replace good assessment skills, and that, frustrating as the pandemic has been, it has forced us to adapt our ways of engagement which, after all, is what Pacific nurses excel at every day.

Kiribati log roll

Photos provided by Angie Gittus and Bronwen Griffiths

Ni-Vanuatu Graduation

PARA-D'ISOLATION

Sophie Knott

Sophie Knott is a British Nurse and Paramedic with a background in emergency and critical care. She now works in aeromedical retrieval and calls Australia home.

My eyes lit up when I came across this dream posting: *Doctor, nurse or paramedic wanted for a private resort on a paradise tropical island off Madagascar.*

I am a British-trained emergency department (ED) nurse and paramedic, happily employed with NSW Ambulance Aeromedical, but always ready for the next adventure. To my surprise, I was offered the job and in 2019, I enjoyed a blissful six-week placement in paradise, providing on-call medical cover to guests of the exclusive private island, first aid training to the staff, and basic medical cover to the locals.

In February 2020, I received another unexpected call asking if I'd like to return to paradise for three weeks in March. While the heat had dissipated from our catastrophic bushfires, there were whispers of an emerging respiratory illness in countries beyond our shores, but somewhat off the Australian radar. So, completely oblivious to the imminent global health crisis, I jumped at the chance for another visit to paradise. Who wouldn't?

By the time I reached the island five days after leaving Sydney, it was apparent that there was a significant shift in the global situation. I was given 24 hours' notice to leave Madagascar before the international airport closed. Faced with the ethical dilemma of leaving the island staff and locals with no medical coverage during an evolving pandemic it was a nondecision to stay however I was still oblivious to the true magnitude of what lay ahead.

With international borders closed and no incoming tourists, the hotel mothballed into hibernation, with significant employee redundancies. The island went into survival mode. Those who had somewhere safe to stay on the mainland were relocated to reduce the demand for incoming supplies and improve their access to government health facilities.

When the dust settled, 150 people remained on the 5km^2 island while I frantically attempted to source an oxygen cylinder and Personal Protective Equipment (PPE). Villages on the island had simple wooden houses with no electricity or water and a drop toilet shared by the entire community. Preventing community transmission would be near impossible if the virus reached the island; prevention was the only option.

As an ED nurse at heart, infection control was never high on my list of joys but became critical as the pandemic developed. I was reliant upon online information provided by the World Health Organization (WHO), the Africa Centres for Disease Control and Prevention (CDC), and ACEM Global Emergency Care Committee (GECCo) COVID-19 Online Support Forums.

I wrote and revised policies and guidelines endlessly, hopeful that people would read them. With careful planning we reduced food and fuel supply deliveries from the mainland to fortnightly, with an extensive bleaching process for all items brought ashore. We placed the disgruntled boat crew into quarantine in the closed village school.

While the infection numbers slowly crept upwards on the mainland, the days passed without significant incident on the island. The worst injury sustained was, in fact, my own, after an inversion injury rendered me non-weight bearing with a suspected fracture. I fashioned a makeshift Controlled Ankle Motion (CAM) boot in lieu of an X-ray or plaster. The nearest hospital was three hours by boat and then three hours driving on unsealed, often flooded roads.

When I wasn't busy with island work, I worked on my Masters degree and some research publications, but knew that I also needed to look after myself. When I was feeling down, spending time playing, singing and dancing with the village kids rarely failed to lift my spirits.

By August, my mental health was an increasing battle and, when Air France announced the first flight from the northern airport to connect to a flight to Paris, I made the difficult decision to take it and visit my family in Europe on the way back to Australia.

The transition from island life to European society was dramatic. As I witnessed the true impact of COVID-19 firsthand, I felt like I'd landed from Mars as I experienced for the first time the restrictions which most people were now used to. It's lucky that I had become so practised in spending time alone because after two weeks isolating in the United Kingdom (UK), France and then the UK again, and four cancelled flights to Australia, I finally made it back to Sydney and had another two weeks in hotel quarantine.

I missed the ocean but enjoyed the food choices and Wi-Fi. I continue to practise gratitude and put perspective back into my 'normal' life. What would I tell my February self? Buckle up for the adventure of a lifetime and you're going to need a jumper.

A CALL TO ACTION

ACEM Launches the Global Emergency Care Community of Practice

The ACEM Global Emergency Care Committee (GECCo) is all set to launch the Global Emergency Care Community of Practice (GECCoP) early this year. Its aim is to bring together like-minded individuals to share ideas, innovations and opportunities, and facilitate effective communication and partnership between individuals and organisations engaged in Global Emergency Care (GEC) capacity development across the Indo-Pacific region.

The multi-disciplinary GECCoP will form an important link between GECCo and the ACEM GEC Network. It will bring together the ACEM GEC special interest group, FACEM and trainee members, other individual ACEM-linked practitioners interested in GEC, ACEM's existing GEC partners and other GEC key stakeholders across the Indo-Pacific region. The GECCoP will meet virtually at least twice per year providing a forum for resource sharing, networking, and mutual learning among the GEC community. To promote multi-disciplinary engagement, GECCoP will be co-chaired by a Fellow of the Australasian College for Emergency Medicine (FACEM) as well as a non-medical GEC practitioner from within or beyond Australia and Aotearoa New Zealand. The term dates for co-chairs will coincide with the term of office of the ACEM Council of Advocacy, Practice and Partnerships (CAPP).

Excitingly, following the expression of interest process conducted from December 2021, GECCo warmly welcomes the inaugural GECCoP Co-Chairs Dr Rob Mitchell (FACEM Chair) and Ms Sarah Bornstein (Non-medical Chair).

Dr Rob Mitchell

Rob Mitchell is an emergency physician at the Alfred Hospital Emergency and Trauma Centre in Melbourne. He has a strong interest in GEC, having previously completed Australian Volunteers for International Development assignments in Papua New Guinea (PNG) and Solomon Islands.

In addition to his clinical roles, Rob is Deputy Chair of the ACEM GECCo and faculty for the Alfred Health/Monash University Capacity Building in GEC program. He is involved with emergency care capacity development projects across PNG, Solomon Islands and Vanuatu, and has contributed to a number of COVID-19 response initiatives focussed on the Pacific region.

Linked with this work, Rob is completing a PhD at Monash University School of Public Health and Preventive Medicine focussed on emergency department triage in resource limited settings, supported by a National Health and Medical Research Council Postgraduate Scholarship. He holds a Master of Public Health and Tropical Medicine and Postgraduate Certificate of Disaster and Refugee Health from James Cook University, and in 2014 completed a Churchill Fellowship focussed on GEC training.

Image: Intern Dr Phillip Notere (l) and Dr Rob Mitchell (r) at the National Referral Hospital, Solomon Islands. Photo by Nick Sas.

Ms Sarah Bornstein

Sarah is an Emergency Nurse from Sydney, New South Wales who has been working in EDs around Australia and PNG for the past 10 years.

Since 2020, Sarah has been working as Project Lead of the Emergency Care Capacity Development Support Model Project in PNG through ACEM. Sarah has supported the implementation of a new triage system in four PNG Emergency Departments (EDs), as well as provided support to emergency care teams during the COVID-19 pandemic. Sarah also actively contributes to GEC emergency nursing research, education and forums across the region.

Sarah completed a Bachelor of Arts and Master of Nursing at the University of Sydney in 2010, then completed a Master of Clinical Nursing with emergency specialisation in 2015 at the University of Tasmania. She is currently completing a Master of Global Health at the University of Sydney.

How to join

Participation in GECCoP is free of cost. There are two categories of membership: organisational and individual. The latter is for clinicians and development practitioners with an interest in GEC. Whilst the organisational membership is for those stakeholders involved in GEC capacity development, including those that have a direct engagement and established working relationship and those interested in learning more about partnering with ACEM.

@ Further details about joining GECCoP and the inaugural meeting will be disseminated through the ACEM GEC Network and to GEC partners in the very near future. If you wish to join our network or receive any upcoming information, please contact the ACEM GEC Desk at: **gecnetwork@acem.org.au.**

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Want to find out more or get involved?
To find more stories about the work of the Global Emergency Care Network, or to find out how you can get involved visit the webpage at **http://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Global-Emergency-Care** or email **gecnetwork@acem.org.au**