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Enhancing Global Acute Care: Understanding the WHO's ACAN

This episode of the World Shared Practice Forum Podcast dives into the origins and objectives of the Acute Care Action Network (ACAN) led by Dr. Lee Wallis at the World Health Organization. Discover how ACAN aims to integrate emergency, critical, and operative care to enhance healthcare systems globally, focusing on universal health coverage and preparedness for health emergencies. Dr. Wallis shares insights into the challenges posed by the COVID-19 pandemic, the establishment of ACAN, and its ambitious goals in the face of funding constraints. This episode is essential for healthcare professionals eager to understand global healthcare strategies and improve acute care delivery.

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Sarah Marcley *00:04*
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Jeff Burns *00:18*
Welcome to the World Shared Practice Forum on OPENPediatrics. On this podcast today, we're very pleased to have with us Dr Lee Wallis. Dr Wallis is the lead for Emergency and Critical Care at the World Health Organization in Geneva, within the Clinical Services and Systems unit. Before joining the WHO, he led emergency care in the Western Cape government of South Africa and was academic head of Emergency Medicine at the University of Cape Town. Lee, you and I met for the first time in person in October of 2024 when you convened the first Acute Care Action Network [ACAN] conference at the WHO headquarters in Geneva, and I was struck by the number of organizations from around the world. I was there, as you know, representing the World Federation of Pediatric Intensive and Critical Care Societies [WFPICCS]. And I can say briefly that our organization is keenly interested in participating in the Acute Care Action Network and for our audience, can you describe the ACAN, Acute Care Action Network initiative, and what drove its creation?

Lee Wallis *01:33*
Thanks very much for the question and thank you for the opportunity to be on your podcast. It's great. Very happy that we're getting some exposure like this. So yeah, that's a question that needs a little bit of backstory, if that's okay. So just a little bit about that. We're a member state organization like the United Nations, the overall body, though the UN has its general assembly. We have our World Health Assembly, and 194 member states come together once a year, and they vote on a number of directives for the organization. They could be passed as resolutions, or they could be passed as decisions. The member states are in charge, and we're the Secretariat, so we do what we're instructed to do by Member States. So, over the last 20 years or so, there have been a number of resolutions that have been somehow directly relevant to emergency care, critical care, surgery, anesthesia, emergency response, trauma. We ended up in the 76th assembly, which was 2023 and ended up with resolution 76.2 which is titled Integrated Emergency Critical and Operative Care, or universal health coverage and protection from health emergencies. So that was unanimously voted in. So, in this case, for the ECO resolution, it's our abbreviation, or our nomenclature for integrated emergency, critical and operative care and operative care encompassing surgery and anesthesia. So, we were given a mandate in that resolution and the ECO resolution really is, is focused on two parts. So universal health coverage is

really about the day to day clinical service provision. So how can integrated emergency, critical and operative care, and by the "o" part that we mean surgery and anesthesia? So how can this integrated ecosystem strengthen the provision of day to day clinical care in a system that's based around the primary health care model where care is provided as close as possible to where you live, and you have a longitudinal relationship with a care provider. And you dip in and out of health facilities at a higher level of care as you need to with effective referral and counter referral measures in place. The other part of the resolution is the protection from health emergencies. So how can integrated ECO help countries to prepare for and respond to and recover from large scale emergencies? So that mandate came in May 2023 and one of the key things that it instructed WHO to do was to coordinate effectively with partners in this space. So, our key strategic response was that, with that was to establish a Partner Network, and that is what ACAN is, the Acute Care Action Network. If I was in an elevator with someone, I had to tell you about ACAN the one sentence is, it's for coordinated implementation of WHO's acute care tools. So, the key parts of that are the coordination. That's why we want all the partners around the table together. Implementation: so, this is not about tool development. That's our job as the Secretariat to develop the tools. ACAN's job is to implement and measure. Measure impact, measure the best ways of implementing and so on and acute care tools. That is not to say that is tools on emergency care, critical care, surgery, anesthesia. It also includes maternal and child health tools. So, all of the amazing work that's out there, from WHO on integrated management of pregnancy and childbirth, for instance, would fall and a lot of that falls on us, acute care. There's a lot of acute care in the malaria guidance. There's a lot of acute care in the non-communicable disease guidance. So, it's across the house.

Jeff Burns *05:39*
So Lee, thank you for that introduction, because it does require that background. So, A-C-A-N, ACAN (Acute Care Action Network), ambitious, necessary. Two questions: one is, first, it's as you outlined, emergency care, intensive care, operative care, but not pre-hospital care, and just a little bit on the reasoning to not include prehospital care.

Lee Wallis *06:09*
That's a good question, but it tells me that we don't do a great job of communicating pre-hospital care. We include in the emergency care bundle, so it absolutely is ECO we take from the community and back to the community. So, we include community first aid response, we include community health workers. We include primary care, pre-hospital care, and then facility based, which is where the bulk of emergency care is provided, but certainly where most critical and operative care would be. And then back through rehabilitation, into the community. If you looked on our website right now, this unit that we're in was formed in 2016 and as one person, it was emergency and trauma care, and the focus was emergency and trauma. So, some of the tools that we had out before COVID were emergency related. We then had a fairly long hiatus with COVID. And we've been working pretty hard on critical care and surgery and anesthesia material since we're going to produce, for example, the basic critical care course very soon, but before World Health Assembly in May. So now I'm on record as saying it publicly. Before World Health Assembly will be launching our pre-hospital toolkit, so training courses for ambulance providers, operational guidance, clinical protocols, assessment tools. So, we've been working on that for a long time. It's out at peer review at the moment, and will be, you know, our first formal pre-hospital care guidance since the 2005 pre-hospital trauma care systems, which is very much focused on trauma care delivery and ambulance.

Jeff Burns *07:52*
And the other question, briefly is, you noted that the Ethiopian government first proposed this to the World Health Organization prior to the pandemic. I would imagine that the pandemic probably accelerated the urgency and need to focus in this area. Am I correct?

Lee Wallis *08:12*
Absolutely. So, one thing that happened through the pandemic was WHO did what's called a pulse survey. So surveyed all member states four times about impact on the system and services. And we know that a huge percentage, I forget the numbers exactly, but huge percentages reported disruptions in emergency care and critical care. And that increased as the pandemic went on. We know that the most disrupted service was elective surgery, which I'm sure anyone listening would know from their own experience. It canceled operations, and actually, in parts of the world, it's suggested they'll take a generation to catch up that back log. So, as we came out of the pandemic this much more clear focus on the need for integrated care. Much clearer focus on the need for systems that allow access both on a day to day basis and during an emergency. But a very strong realization that if you want to respond in emergency and it's not working on a day to day basis, it's not going to work well when crisis happens. So, we've had a lot more enthusiasm, I guess is the word for this from countries. So partly, the resolution which got through very good—normally, resolutions have about an 18 months leading before assembly. This one had about six months, so it was a lot of scrambling, but the countries came behind it very, very strongly. But we've also had a lot more demand. Almost exponentially increase in demand from countries for support on their ECO services and their acute care services, because ministry is realizing very clearly that if you have gaps in your acute care delivery, first of all, you're not providing the quality access to care that your population needs. And we know that simple things are very impactful in terms of clinical outcome, but you're also not going to be prepared for the next pandemic or conflict or earthquake. Just on the impact Dr Burns, maybe this is something you would come to later, but we know from multiple studies that if you do simple things in systems where they're really not set up for acute care, you can see really dramatic mortality. In part, we've seen this with introduction of triaging pediatric emergency units in Malawi, for instance, with almost a 50% mortality reduction. We've studied some very simple WHO basic emergency care course, the basic emergency care course and basic emergency tools for use in facilities. We studied them over two years in 17 hospitals in Nepal, Uganda and Zambia, 35,000 patients split with a sort of before and after design, and patients who presented with DKA or under five diarrhea, patients with pneumonia or asthma or road injury or postpartum hemorrhage. And we saw between 34% and 50% mortality impact on inpatient mortality from something that cost a couple of thousand dollars per hospital to implement and was very easily sustainable. So, we know these things are massively impactful, and countries know that too. So, there's really a very big demand right now.

Jeff Burns *11:43*
Dr Wallis, this sounds like a very interesting study, and I understand you're still analyzing the data and that's yet to be published, but I think all of us would benefit from looking at that. As you said, the notion that sometimes simple changes in a complex system can have dramatic effects, I think is known to many of us. Do we move on to now what are the objectives of the Acute Care Action Network (ACAN) and is there a timeline? This is, again, it's obviously so necessary, but it's so ambitious with the variability around the world. What are its objectives?

Lee Wallis *12:23*

The timeline is probably the easiest bit to answer. The two part answer is immediate and continuous. The need is very high. And if we believe that the simple things that we can implement really are impactful, which we we do, and I know you do, and the acute care community really believes in these interventions, then really, we've got, we certainly have an obligation. Or I've heard people talking about moral obligations or ethical obligations or professional obligations, however you want to phrase it, there's an obligation to roll out. If we believe these things so impactful, we need to be pushing very hard, and first to get these things out. ACAN will continue through WHO for the foreseeable we have another. It doesn't really matter the details too much, but following the resolution, we had what's called a decision, which said we have to develop a global strategy and a global action plan for integrated emergency, critical and operative care. And that will be for 2026 to 2035 so that will be a framework on which countries can say, these are things I'm going to do, and this is how I'm going to measure the system to show benefit. So, we know we've got at least a 10 year timeline of focused attention, where ACAN will be really important. Between the 2023 meeting and last year the first convening, we did two things. One is we established working groups, and the other is we established some, what we've called operational priorities. I'm gonna there's five of them, so I'm gonna to just bullet them out. The first is strengthening acute care services. I mentioned we have these simple tools across all sorts of across the life course, across large scale images, so on. So, implementing those through a coordinated network. The second is empowering communities. So that's interesting. Communities are both users of acute care, but they also provide it if you train people in first aid. So, we really want to focus on implementing first aid response programs and then studying care-seeking behavior for acute care. The third is improving quality, so supporting clinical quality improvement, particularly at facility level, but also in the pre-hospital environment. And then the fourth and fifth are really about the system. So, we have one around enhancing access, which is about what services are available at each level of the health system. So, if you picked, for instance, trauma in the community or in primary care or a first level hospital, what should you be able to do for trauma? Because that then determines what training the providers need. It determines what equipment they need, what medications they need, and so on. And then the final one is what we call informing action. So how do you assess and plan at the system level, at the pathway level, so how people are moving through the system and then at the facility level? So, we've got those five, strengthening acute care, empowering communities, improving quality, enhancing access and informing action. We've bundled them really into three working groups, and then we have another working group on you won't be surprised to hear at all, but resource mobilization and advocacy, because we didn't have a lot of resources when we came together in October last year, and the pie got a lot smaller since then. So, resource mobilizations can be really important.

Jeff Burns *16:05*
Lee, you know, since October, as I mentioned, and you've been stating WFPICCS has been very involved in doing what we can to start to participate in ACAN. And then, of course, the funding issues are hitting the WHO. What are the milestones for ACAN going forward right now, given that we're speaking in March of 2025, and a lot of disruption in the support for the WHO. What are the revised timelines for ACAN?

Lee Wallis *16:35*
So, thanks for throwing in the word revised timelines. Because when we were all together end of October, we undertook by January to have established these working groups. To have the groups working through this year on a two year—so we generally do our planning on two year cycles. So, we had a two year window in mind for these, the first priorities and the working groups. And that we'd have

quarterly meetings of all of the working group chairs, and then every six months, we'd have a full ACAN meeting, one virtual and one in-person. Things have been shaken up to the point that the team were very disrupted, and attention elsewhere around prioritization and cost reduction. So, we just sent out the emails this week, actually, to get those chair calls and to get the work groups running. So, it's a complete mea culpa, from my side, from our team side, that we haven't been able to get to this, but we are starting now. We've sent the emails out; we're going to schedule the working groups first calls in the second half of March. We have the first chair call in the first week of April, and that's really our kickoff. That's when the work will start, and we want to be able to report back. Unfortunately, the June meeting of the whole ACAN is not going to have huge report back now because of this delay. But by the November meeting, we want to have a proper sense of what implementation is going to be happening, how we're going to be measuring community care-seeking behavior, for example. What we're going to be doing around resource mobilization, and all of that work should have started. It's all an endless we will, we should never stop doing this, but we will be putting measurables and deliverables in place for the working groups to aim towards. Just a comment on I'm not sure how much your listeners know. I mean, I guess if most of your listeners are in the US you have a decent sense, but we're in the order right now, different parts of WHO are cutting something between 20% and 30%, 35% of activity, of cost, of staff, of consultants. So, we've seen a very dramatic change in the organization, and ACAN will stay through that, but you know, the bandwidth that we have to focus will change over that time as well. So, it's an unfortunate time, and it has delayed us. But I think we're ready now. We've got some of the technical content that we needed out finished now, and it's going through the final publication process. So now we can really redouble our efforts on ACAN and get moving forward.

Jeff Burns *19:30*
Lee, as you know, WFPICCS is a society of societies. We represent pediatric intensive care critical care societies from literally across the world. And the audience listening today are physicians, nurses and allied health personnel who care for critically ill children across low, middle income and high income countries and certainly through WFPICCS we're going to be tapping everyone to contribute to ACAN's success. But how else can our listeners support this initiative, or support the WHO, during this time of the retrenchment in funding by almost a third from what it was even four months ago at the World Health Organization.

Lee Wallis *20:17*
Thanks. That's a great opportunity to actually talk a little bit about ways of working with WHO, which is something we get asked about a lot. And it's good to tell it to a big audience of people, individually. So firstly, WFPICCS. So again, thank you for your enthusiastic support and the work that we do, for your engagement and for the work that you and your members do, which is what really makes a difference out there. In terms of being at ACAN, WFPICCS gets a representative, which is usually the president or nominee. So that's not really the solution, but the work of ACAN, we often get stuck a little bit. I had a professional society life before WHO as well. So, I've seen this as well. It's, it's easy to get stuck a little bit where you, you get stuck with the leadership group, who are all super busy, people in their real jobs, in their lives, and then with the organization. And then when you say, okay, we need, we need this study doing. We need this implementation doing. If you keep that focus on the leadership group, you end up with people who are too busy to do it. So that's the point when we need to say, okay WFPICCS, access your members, access your network. Let's find two, five, ten, however, many people who are willing to roll their sleeves up and do this work. It might be implementing tools, running courses. It might be reviewing and spell checking slide decks and formatting. Everything needs doing, from if they were

physically present, you know, from the LinkedIn and vote copy and all the way to giving detailed technical input on really granular, important clinical questions and everything in between. So, an expanded workforce that we can access through your leadership is fantastic. The second part, which is about people engaging WHO as individuals, we used to have these internship and fellowship programs, which went away. I have a feeling that we'll have these volunteer pathways coming back now, we've had some indications of that as part of this change in our funding availability. At the moment, it's very difficult for individuals to engage but separate to ACAN WFPICCS has a memorandum of understanding with us that formalizes your relationship with us. So, if there was a work stream in that MOU and you know, you can talk to your membership about what area the terms of reference are in there, if there's an area that relates directly to that, and you said, okay, Lee, we've got this nurse from this society who is available for a bit of time and could work on this area. We can find work for them in that area as individuals. So, there's this sort of expanded thing through ACAN then there's the opportunities individuals through the MOU that you have with us.

Jeff Burns *23:08*
Wonderful. We've been speaking today with Dr Lee Wallis. Dr Wallis is the lead for emergency and critical care at the World Health Organization in Geneva. Prior to that, he was the lead for emergency care at the Western Cape government of South Africa and the academic head of Emergency Medicine at the University of Cape Town. Lee, through your work at the WHO over the last four years or so, you've seen some unusual and interesting times. And now going forward at the WHO, with the constraint and resources your leadership is going to be valued more than ever, and on behalf of all of our audience and behalf of WFPICCS, we've appreciated engaging with you and your leadership, and we're committed to supporting ACAN going forward. Thank you for being with us today.

Lee Wallis *23:58*
Fantastic, and thank you for the opportunity to be here and to work with you and your organization.

Sarah Marcley *24:04*
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