GECCoP Meeting Communique – 13 September 2023

The Global Emergency Care Community of Practice (GECCoP) meeting was conducted as a hybrid meeting on 13 September 2023 at 9:30 – 11:30 AEST. There were approximately 40 virtual and 15 in person attendees.

1. Introduction

The GECCoP chairs, Sarah Bornstein, and Donna Mills, after initial standing proceedings, acknowledgement of country and housekeeping, introduced themselves and welcomed all attendees to the third GECCoP meeting.
The theme of this GECCoP meeting is 'Deciphering GEDSI: what inclusion means in Emergency Care' and involves four different speakers presenting on their experiences on 'gender equality, disability and social inclusion' in GEC with opportunities for questions and discussions after each presentation.

2. Gender equality, disability, and social inclusion (GEDSI) in GEC

2.1 Women on the frontline: Exploring the gendered experience for Pacific healthcare workers during the COVID-19 pandemic & Some GEDSI reflections – Dr Georgina Phillips, Emergency Physician FACEM, PhD Scholar & Dr Mangu Kendino, Emergency Physician and Retrievalist based in Port Moresby, PNG

Presentation Outline

Dr Georgina Phillips is an Emergency Physician at St Vincent's, Melbourne as well as a PhD Scholar at the School of Public Health and Preventive Medicine at Monash University. Her area of academic interest is the impact of emergency care capacity development in limited-resource environments, especially through the lens of gender.

Dr Mangu Kendino is an Emergency Physician of 6 years and Retrievalist based in Port Moresby, PNG, working at Port Moresby General Hospital. She is also the co-ordinator of the Post Graduate Diploma in Emergency Medicine Program at the University of PNG, and she has been a role-model and mentor to many Pacific Emergency Medicine doctors. Dr Mangu is also the Chief Medical Officer for St John's Ambulance and is a MIMMS/HMIMMS instructor.

Introduction: Why?

Why research gender in health systems?

- Health systems are not 'gender neutral'
- Gender as a power relation
- Gender intersecting with other social stratifiers

Why focus on women?

- 70% of the global health workforce
- 90% in patient-facing roles
- Underpaid, undervalued, under-represented in leadership roles

Gender at the frontline

Women at the frontline of health service delivery
COVID-19 as a multiplier
PPE, care burdens, unsafe rostering, mental health
The Pacific as a unique region: Strengths and vulnerabilities

Women at the frontline – the research process

Feminist research principles (methodological considerations) Lafrance, Wigginton. Feminism and Psychology.2019

Women at the frontline – what we found

Key themes

Women's emancipatory leadership
Women's bodies and responsibilities
Women as workers
Women in Pacific culture

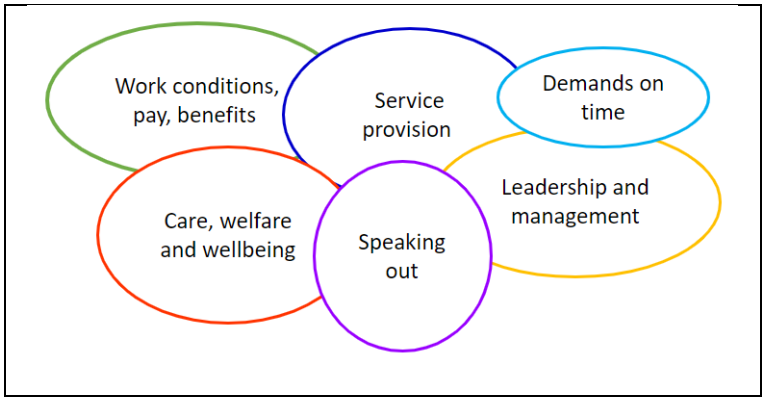
Women at the frontline – what it means

Workforce maldistribution and risks
  shouldering the burden – at home and at work
  women as mothers; pathologised, problematised
Workplace segregation
  women's emotional labour
  speaking platforms
Symbolic capital

Gendered power Morgan R, et al. Health Policy and Planning. 2016

- Who has what
- Who does what
- How values are defined
- Who decides

Re-thinking power (in health)
  dynamic
  transformative if recognised and enabled (symbolic capital)



Gender research for transformation

Research as a catalyst for action:
At home
  the patriarchy is everywhere: global challenges reflected locally
  evidence counteracts fragility and conflict

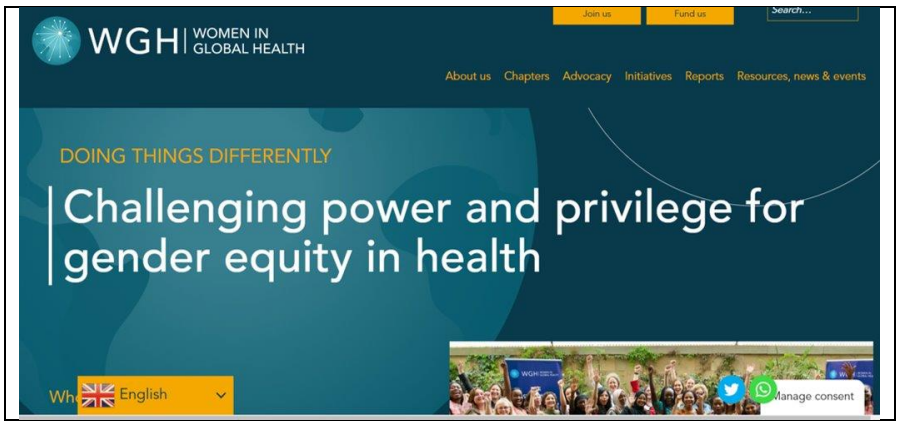
Around the Pacific region
  Fiji example
  PNG experience

What comes next?

Hard, long work towards gender (and other forms of) equity
Systems and policy level: Gender transformative policies and methods

Research collaborators, co-authors and champions

- COVID-19 'Experience from the frontline' research team



2.2 PNG and the GEDSI Perspective – Dr Mangu Kendino, Emergency Physician and Retrievalist based in Port Moresby, PNG

Dr Mangu Kendino is an Emergency Physician of 6 years and Retrievalist based in Port Moresby, PNG, working at Port Moresby General Hospital. She is also the co-ordinator of the Post Graduate Diploma in Emergency Medicine Program at the University of PNG, and she has been a role-model and mentor to many Pacific Emergency Medicine doctors. Dr Mangu is also the Chief Medical Officer for St John Ambulance and is a MIMMS/HMIMMS instructor.

Regarding the research project that she and Dr Georgina Phillips have undertaken, Mangu advised that there was no challenge here with this project, or particular intentions, it was to give women a voice.
She described that in PNG in the workspace, there are cultural differences, it is a male dominated society. Having gone through Covid and looking at the aspect of how different women are and the perspective they can bring to health care because they hold multiple other roles, such as mother, wife, sister, daughter, granddaughter, these all contribute to your profession and ability to provide health care and service.
Mangu shared that listening to some of the quotes during the research, she made some recollections of these herself and it reminded her of some of her colleagues, particularly female colleagues, and some of the pressures and stressors they all went through. And that having that mentorship role and being able to provide that support was something that was good in that aspect.

Mangu is based at Port Moresby General Hospital with a team of just over 30 doctors which is not enough for the approximate 180 patients they see daily. About 60-40% male to female gender ratio in medical team, in nursing team, the majority are female. Mangu also does Ambulance work with St John's as Medical Director working on policy development, CPD, reviews and supported improvement of service care and delivery.
Again, in the Ambulance service, Mangu advised that they do not have paramedic training, but they have Ambulance Officers with a certificate 3 & 4 qualification, and the clinicians who are employed are majority females. This work involves critically ill patients, managing complications of non-communicable diseases and infectious diseases, which is a high priority in this part of the world and in LMIC's in general.
With male domination in the PNG society being a deep cultural thing, Mangu shares it has been so rewarding to see that in the professional space, it looks like women are starting to assume roles and have promotions all on meritocracy, just how well they are able to perform and exert their leadership role in that aspect, it's being recognised which is an important part to witness so far.

Mangu goes on to say that another thing about PNG is that a lot of people have a religious background and beliefs, Christianity is a big aspect of society. And so, women are seen and viewed in this space of how their moral and ethical conduct is and so it determines how people are being watched in terms of their moral compass. Which is another view that is placed on women in this professional space and being healthcare workers.

To focus on gender equity in the ED, Mangu says that they need to bring attention to particular case types where they would focus on looking at how exactly it is that they manage or assess the patients. A big trauma presentation to the ED is domestic violence. Gender based violence in the country is a big thing,

legislation has been focussed on the aspect of giving it more prominence so there are higher penalties against it. It also puts health care workers in the spotlight, it makes them have to give further emphasis on what our role is, how do they report this, how to protect the victim. Not just male against female, but also females as the perpetrators of male violence as well. This is one aspect of gender equity in the emergency departments currently.

Another aspect of gender equity focus is on cancers. Giving a lot of attention to women's cancers. Mangu describes that in places where primary health care doesn't exist to absolute heights and degrees, the emergency department still basically functions as a primary focal point of presentations for the department. Therefor it means that they are having that role to be both responsible for initial assessment diagnosis and then transfer into the correct pathways for diagnosis to be made, or even having to meet patients at the other end of the spectrum, palliative stage, the pain management stage. In Mangus view, those are the specific aspects having to be considered, and so it would be good to have aspects within the department itself where there is isolated places where that can be given specific care and attention to in the department.

These are the main aspects that Mangu wanted to talk to, and she reiterates that it has been rewarding to see that kind of assimilation towards more focused emphasis on social inclusion, those with disabilities being managed as well, she is hoping that is going to progress more and looks forward to listening to the next two speakers for today who are going to share their insights.

2.3 Disability and Gender – Elsie Talaofiri, Physiotherapist and Director for the rehabilitation and disability department under the Ministry of Health in the Solomon Islands

Elsie is a Physiotherapist by profession, she has been in the service for quite a while and completed her Master of Business Admin in 2019, and postgraduate in Health Leadership Management in 2020. Elsies main role is overseeing the rehabilitation services in the country and the focal point for disability for Soloman Islands.

Elsie explains that Soloman Islands is a very small country that has been having challenges in terms of disability services, in health, social and other areas, in terms of both mainstreaming disability services and disability specific services.
The main role of the Department in rehabilitation and disability has two main functions. One function under rehabilitation is to integrate rehabilitation into the health system so it can be seen as a vital focus or services that could also support the medical care for persons going through illness or health conditions that need functioning, the main focus is on functioning for people who are receiving rehabilitation services.
In terms of the Departments function in disability, they want to mainstream disability across sector and at levels of the sector, and also within the different Ministries and all other agencies that provide disability related work. And they stand as a focal point for the government in ensuring that disability and gender is included for recognising the needs of persons with disability in all the different services that is being provided both in social and in health.

Elsie goes on to say, with that, they have a lot of challenges, but no proper documentation in place to really come up with what other challenges that they face in terms of disability in gender, disability in health services, disability in other areas so she will focus here on disability in disaster and preparedness.

Elsie advised that looking into services for disability in terms of rehabilitation and emergency medical team disability has been left out in all the disasters that have been happening in the country. Until her team have pulled up themselves in front of the emergency team and say that they are here to also support, or when a disaster strikes, and the medical team come across a person with a disability then they will call back asking for help, but it can be a far distance so take more time for them to get the service.

Elsie advised that ethnic violence is also one that contributes a lot in terms of disability services. The fragile state of the institutions they have and also the increasing crime and women and girls are affected in society, and they have been keeping quiet in silence. There is research that has been done with the UNFPA – A Deeper Silence, they (the Department) have tried to come up with areas they can work on in terms of reproductive health and disability.

Elsie further outlines that in terms of disaster, they have not done anything in this area, however, most of the challenges that they face are similar in terms of physical environments that are not user friendly and accessible, even information sharing for women and girls with disability on disaster, is not readily available. And as per the previous speaker, we are also a male dominated society and social exclusion is also one of the biggest challenges that is being faced by women and girls with disability and even children. In terms of disaster, the absence of assistive mobility devices is a very big challenge and even having barriers into the health care in rural communities and not just there, even up to the NRH they still have challenges with mobility devices for patients to use to be able to mobilise easily to get access to health services. Some women and girls with disability have been through education, it comes to a challenge when they have completed their studies in high school as the workplace environment is not accessible, so they are being excluded from being employed in a workplace.

These are more or less some of the challenges that are faced, it also comes back to negative attitudes of people towards disability and not recognising the capabilities in the workplace or where disaster strikes, people say that because they already have disability, they can just be left there, or sometimes the people with disability are forgotten and it's the relatives who go to the Department.

Elsie also reflected that as health care workers themselves, they also have attitudes and behaviours, in terms of ignoring people or even negligence to duty, not taking on board what they should be doing. Or even, the biggest challenge for them to really move on with this is the commitment form the Government in recognising the need for disability, gender inclusion into the services.

But, Elsie emphasised, there is continuous work going on, not only in the country but with the Pacific Rim, they continue to work together. With the Pacific Framework for the Rights of Persons with Disabilities they have come up with a disaster risk management priority area that their goal is to include persons with disability with climate change adaptation measures, and also to reduce the risk management plans and the policies.

Elsie states that they identified a big gap, that if they do not have a working document or a policy or a corporate plan or similar in place, then they won't be heard, or seen as a priority to address the area of their need. So with this, at the Pacific Disability Forum, Forum Secretaries all came together and put this together and the Government Ministers have signed off on the Pacific Framework. The strategy is that they have to develop guidelines of disability risk reduction plans and even promoting disability inclusive climate change resilience program and disaster risk management. Much of her role is in the disability function for the Department in ensuring that disability and gender is included in whatever they do and mainstreaming policies with other Ministries. With that they have continued to strive in ensuring as the government focal point to be included in all the different policies for example, in education. The Department would like to develop their own national development strategic plan as well so that they can be sure that they have a pathway to go and a roadmap there to follow so that everyone can tag along with them, and they can be inclusive in what they do.

Last year, Elsie said that in December last year, they launched the Soloman Islands Disability Inclusive Development policy with a priority area of disaster and humanitarian. They have quite a number of things to work on as their guide for that priority area of the policy. They want to strengthen working with other Government partners and their NGOs in terms of disaster response.
This is a positive achievement that they have had in terms of disability and gender.

Elsie advises that they have a rehabilitation strategy plan as well which was launched together with the policy last year in December and they also have a priority area in the leadership and Governance. They have to develop an emergency preparedness response plan, and this will include capturing women and girls included in this strategy plan and to work closely with their stakeholders as well. They recently tried to further their work and linked up with the AUSMAT team and three of Soloman Islands participants were sent over to Darwin to do training so they can come back, and they can be part of the work on the disaster response plan for country in terms of rehabilitation. Most of the areas they want to focus on they use the ICF framework that they want to ensure that their products and technology to be used in all the different areas of work, not only health, but other social areas are to be accessible and user friendly and be readily available with good information. In terms of disaster, they have to be ensuring that the environment for people with disability, particularly women and girls who are vulnerable to know where they are living and to ensure that they are on the safe sides as there are also human made changes to the environment that can cause disaster.

Elsie says that support and relationship is also one of the areas that they want to really look into because again it comes back to attitudes and behaviour of their relatives and family members that can make it challenging for women and girls with disability to access the services.
And then as the focal point for disability, the service, the systems, and the policies, they want them to be inclusive, so they are promoting that at every review of policy they want to ensure there is a component that captures gender inclusion for girls and women with disability.

2.4 Understanding GEDSI and Emergency Care – Larissa Burke, Senior Advisor (GEDSI) to the Global Health Division at the Department of Foreign Affairs and Trade (DFAT)

Presentation Outline

Ms Larissa Burke is a Senior Advisor (GEDSI) to the Global Health Division at the Department of Foreign Affairs and Trade (DFAT) in Canberra, Australia. She is a Physiotherapist with a Master of International Public Health who has a strong interest in capacity building and the intersectionality of GEDSI. She has worked in both Fiji and Vanuatu in the disability sector assisting with skills exchange and disability inclusion. She also has experience advising and supporting capacity development on equity and inclusion for donors, managing contractors and NGOs.

Larissa talked about the emergence of GEDSI acronym over the few years being interesting, that the focus on gender and disability inclusion is not new, but we are seeing this coming together into the one acronym and the integration of approaches. What we know is that they have been cross cutting priorities for a number of years, and they have been reconfirmed by our current government with even higher expectations on how we are delivering on our values around gender equality and disability inclusion in particular.

Larissa referred to a quote recently made by the Foreign Minister at the Gender Equality Symposium "Gender equality is not a 'nice' objective, to be deferred or deprioritised against 'serious' matters of health or economic prosperity. It is a prerequisite for those other objectives to be achieved." (28 July 2023) Gender Equality Symposium, Brisbane Convention and Exhibition Centre, Brisbane -- Speech from Foreign Minister Penny Wong

Recognition that to achieve for us to achieve good health outcomes we need to be integrating and addressing gender equality.

Gender and Sex

Larissa advised that it can be useful to go back to principles in our health and development programs. These both matter in relation to health, but when we are talking about smashing the system, we are really thinking about what are the norms, the social constructs that we can shift and change to create more equitable outcomes.

How do biological sex and gender affect health outcomes?

- Exposure
- Health seeking behaviour
- Access to services
- Quality of care
- Roles and responsibilities
- Pathophysiology
- Decision making power

Health inequities and gender:

- Access to health information
- Limited autonomy and decision making
- Gender or attitude of health workers
- Quality of care received
- Roles and responsibilities - and location and available time of services
- Access to resources
- Health behaviours

- Structural barriers and policies

Disability

Larissa explained that what they often still see in their programs is a medical model and approach to disability where we are thinking that the problem to be fixed is the impairment or the underlying health condition and that is often where we focus. There has been a real transition over a number of years to shift our thinking around disability to where we think its actually the barriers in society that contribute to creating disability and that is where we want to focus our attention, how is it that we can we address the barriers in society. It is still really important that we are thinking about the individual and function and health of course but thinking about the barriers is incredibly important.

What are the major contributors to health inequities experiences by people with disabilities?
Taken from the Global report on health equity for persons with disabilities published by WHO.

- Barriers getting to and accessing health services
- Social conditions and determinants of health
- Prevention and control programs not inclusive

Health inequities for people with disabilities:

- A higher incidence of communicable and noncommunicable diseases
- At risk of dying up to 20 years earlier
- Inequities cannot be explained by underlying health conditions or impairments
- Caused by unjust or unfair factors that are avoidable
- Outcomes are worse for certain groups of persons with disabilities

Gender and social inequities in the context of COVID-19

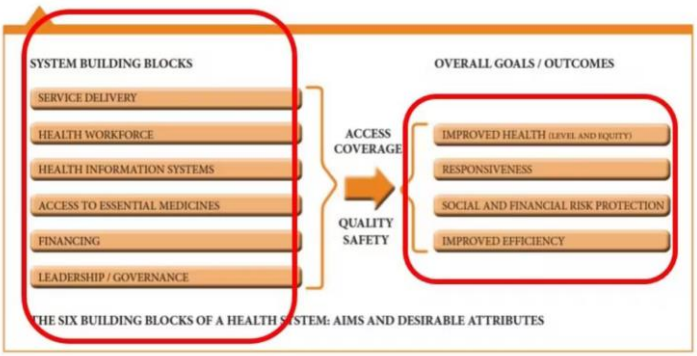
Larissa says that it's important to recognise that these inequities have never been more obvious that in the context of COVID-19, which has really underscored how those underlying inequities really influence who is most vulnerable in health emergencies. We know based on early presentations:

- Approx. 70% of the health and care workforce are women meaning they are more vulnerable.
- Approx. Only 25% of women fill senior health roles and have the power over decision making.
- Majority of policies found to be gender unaware.
- Disaggregated data a gap along the care pathway – where this data was available, it was showing persons with disability were 2.8 x more likely to die from COVID-19 and they weren't always prioritised in vaccination policy.

Integration of GEDSI in emergency care

Larissa asserts that we know that the role of gender and social inequities on health outcomes is quite clear, she advised that ACFID sees a lot in their programs being implemented by partners, the entry points that are quite obvious are around service delivery (as per the below diagram) and how we can be addressing barriers to access, this is an incredibly important and an important starting place.

However, she thinks what we do want to move towards, is how we are working across all of the building blocks, so getting beyond service delivery and thinking about all of the system building blocks as per the below diagram.



ACFID is supporting some great work in this space

- The PNG-Australia Transition to Health (PATH) – focus on improving women's leadership in provincial health authorities
- Australia has done some in Timor Leste with developing a disability inclusive health worker training tool kit that has been embedded into the national training institute and rolled out to at least 300 health workers, really intended to address attitudes, how is it that we can improve out awareness and understanding of disability?

Summary: Contributing factors to health inequities

- Social determinants of health
- Social conditions, relations, power dynamics
- Barriers across the health system
- Health policies, systems and interventions often not designed with inclusion in mind

Summary: Addressing health inequities

- Is a prerequisite for resilient health systems and health responses
- Relies on taking targeted and well-informed approaches
- Needs to consider all of the health systems building blocks

Some principles for inclusion in emergency care

- Consult underrepresented groups
- Address barriers
- Insert into strategic discussions
- Ask the question: who is missing and at risk of being left behind

2.5 General discussion and responses to questions

- Sarah Bornstein commented that she feels there is a disconnect between clinicians and donors, so asked Larisssa how we can better communicate between the two about GEDSI, in particular around writing grants, or applying for funding, where there is inevitably a criteria about GEDSI. How to better communicate and express to donors the things clinicians are doing, and how to sound less like clinicians and speak in the way donors want to receive the information.
    - *Larissa responded that she is acutely aware that being able to translate GEDSI as a priority into a particular sector is important and being able to translate it into health matters. There are key principles that you can apply across any sector but being able to translate it into clinical practice is important. One of the foundational key practices is around an analytical lens, so understanding, in the context, what are the particular barriers, what are the experiences of diverse and different and marginalised groups that would communicate an understanding of the strategies that you can take to address those barriers.*
    - *There is a sense of how we are engaging people as active contributors and not just beneficiaries. This is also an important perspective.*
    - *There are hard and fast rules in the International Development Policy around setting objectives and making GEDSI really front and centre and putting people with disabilities at the centre so there are clear lines that are being communicated through our own development policy.*
    - *Larissa says that really, it's around how do we provide that lens and contextual understanding and strategies that are adapted toa particular activity and the scope of that activity and reflected understanding of the context.*

- Rob Mitchell asked - donors increasingly (and appropriately) mandate a focus on GEDSI - but to what extent does that translate to better outcomes (vs lip service) - particularly equity in healthcare access and outcomes for our patients, and for health care workers?
    - *Larissa responded that there is ongoing work to do to translate it to outcomes, its quite easy to translate it through to outputs and for example, how many people we are training or proving accessibility of a building, but how does it actually translate to improve access and improved health outcomes, and this is difficult to measure in a short term, it is always a medium to longer term outcome measure.*
    - *We do see changes around outcomes but she thinks there is a long way to go in the health sector, particularly in certain areas such as disability inclusion to be able to see it really translate, and we have a bit of work to on both the demand and supply side in order to achieve that. And for sustainable outcomes it takes systems change and system changes take time. We want to see more of a focus on that, and less of a focus on the outputs which are important but sometimes that is where we stop, and we want to be able to see some movement on that.*

- Georgina Phillips commented that there are very few women at a leadership level in our region in clinical care, and we want to privilege women and prioritise them and elevate their leadership voices, but then the burden falls very heavily on a small number of women, this is the same in First Nations health. And you don't want to burden the few people with the extra work of having to shoulder the load of being the spokes person for gender equity. It takes time to change systems and to bring that equity into the leadership space, and we know that women take on the emotional load, it is an extra burden of work. So how do you manage the burden, distribute it equitably, not totally burn out the very few women leaders in the process of trying to transform the system.

- Bron Griffiths asked Elsie about her best tips and to share some of the insights about the practical steps that allowed her to transition from the enormous, and quite overwhelming list of challenges to such practical steps forward in a range of areas and policy platforms?
    - *Elsie advised that networking and meeting people, getting connected to people is one of the strategies that she uses to achieve the goals that she has, as well as continuous communication. Building relationships between groups will give you more ideas on opening up and you will achieve more with an open mind. If you have a team that works with you, you will achieve your goals, if they do not, you will have a challenge. Having a road map to guide work pulls people together to achieve what they are moving towards.*

- Lois Knight asked about the notion of being a useful outsider in change process in GEDSI and other areas in country, how international support crew can be most useful to local communities making locally led change.

    - *Elsie advised that the Disability Policy and Rehabilitation Strategy Plan are developed and worked on locally, they work with stakeholders when putting things together. Getting donor partners on board, implementing agencies, NGO partners, local and international will be the next step to work towards putting together the action and implementation plan to implement these two documents that have areas of gender inclusion and disaster preparedness for the vulnerable and the marginalised.*

    - *Mangu advised that she has had multiple interactions with AVI volunteers so far in both hospital and prehospital. She has found that the initial meet up and stages, is always a mutual learning process, this is an important step, that mutual learning, working out what is available and what can we do to improve implementation. After this phase, like an orientation, then we start looking at how we can work together in order to identify what more outcomes can be achieved. Mangu reflected that following this forum and hearing the other speakers shared insights on GEDSI, she is now really conscious of the fact that there are probably more things that can be measured because with a baseline there is insight into what else can be improved and what can be achieved. The discussion has opened her eyes and a given perspective of what to look towards and how to make best use of the international support that comes in to improve health care in general and her focus of emergency care.*

    - *Erica Bleakley commented that multidisciplinary practice does not just count doctors and nurses, and when talking about disability, particularly disability inclusive practice in*

emergency departments, hospitals and emergency responses, it's really important to also think about the rehabilitation workforce. And unfortunately, she does not see a lot of development actors that are working from a medical and nursing perspective advocating for growing a rehabilitation workforce that can actually support disability inclusion. It raises concerns, from her perspective, from working in the Australian health system where having a rehabilitation workforce is taken for granted. She is not sure why we don't think that is important or it is not being prioritised enough in some of these places. We need to ask why we expect one person, such as Elsie in her role, to be managing the full spectrum of disability services and inclusion, plus an acute rehabilitation department and community-based rehab spread across a very large area. One of the reasons is because they have a very small workforce. Erica says she gets told all the time about the challenges for rehabilitation in the Pacific because of the size of the workforce, but she sees very little advocacy from groups beyond the rehabilitation sector around really meaningful action to not only build capacity of existing staff but also growing the workforce to achieve things like disability inclusion and provide a great community-based rehab service for people with injuries and illnesses and also people with existing disabilities. We want to mainstream disability so that we are reducing barriers for medical care. We also know that rehabilitation has really profound effects on people with disability in terms of safety, vulnerability, ability to be functional and being functionally independent. If we really want to make meaningful action and do meaningful work around disability inclusion, we need to make sure that the workforce is there to support that.

- *Elsie commented that as Erica just said, it is quite a lot on the disability and rehabilitation department plate, they are advocating for disability function to be moved to another ministry, but the other ministries will not take it on as it seems they think that disability functions will take a big role in the sphere of disability because of human rights etc., However, in June 2022, after 10 years, Solomon Islands has finally ratified the UN Convention on the rights of persons with disabilities, they can now start moving on and fight for disability focal point to be moved to another government ministry to look after and oversee the social issues facing people with disabilities, as well as the disability policy already approved which would be the working document for that department if it proceeds that way. So that the ministry of health can take on the rehabilitation role. This is a work in progress, one step at a time, looking for greater things to happen next year.*

3. Meeting closing

The co-chairs thanked all the speakers and GECCoP audience for their contributions and collaboration, highlighting the diverse range of GEC clinicians and non-clinician in attendance. They encouraged the audience to involve all people interested in GEC from their networks so can continue to grow this Community.

4. Next GECCoP Meeting

The next GECCoP meeting is TBC. The theme of this meeting will be nursing focused to highlight the incredible work that the nursing community is doing in the global emergency care community. The co-chairs asked the audience to reach out if it were something they would like to be involved in.

In addition, the audience was asked for their feedback on a GECCoP logo via a vote in the chat. The audience's preferred logo is:

GECCOP
GLOBAL EMERGENCY CARE
COMMUNITY OF PRACTICE