THE 2023 EAST AFRICAN COMMUNITY

PHYSIOTHERAPY **SCIENTIFIC CONGRESS**

Sai Rock Beach Hotel, Mombasa
29th November - 1st December 2023

THEME: Leadership & Governance in Physiotherapy Practice
SUB-THEME: Transformative Physiotherapy Services through Digital Technologies

Table Of Content

Our Guests

H.E Dr. Ida Odinga, EGH

Dr. Zeinab Gura Roka
Deputy DG, Medical Services, MOH

Dr. Swabah Omar Ahmed
CECM, Health - Mombasa

Dr. Nyawira Mwangi
Deputy Director Academics, KMTC

The East Africa Physiotherapy Community

Harmonizing Physiotherapy Training and Practice for a better integration in East Africa Region was the first theme that brought it the togetherness of East African Community Physiotherapists. This inaugural meeting took place back in October 21st and 22nd at the Telemedicine Centre in King Faisal Hospital, Kigali-Rwanda.

The inaugural committee elected represented the face of East Africa Community as follows:
Jean Damascene (Rwanda)- President
Priscilla Ondonga (Uganda)- Vice President
Mary Chandiwo (Tanzania)- General Secretary
Christine Rwayongwe (Burundi)- Treasurer

Member Organization Representatives
Raphael Owako- Kenya
Annet Nakalyango- Uganda
David Tumusiime- Rwanda
Regina Mbarasananiye- Burundi
Denise Rwelamira- Tanzania

With a recommendation of 1 term of two years in office, renewable only once. Due to various socio-economic dynamics, this dream hasn't been realized.

In May 2022, various Physiotherapy Associations and Societies with the East African Community so the need to revive this dream. On May 13th 2022, rebirth of East African Community PT Organization was conceptualized. Further deliberations with consultative meetings took place that saw the establishment of a new Board as follows:

- Henry Opondo (Kenya) - President
- Isaac Kakooza (Uganda)- Vice President
- Jean Damascene (Rwanda)- General Secretary
- Mwajuumah Nakaziba (Uganda)- Public Relation Officer

Country Representatives:
- Hellen Namasende- Uganda
- Dr. Catherine Wambua - Kenya
- Dr. Nuhu Assumani- Rwanda
- Gerard Ndacayisaiba- Burundi
- Jean Mapinduzi - Burundi
- Yurub Mohammed - Somalia
- Dorice Adrian - Tanzania
- Hellen Kalegele- Tanzania

Objectives of the Cooperation remains:
- Continuous Physiotherapy Education
- Enhancement of Research Initiatives
- Provision of Quality PT services in East Africa
- Provide new and adequate insights that will generate positive development in the field of PT across the region and internationally

The rebirth of EAC Physiotherapy Community

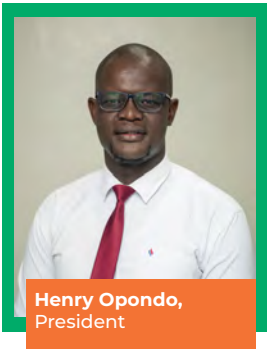
The EAC Physiotherapy Community Committee

About KSP

The Kenya Society of Physiotherapists (KSP) is an umbrella body that brings together all physiotherapists practicing across Kenya. Our vision is to be a leading Society in the enhancement of training, regulation, promotion and welfare of its members and deliverance of quality physiotherapy service to our clients.

The National Executive Committee

The National Executive Committee (NEC) is the top most leadership organ of the Kenya Society of Physiotherapists (KSP). It is established under the KSP constitution of 2021. The primary mandate is to promote development and implementation of strategic objectives to advance physiotherapy practice and optimised health, movement, and well-being of society through integrated clinical practices, education, and research.



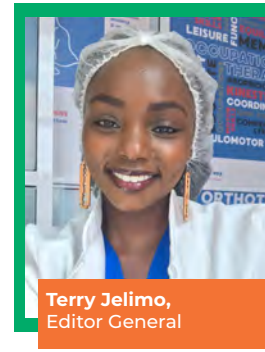
Henry Opondo,
President

Vincent Gesora,
Vice President

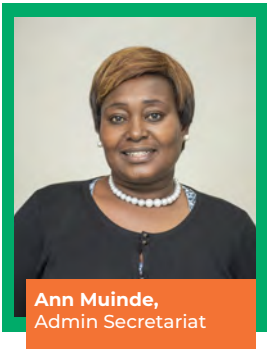
Onesmus Ngungua,
General Secretary

Harrison Gicheru,
Treasurer

Thomas Mutunga,
Asst. General Secretary



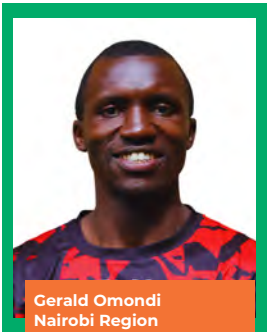
Terry Jelimo,
Editor General



Ann Muinde,
Admin Secretariat

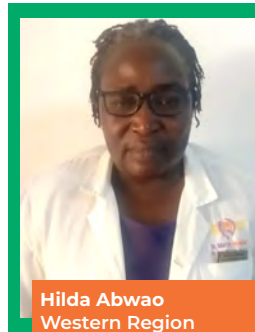
The Regional Executive Committee

The Regional Executive Committee is established under the KSP constitution of 2021. The committee is composed of elected regional chairpersons for the 8 KSP branches. Their primary mandate is coordination of KSP activities in the regions and linkin and representing the regions at the National Executive Committee (NEC).



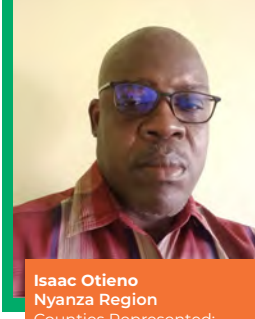
Gerald Omondi
Nairobi Region
County Represented:
Nairobi Metropolitan

Beth Mpinda,
Coast Region
Counties Represented:
Taita Taveta, Mombasa, Kwale, Malindi (Kilifi), Tana River & Lamu



Hilda Abwao
Western Region
Counties Represented:
Busia, Kakamega, Bungoma, & Vihiga

Oliver Keitany
North Rift Region
Counties Represented:
Uasin-Ghisu, Elgeyo Marakwet, Baringo, Nandi, Turkana, WestPokot & Trans-Nzoia



Isaac Otieno
Nyanza Region
Counties Represented:
Siaya, Kisumu, Nyamira, Homabay & Migori

Godana Doti,
Eastern Region
Counties Represented:
Meru, Marsabit, Isiolo, Tharaka Nithi, Embu, Machakos, Kitui, & Makueni

Charles Kioko
North Eastern Region
Counties Represented:
Garissa, Wajir & Mandera

Elections yet to be done
South Rift Region
Nakuru, Narok, Kericho, Bomet, Samburu & Kajiado

THE LOCAL ORGANISING COMMITTEE (LOC)

The Local Organising Committee (LOC) is established under the KSP constitution of 2021. Their primary mandate is to establish, plan and coordinate all the national scientific conferences and other general national events

Samwel Muema,
Chairperson, LOC

Henry Opondo,
President, KSP

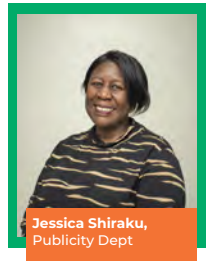
Martha Mmasi,
Chief PT, MOH

Douglas Kotut,
CEO PCK

Onesmus Ngungua,
Registration Dept

Dickson Okumu,
Scientific Dept

Kennedy Mogire,
Hospitality Dept

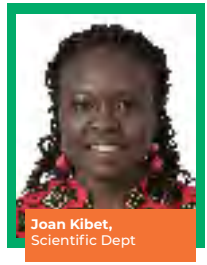


Jessica Shiraku,
Publicity Dept

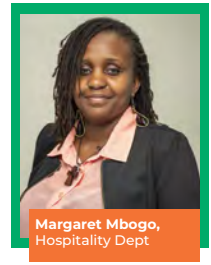
Elizabeth Mwikali,
Hospitality Dept

Victoria Choi,
Hospitality Dept

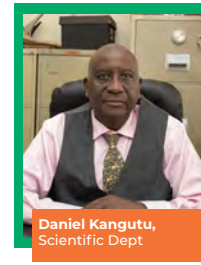
Raphael Owako,
Logistics Dept



Joan Kibet,
Scientific Dept



Margaret Mbogo,
Hospitality Dept



Daniel Kangutu,
Scientific Dept

PRESIDENT'S Message

Banda Henry Opondo

Ladies and gentlemen, distinguished colleagues, and honored guests, Good morning!

Wasuze otya to our Ugandan Delegations lead my your able UAP General Secretary Ms. Mwajuma Nakaziba, Mwaramutse to our Rwandan Delegations and Sabah Alkhayr to my brother and Sister from Somalia and Sudan.

My heart is warm and a permits me to extend heartfelt welcome to the beautiful coastal city of Mombasa, Kenya, where we are gathered for the 2nd East Africa Physiotherapy Conference 2023! It is an immense pleasure to see so many dedicated professionals, researchers, and leaders in the field of physiotherapy here today.

We are honored to have with us the esteemed Guests H.E. Dr. Ida Odinga,EGH who shall grace this occasion with her presence; not forgetting our host- the Mombasa County Executive Committee Member for Health- Dr. Swabah Omar Ahmed and finally a friend to our profession Dr. Nyawira Mwangi - the Deputy Director Academics at the Kenya Medical Training College.

We are also privileged to welcome other important guests who have taken the time to join us in this celebration of knowledge and progress in the realm of physiotherapy outside this great Coastal County and Outside this gateway Country to the East Africa.

As we gather here in Kenya, a nation known for its rich cultural heritage, breathtaking landscapes, and a spirit of innovation, we are reminded of the immense potential that lies within the East African region. Our conference theme, "Leadership and Governance in Physiotherapy Practice," underscores the critical role that leadership plays in shaping the trajectory of our profession. Effective leadership and governance are the cornerstones upon which we build the future of physiotherapy in our communities and beyond.

Additionally, our sub-theme, "Transformative Physiotherapy Services through Digital Technology," spotlights the transformative power of technology in our field. In a world that is rapidly embracing digital advancements, we have an extraordinary opportunity to harness these tools to revolutionize the way we provide care, making it more accessible, efficient, and patient-centric.

Throughout the conference, we will have the privilege of delving into these important topics, engaging in thought-provoking discussions, and learning from one another's experiences and expertise. This gathering serves as a platform for sharing best practices, exploring innovative approaches, and addressing the challenges and opportunities that lie ahead.

I want to take a moment to express our deepest gratitude to the dedicated organizing committee, our generous sponsors and partners, to mention but just a few are the Harleys Limited and Medex East Africa, and the countless individuals who have worked tirelessly behind the scenes to bring this conference to fruition. The LOC, your unwavering commitment to advancing the field of physiotherapy in East Africa is truly commendable.

In closing, I encourage all of you to fully embrace this conference as an opportunity to grow, to connect, and to inspire. Let us seize this moment to not only expand our knowledge but also to establish lasting connections and collaborations that will propel our profession forward.

Once again, a warm and heartfelt welcome to Mombasa, Kenya. Together, as a community of physiotherapy professionals, let us embark on a journey of learning, leadership, and innovation during the East Africa Physiotherapy Conference 2023.
Thank you, and let the conference commence!

Banda Henry Opondo,
President, Kenya Society of Physiotherapists
Chairman, Physiotherapy Council of Kenya
President, East African Community PT Organization

LOC Chairman
Welcome Speech

Samwel Muema,
Chairperson, LOC

It is once again my great pleasure to welcome the East African Physiotherapy family to this year's East Africa Community Physiotherapy Scientific Conference to be held at the Sai Rock Beach Hotel in Mombasa - Kenya.

Mombasa City is Kenya's second largest City after Nairobi. This historic Coastal town is known for its beautiful beaches and white - blue colonial architecture. It is the oldest city in Kenya and a great place to be. It is famous for its sparkling white sand beaches and exotic hotels like our venue which hosts this year's conference.
The Local Organizing Committee has identified a few 'must' visit areas in Mombasa namely: Fort Jesus Museum built by the Portuguese sailors in 1593 - 1596 to protect the port of Mombasa. It is one of the most outstanding and well preserved examples of 16th century Portuguese military fortification and a historical landmark. Other places you may wish to find time to visit are the Mama Ngina water front, Mombasa Marine Park, Nyali beach, the Great Tusks, and Mombasa old town. Mombasa town undoubtedly, remains Kenya's foremost tourist destination both for local and international tourists.

The conference proper will have a pre- congress program that will be made of breakaway learning sessions from which participants will choose upon registration.

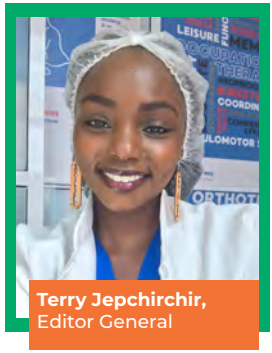
The breakaway sessions will consist of Orthopedic Manual Therapy, Neuro physiotherapy among others. Scientific Paper Presentations will be done in the morning plenary of the last day 1st December of 2023. There are numerous papers so far selected which will provide a great variety of learning experience to our participants.

Over 200 delegates are expected from Kenya, Uganda, Rwanda, Sudan, and Cameroon.
Once again, the conference local organizing committee and the entire Kenyan Physiotherapy family look forward to hosting you in an eventful and colorful conference event.

KARIBUNI SANA

SAMMY K MUEMA,
CONSULTANT PHYSIOTHERAPIST
PHYSIO AND PSYCOCARE CENTRE
PARKLANDS - NAIROBI

EDITOR'S Note



Terry Jepchirchir,
Editor General

Embarking on the progress we have achieved during the past year, and as we look towards the future, let us take this opportunity to encourage our community to continue to deliver outstanding service to our medical community. The future success of the KSP community relies on all of us to do our part.

In doing so, will benefit all of our Kenyan brothers and sisters. Everyone's effort is value-added. We strive to offer our community quality Physiotherapy services and improve training, regulation, and the welfare of our Physiotherapy society.

Let us build on our achievements by fostering an environment that actively encourages eliminating discrimination by developing, implementing, promoting/endorsing, evaluating, and monitoring inclusive policies, procedures, standards of practice, and codes of conduct.

Establish local diversity and inclusion policies and action plans in all Physiotherapy settings, including clinical, governance, management, research, and education. Prepare all members to adapt to the different situations they may experience daily.

Teach members how to use critical thinking; it will enable them to solve complex problems while performing their duties as Physiotherapists. As we come to the end of the year, I wish you God's blessings, grace, favour and protection in the Festive Seasons.

Happy holidays!

KSP Hon. Sec. General Welcome Speech

Onesmus Ngungua,
Hon. Secretary General

On behalf of the Kenya Society of Physiotherapists, I take this opportunity to welcome you all to the Coastal town of Mombasa, Kenya. Mombasa is the second capital city of Kenya with very rich historical background dating way back in the 16th century.

The Kenya Society of Physiotherapists and Local Organizing Committee have yet again chosen to host this conference in Mombasa being the most preferred tourist destination both locally, regionally .and internationally.

It is hoped that the conference will provide a platform for delegates to share knowledge and experience through Scientific Papers Presentations and evidence-based training, practice, and research.

Our partners have lined up exhibition of modern physiotherapy equipment, current assistive and rehabilitative devices available in the market. Please ensure that you find time to visit their booths.

Once more welcome to Mombasa - Kenya Karibu Mombasa!

The Conference
PROGRAM

DAY 1 WEDNESDAY 29TH NOV 2023

TIME	EVENT	ACTION	SESSION CHAIR
07:30 am – 08:30 am	Registration (Registration starts on 28th from 2:00pm to 6:00pm.)	Registration Dept	Kenya Society of Physiotherapists
08:30 am	Welcoming remarks and introduction	Chairman LOC	E.A PT Org.
09:30 am	MOH	Chief PT, MOH	Chairman LOC
10:00 am	PCK	PCK CEO	
10:30 am	Health Break		
11:00 am	Key Note Adress	KMTC - Dr. Nyawira	President KSP
11:30 am – 12: 00 noon	Leadership and Governance in EA Physio-therapy organization: Digital First Model for Rehabilitation	Jean Damascene	
12: 00 am – 12: 20 pm	Development and use of standardized data collection tools to support and inform physiotherapy practice in Kenya	Isaac Otieno	Daniel. Kangutu
12:20 pm – 12:40 pm	Bridging the leadership gaps that hinder rehabilitation from realizing its full potential in Universal Health Coverage (UHC) in Kenya	Caleb Owino	
12:40 pm	The future of Physiotherapy in Somalia	Dr. Faisal M. Qasim	
	Health Break		
13:00 pm	Break away session		Mr. Kennedy Mogire Ouko
14:15 pm	1. Lymphoedema assessment & management	Janet M. Mwau PT	
17:30pm	2. Maximizing Functional Recovery in Acute & Chronic Stroke	Smitha Vos. DPT	Mwajuma Nakasiba
	3. Dry needling treatment technique of myo-fascial pain of the buttock as it relates to low back pain. An evidence-based approach	Okumu Shadrack Wabwire PT, OMPT, DN, NMR	Jean Damascene
17:30pm – 6:00pm	Plenary		

DAY 2 THURSDAY 30TH NOV 2023

TIME	EVENT	ACTION	SESSION CHAIR
08:00 am – 08:30 am	Plenary Session	Chairman, LOC	Mr. Raphael Owako
08:30 am – 10:30 am	Break away session: 4. Examination, evaluation, and treatment of the sacroiliac joint as it relates to low back pain. An evidence-based approach	Okumu Shadrack Wabwire PT, OMPT, DN, NMR & Gerald Omondi PT. OMT	Ms. Jessica Shiraku
	5. Assessment and management of stroke	Dr. Naomi Kingau PT, PhD	Dr. Faisal M. Qasim
	6. Cervicogenic headache: Manual therapy examination and treatment	Mr. Erastus Osewe PT, Bsc, OMT	Ms. Elizabeth Mwikali
10: 30 am	Health Break		
11:00 am	Official Opening	Guest Speakers	President KSP
12:00 am	Partner Presentations	Chairman LOC	Ms Jessica Shiraku
13:00 pm	Health Break		
14:00 - 17:00 pm	Breakaway Sessions cont: 4. Examination, evaluation, and treatment of the sacroiliac joint as it relates to low back pain: An evidence-based approach	Okumu Shadrack Wabwire PT, OMPT, DN, NMR & Gerald Omondi PT. OMT	Ms. Jessica Shiraku
	5. Assessment and management of stroke	Dr. Naomi Kingau PT, PhD	Dr. Faisal M. Qasim
	6. Cervicogenic headache: Manual therapy examination and treatment	Mr. Erastus Osewe PT, Bsc, OMT	Ms. Elizabeth Mwikali

DAY 3: FRIDAY 1ST DEC 2023

TIME	EVENT	ACTION	SESSION CHAIR
08:00 am – 08:20 am	Plenary	Chairman, LOC	Mwajuma Nasiiba
08:30 am – 09:30 am	Scientific papers: 1. Effects Of Prescribed Low-Intensity Resistance Exercise on Prehypertension and Other Related Factors in Individuals Living Within Homa Bay Township, Western Kenya.	Eliakim Konje Moses	Mr. Kangutu & Ms. Jessicah Shiraku
	2. Exploring Digital Technologies in Women's Health Rehabilitation: Opportunities in Africa	Eunice Kabana PT, Pelvic Health Specialist	
	3. Knowledge of Physiotherapy Among Final Year Students Faculty of Medicine in Universities at Khartoum State	Balsam Mohamed	
	4. Enhancing Early Mobilization & Rehabilitation in Intensive Care Unit: A Case Study of Implementation Challenges and Strategies in a Local Hospital Setting	Ms. Gladys Omiso. PT, OMPT.	
	5. The Five Primary Kinetic Chains and Dynamic Neuromuscular Assessment	Mutiibwa Allan PT, NKT, DNA.	
	6. HIV Advocacy: Knowledge Translation and Implementation at Three Diverse Sites in Sub-Saharan Africa	Eliakim Konje Moses	
09:30 am	Plenary		
09:40 am – 10:30 am	7. UR-CEBE Activities related to the Digital Rehabilitation	Juliette Gasana MSc. University of Rwanda	
	8. Exploring Rehabilitation Options and Resources of Support for Stroke Survivors' in Eldoret, Kenya	Dr. Naomi Kingau PT, PhD	
	9. Sub-Classification of Low Back Pain Patients Treated at Mbagathi Sub-County Hospital Outpatient Physiotherapy Department: A Retrospective Study	Moses W. Katasi	
	10. Exploring The Landscape of Digital Rehabilitation Solutions in Kenya: A Qualitative Study	Dr. Naomi Kingau PT, PhD	
	11. World Physiotherapy Future Network And National Student And East Africa Community Physiotherapy Organizations: Role in the advancement of the physiotherapy profession	Mhimbuura Brian	
10:30 am	Plenary		
10:40 am	Health Break		
11:10 am – 12:50 pm	12. Rehabilitation for All Through Digital Innovation and New Competencies (Radic)	Dr. Nancy Amaya. HOD PT Moi University	Ms. Elizabeth Mwikali & Mr. Dickson Okumu
	13. Functioning Problems Associated with Health Conditions with Greatest Disease Burden in Kenya: A Scoping Review	Dr. Naomi Kingau PT, PhD	
	14. Impact of Nutritional Status on Physiotherapy Rehabilitation Outco mes Among Children with Cerebral Palsy at Ours-Ruharo-Mission Hospital, Mbarara Southwestern Uganda.	Ricky Mugume Kasaija	
	15.Strategy implementation and organizational performance of institutions of higher learning: A case Kenya Medical Training College	Mr. Jotham Munala. PT, Msc Ortho.	
12:50 pm	Plenary		
13:10 pm	Health Break		
14:30 pm	KSP AGM/INSTITUTIONAL/SITE VISIT	KSP President	KSP Vice President
17:00 pm	Health Break		

Transforming Physiotherapy in Kenya

Douglas Kotut,
CEO PCK

Physiotherapy, a vital component of modern healthcare, is constantly evolving to meet the changing needs of patients and healthcare systems. Its therefore imperative that physiotherapy practice and training is transformed to ensure that the profession remains effective and relevant now and in the future.

The ever-changing landscape of healthcare globally and locally demands that physiotherapists adapt to new technologies and evidence-based practices. One significant transformation is the integration of digital health solutions. Tele-rehabilitation and mobile apps enable physiotherapists to

Training programs need to incorporate education on these tools and platforms to ensure future professionals are proficient at using them.
Strengthening of specialization in physiotherapy is essential for improving patient care and overall healthcare outcomes. This can be achieved through several key strategies.

First, investing in advanced education and training programs for physiotherapists, focusing on specialized areas such as sports rehabilitation, cardiorespiratory care, geriatrics care, palliative care, pediatric care, neuro-rehabilitation, women health among others.

Secondly, fostering collaboration between physiotherapists and other healthcare professionals like doctors, nurses, occupational therapists, prosthetists and orthotists, speech therapists etc. ensures a more holistic approach to patient care.
Research is a driving force in the evolution of physiotherapy.

The profession needs to continually incorporate the latest scientific advancements into practice. Training programs should emphasize research literacy, ensuring that physiotherapists can critically evaluate and implement evidence-based approaches. Moreover, the profession needs to invest in high quality operational research that can inform effective policy choices.

Research findings can demonstrate the need to invest more resources to physiotherapy services at both the National and County levels which still suffer from historical under financing.

Another crucial aspect of transformation lies in the shift towards a patient-centric approach. Traditionally, physiotherapists have largely focused on treating an area with the disorder.

However, a holistic approach that considers the patient's lifestyle, mental health, and overall well-being is now gaining much traction. This change requires a reevaluation of the curriculum and training methods, emphasizing communication, empathy, and patient-centered care.

Incorporating cultural competence is another essential aspect of transformation. The increasing cultural diversity of patient populations requires physiotherapists to be sensitive to different cultural beliefs and practices. Cultural competency training could be integrated into physiotherapy education to ensure effective care delivery.

Physiotherapy is also experiencing changes in its scope of practice. With the increasing burden of chronic diseases and an aging population, physiotherapists are now involved in prevention and health promotion. Training and practice should reflect these expanded roles, covering areas like population health, health behavior change, and preventive strategies which should start all the way from the community level.

There is also a need to develop strong leadership and governance structures at all levels of the profession. This includes the professional society, the regulatory body, the National Government, County Government and the private sector. This is key in ensuring that profession is well represented at policy levels and issues touching on the profession are clearly articulated and advocated at the decision-making tables

Lastly, the need for ongoing professional development cannot be overstated. The fast pace of healthcare advancements demands that practicing physiotherapists continually update their skills and knowledge. Physiotherapists should embrace a culture of lifelong learning and skills enhancement as opposed to enrolling for a course or a training just as a fulfilment for renewal of licensure.

In conclusion, transformation of physiotherapy practice and training is crucial to meeting the evolving needs of patients and the healthcare industry. This transformation should include the integration of digital health solutions, a patient-centric approach, interprofessional collaboration, research literacy, cultural competence, expanded scope of practice, and a commitment to lifelong learning.

By embracing these changes, physiotherapy can remain a dynamic and effective field in modern healthcare.

DOUGLAS KOTUT,
Chief Executive Officer, PCK.

Contributions

VOLUNTEERING – A PROFESSIONAL CHALLENGE IN OUR COUNTIES

In volunteering, physiotherapists have a unique opportunity to extend their professional and personal skills in work that is both stimulating and highly rewarding. Volunteering has been advocated as an activity that can nurture interpersonal trust, tolerance, and empathy for others. It also gives you the opportunity to practice and develop your social skills and is where sacrifice and compassion work together to inspire and encourage people to action for the betterment of the communities where they live.

The incidence of those who require physiotherapy service is high in our 47 counties and many people lead restricted lives because of a lack of basic rehabilitation that physiotherapy can provide 'free of charge' through volunteering, but with busy lives, it can be hard to find time to volunteer whereas, there is little or no moral support amongst physiotherapists' leadership within our regions. However, the benefits of volunteering can be enormous; volunteering offers vital help to people in need of service, worthwhile causes, and the community, but the benefits can be even greater for you, the volunteer. The right match can help you to find friends, connect with the community, learn new skills, and even advance your career.

Giving to others can also help protect your social, mental, and physical health. It can reduce stress, combat depression, keep you mentally stimulated, and provide a sense of purpose. While it's true that the more you volunteer, the more benefits you'll experience, volunteering doesn't have to involve a long-term commitment or take a huge amount of time out of your busy day. Giving in even simple ways can help those in need and improve your health and happiness.

Physiotherapist volunteers need to have adequate resources in our hospitals, guidance, and assistance to perform their tasks and overcome challenges while performing their duties. They also need to have access to opportunities for personal development, recognition, and reward. Lack of support from their seniors and or workmates can lead to stress, burnout, boredom, and demotivation. Therefore, it is vital to provide and facilitate support for your volunteers, and you can do this by assigning mentors or buddies, providing supervision and coaching, offering referrals and resources, and creating a culture of care and respect.

Volunteers need to have clear and consistent information about their roles, expectations, responsibilities, and goals. They also need to have regular and meaningful interactions with staff, other volunteers, and beneficiaries.

Poor communication can lead to confusion, frustration, isolation, and dissatisfaction among volunteers. Therefore, it is essential to establish and maintain effective communication channels and strategies. Our counties have failed miserly to honor physiotherapists' volunteers who offer their services for free and instead use them for their own selfish desires. An employed physiotherapist would abscond duty for weeks or months, and leave the workstation for the volunteering physiotherapist.

Volunteers may have expectations from the organization, the staff, and the beneficiaries for future employment consideration. They may expect more or less involvement, flexibility, autonomy, feedback, or impact, but when an opportunity arises, you find a different person seconded. More than ever, fight for this one who volunteers in your hospital because when an opportunity was not there, the physiotherapist volunteer was there with you!

Finally, it is important to show your gratitude and appreciation regularly and sincerely. You can do this by sending thank-you notes, giving feedback, celebrating achievements, offering incentives, and providing opportunities for growth and learning. From what I have observed, prospective volunteers do occasionally ask about the perks and incentives for volunteering and they deserve more if that department would value them that much, or if the in-charge would value them or the county physiotherapist rehab.

As a physiotherapist, you are in high demand! Voluntary work is an excellent means through which both prospective and current physiotherapist may enhance their abilities and understanding pertaining to the practice of physiotherapy. Gain confidence, self-esteem, motivation, and a sense of achievement!

"Compassion ignites volunteerism," Stagnitta said. "Volunteers are compassionate. That is why they want to volunteer – to make a difference in the lives of others."

URINARY INCONTINENCE

Definition: inability of body to control evacuative functions of urination or defecation: partial or complete loss of bowel or bladder control.

TYPES OF INCONTINENCE

Stress incontinence is defined as leakage associated with physical activity or increased intra-abdominal pressure, such as coughing, sneezing or rising from a chair.

Urgency incontinence is leakage associated with, or immediately after, the sudden need to void. Overflow incontinence occurs when there is obstruction at the bladder neck or an impairment of detrusor contractility, so that leakage occurs from an over-filled bladder, often without urgency. It is more commonly seen in males.

Overflow incontinence can be caused by urethral obstruction, prolapse of the pelvic organs, neurological damage and conditions that can reduce sensation in the bladder, such as stroke, diabetes and sclerosis.

HISTORY AND EXAMINATION

- Frequency of voiding
- Frequency of leakage
- The triggers associated with leakage
- The use of pads or other protective devices
- Diet and fluid intake, including caffeine and alcohol intake
- Lower urinary tract symptoms, e.g. UTI symptoms, postvoid dribbling, needing to urinate again immediately
- Other genitourinary symptoms
- Constipation and fecal incontinence/soiling*
- Sexual function (i.e. psychosocial effects of incontinence)
- Past history of: bladder surgery, hysterectomy, childbirth (including number of births and mode of deliveries)
- Medicine use
- Smoking status

PHYSIOTHERAPY MANAGEMENT

Pelvic floor muscle exercises are used to strengthen the muscles under the uterus, bladder and bowel. They are used in both males and females who have problems with urinary incontinence or bowel control, and following pregnancy and childbirth in females.

When performed correctly over several months, with good patient compliance, they can be effective in reducing stress incontinence for most people with mild to moderate stress incontinence.

Most pelvic floor muscle exercise interventions will be designed and initiated under the supervision of a Physiotherapist.

An individualized programme of exercises is usually developed for each patient. Where referral is not possible or where the wait time for referral will be significant, an exercise regimen may be initiated in primary care. Pelvic floor muscle exercises can be described to the patient as tensing the muscles used to hold in urine.

Advise the patient that next time they are voiding to attempt to stop the flow in order to “visualise” the muscles that should be tensed. Attempting to stop the flow of urine should only be used to assess whether the correct muscles are being contracted and not as part of the exercise programme itself. Unless the technique is correctly demonstrated, some females may do a Valsalva maneuver instead of contraction when they try to perform pelvic floor muscle exercises.

If there is concern that the patient is performing the technique incorrectly, muscle contraction can be assessed with a digital examination. Strengthening exercises are performed by tensing, holding and then relaxing the muscles. The exercise programme should comprise three sets of eight contractions, daily.

Each contraction should be held for approximately ten seconds. Between each contraction, the pelvic floor muscles are relaxed for several seconds. During contractions, it is important to isolate the pelvic floor muscles. To do this, tell the patient to keep the gluteal and thigh muscles relaxed during each contraction and to breath normally throughout the exercise.

Initially the patient may find it easiest to do the exercise while sitting or lying down, but once comfortable with the exercise they can be done at any time, place or body position. In addition, advise the patient that it may be more comfortable to empty their bladder prior to doing the exercise.

A Physiotherapist may also suggest the use of biofeedback, electrical stimulation or vaginal cones as adjuncts to exercise where appropriate, e.g. in females with an absent or very weak contraction, or to increase confidence that the exercise is being done correctly.

Commercially available products, such as Kegel balls and pelvic toners, are advertised as being effective for preventing incontinence and strengthening the pelvic floor. It is difficult to quantify the efficacy of such products, and it is advisable to discuss their use with a Physiotherapist first.

TERRY JEPCHIRCHIR CHELIMO,
PELVIC PHYSIOTHERAPIST.

WHAT IT TAKES TO BUILD MUSCLES. (TRAINING, RECOVERY, NUTRITION)

TRAINING
Starting at the highest level possible, training serves a simple purpose: Providing a growth stimulus for the muscle. As a reaction to the growth stimulus, an adaptive response is triggered in your body. This adaptive response is the trigger that causes your muscle to grow to adapt to the stress you put your muscle under with the growth stimulus (workout). That's what we call hypertrophy.

Now, let's go a bit deeper. What does it actually take to provide a growth stimulus? For most of you, surprisingly little. The two most important training variables we have to structure our workout around are volume (how many sets we do) and intensity (how hard we train). A low-volume, high-intensity approach as it has great benefits for hypertrophy while being time efficient.

To make this approach work, we obviously need to train at a high intensity, which means taking all of our sets to failure (the stage where you can't complete another rep without breaking form). We do this with a technique called progressive overload. If you are not familiar with the concept of progressive overload, it is about increasing the weight or reps for each exercise every (other) workout. This way, we make sure that we are actually training at a high intensity and are not leaving any reps in the tank.

Volume and intensity are in a direct relationship with each other. Until a certain degree, we can decrease our volume when we increase the intensity and increase our volume if we decrease the intensity. Don't start changing splits and exercises every few weeks because you believe it will result in greater muscle gains. If you already have a decent program, there is limited benefit in trying to optimize the exercise selections. You will see more results from optimizing recovery and nutrition.

RECOVERY
Directly linked with training is recovery. Many people tend to underestimate the importance of having an adequate recovery despite the process being quite simple: You train to provide a growth stimulus, you eat to fuel the muscle growth, and you recover to give your muscles time to grow. It is important that our muscles can recover between training sessions to progress and stay injury-free. Therefore, let's assume you already follow a low volume, high-intensity approach and have proper recovery time between two workouts. But we can do more for recovery while we are not training to give our body the best chance to build new muscle tissue.

The most important part is getting proper sleep. As with everything, the amount of sleep you need differs from person to person, but chances are, if you sleep less than 7 hours per night, you are not getting enough sleep. But not only getting enough sleep is important. You should also try to optimize the quality of your sleep. You can do this by following a sleep schedule, not consuming caffeine or blue light shortly before going to bed and darkening and cooling down your room. If you get proper sleep, you have already done the most important part regarding recovery. But if you want to optimize it further, you can also investigate the benefits of heat and cold therapy, stretching, stress reduction, or active recovery.

Everybody is different in terms of how much recovery he needs, but the rule of thumb is quite simple: If you can't increase the reps or weights on each exercise every (other) workout despite training at a high intensity and having proper nutrition, you are not giving your muscles enough time to rest and grow.

NUTRITION
"Abs are made in the kitchen" is a saying everybody knows, and it is mostly true. From my experience, the number one reason people are not making proper gains is not because of their workout or recovery, it's because of their nutrition. And while many get lost in the nuances of nutrition, the basics for gaining muscle are simple: Optimize calorie and protein intake according to your goal. Starting with calories, as calories are the key to all your physique goals. Put simply, if you want to gain weight, you want to be in a caloric surplus; if you want to lose weight, you want to be in a caloric deficit. This is also known as "calories in, calories out". There is no other way.

Calories are so important for your body because a calorie is nothing else than a unit of energy. For every process happening in our body, we need energy. This energy can come from outside the body (food) or from energy stored within our body (e.g. fat). You can look at your body as an energy balance and need to question yourself at the end of the day: did I take in more calories than I burned? The answer to that question decides if you lost or gained weight that day.

If you want to lose weight, you need to be in a calorie deficit, which means that your body burns more energy (calories) than you fuel it with. As a consequence, the body starts burning energy stored in your body, starting with fat, and you lose weight. Conversely, if you want to build muscle, you need a calorie surplus because building and repairing muscle tissues is a very energy-intense task.

In practice, you want to be at least 300 calories below your caloric maintenance level to lose weight or 300 calories above to gain muscle. However, calculating your caloric maintenance level can be imprecise, so it's best to adapt your diet based on your results. Besides calories, protein plays another essential part in building muscle. Protein consists of amino acids, which are the building blocks of muscles. The process of the body breaking down protein into amino acids to repair and grow the muscles is called muscle protein synthesis and is what actually grows the muscle.

If you only need to remember one thing about protein, remember this. On the simplest level, you should make sure to consume 0.7-1.0g of protein per 1lb of body weight per day (1.6-2.2g/kg). You also don't need to worry too much about when to consume your protein, it's more important to reach your daily target. Another important factor is the quality of the protein.

The quality is determined by the amino acid profile (which amino acids it contains) and bioavailability (how much your body can use) of the protein. Looking at the bioavailability, there is a general trend that animal-based protein source have a higher bioavailability than plant-based protein sources. That could mean that if you eat 30g of protein from beans, your body may only use 25g of that protein. Therefore, it is especially important for vegetarians and vegans a good idea to have a protein intake at the higher end of the spectrum.

9 TIPS TO LOSE WEIGHT & KEEP IT OFF

- Eat 1.25 g of protein per pound of LEAN 2 body weight. As long as you're undereating protein, you will be overeating carbohydrates. This is the biggest issue for why people struggle with weight loss. Eating 100 g of protein is the main reason why you're constantly hungry.

- Limit refined carbs, sugars and seed oils. Consuming an ultra-processed food diet drives increased caloric intake by ~500-600 calories. It also contributes to metabolic havoc in your body. Limiting ultra-processed foods makes more room for you to eat real food.

- Exercise: Resistance training 3-5 X week for 45 minutes. Cardio 3 X week for 15-30 minutes. Sprints 3 X week, 3-5 sprints for 15-30 seconds each Bonus points if you sprint up a hill.

- Combine protein with other SATIATING foods. Cruciferous vegetables. Potatoes & onions (just don't add loads of butter) Salad or other dark greens, Apple or berries

- Portion control. Portion out your meals so that you are not overeating. A good rule of thumb for each meal: 6-8 ounces of protein, 2-6 ounces of vegetables, 2-4 ounces of starchy carbs/fruit

- Eat until you are 80% full. Eat until you are no longer hungry but not stuffed. This is one of the easiest ways to reduce calorie intake without realizing it.

- Consume salt and electrolytes.

LACK of salt = LACK of energy to exercise.
LACK of salt = INCREASED INSULIN = FAT STORAGE
LACK of salt = INCREASED SUGAR CRAVINGS

- HOME COOKED FOOD > FAST-FOOD. Eating a home cooked meal will allow you to control the ingredients in the food that you eat. Most fast-food places cook with SEED oils and add loads of fat to make their meals taste good. This is an easy way to reduce caloric intake.

- Get 8 hours of sleep. Just four nights of poor sleep increases insulin resistance by 16%. Sleep deprivation REDUCES fat burning and INCREASES muscle breakdown. One night of poor sleep = 559 MORE calories consumed the next day.

Lack of sleep = LESS MUSCLE and MORE FAT

HUMPHREY MEMBA,
PHYSIOTHERAPIST

OUR SEAT AT THE TABLE

I got into practice at a time when covid -19 had created havoc in the industry. With confounding pressure to be innovative and creative in delivering the best care, more information suddenly became available.

People were more sympathetic towards saving the dying human race and more willing to show the world how they were contributing to the crisis resolution. Physical therapy was not left behind. This unexpected time saw a massive increase in dissemination of information. People were more receptive to learning what they don't know and yes, the expert notion in a particular field was quickly dropped.

Let me give you a bit of background on why this was exciting for me; and I believe for other young clinicians. I am from one of the cohorts that found education in PT evolving in mighty steps. When I joined university, I was admitted straight from secondary school into a four-year program to attain a BSc in Physiotherapy. Mind you, I had never interacted with a physical therapist before.

In fact, to me, anyone who wore a white coat and reported to the hospital for work was simply a doctor. So, with very little background on what I was going to study, I enthusiastically joined my fellow freshmen in classes. As fate would have it, in our 2nd year, upgrading students joined us. They had been in the field for a while and in they came with clinical practice stories. One common thread was that most of them, if not all, worked in a hospital set up.

As the years went by and we got to learn more, we started getting into the specifics of practice. Our classes were full of interesting specializations like neurologic, women's health and sports medicine. The clinical practice bit did not always match the class work as we were sent out only to hospital set ups.

Our counterparts seemed to be green to the information too with only one or two exceptions who had maybe practiced in a different setting. The interesting people who actually practiced in specialized fields were all external lecturers who had trained outside the country and had been invited to teach a few units. We only got to learn from them when we were very senior students.

So, in hindsight, when I was graduating, I believed my fate would be to end up in a hospital where I attended to hospital related cases. This was not only sealed in my mind, but it also created doubt and fear on whether I really wanted to pursue this field for the REST of my life. Mind you, those from my group who had more exposure had already quit the practice before we began and branched out to what seemed more lucrative and exciting than reporting to a hospital every day.

Fortunately for me, pun intended, covid hit just as I was graduating. The hospital I was working in then suddenly became interesting as the physiotherapy niche was felt in respiratory care.

We had to learn and learn fast how to teach breathing techniques, manage long-covid and even do telemedicine for conditions that did not require in person contact. That was the beginning of the floodgates, and as the saying goes, when it rains it pours.

Multi-disciplinary approach to treatment became the fall back in medicine in large. We were now all fighting one common enemy, which ideally should have been the approach from the word go. This interaction meant everyone was contributing to care not only for covid patients but for every other single condition.

Through this collaboration, our voices were becoming louder in other specializations such as oncology and palliative care, lymphedema management, pelvic health and women's health etc. We were heard in all in the important rooms and those who previously sat at the table made room for us.

This has given birth to bold moves by practitioners. There has been a significant rise in private practices whereby physiotherapists are daring to open specialized clinics and hospitals. They are not worried about lack of clients or lack of reimbursements to their investments. Now, they can rely on other clinicians to refer patients to them and also trust in the power of information dissemination, that clients will perpetually walk into their spaces seeking help.

This realization has been an overwhelming encouragement that one does not have to be a generalist confined to a hospital but can be a specialist in different avenues. New work spaces have also emerged with physiotherapists infiltrating wellness industries. It is no longer a novel idea to have a boutique physical therapy space that offers services like yoga, Pilates, dry needling, cupping and many more emerging treatment techniques.

Right now, in this moment in time, I am more like overly excited at the possibilities. I might say, I even feel lucky to be living in this era. Just as being alive with Beyonce! There is a lot of promise and a lot of potential to be realized. And so, if you are feeling a little wobbly in this career choice, I challenge you to think out of the box. Network. Articulate your value, find your footing and do not be afraid to engage.

VERONICA KIRIGO

Abstracts

EXPLORING THE LANDSCAPE OF DIGITAL REHABILITATION SOLUTIONS IN KENYA: A QUALITATIVE STUDY

Background: The integration of digital technologies in healthcare and rehabilitation is an emerging and dynamic area of interest, particularly in low and middle-income countries like Kenya. Understanding the contextual nuances of rehabilitation needs and digital technology adoption in Kenya is vital for the development of effective and culturally-sensitive digital rehabilitation interventions.

Aim: To explore the present status of rehabilitation needs, their availability, and accessibility in Kenya. Likewise, the study delved into the current utilization of digital technologies in everyday life and to assess the viability and reception of digital rehabilitation solutions as perceived by healthcare professionals.

Methods: A qualitative descriptive study was conducted, using an interpretive paradigm. Fifty-three rehabilitation professionals, including physiotherapists, occupational therapists, and orthopedic technologists were purposively selected. Interview guide was used to conduct semi-structured interviews. Thematic content analysis was utilized to identify key themes and patterns within the data. Participants were recruited from diverse healthcare settings across Kenya to ensure a comprehensive representation of the Kenyan rehabilitation landscape.

Results: The study revealed a complex and multifaceted rehabilitation landscape in Kenya, characterized by a high demand for rehabilitation services driven by diverse medical conditions. The existing rehabilitation services in Kenya face various challenges, such as resource constraints, inadequate infrastructure, and limited access to rehabilitation facilities, especially in rural areas.

Kenyan society's use of digital technologies was found to be on the rise, with an increasing penetration of smartphones and internet access. These technologies were being utilized for information-seeking, communication, and even some aspects of healthcare management. Healthcare professionals acknowledged the potential of digital solutions in rehabilitation and expressed willingness to integrate digital technologies into their practice.

The feasibility and acceptability of digital rehabilitation solutions among healthcare professionals in Kenya were largely positive, with a recognition of the potential to improve accessibility, efficiency, and patient engagement. However, concerns regarding resource constraints, digital literacy, and data privacy were also raised. The need for culturally relevant and accessible digital solutions was emphasized to ensure acceptability and effectiveness.

Conclusion: This qualitative study provided insights into the current rehabilitation needs in Kenya, the growing use of digital technologies, and the feasibility and acceptability of digital rehabilitation solutions from the perspective of healthcare professionals. The findings highlight the importance of developing context-specific digital rehabilitation interventions that address the unique challenges and opportunities within the Kenyan healthcare landscape. Such solutions have the potential to enhance the quality and reach of rehabilitation services, ultimately improving the well-being and quality of life for individuals in need of rehabilitation in Kenya.

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DEVELOPMENT AND USE OF STANDARDIZED DATA COLLECTION TOOLS TO SUPPORT AND INFORM PHYSIOTHERAPY PRACTICE IN KENYA

Abstract
Globally clinicians are being faced with the need to demonstrate for the way clinical services are delivered and the quality of the delivery. It has also increasingly become important to develop a comprehensive profile of patients with which conditions are accessing services offered, who benefits from these services, how much these services cost in terms of clinician's time and finances, the use of other health care resources and the effectiveness of interventions utilized in relation to quality outcomes.

Clinicians therefore need to be keen to have mechanisms to identify what approaches are best to utilize in their own practice settings, how they can be made to work best and how they can be improved from professional development perspective to assist in both decision making and inform policy. They are also anxious to improve their skills based on informed retrospective practice and identify gaps in their knowledge and skills that can be used to develop systems to capture adequate information about what they practice.

This background identifies how standardized data collection (SDC) tools can be utilized in practice to generate information required in a robust, agreed and accessible way. It summarizes a method of SDC tool development and demonstrates how SDC can be used in physiotherapy National health services, private practice including civil society organizations under the umbrella of rehabilitative services in Kenya.

The relevance world over is that increasingly, physiotherapy services are being held and will be accountable for the quality and equity of care provided. In addition, physiotherapists can find it useful to have benchmarks with which to compare their own and their departmental performance in terms of clinical activities and outcome.

It is therefore befitting to present the SDC for physiotherapy in the upcoming East Africa Confrere.

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REHABILITATION FOR ALL THROUGH DIGITAL INNOVATION AND NEW COMPETENCIES (RADIC)

Background: The project answers to the need to develop digital rehabilitation in Eastern Africa through transnational cooperation in higher education focusing on capacity building of teachers and professionals to enhance the competence development of students and the working life. According to research, an estimated 2.4 billion people globally are currently living with health conditions that benefit from rehabilitation (Cieza et al. 2019). Globally rehabilitation is not prioritized as needed, although the demand for services continue to grow due to aging and through the increase of non-communicable diseases. Especially in Low- and Middle- income countries (LMIC), the rehabilitation need is largely unmet. This often due to limited number of trained professionals.

Aim: The project paves a way to develop new, cost-effective, person-centered, and scalable innovations for rehabilitation, targeted for the Eastern African region. WHO defines rehabilitation as "a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments". (WHO).

Although rehabilitation is promoted through different international initiatives, it is still evolving as a concept, offering opportunities for innovation and new models of care. In 2017, WHO launched the Rehabilitation 2030 initiative, in which the 2030 Call for Action provides a guide to health system strengthening practices with a focus on rehabilitation.

It identifies the following priority areas, supported by the project: to develop a strong multidisciplinary rehabilitation workforce, to expand financing for rehabilitation and to improve data collection and research on rehabilitation. (WHO 2017).

Strengthening the rehabilitation in health system is the key strategy for achieving Universal Health Coverage. However, various countries are yet to adopt the strategy and its guidelines in the best possible manner, despite its importance. Use of digital rehabilitation strategically can help to build resilience in situations where systems become ineffective, overloaded or are not developed to meet the demand. (Murtonen et al. 2021).

Study setting: This especially concerns the low- and middle-income countries, where the digital transformation provides an opportunity to disrupt present models of care that traditionally relies heavily on the expertise of rehabilitation workforce. In recent years, higher education institutions in Eastern Africa have realized the need to increase their research and innovation capacities to support the digital transformation in rehabilitation and to answer to the mismatch between needs of the society, markets, and the service sector.

Access to rehabilitation is also a development problem that has not been addressed to extent needed. Higher education has a key role in developing digital rehabilitation services leading to increased access and the improved quality of care in different countries in Eastern Africa.

Modernization of rehabilitation education through interdisciplinary methods offer economic and social value, enabling the transfer of competences across the societies, supporting the wellbeing of all citizens. Project aims to modernize the curricula of the partner higher education institutions (HEIs) through digitalization and to develop a stronger, long-lasting cooperation across the education and working life in the African partner countries (AU partners).

In the project context, digital rehabilitation includes, for instance, the use of tele- and distance rehabilitation applications and services, wearable physical activity trackers, emails, video, speech, and text messaging solutions. Digital rehabilitation can also include the use of new emerging technologies designed for direct empowerment of users in self-management and care. Thus, at best, digital rehabilitation can make rehabilitation more accessible and effective than an activity tied to the traditional guidance, and physical or online presence of the professional.

According to the needs analysis, project offers AU partner HEIs the opportunity to leapfrog in digital rehabilitation compared to high-income countries as professionals are often few and systems, in practice, already focus on transforming skills and knowledge to the clients. Most digital rehabilitation solutions presently are designed for trained professionals who use those with clients, creating an unnecessary bottle neck in service provision directly to the client. Feasible, appropriate, meaningful, and effective solutions provided directly to end-users will radically increase access to rehabilitation. HEI has important role to facilitate this transformation through research and development, including competence development (Murtonen et al. 2021).

Following the Strand guidelines, altogether six African HEIs were chosen to the project from Kenya, Rwanda, and Tanzania: Moi University (MU), Jomo Kenyatta University of Agriculture and Technology (JKUAT), University of Rwanda (UR), The University of Global Health Equity (UGHE), The Kilimanjaro Christian Medical University College (KCMUCo), State University of Zanzibar (SUZA). In the context of this action, partners answer to the need to strategically leverage digital tools, technologies, and services in rehabilitation through educational development for sustainability.

Sustainability is reached through local ownership of the competences developed with on-going transfer of developed practices in the partner countries.

Primary target groups of this project include AU partner HEIs teachers and professionals, students, and the working life. Other target groups include various professionals in social and health care, the business sector, rehabilitation clients, and the society at large.

Methods: Stakeholders (rehabilitation professionals) in East African RADIC project countries: Kenya, Tanzania, and Rwanda will be recruited by partner HEIs and project workers by disseminating the survey through their own channels, social media and contacting the possible stakeholders directly (e.g., via national associations).

Quantitative and qualitative data collection using a specially devised online questionnaire using Finnish, data secure Webropol-program (https://we-bropol.com/). The collected quantitative data will be presented by using tables and graphs, the collected qualitative data will be analyzed by data driven content analysis. The survey will be anonymous, only general socio-demographic information (such as country of residence, occupation, and years of working experience) will be requested. Ethical considerations will be made in every HEI regarding the content of the questionnaire.

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IMPACT OF NUTRITIONAL STATUS ON PHYSIOTHERAPY REHABILITATION OUTCOMES AMONG CHILDREN WITH CEREBRAL PALSY AT OURS-RUHARO-MISSION HOSPITAL, MBARARA SOUTHWESTERN UGANDA.

Team Members: Mbabazi Esther, Namukhowa Paul, Kitabanga Umar, Kato Stephen, Ricky Mugume Kasaija, Kwizera Godfrey

Background: Malnutrition significantly affects children with Cerebral Palsy (CWCP). Cerebral Palsy causes feeding difficulties, increasing the risk of malnutrition, and often malnutrition in CWCP results in compromised immunity, cognitive problems, and stunted growth. Malnutrition-related deaths account for 35-45% of deaths in children aged 6-59 months, with a high prevalence in Africa. CWCP experience delayed growth, motor dysfunction, and have a need for multidisciplinary care. Rehabilitation mainly aims to improve function and reduce disability.

Uganda has a high prevalence of Cerebral Palsy, but limited data on malnutrition factors and their impact on rehabilitation. Therefore, this study aims to identify factors associated with malnutrition and evaluate its impact on acquiring developmental milestones in CWCP undergoing rehabilitation in southwestern Uganda.

Objective: To determine the factors associated with malnutrition and the effect of nutritional status on the physiotherapy rehabilitation outcomes in CWCP at OURS Ruharo Mission Hospital.
Methods: The study employed a cross-sectional study design with a quantitative approach. The target population included Children With Cerebral Palsy. A sample size of 64 participants was determined using the RaoSoft calculator, and purposive sampling was employed. Eligibility criteria focused on children aged 3 to 12 years, who had been consistently receiving rehabilitation for at least one session per week for a minimum of a year.

The study acquired permissions, reviewed rehabilitation records to select participants (children and caretakers), employed a questionnaire, and used GMFM-88 scores to evaluate the nutritional status and functional growth of the children. The collected data was entered and cleaned using Microsoft Excel, and analysis was performed using STATA. The results were described, presented, and discussed, leading to the conclusions drawn in this thesis. Quality control measures were implemented, including researcher training on study procedures, research ethics, and confidentiality.

Results: A total of 64 participants (children) were included in the study. Of these, 33 (51.56%) had a history of malnutrition, while 31 (48.44%) did not. The majority of participants (50%) were aged 3-5 years. More males (54.69%) had a history of malnutrition compared to females (45.31%). Most primary caretakers were mothers (79.68%). Among caretakers, 9.38% were employed, 64.06% had informal employment, and 23.44% were unemployed.

Breastfeeding for less than 6 months raised the risk of malnutrition 5-fold compared to 7-24 months or more (OR=5). Introducing other kinds of milk before 12 months increased the risk by 4.5 times (OR=4.5). Feeding less than 3 times per day raised the risk of malnutrition 12-fold compared to 4-5 times per day (OR=12). Feeding only liquids/semi-solids raised the risk 93 times compared to solids/liquids (OR=93). The inability to self-feed increased the risk 12 times (OR=12). Feeding difficulties raised the risk 8 times (OR=8). Early solid food introduction had no significant impact. A non-balanced diet increased the risk 7 times (OR=7). The main feeding difficulty for malnourished children was chewing (39.39%).

Non-malnourished children scored significantly higher on GMFM assessments than those with a history of malnutrition. The non-malnourished group outperformed the malnourished group across all GMFM aspects, with differences ranging from 20.25% to 27.24%. On average, the total goal score for non-malnourished children was 25%, which is 10% higher than that of malnourished children. These findings underscore the substantial influence of nutritional status on the rehabilitation outcomes of children with Cerebral Palsy.

Conclusion: Associated factors of malnutrition in CWCP encompass the duration of breastfeeding, feeding frequency, timing of complementary food introduction, food consistency, timing of alternative milk introduction, self-feeding ability, and presence of feeding difficulties. The nutritional status significantly influences the outcomes of physiotherapy rehabilitation in CWCP. Prioritizing the screening of associated factors of malnutrition and addressing them to prevent malnutrition, along with prompt intervention upon identifying malnutrition, should be emphasised. This approach aims to ensure positive results from the physiotherapy rehabilitation of CWCP.

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A RETROSPECTIVE STUDY OF LOW BACK PAIN SUB-CLASSIFICATION IN KENYA.

Moses W. Katasi, Rebecca Mwangangi, Catherine N. Gituro

ABSTRACT

Background: There is a need in categorizing low back pain into sub-classifications. In physiotherapy many classifications are in existence, in practice many physiotherapists might overlook classifying low back pain patients, a condition that has become a major complaint in the general population. Its presentation is unique from one individual to the other irrespective of the etiology, body structure, and age group.

In physiotherapy practice, a minority of physiotherapists can classify low back pain into different sub-classifications. The increased prevalence of this condition is dramatic in the general population, it's rise and recurrence, impacts people's daily lives and restrains individuals to perform to their maximum full potential, both at work and at an individual's functional capacity. Physiotherapists would effectively manage patients and enhance fast, quick approaches to treatment models in physiotherapy upon classifying low back pain into different sub-classifications.

Objective: The main objective of this study was to identify different sub-classifications of low-back pain and treatments used in the out-patient physiotherapy department at Mbagathi Sub-County Hospital in Nairobi Kenya.

Methods: Through a retrospective study, data was collected through systematic sampling, code numbers were used instead of details of patients' files in data collection, and data secured in documents encrypted with passwords, stored in computers hard disk with password secured. Data description was done through SPSS, ethical review, and approval by Amref Ethical and Scientific Review Committee and the study was carried out in Mbagathi Sub-County Hospital approved by the Medical Superintendent.

Results: In this study, a majority of classification diagnoses were either based on the duration of back pain as acute, sub-acute, or chronic. Physiotherapists also classified low back pain based on the patho-anatomical origin of symptoms that mostly reflected the following structures affected; lumbar intervertebral disc (30.2%), muscles (26.7%), then nerve root (19.2%). Facet joint and sacroiliac diagnoses were the least at 13.9% and 10% respectively. The basis of patho-anatomical diagnosis was not rather fully elaborated on file records.

Classified diagnosis based on the duration of low back pain had varied patterns of representation, sub-acute low back pain was 39.4%, chronic 37.1% and 23.5% for acute low back pain.

Classification based on ICF Domain Categories was captured in record review with Pain in the lower limb (36.1%), followed by mobility deficit of several joints (24.5%), then radiating pain in a segment or region (20.0%). Further, 7.6% of patients were diagnosed with generalized pain 7.0% had mobility impaired control of complex voluntary movements, and 3.9% on records represented sensitivity to a noxious stimulus.

The findings were consistent with those found in other studies that classified low back pain based on various factors through identifying the most common pathoanatomical structures. Treatments captured in the file records showed that exercise combined with therapeutic modalities and manual therapy was administered to a majority of patients (35.4%), therapeutic modalities and manual therapy 24.5%, exercise combined with therapeutic modalities (16.9%).

A total of 8.4% of patients were treated by manual therapy, while 6.2% were treated by manual therapy combined with exercise and exercise and therapeutic modalities were administered to 5.2% and 3.4% of patients respectively. In relation to the outcome of treatments given above there was no conclusive data on file records gathered with no significant evidence that the outcome was effective for patients treated. As much as treatment was given there was no doubt that there was satisfaction from the patients or rather the patients would have reported to be responding probably worse, not improved, slightly improved or much improved from the treatments done.

Conclusion: This study concludes that a majority of the diagnosis were based on the pathoanatomical classification, based on ICF Domain Categories and injury or disease diagnosis, as much as these diagnoses were captured they were not conclusive on the record to specifics but rather as a general perspective in classification. Treatments used correlated to the classifications given with other treatments repeatedly were recorded and appeared common in all sub-classifications. The outcome of the treatments were not recorded showcasing a gap in data entry. In the case as much as the treatments given were deemed effective or not there was no data recorded to show evidence.

Recommendations Most of the records revealed that physiotherapists did not record the evaluation, patient progress, and review while managing back pain in the outpatient department. There is still more need to sensitize and educate physiotherapists to sub-classify low back pain to enable proper selection of appropriate and effective treatments. The recommendations will help physiotherapists to classify, design, and intervene with treatments that suites individual patients' need.

Recommendations include:

- Creating a patient file record that fits the credentials of a SOAPIER format.
- Encourage physiotherapists to fill in file records as required.
- Department to encourage and promote continuous medical education among physiotherapists to enhance more information on back pain classification, assessment and treatment in relation to evidence-based practice.
- Patient education to be encouraged.
- Physiotherapists to improve and review patients and record the findings in every patient visit.

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ASSESSMENT AND MANAGEMENT OF STROKE (TRAINING)

Understanding Stroke: Begin with an overview of what a stroke is, including its types (ischemic, hemorrhagic) and risk factors. Understanding the basics of stroke is crucial for effective rehabilitation.

Stroke Assessment: Teach participants how to assess and evaluate stroke survivors, including conducting initial assessments, recognizing the severity of impairments, and identifying potential complications.

Rehabilitation Goals: Discuss the overarching goals of stroke rehabilitation, emphasizing functional independence, quality of life, and preventing secondary complications.

Patient-Centered Care: Stress the importance of patient-centered care, which involves tailoring rehabilitation programs to the individual needs and goals of stroke survivors.

Multidisciplinary Team Approach: Explain the significance of a multidisciplinary team, including therapists, nurses, doctors, and social workers, in providing comprehensive care.

Neuroplasticity: Describe the concept of neuroplasticity and how the brain can rewire itself through rehabilitation exercises and therapies.

Physical Rehabilitation: Cover exercises, therapies, and strategies to improve motor skills, mobility, balance, and strength in stroke survivors.

Assistive Devices and Technology: Explain the use of assistive devices and technology to aid stroke survivors in regaining independence.

Medication Management: Educate on the appropriate use of medications, including anticoagulants and antiplatelet drugs, for stroke prevention and management.

Pain Management: Discuss strategies for managing post-stroke pain and discomfort.

Secondary Prevention: Cover lifestyle modifications, such as diet, exercise, and smoking cessation, to prevent recurrent strokes.

Family and Caregiver Education: Highlight the importance of educating and supporting family members and caregivers in the care of stroke survivors.

Rehabilitation Challenges: Address common challenges in stroke rehabilitation, such as spasticity, contractures, and pressure ulcers.

Emerging Trends and Research: Keep participants updated on the latest research, technologies, and trends in stroke rehabilitation.

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COURSE TITLE ABSTRACT: EXAMINATION, EVALUATION, AND TREATMENT OF THE SACROILIAC JOINT AS IT RELATES TO LOW BACK PAIN. AN EVIDENCE-BASED APPROACH(TRAINING)

INSTRUCTOR: Okumu Shadrack Wabwire PT, OMPT, DN, NMR

COURSE GUIDELINES:

1. Lecture-intensive focus is designed to help you a better understanding of the the current best evidence for the treatment of low back pain "SIJ"
2. However, there will be an opportunity to observe and participate in diagnostic examination and higher-level manual therapy procedures (any volunteers?)
3. Discussion encouraged (open forum don't be shy!), questions should be
4. evidenced-based and pertinent to course material, but input based on experience is also welcome.

COURSE OBJECTIVES:

1. Synthesize data from the examination and evaluation process to make Evidence-based clinical judgments regarding differential diagnosis and patient management in individuals with SIJ dysfunction.
2. Select appropriate intervention strategies based on a biopsychosocial healthcare delivery model to optimize patient care outcomes.
3. Integrate the examination and management of lumbopelvic and sacroiliac dysfunction within the context of a comprehensive treatment-based
4. classification system (e.g., ICF).
5. Compare and contrast patients who are likely to benefit from manipulation, stabilization exercises, specific exercises, and traction approaches using current best evidence in the context of a case study.
6. Understand the theoretical models of pain science.
7. Application of outcome measures in regard to the patient exam, prognosis, and goal-setting

REQUIREMENTS

3 plinths for high-level manual therapy procedures

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KNOWLEDGE OF PHYSIOTHERAPY AMONG FINAL YEAR STUDENTS FACULTY OF MEDICINE IN UNIVERSITIES AT KHARTOUM STATE

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Abstract

Background: The knowledge of the physiotherapy profession for future doctors is important, they must have a good knowledge about physiotherapy to be able to work in an intra-disciplinary team to achieve optimal patient care.

Objectives: To investigate the knowledge of physiotherapy among final year students that study medicine in universities at Khartoum State. To determine the sources where they get their knowledge about physiotherapy. To investigate the extent of student's awareness about physiotherapy.

Method: A cross sectional study was conducted, with a total of 330 participants, who are final year students studying medicine from different universities at Khartoum State. An online questionnaire designed via Google form, consists of 29-items closed-ended questionnaire. It was sent to participates in their batch group chat. The data was collected and statistically analyzed.

Results: This study showed that there was a lack of awareness about physiotherapy specialties specifically Cardiopulmonary, Oncology, Pediatrics, Geriatrics and Women's Health. Also the results found there was a misconceptions about physiotherapy practitioners, 44.5% of respondents believed that massagers are one of physiotherapy practitioners. 87.9% of participants thought that physiotherapists cannot be first contact practitioners. A majority of participants did not acquired knowledge about physiotherapy from their university.

Conclusion: The findings indicated that final year students do not have complete awareness about the physiotherapy. The results also showed that the common sources of information are the Internet and social media. It is recommended that students studying medicine can be given education about the physiotherapy and it can be integrated in their study.
Keywords: Knowledge, Physiotherapy, Students

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SUB-CLASSIFICATION OF LOW BACK PAIN PATIENTS TREATED AT MBAGATHI SUB-COUNTY HOSPITAL OUTPATIENT PHYSIOTHERAPY DEPARTMENT: A RETROSPECTIVE STUDY
Authors: Moses W. Katasi, Rebecca N. M. Mwangangi, Catherine N. Gituro

ABSTRACT
Background: Low back pain categorization into sub-classifications is vital in physiotherapy practice, yet it is frequently overlooked despite its prevalence as a major complaint in the general population. The presentation of low back pain is highly diverse, irrespective of etiology, body structure, or age, making effective classification challenging and consequently affects treatment approach to be used. The increased prevalence of this condition is dramatic in the general population, it's rise and recurrence, impacts people's daily lives and restrains individuals to perform to their maximum full potential, both at work and at an individual's functional capacity. This study, conducted at Mbagathi Sub-County Hospital in Nairobi, Kenya, sought to identify sub-classifications and the treatments administered in the outpatient physiotherapy department.

Objective: The main objective of this study was to identify various sub-classifications of low-back pain and assess the treatments utilized in the outpatient physiotherapy department at Mbagathi Sub-County Hospital.

Methods: This study was ethically done upon authorization by the Amref Ethical and Scientific Review Committee (ESRC), the National Commission for Science Technology and Innovation (NACOSTI) and Mbagathi Sub-County Hospital. This study was a retrospective study that employed a systematic sampling procedure for data collection, with patient details replaced by code numbers to ensure data security. Data was stored in password-encrypted documents on computer hard drives. The data was captured on excel to SPSS for analysis.

Results: Majority of classification diagnoses were based on the duration of back pain, with acute (23.5%), sub-acute (39.4%), and chronic (37.1%) being the predominant categories. Physiotherapists also classified low back pain based on patho-anatomical origin, with the lumbar intervertebral disc (30.2%) and muscles (26.7%) being the most frequently affected structures. Nerve root (19.2%), facet joint (13.9%), and sacroiliac (10%) diagnoses were less common. The classifications based on patho-anatomical diagnoses were not adequately detailed in patient records.

Classification based on ICF Domain Categories revealed the following: pain in the lower limb (36.1%), mobility deficit of several joints (24.5%), radiating pain in a segment or region (20.0%), generalized pain (7.6%), mobility-impaired control of complex voluntary movements (7.0%), and sensitivity to a noxious stimulus (3.9%).

Treatments captured in the patient records predominantly included exercise combined with therapeutic modalities and manual therapy (35.4%), therapeutic modalities and manual therapy (24.5%), exercise combined with therapeutic modalities (16.9%), manual therapy (8.4%), manual therapy combined with exercise (6.2%), exercise 5.2% while use of therapeutic modalities alone was 3.4%.

In this study the outcomes of these treatments were not conclusively documented, with this gap on data recording by physiotherapists it was impossible to ascertain the outcome of these treatment approaches based on the classifications in this study.

Conclusion: This study concludes that low back pain diagnoses mainly rely on duration and patho-anatomical classifications while use of ICF domain categories of classification was minimally used. However, these classifications are often insufficiently detailed in the records. Treatments correlate with these classifications but lack conclusive data on treatment outcomes, however more study can be done to specifically ascertain the correlation of classifications given against the treatment approach. Further this study also highlights a critical gap in data entry. Improved data collection and outcome tracking would be essential to enhance the management of low back pain in physiotherapy practice.

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EXPLORING DIGITAL TECHNOLOGIES IN WOMEN'S HEALTH REHABILITATION: OPPORTUNITIES IN AFRICA

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Abstract

Background

Nearly 2.5 billion people worldwide would benefit from rehabilitation services, though only 50% of countries can provide rehabilitation services to 20% of those in need. These evaluations have not specifically included health conditions disproportionately affecting women, such as urinary incontinence (UI), for which there is Level I evidence supporting rehabilitative interventions. In Sub-Saharan Africa (SSA), UI affects over 120 million women. Digital technologies may support capacity-building in UI care in SSA.

Purpose

To describe the evidence for a technology for UI treatment in the USA and opportunities to inform a digital technology-enabled pelvic floor rehabilitation solution in SSA.

Methods

To address the underutilization of pelvic rehabilitation and deficits in the healthcare workforce in the USA, a technology was developed that combines hardware and software to effectively treat UI. This is foundational to development of a digital technology-enabled solution that may be transformative for rehabilitative services in Africa. Formative research was conducted in August- September 2023 in Lagos, Nigeria and Nairobi, Kenya. This included interviews and focus group discussions with women with UI and with healthcare providers engaged in women's health and UI treatment.

Results

The US-based technology has demonstrated superior outcomes among women with UI in both Randomized Controlled Trial and Real-World Evidence scenarios when compared to a control group after 8-weeks. Published results demonstrate durability at 12-months. This has informed formative research in Nigeria and Kenya to inform development of a technology-enabled solution for UI in the African context. Feasibility testing of a clinic-based, technology-enabled solution for women with UI will be conducted in 2024. User-centered design research during this same period will specifically facilitate software development for at-home support. Insights from clinicians highlight desire and acceptability of digital health and technology-enabled solutions to manage this health condition.

Conclusion(s)

Evidence-based digital technologies are expanding rehabilitative care for UI in women in the USA and may do the same in SSA.

Keywords
Urinary incontinence, pelvic floor muscle training, digital technology, capacity-building
Funding Acknowledgement
Drs. McKinney and Keyser are employees of Axena Health, Inc., the product manufacturer.
Ethical Approval
No ethical approval was required for this abstract.

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COURSE TITLE: DRY NEEDLING TREATMENT TECHNIQUE OF MYOFASCIAL PAIN OF THE BUTTOCK AS IT RELATES TO LOW BACK PAIN. AN EVIDENCE-BASED APPROACH (TRAINING)
INSTRUCTOR: Okumu Shadrack Wabwire PT, OMPT, DN, NMR

COURSE DESCRIPTION:
This is a 2 hours course designed to teach physical therapists, and other licensed medical personnel to use dry needling with musculoskeletal diagnoses as an invaluable tool with other physical therapy techniques. It includes treatment of scars, superficial dry needling techniques, and myofascial trigger points of the buttock.

Myofascial pain is a very common occurrence in these areas and is often the major perpetuating factor creating pain which restricts restoration of normal function of the area.
Trigger points cause muscle tightness, weakness, and spontaneous pain. They cause loss of muscle balance around a joint leading to the formation of trigger points of agonists, antagonists, and inevitably joint lesions.

COURSE OBJECTIVES:
1. Integrate myofascial concepts into the assessment and diagnosis of musculoskeletal disorders and nociceptive pain
2. Apply the neurophysiology of both Myofascial pain and mechanisms for needle deactivation of trigger points located in the gluteal region musculature as it relates to low back pain and referred pain
3. Identify 5 active and 5 latent myofascial trigger points using common referral patterns
4. Integrate specific principles of dry needling to set up a clean field needling station and perform safe needling techniques.
5. Integrate knowledge from “best clinical practice” and research evidence when introducing dry needling techniques to treat different musculoskeletal conditions associated with myofascial pain syndrome.
6. Applying pain science to dry needling
7. Treatment of neuropathic pain
8. Understanding the goals of deep dry needling and superficial dry needling

REQUIREMENTS
3 plinths for the demonstration of dry needling treatment technique procedures

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LYMPHOEDEMA ASSESSMENT AND MANAGEMENT (TRAINING)
INSTRUCTOR: JANET M. MWAU PT, Lymphoedema Therapist, BScPT(OG)

Background:
Lymphoedema is a condition of localized fluid retention and tissue swelling resulting from compromised lymphatic system function.

Purpose:
This presentation and training session aim to provide physiotherapy professionals with a comprehensive understanding of lymphoedema, including its assessment and management, to enhance their ability to address this complex condition effectively.

Methods:
The training will focus on evidence-based approaches, such as manual lymphatic drainage, multi-layer lymphoedema bandaging, tailored exercise regimens, and patient education. Participants will engage in practical demonstrations and interactive sessions to gain hands-on experience and a deeper comprehension of the implementation of these treatment modalities.

Results:
Upon completion of the session, attendees will be equipped with the knowledge and practical skills necessary to tailor management plans according to individual patient needs, considering the specific stage and severity of lymphoedema.

Conclusion(s):
This initiative aims to empower physiotherapy professionals to deliver evidence-based care, thus improving the quality of life for individuals managing lymphoedema. By enhancing the understanding of assessment techniques and intervention strategies, the training seeks to raise awareness and improve patient outcomes for this challenging condition.

Implications:
Enhanced expertise in lymphoedema assessment and management among physiotherapy professionals can lead to improved patient care, increased patient satisfaction, and a greater understanding of the complexities involved in addressing lymphoedema.

Key-words:
Lymphoedema, physiotherapy, assessment, management, manual lymphatic drainage, patient education.

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EXPLORING REHABILITATION OPTIONS AND RESOURCES OF SUPPORT FOR STROKE SURVIVORS' IN ELDORET, KENYA: QUALITATIVE STUDY

Background: Stroke is a major cause of death and disability in adults globally. Most post-stroke survivors experience various impairments which requires rehabilitation. Likewise, returning home after a stroke represents challenging moments full of struggle. This study therefore, explores options of rehabilitation and resources of support for stroke survivors in Eldoret, Kenya.

Method: A qualitative descriptive approach was used to conduct the study. The study utilized semi-structured interviews. Fifteen dyads of stroke survivors (10 men and 5 women; aged 40–75 years) were enrolled from a rehabilitation outpatient clinic (Medical Park Physical Therapy) in Eldoret, Kenya. Interviews were conducted at the patients' house and an inductive approach was used to enable thematic content analysis.

Results: Three dominant themes, and several categories emerged from the participants, this included; (1) Rehabilitation services available for stroke survivors (2) Resources of support.

Conclusions: The study found that stroke units are only available at the national hospitals, and not accessible to many. Patient receive physiotherapy and occupational therapy services during hospital stay but has poor access post discharge. Transport, distance and lack of finances have been highlighted as the main challenges. There is scarcity of speech therapist as well as advanced orthotics for stroke rehabilitation. From a clinical perspective, health care system should be better structured to accommodate continuity of care post discharge for stroke survivors.

Key Words: Stroke, Rehabilitation, Resources, Support, Survivors

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FUNCTIONING PROBLEMS ASSOCIATED WITH HEALTH CONDITIONS WITH GREATEST DISEASE BURDEN IN KENYA: A SCOPING REVIEW

Background: A notable rise in health-related disability for which evidence-based rehabilitation is beneficial is evident in low-to-middle income countries.

Method: Scoping review aimed to systematically identify and map the most common functioning problems associated with health conditions that contribute most to disability in Kenya using the International Classification of Functioning, Disability and Health (ICF) framework. Peer-reviewed evidence published from January 2006 to December 2023 was systematically searched from five databases.

Results: Some 43 studies reporting on functioning problems (impairments, activity limitations, and participation restrictions) in Kenya adults (>18 years) related to 10 health (GBD) conditions were included. A total of 25 different functioning problems were mapped to the ICF. The most prevalent problems (5) were related to mobility, pain, and mental health but spanned across several ICF domains and categories, and were mostly in patients at primary care.

Conclusion: The high prevalence and wide range of functioning problems may be particularly burdensome on an already strained primary health care (PHC) system.

Recommendation: This points towards targeted planning of innovative strategies towards strengthening rehabilitation service delivery at primary care to address these complexities where there is an inadequate rehabilitation workforce.

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ENHANCING EARLY MOBILIZATION AND REHABILITATION IN INTENSIVE CARE UNIT (ICU): A CASE STUDY OF IMPLEMENTATION CHALLENGES AND STRATEGIES IN A LOCAL HOSPITAL SETTING
Ms. Gladys Omiso. PT, OMT, BscPT

Introduction:
The significance of early mobilization in ICU has gained recognition for its potential to prevent complications arising from prolonged immobility. However, its prevalence and successful implementation remain variable and influenced by diverse factors, including healthcare resources and organizational culture. This case study aims to shed light on the benefits of early mobilization, barriers hindering its implementation, and strategies to overcome these challenges in a local hospital setting.

Literature Review:
Existing literature demonstrates varying degrees of early mobilization prevalence in ICUs across different countries, emphasizing the critical role it plays in preventing immobilization-related complications and improving patient outcomes. Despite its evident advantages, a lack of resources, safety concerns, and resistance from healthcare providers pose significant barriers to its successful execution.

Case History:
Patient X, a 35-year-old female diagnosed with Guillain Barre Syndrome, was admitted to the ICU with progressive limb weakness. The implementation of early mobilization, along with immunoglobulin therapy, significantly contributed to her gradual recovery and facilitated her transfer to a general ward for further rehabilitation.

Physical Examination:
The physical examination revealed the patient's progressive improvement in strength and mobility over the course of early mobilization, underscoring the positive impact of this intervention on the patient's condition and recovery.

Intervention:
The multidisciplinary early mobilization intervention, personalized to the patient's condition, included assisted sitting, standing, and walking, facilitated by a collaborative effort between physiotherapists, medical professionals, and nursing staff.

Outcomes:
The outcomes highlighted the positive impact of early mobilization, demonstrating a reduction in ICU stay duration, improved muscle strength, and prevention of immobilization-related complications, ultimately contributing to the patient's overall recovery and rehabilitation.

Discussion:
The discussion addresses the challenges and benefits of early mobilization, emphasizing the importance of a collaborative and multidisciplinary approach in overcoming barriers to its implementation in the ICU. The role of effective communication, resource management, and personalized interventions are underscored as crucial factors for successful early mobilization.

Summary:
In summary, this case study provides understandings into the challenges and benefits of implementing early mobilization in ICU settings. It highlights the crucial role of collaborative efforts and tailored interventions in ensuring the successful performance of early mobilization strategies, ultimately leading to improved patient outcomes and enhanced quality of care in ICU settings.

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BRIDGING THE LEADERSHIP GAPS THAT HINDER REHABILITATION FROM REALIZING ITS FULL POTENTIAL IN UNIVERSAL HEALTH COVERAGE (UHC) IN KENYA
Caleb Owino Odhone

Background.
WHO in Genève endorsed some historic resolutions on strengthening rehabilitation in health system. The resolutions call for expanding and integrating rehabilitation in health system as part of UHC and emphasizing the importance of rehab in primary care and as part of emergency preparedness and response. For rehabilitation and physiotherapy in particular to realize the intended resolutions, a deliberate and bold step must be taken to appropriately be represented in all decision making and implementation table both at the national and county level.

Body
In this presentation, I have looked at various country that has strong rehabilitation frame work and standardized leadership organogram like South Africa and Canada in comparison to Kenyan rehabilitation leadership structure and has made me come up with a proposed leadership structure both at the national level and county level that will enhance representation and standardization at the county level.
Am also enhancing competitive appointment process as per public service commission standard and S.O.S requirements to make us have a substantive office.

Conclusion
The above proposed leadership organogram will not only enhance representation in critical decision-making table but will also enhance rehabilitation both at the national and county level

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HIV ADVOCACY: KNOWLEDGE TRANSLATION AND IMPLEMENTATION AT THREE DIVERSE SITES IN SUB-SAHARAN AFRICA

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Keywords: HIV; advocacy; knowledge translation; rehabilitation and physiotherapy; undergraduate.

Abstract
Purpose: To explore how the gap in knowledge translation around HIV and rehabilitation could be addressed using advocacy. This article describes and reflects on lessons learned from incorporating content on HIV and advocacy into the curricula at three diverse physiotherapy (PT) programs in sub-Saharan Africa.

Methods: A realistic evaluation approach was followed. Three study sites were purposively chosen to reflect diverse settings with respect to pedagogical approach, university or college, degree or diploma programs, use of technology, and regional prevalence of HIV. A multi-faceted intervention was implemented that included three activities: (i) to develop three core components of a novel knowledge translation intervention designed to improve knowledge, attitudes, and self-efficacy in HIV and rehabilitation advocacy among PT students; (ii) to tailor and implement the knowledge translation intervention by local faculty according to the context and needs of their program and to implement this with a cohort of PT students at each of the three study sites; and (iii) to evaluate the adaptation and implementation of the intervention at each site.

Results: Differences exist between the three-country programmes, specifically in the length of time the degree takes, the extent of HIV inclusion in the curriculum and years of the study included in the project. Conclusions: This research adds to the call to shift the focus of HIV care from just test-and-treat, or on just keeping people alive, towards a broader approach that centres the whole person, that focuses not only on surviving but on thriving, and which commits to the goal of optimising functioning and living full, whole lives with HIV.

Advocacy across the continuum of care plays a pivotal role in translating research findings into practice. Implications for rehabilitation Results are relevant for policymakers in government and at senior levels within universities whose mandates include informing, reviewing, and driving educational programs and curricula. The result from this project illuminates the role for rehabilitation and allows for incorporating HIV into curriculum and practice for physiotherapists and other related stakeholders so that they can advocate for and with patients.

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EFFECTS OF PRESCRIBED LOW-INTENSITY RESISTANCE EXERCISE ON PREHYPERTENSION AND OTHER RELATED FACTORS IN INDIVIDUALS LIVING WITHIN HOMA BAY TOWNSHIP, WESTERN KENYA

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Keywords: low-intensity resistance exercise, prehypertension, lipid profile, anthropometric.

ABSTRACT
Introduction: Prehypertension is the precursor to hypertension. It's anticipated that prehypertension will affect one-third of the population worldwide by 2025. For instance, Homa Bay County Referral Hospital has reported an increase in pre-hypertensive patients over the past 5 years. Thus, this study aimed to determine the effects of prescribed low-intensity resistance exercise on prehypertension, anthropometric measurements, and biochemical levels in individuals living within Homa Bay Township.

Methods: A randomized controlled trial study design was employed on 34 (17 experimental and 17 controls) pre-hypertensive adults. Participants performed prescribed low-intensity resistance exercise for a period of 3 months. Blood pressure, biochemical, and anthropometric data were collected on pre, mid, and post-training. ANOVA with a within-subjects factor of time and treatment type was used to determine the differences between the two groups.

Results: Except for BMI [F (1, 32) =8.06, p=0.008], the study found that the prescribed low-intensity resistance exercise did not affect other anthropometric measurement of pre-hypertensive individuals. Prescribed low-intensity resistance exercises significantly, F (1, 32) =5.01, p=0.03, lowered the pre-hypertensive pressure in the experimental group to normotensive at post-study (from 127.59+5.01 to 115.88+6.06 mmHg systolic pressure) as compared to the control group (from 128.94+4.64 to 122.47+2.87 mmHg systolic pressure). Although lipid profiles and fasting blood glucose decreased in both experimental and control groups, the decline was more marked in the experimental group, suggesting that prescribed low-intensity exercise could decrease the variables.

Conclusion: This study provides evidence that prescribed low-intensity resistance exercises prescription in prehypertension can prevent progression to hypertension.

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THE FIVE PRIMARY KINETIC CHAINS AND DYNAMIC NEUROMUSCULAR ASSESSMENT
PRESENTER: MUTIIBWA ALLAN PT, NKT, DNA (UGANDA)

The 5 Primary Kinetic Chains (5PKC) – developed by Joseph Schwartz – are based on the theorem behind Andry Vleeming's Core Subsystems and how those subsystems connect the entire fascial fabric through the kinetic chains. Each chart outlines a primary physiological principle in movement: bones, joints, ligaments, tendons, muscles and fascia do not work in isolation. They work synergistically to create movement. When movement is balanced and efficient, the players are all cooperating.

Selected topic: Anatomy, Biomechanics and Motor Control
The 5 Primary Kinetic Chains, an Expansion of Dr. Vleeming's Five Subsystems
SCHWARTZ, J. Lyons, Colorado USA

Introduction: The Five Primary Kinetic Chains (5PKCs) provides clinicians with a template for assessment of the musculoskeletal system. In this body of work, the term kinetic chain describes how bones, joints, muscles, and connective tissue structures integrate for efficient and fluid movement. Other terminologies describing how structural components work together are anatomical slings and subsystems, myofascial slings and force transmission systems. The body does not work in isolation.
Instead, the body accomplishes movement as an integrated whole. This is the premise for expanding Vleeming's subsystems to include the whole structure.

The term kinetic chain has two general perspectives. One is based on the microcosm and the other is based on the macrocosm. The microcosm is based on structure; this is the anatomical viewpoint. The macrocosm is based on movement; this is the kinesiological viewpoint. This demonstrates that anatomy and kinesiology are interdependent.

The 5PKCs introduces a new concept, The Five Principal Actions (5PA). The sum total of all five principal actions are present in all forms of movement. The five attributes of the 5PA are breath, shock absorption, axial stability, stored elastic energy, and the translation of stored elastic energy. Each Principal Action is associated with a specific kinetic chain.

The 5PKCs provides a template for gait and act in an interdependent relationship. Each relies on the other to create balanced, efficient, reciprocal movement. The 5PKCs have varied participation with each other during the gait cycle. Simultaneously, the expression of the 5PA mirrors the efficiency of kinetic chain sequencing.

Purpose/Aim: The 5PKCs gives therapists a reference for client assessment. This provides a template for an initial benchmark when restoring optimal movement strategies. The kinesiology charts are suited for the clinician (Table 1), and illustrations (Figure 2) facilitate patient education. As clinicians interact with the charts and illustrations, an understanding of how the subsystems connect to the whole body is further developed.

Material and Methods: The development of the 5PKCs has come from several distinct sources. The three major influences are Vleeming's Five Subsystems, Michaud's Human Locomotion, and Sonnon's BioMechanical Exercise™.
Results: Clinicians can utilize the 5PKCs to help clients resolve structural symptoms of movement dysfunction and pain.

Conclusion(s): The 5PKCs wall charts differ from previous anatomy art. Instead of a static representation of the body, the 5PKC represents the body in motion.

Keywords: kinetic chain, movement, gait, subsystem

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CERVICOGENIC HEADACHE: MANUAL THERAPY EXAMINATION AND TREATMENT
Presenter: Erastus Omil Osewe

Abstract
Orthopaedic Manual therapy is a specialized Physiotherapy treatment for the management of musculoskeletal injuries. It's based on a lot of clinical reasoning and uses manual treatment techniques and therapeutic exercises.

Background
The cervical region contains many pain-sensitive structures, and that these are prone to injury (Malhotra, Pace, Maya, Colman, Gelb, Mehta & Kontorovich,2020). The anatomical and physiological mechanisms are in place to allow referral of pain to the head including frontal head regions and even the orbit in patients with pain originating from many of these neck structures (Becker, 2010).

Cervicogenic headache is rather intense head pain usually unilateral, spreading from the neck to the frontal and temporal regions, and triggered by certain movements or sustained provocative head positions (Khaliq, Malik, Jahan & Zia, 2022). Digital pressure over triggering areas at the upper nuchal area reproduces the spontaneous pain pattern. Available clinical criteria differentiate this picture from other headache disorders.

Migraine may be induced by cervical trigger factors in some case. Occipital neuralgia refers to pain restricted to the distribution of the affected nerve and should not be mistaken as cervicogenic headache. Clinical studies have shown that pain from cervical spine structures can in fact be referred to the head. On the other hand, clinical treatment trials involving patients with proven painful disorders of upper cervical zygapophysial joints have shown significant headache relief with treatment directed at cervical pain generators. A wide variety of treatment options is available for people with headache and neck pain (Castien & Hertogh, 2019). Some of these interventions are recommended in guidelines on headache: self-management strategies, pharmacological and non-pharmacological interventions (Uthaikhup, Assapun, Watcharasaksilp & Jull, 2017). Physiotherapy treatment is a frequently applied treatment for headache (Castien & Hertogh, 2019).

Purpose: This presentation aims to educate on physical examination and prescription of appropriate physiotherapy treatment to patients with cervicogenic headache.

Conclusion: In conclusion, painful disorders of the neck can give rise to headache, and the challenge is to identify these patients and treat them successfully.

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AN OVERVIEW OF A PELVIC HEALTH TELEREHABILITATION AWARENESS PROGRAM DONE AMONG A GROUP OF WOMEN IN CENTRAL UGANDA.

Ankwasa Brendah, pelvic health physiotherapist, BSP MUST.

Introduction

Pelvic floor dysfunction (PFD) is a common problem in Uganda (Josaphat et al., 2023), however many Ugandans are not aware of pelvic rehabilitation which has been proven to manage PFD. Telerehabilitation is the delivery of rehabilitation services via information and communication technologies. Recently, the COVID-19 pandemic highlighted the importance of providing online treatment options (Naif et al., 2021).
The Ssenga Physio Clinic offers a holistic approach to pelvic health care including Ssenga Physio School; a telerehabilitation project, which aims at increasing awareness of pelvic health rehabilitation to the general public using social media.

Program description

The Ssenga Physio School (SPS) has 6 online modules; preparing for pregnancy, the holistic approach, prenatal exercises, birth and postnatal exercises. The content of the modules was developed by experienced pelvic health physiotherapists. Some of the modules were adapted from physiopedia with permission.
The Ssenga Physio School online what's app group was formed with a main aim of disseminating information on pelvic health rehabilitation. Through this program, 211 women have received access to information about pelvic health rehabilitation over a period of 2 months.

Findings

One focus group discussion (FGD) for assessing impact of SPS was conducted with eight females in Kampala, central Uganda, who had joined the Ssenga Physio School Online what's app group.
From the FGD, the SPS program was well accepted by most participants, despite some technology challenges. Women expressed pelvic health concerns and fears before attending SPS. Many report that they had received limited support from the community and the health system.
After attending, women were more informed and sought pelvic rehabilitation services. One of the women said, "I was very scared of pregnancy because of the operation I had, I went for checkup at Ssenga Physio Clinic after attending SPS, was given easy exercises that healed my pain."

Conclusions
Interventions like online programs seem to be effective in increasing awareness of pelvic health rehabilitation which prevents and treats pelvic floor Dysfunction and other pelvic health conditions.
Recommendations.
Governmental authorities, physical therapy councils and corresponding associations should be involved in increasing awareness of pelvic health rehabilitation using digital technologies.

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MAXIMIZING FUNCTIONAL RECOVERY IN ACUTE AND CHRONIC STROKE
Presenter: Smitha Vos

Brief Bio: Smitha is a passionate physiotherapist with over 10 years of professional experience in neurological rehabilitation and 5 years' experience in vestibular rehabilitation and clinical teaching. A majority of her professional career has been in the US.
She is a registered member of the APTA (American physiotherapy therapy Association) and prides herself in creatively incorporating
evidence based rehab techniques to achieve the best possible outcomes.
The presentation will mainly address.
• Current treatment trends and techniques in stroke rehab
• Tools of treatment in stroke rehab
• Incorporation of digital technology in treatment

TOPIC BRIEF
Stroke is the leading cause of disability , dementia and death worldwide. Approximately 70% of deaths from stroke and 87% of stroke related disability occur in low income and middle income countries. Data published within the last decade shows that in Africa, stroke has an annual incidence rate of up to 316 per 100,000, a prevalence of up to 1,460 per 100,000 and a 3 year fatality rate greater than 80%.

On a positive note, evidence based research in physiotherapy management of stroke has progressed rapidly and more efficient methods of treatment have evolved thereby improving the outcomes for even those with stroke impairments more than a year. I will be presenting on the different stages of stroke, appropriate treatment strategies for every phase, (acute, subacute and chronic) including strengthening, tone management, cardiovascular optimization, optimal motor learning strategies, gait impairment, balance and valuable outcome measures to document progress. This will help physiotherapists tailor their treatments more specifically to the each individual's needs.

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WORLD PHYSIOTHERAPY FUTURE NETWORK AND NATIONAL STUDENT AND EAST AFRICA COMMUNITY PHYSIOTHERAPY ORGANIZATIONS: Role in the advancement of the physiotherapy profession.
By Mhimbuura Brian

Abstract:
Physiotherapy is a medical profession that aims at alleviating pain and restoring movement and function to as near normal as possible when someone is affected by injury, illness, disability or the process of aging. Like other medical professions, Physiotherapy is science-based and continuously aims at extending, applying, evaluating and reviewing the evidence that underpins and informs its clinical judgment and informed interpretation, practice and service delivery.

Physiotherapists are skilled professionals involved in assessment and treatment of a wide range of conditions which threaten physical function in both adults and children. Their contribution is evident throughout a number of both public and private settings such as hospitals, clinics, sports clubs, industries and community settings.

To raise awareness and strengthen the profession, several bodies and associations have been created to unite Physiotherapy professionals in various regions and parts of the world under respective national or regional umbrella associations with the overall body being the World Confederation for Physiotherapists (WCPT) and in the African region alone, now about 25 national Associations for Physiotherapists exist.

In East Africa, the profession is growing at a first rate and the World Physiotherapy African Region East Africa sub-region organisation for Physiotherapy professionals exists. Better still, countries have national Associations for professional physiotherapists such as Uganda Association of Physiotherapists (UAP), Kenya Society of Physiotherapists (KSP), Rwanda Physical Therapy Organisation (RPTO) etc, however, there is no association for Physiotherapy students from various institutions and countries at the East African regional level so far.

For the profession to grow and enjoy continuous improvement, organizations such as world Physiotherapy Future Network and East African Community students Associations, which bring together trainees in the profession to interact academically and socially both amongst themselves in preparation for the professional arena as well as with other interest groups e.g. other medical associations and bodies is more appealing. Therefore, we, herein, propose for;

1. The creation of a Sub-regional physiotherapy students' association which shall bring together all the different currently existing institution-based and/or national physiotherapy students associations in East Africa.
2. Strengthening the World Physiotherapy Future Network within the East African Subregion
3. Encourage creation of National Physiotherapy students associations and aligned with respective member organization

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PELVIS: ORTHOPEDIC MANUAL THERAPY EXAMINATION AND TREATMENT OF THE SACROILIAC JOINT
Presenter: Gerald A Omondi

Background
The sacroiliac (SI) joint is a crucial component of the lumbopelvic complex, providing stability and facilitating movement between the sacrum and the ilium. However, SI joint dysfunction, often characterized by pain and limited mobility, is a common cause of low back pain and pelvic girdle pain.

Purpose: This presentation will delve into the realm of orthopedic manual therapy (OMT) as a comprehensive approach to assessing and treating SI joint dysfunction. The presentation will highlight the anatomical and biomechanical factors contributing to SI joint problems, emphasizing the importance of a thorough assessment to identify the underlying cause of pain and dysfunction. Conclusion: OMT offers a safe and effective treatment modality for SI joint dysfunction. Through a combination of joint mobilization, soft tissue manipulation, and neuromuscular re-education, OMT practitioners can restore joint mobility, alleviate pain, and enhance functional movement patterns.

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STRATEGY IMPLEMENTATION PRACTICES AND ORGANISATIONAL PERFORMANCE OF INSTITUTIONS OF HIGHER LEARNING: A CASE OF KENYA MEDICAL TRAINING COLLEGE

Jotham M. Munala – Strategy Expert, Lecturer & Physiotherapist, Kenya Medical Training College.
Evans Mwasiaji (PhD) – Lecturer, Kenyatta University

ABSTRACT

Introduction: Effective strategy implementation is considered critical towards the achievement of institutional objectives by facilitating better organizational performance for long term sustainability. In Kenya, state owned corporations such as the Kenya Medical Training College (KMTC) continue to perform below stakeholder expectations, and over rely on the exchequer for budget support, resulting in loss of viability and inability to effectively deliver on its core mandate. Numerous studies on corporate strategy have reported a correlation between implementation poor practices strategy and underperformance in many commercial and not for profit organizations.

Objective: This study therefore sought to examine strategic leadership and effective communication during strategy implementation and its effect on organizational performance among institutions of higher learning. Through extensive review of extant literature, the Balanced Scorecard, Institutional and Agency theories were chosen to anchor this study.

Design: The study adopted descriptive research design in line with the general objective of the study, while census method was used to enrol the study participants. The unit of analysis was the Kenya Medical Training College, while the unit of observation was 84 senior managers at the college. Relevant data generated using Likert scale type questionnaire were analysed using the Statistical Package for Social Sciences version 26.

Results: The study results were presented using descriptive statistics. Multiple linear regression was used to test for association between variables, and statistics set at $p< 0.05$ at a confidence level of 95%. The study revealed that both strategic leadership and effective communication were positively associated with organizational performance at KMTC. However, only effective communication (p Value = 0.031) was deemed to have a statistically significant influence on organizational performance.

Conclusion: The position taken by this study is that continuous effective communication is critical during strategy formulation and implementation process for the purpose of facilitating the realization of the set organizational performance objectives.

Recommendation: This study therefore recommends that the Chief Executive Officer at the Kenya Medical Training College should sensitize managerial position holders and support staff on proposed future changes, and persuade all key stakeholders to adopt behaviour compatible to the desired strategic change. The Chief Executive Officer should also actively involve staff in the change process, while simultaneously reducing time lag in communication within, between and among campuses and college headquarters.

Study Impact: The expected study output is effective and optimal strategy implementation, enhanced service delivery and improved organizational performance.

Keywords: Strategy, strategy implementation practices, KMTC, organizational performance

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