WEBVTT

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Morning. Everybody we're really welcome to see you here.

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We're just gonna give it one or 2??min for everybody to join the Webinar.

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It's lovely to see the numbers ticking up for us on the screen of who's here today?

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How many are we at Alice? How many of joined live just now

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50 at the moment, which is all good. So just give it a little bit longer, and then

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500 registered altogether. Is that right?

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Is correct, so literally just 1??min and then we will. It starts it

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Hey? Just still taking out

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How does this sense? She's had a few issues, a login process.

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Okay.

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Eric, we have a weird break after your your speaker slot, so don't worry.

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If this overrun slightly because of the slight delay in starting

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So what I think, what I will do, just what our last few are.

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Attendees are hopefully joining, although we're expecting a lot of people to come and go a little bit through the day.

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But I'd like to. Well, everybody to our Adapts Conference.

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So for those of you that are not members of adapt, but have joined us because we've got a wonderful international sort of registration list adapt is physiotherapists Mainly from the Uk we're all members of the Charter society of Physiotherapy in the

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uk and this is one of our professional networks.

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But we are open to international members and we're very much here because we're physiotherapists in the Uk.

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Or Uk. Original physiotherapists, who are now based internationally and overseas, who very much want to support the development of physiotherapy and rehabilitation, particularly in low-resource settings and for sort of humanitarian art reasons so yeah we're a very

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small group lots of hard work behind the scenes by sort of 10 or 11 committee members, and we're absolutely delighted to bring this conference to you.

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Today and we've got some phenomenal speakers who are always so kind to give their time to sort of our to try and support.

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You know Physiotherapy very much globally around the world, but particularly as I said, in the sort of low resource and humanitarian settings.

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So I'm chair of that so very much welcoming you, and I think you're probably here for me at the end to to close things as well.

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But I'm gonna hand over to Fiona so is one of our you know committee member for many years, and she's really our conference, a sort of leading organizer.

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Has it has, you know, reads, but put so much time and effort into organizing these conferences, so I hope you appreciate me very much.

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You know it's free, and I would we would love to.

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I think we have got some captioning happening. I can't promise it's going to last all day, because I think there might be a timeout on it.

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I'm fortunate you small an organization to have to have such a sort of business version of zoom accounts to be able to guarantee the captioning but hopefully, if if anybody was struggling we are recording this and we will be sharing the recording afterwards and therefore it would

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Be possible to rewatch and watch things slowly, and although it might, the recording might not be sort of completely open on the world wide web, it will be very much open to request if you if you need access to it, we can access it but anyone who's registered for this conference we'll

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We'll get access to it, so that's that's great.

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So I'm gonna pass you to Jonah, who's going to start introducing our first speaker

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Thanks, Alice. Hi, everyone I'm Fiona Lindsay, the research officer in the Adap Committee, and I'll be introducing our amazing speakers today, and Amy, who you can see here as well will be running the Q.

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And a section afterwards so if you've got any questions during the talk, or even after them, just please pop them into the chat box, and we'll get through as many questions as we can in.

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Brief the reason we've chosen this topic is that after last year's conference, which was based on research conducted in low-income countries which you can find on the adapt website we reflected on how available.

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The brilliantly and well-developed resources are, which are often evidence-based and peer reviewed as well.

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But they're not necessarily tangible to so many of us working in the field.

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And and why is that? Because these materials have been made really for us in the field?

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So when I looked into it further, I found that some resources haven't been mobilized efficiently to the people who need them.

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But or perhaps stored in a collective place where it's easy to find them.

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I'll find most things via humanity and inclusion source, and I'll pop a link into that site as they hold so many articles and resources which can be accessed free of charge and of course, physiopia and I found that some resources sit behind payables some have got complex publishing rights

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While others sit behind the organization's mammoth libraries like Wh.

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So and it's just the really difficult to find them, even when we know that they're on there.

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And but there is one area where all of us collectively can help, and that's in the sighting of what we're using is some organizations.

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Who develop these resources like H. I. Or who have expressed concerns about the lack of sighting by users, and as the sort of multinational organizations do depend on finances to develop them, for us we really need to be supporting them, and citing the owners correctly in order that they

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Can continue their developmental work. So I'm going to pop another link into the chat box to a great citing website and it makes things really clear and simple.

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So if you want to take the resources further afield and share them on, you can do that with confidence and so the only thing left to say on behalf of the adapt community is that we are all here you and adapt and all our members and everyone here today with a very specific interest in physical

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rehab, for low resource settings. And it's just really really great to connect with you all.

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So please do share any links and resources that you may know of in this field.

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Pop it into the chat box, and I'm sure others will follow up, because the more we share the more we will know, and the more that's going to support all of us and all our clients.

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So that's enough for me. Let you let me introduce you to our first amazing speaker.

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Eric Works. Hello, welcome! Eric. And Eric spent the last 30 years working the rehabilitation specialist for the Ngo.

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Humanity and inclusion. He now drives the rehabilitation, coordination, and training.

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This needed immediately after emergencies, armed conflict and natural disasters.

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In no middle income countries, and that's included Afghanistan, Georgia, Myanma, Ukraine, Gaza, Congo, Drc, and others.

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And Hi! This is a very special interest in spinal cord injuries, and it's also driving the standards of care forwards.

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In Vietnam Lao, Cambodia, and Miami, and I've heard about you before, Eric, and you are, from what I know, just a force of nature and a huge asset to our profession.

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So thank you so much for but everything that you've done for our profession, and for your time today, in talking to us I'll I'll hand over to you in here

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Yes, well, hello! One. Right

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Right. I just need to solve this little problem. Yep, it's not a problem.

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It's just a connection. Yup. No.

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Can everyone see my screen.

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Yeah, that's that is a yes, I suppose. Yeah.

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Sorry

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Okay. Yeah. Thank you. Yeah. Because I don't see.

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We can see it and hear you loud and clear

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The the the person's anymore and on screen so sorry for a little delay.

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Yeah, well, as a thank you very much for the for the very nice introduction.

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Yeah of well, of my my profile, and I'm really pleased that we can that I can adapt to me in the name of humanity and inclusion, all the different resources here from at least, from the point of view, humanity and inclusion as as was introduced yeah, my background goes

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Quite long. So we talk also many about another period in the humanitarian space, especially when when digital technology was not available and and I think what I would also like to show throughout this presentation is a kind of historical perspective on how things started sometimes with very rudimentary resources mainly paper and a lot

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Of let's say, brings of people that traveled from one place to the other, and using then the resources then available, which was mainly libraries or books that then were integrated into into knowledge sharing yeah now the perspective of humanity.

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And inclusion. Here, I would just give Reef a very quick introduction, I think.

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Well, maybe the figures are a bit outdated, since 2,000. 2,020.

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We work in almost 60 countries, and I think here Ukraine was not yet included.

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It. We have around 420 projects of which we can claim that 50 to 60% do have a physical rehabilitation component and a training components, while others of course, are in the wake of supporting persons with disabilities supporting policy development for developing better workforce rehabilitation workforce in

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Certain countries is also part of this, so the focus of this presentation will look more into how, training in challenging resources is delivered, and what we have learned, or what we can share.

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As well to say what our difficulties and of course, what what could also be be improved.

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As I said, there would be some historical perspective on on resources, and you will realize that well, the wheel was not always reinvented, but it was always shaped in another format or adapted to the technology of the time and as I said going from library books having persons

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Using their brain or their pre-service training, know-how, even carrying their own curriculum books with them from their from their school.

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When they went on the field in. When I talk about 30, 35 years ago.

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That was normally the way it was done. Then there were not many resources that were adapted to the to the challenges that we had in the field working in refugee camps working with countries you know where rehabilitation did not exist as such so you then you needed to be very

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Flexible and let's say also to listen around you.

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What, how to adjust these different? Did that different know-how?

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And adapted to the the process that you were, that you were dealing with.

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So this will also be part a bit of sharing the the challenges yeah.

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Of these resources adjustments, and of course, then we will look also more particularly on the uniqueness of H.

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I activities. Because I understand there are other speakers that will come to present their perspective of their organization, their rich rich development as well.

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And here I will limit myself more to what you meditate.

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Truth, and so far has has experienced in that field. Now the the background of the presentation.

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It's there is also a kind of personal partway that I would like to to share the general standards that exist, and that are widely available, and how to adapt them for the for our in-house material yeah, that is also very important to stress and of course as I said other speakers

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Will also maybe present the the issues and the and their resources as well.

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That hand, that humanity, inclusion is using also as a standard, or have been using for certain areas of work.

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My focus. You know to be a bit more concrete on examples that that I try to to to go through in this in this presentation.

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Will go around. Afghanistan, while, as you know, that country has been going to very brutal changes since its last 30 years since the last 30 years, or 35 years and humanity inclusion has always been present in that country no matter what government was at the the was there but on the

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Other hand historically we created also strong links with the rehabilitation workforce.

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Either that was trained there that was hired by the organization as well with other organizations, and I gave only a few like Icrc.

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Or the the Swedish Committee for Afghanistan.

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So, despite the challenges that this country underwent in terms of having available resources made, that there's still there have been a lot of work that has been done in the past, as well and as was introduced in the beginning I mean a lot of they were sitting on a lot of documentation and a lot of

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Know-how that sometimes did not go beyond outside the country, because the first information that was used was mainly that introduced into English, but had been leading its own life yeah, in in local language in Dari in Pashu where of course that delivery of the of the resources was then much more concrete so that

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Is very special, you know, to take that example, I think, for Afghanistan that I would like to put forward today.

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Now the programs that actually humanity using is implementing and alongside with other partners in development with Icrc.

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Of course, we work also together on referring and creating referral pathways for for for the patients that we are, that we are selecting.

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We have a whole set of emergency mobile teams, emergency mobile teams are made up of physical therapists, sometimes a piano ignition, Mh.

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Where follow-up can be ensured. What the people are discharged, and here also the resources that are needed that that I will develop more have to be adapted as well, not only for the rehabilitation workforce the mid-level of their training but also for patients and their their caretakers, and it means

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that that adaptation to that context is is something that is always very constant.

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And and again, other speakers also will present their tools they're very rich tools on how we have been using them in in in Afghanistan, in the past as well.

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We are active in 5 provinces, which means it's it's it's sometimes we see it as a small group on a hot plate, because the needs are tremendous.

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Now and we look into the needs of Afghanistan and history.

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The provinces were chosen related to either, knowing that traditionally H.

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I was present there for a very long time. Concentration of population as well, and then maybe key issues that arose since the last years in terms of the evolution of the conflict conflicts I know that before these provinces were not accessible for for humanitarian work, and then became accessible because of

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The political changes. Now we are also in a process of creating new projects again.

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And that's why the challenge of creating resources is even is even bigger now.

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And of course the one that are available we are ensuring, or we want, to ensure that they become also available, for Afghanistan, and I will explain a bit more on how on how that is operationalized now, as I said the the specific service.

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Of curriculum, and know how into the community is that we, as we see on the picture.

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You know we are allowed to go really, and the homes of the persons, with with a disability or with an injury to do the follow-up.

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We provide also direct rehab services in rehabilitation centers.

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There is in Kandahar in the South we have a rehabilitation center with a capacity that sees around 10,000 people with disabilities per year.

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Yeah. So it's a very important factor. You know that exists already more than more than 25 years.

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Yeah, there's existing, and we work also, of course, alongside with our partners of Icrc, which are also working with managing also Prc's provincial rehabilitation centers first then on delivering prosthetics and of topics, but also, a whole follow-up care that is

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Needed time because everybody knows that the prosthetic end of an orthotic needs to be followed up, with which we have meditation services in order to provide the best functional recovery and the functional status for for the process needing it we work.

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Also well at times, of course, for emergency responses in hospitals, and I think that the last years and the last months this was the issue.

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You know where we needed to get the training across our human resources to switch from one way of working to another, and then I mean if you're working day today is probably your 6 to 7 vacations, that you.

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Are seeing, and having to fulfill this this, this this we have service, you know, on a regular basis on a day to day basis.

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What it could be that if you would be working in Afghanistan, that in 2 days you would be requested either to having to go for the double off the triple of these patients, and then of course your way of working the resources that you are using the priorities that you're gonna choose to select

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Your your patients, they will have to change, and that needs also to be transpired in the resource.

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The technical resources that you have at your availability as a physiotherapist, or as other mid-level therapists that have to adapt this as well and a very important point is also the assistive product provision that maybe other colleagues also will go more into detail but for for humanity and inclusion, we have very basic

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Modules where we look at not only the delivery of a product, it goes around a service provision.

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It means it starts from looking at the person and his needs.

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Probably his needs that would change as well, because a product will not be delivered.

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As such, to say that he needs it for the rest of his life.

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There are also temporary situations where these products are needed, and, secondly, there is, of course, a very good basic prescription knowledge.

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And to see that when the device is provided, that it is, it is not harmful for for for the for the patient on one side, and, on the other hand, that there is still a way where the person can come back either to the center or to contact the teams again if there would be something happening with his assistive product that

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would that would need repair. That would be review, or that would need any any additional advice

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The characteristics. As I said, to go more in detail on the on on the specific team that we work with is that as I said, there is a potential for swift and easy access to the services for injuries and people with disabilities either coming to a rehabilitation center idle living in the

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Community in the future. What we are also working on is developing a dealing.

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We have project, because, as you know, there is a lot of access issues to care in Afghanistan either to security, but also to a context in terms of gender.

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That is, we deteriorating in Afghanistan, and we are looking at strategies on how we bypass these barriers for access to the to rehabilitation and again, resources are very important because using a resource that can be used in practice using one that needs to be

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Transmitted orally, and another one that needs to be transmitted digitally.

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I mean there is a whole process of how your you select your resource, but the delivery and the impact still needs to be at the best level. Possible.

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So we we'll talk a bit about resources more later on.

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On what what is being used. The team set up that we have can be proportionate to the needs arising so actually we are disposing of around 15 teams.

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Yeah, that are being spread all over these 5 provinces.

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But if there's if a conflict arises we can move one team forward to another place very quickly, or we can double or triple teams.

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Also with with the backlog, or with the with a with a reservoir and a stock of different training materials that they can integrate, and very quickly, either with short training short intake trainings, that if one team moves from another.

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District to another, and and there are other pathologies that they are seeing.

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They can be backed up very quickly with our with our rehabilitation materials.

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Or with our resources. The the level of the workforce, of course, historically, as we said, physiotherapy is is being provided as a most being provided as a training.

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But but of course through different funders, you know, who stimulate the and who supports the the rehabilitation workforce development.

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Went mainly through prosthetic and athletics, where there has been a lot of investment also with IC.

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And there was a consortium also, in which IC.

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And H. I was present to do the upgrade of the physiotherapy training in Afghanistan, and since the last 5 years that has developed a kind of very good new workforce with a three-year curriculum it's a diploma course that was

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Reviewed and and also being delivered. I will also talk a bit more about that later on.

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Now the outreach capacity as such. With all these difference, let's say, with the with the mobile teams, I can go up 2,000 patients per month. Now. What does that mean?

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Of course we are not talking about standards, sessions.

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Yeah, in the state of the art, and there is a home selection process and choices that are being made to prioritize specific conditions, while others then can be put on waiting list or will be referred to specific specialized services, if it is needed so the teams have to be very flexible on one

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side and the flexibility is then delivered more true to training and and update the training.

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On the other hand, they need to be agile as well and agile.

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We meet in Afghanistan means that you need, or you must be able to take decisions on the spots without too much stop-down information coming down because you need to respond quickly and the the essence is to respond to the needs of arising and and not to the hierarchy of of a given of a given

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segment, so that agility is also built into the training on how people can take decisions by themselves, and I think any resource in a in a challenging setting needs to be designed to be to be flexible, for us but also to be able that's the person who is using that resource can

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take decisions and has choices yet to to continue on this, as I said, the training of the the workforce actually that face sticker program, not Tikra, means it's I think it's an acronym for improving existing work for mid-level. Work.

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Force wehabilitation in in Afghanistan, and a very strong focus again on access, and I think I really would like to exist on this.

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Was that it allowed the gender access to education and Afghanistan.

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So you can imagine it's it's a huge challenge now.

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The gender issue, but as a humanity, inclusion, and other partners as well.

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We always hold on to a 50 over 50 presence of workforce, meaning 50% men, 50% women, so that the access to care is always allowed to any gender at any moment, and you can of course imagine that in the last months and year in Afghanistan this has been put under a lot of

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Pressure. But we must say, thanks to the well, the consistency of the national staff.

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They can explain very good in any given setting in any authority to say what we are doing, what we are not doing, and what we will not do if the conditions are not that, and and that is a very clear way in again having a trained workforce that understands the issues of a genderized, approach because

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In our resources. We need also to adapt ourselves to the gender, the age of the persons that are are coming.

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So that is also very important in our in our approach. Now, actually, we have an over again kind of 200 workforce that was trained over the last 4 or 5 years. Now?

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Why? Because they were let's say they got a really fresh input of a reviewed curriculum, basic curriculum that was trained in 4 in 4 training centers all over Afghanistan and as I said, the majority is fact, you know in fact, women and for the moments.

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Some of them have been placed again back into Government service, where they can, where they are supposed to continue the the work that was that was designed for them.

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But unfortunately, with the breakdown or the temporary breakdown of the health system, you know this was challenging, and lots of them have been absorbed by Ngos and notably well our workforce for the for the Mobile teams, I think we we must have be having between 40 and 50 physical therapists

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That we hire on a constant basis, either temporarily or permanently in our in our training workforce.

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So again! The well, what the working conditions of these of the teams they are not always easy, as I said, because a lot of work for them is also to negotiate with the local communities when there is a change in in political context or in security.

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Again, to say what the can do and what they cannot do.

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Their responsiveness as well, is very appreciated by the local population.

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As long as let's say, the resource use is is adapted culturally to the context, and again always explaining what you can do what you can offer what you cannot do and what you will not do if the conditions are met and I think our teams in connection with.

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Their communities have been very, very agile in maintaining always a very good communication with the communities where they work with, so that the care was always maintained and accessible.

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We have, of course, been instances where we decide to stop.

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The work temporarily because it was not clear if our female colleagues could work as freely as the as the male colleagues in the setting, but but, on the other hand, we needed we need to focus that if a local given local authority.

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In one province would not allow, was the right conditions to work.

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We would just move to another province where it was possible.

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Yeah, because fortunately it was only a minority of areas where these problems arose here, while in other areas that care still could continue even after the worse.

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One of the worst breakdowns, the shocks on the health system in in Afghanistan, now in terms of the the potential we have in in developing more the the Workforce, for the moment is that we have physical therapists that provide the clinical service for the different outreach in patient

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care hospital, rehabilitation, etc. The team leaders that need a lot of management skills as well.

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But unfortunately given the context in Afghanistan, and this is also an issue of how to deliver useful resources for rehabilitation.

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Workforce is that this: professionals have few opportunities for exposure to other countries, as we would imagine in in other settings where you know very quickly people can move around, etc.

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But historically, historically, for the last 20 to 30 years.

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Very few Africans were able, at least for the rehabilitation workforce to be trained outside and come back with that knowledge.

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To structure. Better the development of their workforce, while in other countries, let's say sometimes that period doesn't go so long away, so we can still find people that were trained the Broaden that came back to the country in an emergency setting for Afghanistan this is 150 big issue so that's why again

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The resources needed really to be focused on the national development exclusively and not too much expecting that our national workforce in Afghanistan would be exposed to courses in India or in other already not a countries the English levels of course then are not always extended.

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So we we sometimes offer English courses as well for our key T leaders, so that they can consult better resources in the future for their for their workforce, and of course there is the use of the 2 main national languages and I think, that Darry and pash 2 are being spoken, widely but of

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Course, according to certain regions. We ended the level of the midst of the of the therapist.

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We also then advised them to translate this in local language, now dary language seems to be the most national.

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One that's what I what we understand. But Pash 2 is also spoken a lot in London in many in the southern part of the country, so we need also to be flexible with translating.

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And finding the right quality of translation as well. What other resources that we are also looking at in other fields and physiotherapy?

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And and here humanitarian setting is very important. I think it's the the mental, hidden psychosocial issue.

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So our workforce needs to be confidence in addressing and using a listening and communicating with patients, and for this, of course, we have the famous yes, package guidelines where our our physical therapist and our workforce has gets some skills on how to better communicate with patients or also being able in emergencies

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To listen, to Page, to have listening skills and to be able to give the right message to to 2 persons that are sometimes in stress, and of course our psychosocial colleagues.

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Then will jump in as well. But of course that image Pss.

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Approach, mental health and psychosocial port is very, very important in the rehabilitation and for Afghanistan we have chosen that within the emergency mobile teams one should not go with the other without the other and one is not going without the other full moment but again, this is

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Sometimes on the pressure area because of funding issues, and because of sometimes suspiciousness of local authorities that that make that psychosocial counseling can be very sensitive, especially in the in the field of gender because we know that violence violence is a very is very present in our case road of course because people, with

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Injuries may are quite exposed to this. So it's very important that that psychosocial aspect is also very well integrated by the physotherapist to be very sensitive 2 issues of injuries of violence.

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In the history of the of the patients. As I said, that basic curriculum is a whole course.

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Set that is being trained, that is, being delivered by the the African T. Truth.

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Yeah, in the delivery course. Now there has been 2 batches that have been already finished, but we hope that there is enough funding to start other other batches in the future.

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That curriculum is available in English and in Dari, so it can be compared.

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Of course and it always would need updates in the future.

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We also have a collaboration with our with with the trauma hospitals of doctors without borders, Msf.

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Where there, let's say we set up very specific protocols for the rehabilitation workforce mainly physical therapies that work in a hospital environment in the trauma awards and so orthopedic fractures neurological outfall or from nerve damage is there

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The the main, the main focus. And here we have developed thanks to other resources that are explained later, but also in house capacity on providing specific protocols for external fixators.

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Fraction. And now the technology of internal fixation as well, which we know can reduce the the length of state of most of the patients in the in the trauma, awards, in the hospital so that that early stimulation that early we have has to be the message from day one of of the admission

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Of the of the patients in these, in these hospitals, and of course, while here the different tools, the Ao handbook, and we have tools, I will go more into details on it in my what we what what H.

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I is also using in terms of its intake of either the specialists, the experts that come to work for each time our workforce national workforce that is responsible to do the the training and the follow-up of of the national staff in terms of maintaining continuing education developing also hiring local physical

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Therapist, and then, of course, providing them the intake that is needed to either work in a provincial gravitation center in a hospital setting or in emergency medical teams.

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We we look also there with different topics. Yeah. And now more specifically for Afghanistan.

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Most of them are used, but there is one that is going to be a priority as well in the future.

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Is early childhood stimulation. Now we know that, and also to Isc.

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We know that that this is a huge. There's a huge demand, because cerable policy is quite present in the population, but the early childhood stimulation is much more specific because of unfortunately, in the last year the resurgence of malnutrition, and there are neutrition.

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Centers. Now that show up in our settings, I either at community level or at the the provincial rehabilitation centers in the hospital.

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Is why we work, and here we see that malnutrition wants that the family or the child is coming get the care in the hospital.

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They have a very long history of malnutrition.

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So when they go into their ten-day nutrition program there is a need for early stimulation.

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Or to detect if that malnutrition has already affected the normal development of the child.

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So here also the physical therapists that are very key, and in detecting what are the possible delays of development that the child has acquired.

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How can that delay be approached with either referral or either early stimulation, but also very important, providing information, providing information to the to the caretaker of that child in order that that's that's surveillance is created and that the model or the father

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of the child will go to a proper references, so that the child can start the intake or star hits pathway to address the the child development issue due to monetization or to any other cost.

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But we found that this was a very good point to that that.

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That capacity of early detection in malnutrition, in nutrition centers was a very good entry point, and this is what we are going to develop in the next coming months, and years, in Afghanistan as well to to look at how the this: is done now we have a specific

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early childhood, stimulation toolbox that is, that has been developed.

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So we call it. There is one which is called the Blue Box, which is a whole set of exercise.

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Cards that then are being provided to the to the family where they where they're going to work with the child on this exercise cards, and then they have been delivered back the whole package goes for a training of around 1 2 weeks to 3 weeks for a given physiotherapist with some

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Basic experience in pediatrics. But but of course, then the delivery of the program needs to be always in conjunction with our partners of the nutrition center the hospital itself and of course the community as well, meaning that the Mobile teams also have a role to to follow up on

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this another internal training topic is, of course, accompanying P.

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N those services we have provincial rehabilitation centers that provide.

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Lots of piano devices. Of course the whole use the correct use of the piano devices.

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How gay training I with autotics of prosthetics.

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This is also a very strong role of the physical therapist on which we have specific resources developed thanks also with the help of of Icrc, and and resources, I will go to in the in the presentation here a whole set of management tools and this is probably i'll put that a bit of sight but I

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Will also mention them very briefly. Of course, early we rehabilitation in emergencies.

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The safe use of provision and assistive products, and of course, different capitalization.

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Materials are specific project project and programs that are only, let's say, designed all that were on demand of the local context of the local ministry, where we use of course, these some of them.

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Have not been thoroughly being translated in English, so it's very difficult to get them available because most of the local language was was used, of course, to develop them and they got a bit their own life because we felt that the the national physical therapist or national staff was able to carry on with that

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Know-how, and adapted more to the to the local context.

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Now any training, of course, needs to be adapted to the capacity of that workforce, and, as I said, now we feel that the resources that are internationally available will become much more accessible especially to these newly trained physical therapists, in afghanistan since the last 3 4 years, while

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The old workforce. Of course we need to be much more selective on what would be the propose of the training and the outcomes that we that we want from them, while that new workforce has a much more broader base of integrating all the different knowledge and the top of knowledge that is needed there is also the issue of

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Accessibility, because we know in certain areas we can't have face to face contact with our counterparts.

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And that's why we need also to look at how that's online.

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Delivery is being operated in Afghanistan, and of course that continuous cycle of feedback and improvement of the resources that is always needed, because on one hand we need to see what is the impact of the of the resource itself.

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For this we have outcome measures a very basic outcome measure that we use.

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Which is very related to the to the Bartel Index, but it's being understudy for the moment which we call it now the Am.

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Amt, which is a questionnaire of around.

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I think 13 activities that are being tested and graded from 0 to 5.

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It's very easy to use, and very easy to let's say, with the level of workforce to be integrated.

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Now the standard resources that I mentioned a very one key, one that has been developed much more recently is, of course, the early rehabilitation conflict and disasters.

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Its delivery has been done through different platforms, and I will go a bit further on it.

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Here. One platform is, of course, the disaster ready or connected.

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I think most of the the the people here will will be familiar with this.

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So here we just give a slide on the the availability of the early rehabilitation, conflict, disaster, Handbook.

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So, as you know, it is a handbook that's had, let's say, a long birth, I would say over more than one year.

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We're all specialists in different fields came together to look at all the different aspects of managing fractures virtual nerve damage panel, called injury, brain trauma, also the aspect of working in in disaster and conflicts that were that were created now the 6 clinical

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Areas and they are, of course, a very good basis, because we would advise them as being probably one of the latest reviews that we're going to all

the different experts in all their different fields, either we professional organizations.

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You know the whole, the whole materials were reviewed by them.

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There's a lot of links. Yeah, that can be used in that in that handbook.

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You can download it. It's available in French, in Arabic, and in and in English.

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Of course there have been translations in Dari. Yeah, for Afghanistan, and that was a very interesting let's say tests where we selected specific clinical areas.

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That were very relevant, at least for our mobile team, but also for the staff in the Prc.

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And with the the limp with the the the the workforce that had some limited skills in English.

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We offer them this this curriculum here online and then next let's say, with the with the dary translation next to them as a as a handbook, they could follow they could follow the Let's say the delivery, of the of the online material as well, in order that you know this 3 our course.

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Also could be different. There now there was another attempt at physiopia that is also available with the same title, but here, our let's say our discovery was that it was a bit more challenging because the the frames, were not so straightforward.

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It needed probably another type of connection, and bandwidth that was not available in Afghanistan.

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But nevertheless, of course, the physiopia platform is much more up to date as well with a lot of other offers as well.

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But here for our workforce. You don't try to advise them and select what would be relevant for them for the for the the, the, the the conditions that they were seeing and the challenge that they had on this but again for our experiences that today we have this handbook translated in Darry for national

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use, and any rehabilitation workforce physical therapist, but also doctors.

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Here. We have advised them to go online with the the dory version, and then interact with this English version to go to the difference to the different parts of the of the clinical areas, but most of the clinical areas.

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That we have been working with were well, there was amputees.

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Yeah, that have been fractures. But let's say that there is already a good experience based in Afghanistan on these conditions.

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Yeah, given that they are quite prevalent. But the priorities of other conditions were not so well expressed in terms of perfect nerve damage, brain brain trauma, and there it was very difficult in fact to put pull the attention to this as well and what we found is that when we did the continuing education

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courses with officer therapist, or when we were working in the rehab centers and in the hospitals there was a huge demand for head trauma and spinal cord injury and perfect nerve damage so that was very important yeah, because I think it opens that you know this

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this resource also the doctors yeah, and the help force can consult it by themselves.

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But I, only only on the condition of having that basic translation done, and I think this is a good learning process for other settings.

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If it would not be available in that in that national language, he really said, Well, I go a little bit to the now a very important point was also the use of the phone application, yeah, because this resource has also a app that can be downloaded on a smartphone we we tested this and again, between

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Well between having it on a on a web page by saying: You know this marvelous, this marvelous tool can be download on a smartphone.

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Yes, in Europe. Yes, but but in Afghanistan this was a quite a challenge. Yeah.

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So we needed to work with bandwidth. We had found conditions where our health staff or staff or personnel was working in districts with a strong Internet connection, and then would download it on the smartphone.

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There, but it was not. They were not able, of course, to use it at the at the community level.

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Yeah with within the mobile team. So then we needed to find a solution where it was only downloaded as a app.

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But if there were other resources that need to click on to to then they need it.

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Of course, Internet connection, so we really reduced it very basically to the as such.

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We also bypassed a lot of issues of software problems and phone quality to make sure that the whole package here could be downloaded.

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But again it was not so straightforward in terms of having it downloaded on this on their phones.

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But once it was there, and again next accompanied with the dary version, we found that this was a very, very useful resource.

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Yeah for the pts that were working in the in the different and different Dmts.

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As I said, if we look at more at Delay, we have application or access to to bandwidth for Afghanistan.

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I think in the cities, it is not a challenge. Yeah, because we have been doing some mapping on what level of digital access there is, and one that you are at a provincial level.

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This is quite good. Once you go over to the district level, it becomes, of course, more challenging.

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The the user friendliness again. It only works well.

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If there is a basic know-how on ink of English, of course, of the of the health staff, to make sure that they know how to manipulate the smartphone most of the time, because everybody has smartphones but again, the there are sometimes some technical challenges for instance, forgetting the best word or having to have a an an

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Email a specific email address you know that you can refer to.

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And this is all little things that you need to be very practical with, and the best way only is to work with them directly on it, and I remember the first introduction during a training course for this resource it took

me half a day and that we went through all these technical challenges before starting with the content

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To do so. It's not always so so so easy as we, as we would think the Sei Elon platform.

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I think that most of you are familiar with it as well has a very long history, and has been reviewed recently with a new.

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So this is more forpanic or injury. It's very comprehensive.

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Yeah, according to all the professionals and the let's say, the modules that are available there.

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The focus is on interdisciplinary approach, and at least that's the first focus that is done but for physiotherapist, for occupational therapists, for all the professions there are even more detailed models that can be done and for H.

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I. We have been actively participating in. Well, first, the setup of the and the content, let's say, with the experiences we had from the field, but, on the other hand, we have been much more instrumental and trying to push for translation and translation was very important especially for the French speaking area because

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We felt that in Western Africa I mean there is a huge gap in terms of having access to these resources.

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So we worked a lot on having key modules already translated in French in Arabic as well, and there are other languages that you will see if you go on the website that are available or we're certain models are available but others are under development but this is a resource that Hi has been

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using consistency historically and going back to the one of the first ones.

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Let's say that treated the early rehabilitation aspect, and here I would talk about, you know, when we talk about the handbook of early rehabilitation that was issued in 2,020 I think lately this one here is dated from 2,010 and it came from

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The while from the famous earthquake in China. You know where we developed with with our Chinese counterparts, and then in a in general hospitals where the victims of earthquakes were being were being accepted, so we presented there a kind of protocols yeah, which were more like

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Kitchen recipes, in fact, for the for our Chinese counterparts to use that that rehabilitation very very systematically.

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Now, of course they didn't have specific. We had departments of fiscal events in the hospital, so we needed to be very open to having physical therapist operation in.

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Icu, having them also at that side, teaching and having them also at the moment of discharge, so that they could get the key information before going home, related to these earthquake victims.

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On the other hand, when they were specific follow-up programs that lasted between 2 years to trees for specific victims, you know that were very affected.

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We use this protocol, of course, very, very strongly as well.

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Of course, it's maybe a bit outdated now, because I would say today, well, maybe don't use this use the early rehab of course, because that is really where you know the the the whole development has been done and there have been different.

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Versions, and I think there was an intermediate version that was also done with H I.

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That resulted then, in the early Rehab Handbook, and that early we have handbook of courses is, in fact, the outcome of probably 2 treat difference. 2 different books you know historically that have been that have been developed.

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And this one was one of the one of the first ones.

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We look also at patients education, and this is an example from Vietnam, where either you know, developing specific curriculum.

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It's final called injury, and of course there the the Si Elo was used as well, but but we was more important is how we could develop specific information for the patients when they're going home and I think my colleague from enablement group who will also represent today well, has also

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Valuable resources, because we are also working with the enablement resources, on on patient education and Iic to have them translated into dirty and also being a standards a standard tool with the application as well and all the challenges of implementing it so that we would have the early rehab handbook as well as

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The IC. Materials available for our Afghan staff.

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This here was also used, and I think some booklets have been translated into Darry in in Afghanistan as well because they came first in a French version that were translated in English, and then in Vietnamese as you see here but they have also seen their their origin now in in in

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Afghanistan, now to end. I will talk just very briefly about the training pathway within within H.

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I, if time time permits. So as I said, there is an intake process where we also need to have a physical therapist, and our staff, very familiar with head economics on how plan.

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Their organ their their setup. So we have cost calculation tools on how physical therapy departments be, and all departments need to be, let's say, calculated so that there is a sustainability and the cost and the investment, you know that can be seen and the results that are next to

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This should be very clear for our partnerships. We also look at the sustainability, analyzers.

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Process of rehabilitation. Departments even rehabilitation teams.

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Yeah, that are working. If we say, okay, we invest on a monthly basis $3,000.

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You know everything included. And what is the outcome? How many patients they are seeing?

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What is the cost of an average care treatment, process, etc.

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So it's very important for our funders. You know that our physical therapy workforce is also familiar with how to manage their daily activities and how to make them cost effective as well.

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There is also the rehabilitation digital transformation that we are working on on one side.

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It goes to a daily rehab application on which we are using.

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Of course, all the different resources mentioned so far, but then they are then integrated into boxes of different exercises that are being used

in a in a till we have application where either the physical therapist can manage a team of isotherapist virtually yeah, but also each visual therapist has access then to a number of

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Patients that he is following up, provided of course, that the digital connection works and in Afghanistan we are testing this for the moment in a in one specific center where we select we pres select patients either with having a smartphone or being living in an area where they can be connected and another group that is not connected

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But to whom we give a smartphone where they can look at information into a loop, and that they can take on further their their follow-up.

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And of course need them to come back after 3 to 4 weeks, to see if the use of the tool was was effective for them or not.

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So we need to bypass this this issue of connection, that is, that doesn't exist.

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The other clinical toolboxes, for in for our intake, for our national staff and the National staff is also what that famous blue box that was related to exercise programs for pediatrics.

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This is stimulation therapy for minority, children.

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We have also modest on server policy, which have been pulled from different sources as well, and but we then put them in a kind of connector module, which means that the the service.

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User I mean the the trainee will look into the module, but every time he we will explain the basics and how H.

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I would like to put the focus on specific issues of server policy.

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But then we get them in connection with all different resources through the throughout the whole presentation, and we call them more connector modules than in-house models, because we don't develop the content themselves.

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We just connect the user of the service with the different information available and the key points that he should pay attention to when he is when he is setting up these projects, or as a as a manager, but also as a political service provider again, the emergency specifics I will end just with the last 2 the

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last 2 points is the planning and treatment module that is available on the disaster already org.

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This was developed in Syria, now in a context where it's a kind of guideline.

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Yeah, that is being offered to the physical therapist in the field, and then they can.

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It gives them a whole guideline on how to approach your patients.

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Starting from an assessment subjective as well objective, and then they go to the whole development of the module by questioning answers yes and No, and if it's a yes, and no there's a whole algorithm yeah, that gets gets them through first getting a kind of more accurate

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Diagnosis, or a condition that they need to treat, and then make choices from, and then, of course, identify also a home set of exercises in that in that module that are advised for that specific patient as such now it's a kind of.

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Backup sometimes of you know, getting critical thinking into the whole process of our of our workforce, which is not always easy.

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Some of them use it in the beginning on the intake, and after you know they get familiar with it, and it's more natural.

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Yeah, but it's a very good tool for us to let's say, give the therapist and give the the rehabilitation work for the kind of guidance where they have choices and and also reminders, you know to go to the rights to the right process and algorithm of the

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Choices of their treatments and the choices of their outcomes.

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Another one on assistive products, and I think also the speakers will talk more in in in detail about this.

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We had a very, very short module that was developed a few years ago, I think, in the Syrian crisis first translated also in different languages, and it just gives a very basic list of of the products it was even before you know the the essential product list.

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Came out, but we still hold on to it for the moment.

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But of course we know that there are other tools coming up that probably we will have to adapt ourselves to, and that this maybe will be a bit outdated.

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But nevertheless it's still quite simple, and it can be downloaded in Pdf format, but also download it on a on smartphone in order to use it as your as your guidance on a daily basis as a as a as a condition so the take home message here and I

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Hope I have been too long is to, of course, as a with resources adapt them, select them, and use them for the audience that you are working with, and I know For Afghanistan this has been a very long learning process as I said with all the challenges that that are there you need also to

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Anticipate the challenges regarding the delivery.

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Now, when using the source language, it digital connection quality I think it's very important, knowing that it's not because you are in Afghanistan.

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It's not possible. So a lot of things are possible.

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You need to be selective about them, and you need to say you need to choose the things that work, and then be very flexible afterwards.

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Translation is a key to allow the education accessible to the mid-level workforce, and then, when I say translation, even if that mid-level workforce would have English to literacy, even then it's sometimes complex for them, you know to understand technical words so that's why

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That translation into local language or to national language is key, especially to the mid-level workforce.

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We are not working with visual therapies that have master degrees, or even Da's, that have long experiences.

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They are still working at a bit level workforce, and we need them.

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That local language to be the main tool for for communicating knowledge, of course create the whole pathway of resources and maintaining their users.

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I said we have a whole list and the list of our in-house materials, but also the ones that are much more specific.

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For Afghanistan, and that's what I want to show the difference between them on how to use them and create a kind of part way of of using them as well keeping of course, updated on developments of the of all the speakers that will. Follow here.

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Of course I would really really recommend them very highly enablement physiopia, that we owe disaster ready, or and of course, the issue of diffusion.

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The in-house resources and shared resources, and here, unfortunately, as I said, the ones that I have been sharing here they are available online and there is no issue etc.

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But they're the other ones on the internal are now.

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Internal setting is that there are still some copyright issues.

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Some are still under development. So it's not, maybe say proficient to use, and the other ones have also a very specific input that only you might say inclusion is using.

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And then I talk mainly about the the management issues and cost calculation, etc.

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That's that we are using for not only for the key clinical approach but also for sustainability, approach for advocacy, and hopefully in the future.

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That we can also put a relationship between investment and results of course, which is very important for the fundraising.

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So this is a bit my my overview. Of course there are probably P. Q. A. I mean that's that I'm open, for or you.

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Can of course, contact me on this email address, you know, to connect you also with specific resources.

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Online if if it was not clear in my in my presentation.

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So so. Thank you very much for your for your attention.

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Alright. Thank you so much. I think it's amazing how many resources are out there, and you know, even in it, that we didn't know all this work was going all this stuff you're doing.

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And you've got a wonderful floor. We've got people that have joined from all over the world in the chat that are now going to be able to access news these resources that didn't know so this is incredible thank you so much for sharing all your work it's just it's

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Brilliant. We have got a few questions. I'm gonna rattle through quick, but also you could answer someone they can a in a minute if if we don't get through all of them.

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But so we've had one person who's asked, How long does the training for rehabilitation last?

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Is it enough for the trainees and do trainees do home visits

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Our intake for Afghanistan, very specifically is that, of course they need to have the the level of their of their diploma and degree, and experience, that we build on then when it.

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Comes to training them. My my critic trainer in Afghanistan, hit the one week one week full time to go to all the early rehabilitation modules plus practice the provision of assistive devices and of course that then the specific in-house tools which are mainly

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Bent on the outcome measures, yeah, because we need to have specific outcome measures that's famous.

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Amt as well. Then the of course, the the in-house in terms of security issues, logistical issues.

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How to get your equipment delivered to, etc.

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So the whole, let's say, for someone who comes new organization. It's one week one week of training.

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Then the continuing education is at a rate of 2 sessions per year.

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Where? For 3 days, then the the workforce comes together, either with up top-ups or on one side.

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A second one is on topics that the workforce has presented as a priority, and that that people are going to look for. And of course the third day is more like looking at the data the analyzes of the data and the outcomes and to see how we can improvement and what are the challenges of the tool

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That being used. Yeah, so so this is mainly for Afghanistan.

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The contact. Now, of course, in other countries it's maybe different.

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But, as I said, it's very short. Exposure is very short for the for the workforce, but it's for for for for the mobile teams it is very effective

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Brilliant. Thank you so much. Another question. This is from Fiona, who is in South Africa, she was saying.

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The U.S.A. Was in the in the map at the beginning.

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Where you work. There's a lot of the U.S.A.

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And she's asking how much is managing African countries, how much is handicap international do some of this work in Africa

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We are mainly working in in Western Africa and Central Africa.

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Yeah and a bit the north at least as well. But again, once you go under under Mozambique, we are not going further down there.

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If I would say, geographically speaking, Yeah, so. Yeah, but it's mainly Western Africa, French-speaking area.

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Yard, Kongo, Rhonda, Bruni, and then eastern part Uganda, Ethiopia, where we are also presented

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Thank you so much. Your map does reflect that, doesn't it?

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And I think another question here. And do you face any challenges from traditional healers and religious leaders as far as management of patients?

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And that's from M. Kennedy in Uganda.

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Yes, yes, we do in Afghanistan as well.

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But again, once the traditional heroes, you know, when when the persons are going to see the traditional heroes in Afghanistan in certain areas,

in people don't have any economic needs which mean that even if their belief would go to that and they would invest in it it's always a case is

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2 of income that they have. So we see some

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Sometimes people that went through a today on the persons. But, on the other hand, according to the economic evolution of the areas, it always goes down when there is a lot of pressure and it economic pressure on the normal

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The population. So then it's less present. Yet, as the main challenge, because, I said, our teams that work in the community, they explain very clearly what they do and what do, they not do so then the users are quite informed about is this something that is traditional or is it provided for free and does it answer to

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My needs or not. So it's again. It's very important that the teams the team leaders can communicate about the services available and the dos and to do that, and and the don't of the service

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Amazing Eric, thank you so much. We've got a lot more question. We haven't got time to ask them, so we'll see whether we can work through some or with you we're able to type in the chat in a later date but thank you so much and I think we're going to make sure

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that the resources that you shared with us we can share globally across. And that's what a lot of the questions are saying is, can we access it?

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This is amazing. Thank you so much for sharing it so brilliant huge impact from your work.

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Thank you so much for coming here and sharing it, and hopefully the 100 other people that here we can share it further out, and we can get get that information out there. So thank you.

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So much for coming along the sharing, and thank you first for doing your work, and allowing, though income lowly, or settings to be able to utilize it. Thank you

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Thank you very much, and of course enjoy all the other speakers and colleagues of mine.

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You know who that I saw yesterday, by the way, and and Lucia, and all the other colleagues that I'm very happy to to see here also lined up as a speakers for this for this conference thank you very much

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Thank you, Eric, just before I move on to our next speakers.

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Just this is a very quick message for any adapt members who might just be joining us.

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And please consider coming to join adapt committee. You don't need really any experience in global health.

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Just a real interest in this area. The jobs are not onerous, and we've got some really interesting discussions between us about potential opportunities and collaborations emerging from the field.

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So all very welcoming people, and we would love to hear from you.

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So we'll pop a link into the chat box and if you want to come and join the committee, then then please do so now, moving on.

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We have Rachel Lowe and Leslie.

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Anger Matt Mola. Oh, sorry! I'm I'm jumping ahead of myself.

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Where are we? There we are. Rachel is the Rachel Lowe, Neilum, Zira, and Ola Koval Chuk.

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I hope we can see you all. Can we see you all, and we know

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Yep, Rachel's here

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Great, fantastic.

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Yep, great just quick quick, admin thing, Eric.

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Yes.

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Could you mind stopping, sharing your screen so that Rachel can share hers?

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That would be that'd be really helpful. I'm trying to see if I can drop it off, but I'm not sure I can alright. So you allowed to.

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That's it amazing. Thank you, Eric, and maybe if you could go and help type in some extra answers that would be, that would be really great in the Q.

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And many of you know that Rachel's the co-founder of Physiopia, which is the number one physiotherapy website in the world, providing free and open access to thousands of health professionals and improving global health she's also an innovator an

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Explorer and an entrepreneur. She's pioneered the world's largest open-access physiotherapy-related courses, co-founded physiopia plus and relab hs which is of particular interest to us here today

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Rachel's, joined by Neil Vera, the Vice president of the Pakistan Occupational Therapy Association and Vice principal head of Department for the Occupational therapy Department.

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At the college of Rehab Sciences, Neelam combines her clinical teaching and research, experience and she's published herself extensively into developing curriculums and contributing to Global rehabilitation knowledge need aam also works, in several international organizations such as

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who! And the center of health and innovation. Somehow she's also finding the time to complete a master's degree in healthcare management, and they both share that talk with Ola Kravel Chuck and education and workforce developmental specialist Polar works, for the Relab Hs in

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Ukraine, and her background includes a Phd.

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In biological sciences, and she's worked for the Ukrainian Ministry.

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Of health as a state expert, helping develop the decree on the continuous professional development of doctors and the regulation of rehabilitation professions in Ukraine she's worked as a lecturer and has over 30 peer-reviewed publications.

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What a trio! Thank you all so much for coming and talking to us today.

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I'm sure we could listen to you all for a full day, Rachel, you happy to to lead from here

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I am. Thank you very much, Ghana, for the introduction it's like delight to be here today with everyone.

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I'll jump straight in, so I'm gonna share as a slide show.

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Here we go. Okay. So thank you for having me today. Today I'm delighted to be joined with by my colleagues, Neila and Allah. We've multidisciplinary team today.

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To talk about the work that we're doing as part of Relab Hs.

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So re-labhs, learning, acting, and building for rehabilitation and health systems.

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It's a U.S.A. funded consortium.

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6 international partners who have expertise in health systems, research and rehabilitations of service implementation.

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The partners in this project are John Hopkins University, the University of Melbourne.

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Humanity, inclusion that have just been speaking momentum wheels for humanity, miracle, feet, and ourselves at physiopia.

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So we're all working together to co-design and implement interventions that strengthen health systems for the privacy of rehabilitation and systems that can respond to the growing rehabilitation.

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Needs that we all are very aware of these days. So you know, this is a really big project.

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Many partners coming together, and we're doing some really interesting work to support health health systems specifically looking at 4 focal countries.

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We have so, Myanmar me not them Ukraine, Pakistan, and Uganda.

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Many of those countries which have been experiencing more instability since we have started working with them.

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So we obviously have conflict in Burma. We have war in Ukraine, and we also have had the floods and cuts.

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You know political instability in Pakistan as well, so very, very challenging environments to be doing this work in

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Okay. So the the consortium work is really based around the health systems building blocks.

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And so the health systems, buildings, blocks are, a you know.

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They're a framework that who used to describe a health system.

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So this 6 building blocks that are that are on the left of this diagram, and this is a diagram that is used widely used by who and so in service delivery.

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So we're working with do implementing service. Delivery models mainly in primary health care that includes referral mechanisms for rehabilitation and assistive technology for the health workforce I'm going to come back to that because that's what we're speaking about today.

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But just a little bit more about the work that relab is doing in these other building blocks for health information systems.

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We're working with stakeholders such as ministries of Health to integrate rehabilitation into information systems for essential medicines for rehabilitation.

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That really means assistive technology assistive devices. And we're working to develop procurement and provision models around assistive technology you know, combined with the service delivery models for rehabilitation so financing there'll be some economic analyses for

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Rehabilitation, rehabilitation, services, and then for leadership and governance.

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We are creating a leadership institute and also advocating for rehabilitation as a whole at local and global levels.

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Lessons, but what we're gonna talk about today is the workforce, because as physiopia that's where our expertise lies, we you know all our work is around developing resources for workforce development for initially we started just with a very physiotherapy focus because our background is in

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physiotherapy, but we are very aware of the we work as a multidisciplinary team, so and we you know we are acutely aware that the whole multi-disciplinary team use this via Pd.

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In the resources we have, so we are becoming more inclusive to all rehabilitation, professionals.

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So having a screen, rehabilitation workforce is a is a key component of any effective health system.

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You cannot have a health system without the workforce which is good, because that's the work that we do.

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At Physiopia, so so some we've done a lot of formative work as we've as we've started this project with our partners in relabate chess we have been, doing an evaluation of global workforce development.

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Needs. So this has been a a survey, and a survey, and follow up interviews around the perceived workforce development needs.

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From organizations, rehabilitation organizations all over the world, so there's been a really good representation from countries.

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I think we reached around a 120 countries, and they really good representation equally across all rehabilitation professions.

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So we and these are pre this is preliminary information that I'm providing.

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Today we've had around 700 survey responses, and we've also done them around 18 to use to kind of clarify those responses

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From this work the surveys and interviews there has been this 2 key themes that have come out of this work.

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The first one is around knowledge and skills development. So it's really this really comes out forefront when we start talking about what a workforce development needs and what people say is that they need more knowledge and skills that is exact that is what people say they feel.

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That their patients are not reaching their full functional potential because they don't have that.

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Not they don't feel that they have the knowledge and skills needed to do that.

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And this came up in 5 kind of key areas and and and it's really interesting.

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And and it when you start looking at the results that come in it.

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Just these these areas really stand out in pediatrics.

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People talk about cerebral palsy in Europe.

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People talk about stroke and spinal cord, injuries, and all of us here, you know we all know we will have seen these topics coming up and the need for these and they get talked about all the time Mpt.

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Rehabilitation, all the assistive devices and gate analysis, and then also within those themes the need for knowledge around multidisciplinary care and working in multi-disciplinary teams

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And then it does. It is worth mentioning. The broad topic.

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So these very broad topics that come up as well around manual therapy cardio hormone, and general rehabilitation.

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So I don't think that's news to any of us, but it is very good to know this.

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Have this knowledge to be able to influence the work that we will do.

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Going forward.

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The other theme that comes out of this workforce development analysis is and and and this gets talked about. A lot.

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Is the barriers to accessing online education, and it's kind of interesting that that comes out of out as a theme.

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But I think it's because people understand or or perceive that they don't have the knowledge and skills.

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That they need. And so, therefore and they don't have access to those knowledge and skills within their context.

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And so they're trying to access these knowledge and skills.

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Online so then the barriers become a significant factor. Which is why this, I think, has come out of as a theme.

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So in many countries. There's so this: th, these are the theme within this theme.

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These are the things that came out. So there's a lack of motivation to actually do online training.

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And and often. This is because there's a there's an absence of requirement to do professional development in a country, and we are doing some other work alongside.

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This work to explore professional development requirements in countries for rehabilitation, professionals all over the world, and it's really interesting to see just how little requirement there is to do professional development.

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I'm quite surprised at how little there is. What's coming out with that work.

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But then alongside that lack of requirement people look for external guidance to motivate them, to do the online.

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Training. So when they're just doing online training on their own, they don't have any, you know, support or guidance.

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So people lack that. And then along with port digital literacy.

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And so using the Internet, finding trustworthy resources and the lack of resources.

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People just don't on't able to access them, because they're just not available to them.

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So like books, and journals, or or they're just cost inefficient for people to to access them.

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But also as Eric talks a little bit about limited resources.

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So you know data and Internet access accessing computers having electricity.

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All those things are required to do online education to develop these knowledge and skills.

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When they're not available to you where you live and where you can access them

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So alongside the interviews and surveys. We also did some workshops, so we held some specific workshops in Uganda, Pakistan and Ukraine to discuss work for workforce development needs and we also Tended a meeting in Coenhagen which had All the former

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Soviet republics there, and these these workshops in the meeting.

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These are very these are leaders within professional organizations, rehabilitation organizations, and ministries of health, for example, and so, the conversation kind of goes to a different point to get from raises to a different level but it still does come up with similar themes

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So when we have these comments, there are 4 key themes that come out as workforce challenges in in countries around the world.

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And these challenges come up everywhere, and every country has these challenges, whether it's a low income country or a high-income country.

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There is some kind of challenge for the workforce around one of these themes.

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So professional regulation. We've just talked about this honestly.

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There are, you might be able to count on 2 hands. How many countries have a requirement to do professional development?

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The capacity of academic instructions to deliver programs of international standards it's not criticism, but it comes up as something that people always say in their own countries.

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That that's an issue, a challenge for their workforce clinical practice comes out again.

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So this came out from the surveys of the interviews.

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People are always hungry for more knowledge and skills. They always say that there is a lack of access to knowledge and skills training in their country and then advocacy.

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So advocacy is around raising a awareness of rehabilitation, busy therapy occupational therapy, speech and language.

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Therapy, prosthetics and robotics.

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All these multi-disciplines within policymakers, governments, and leadership.

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So, but not only in in those policy kind of areas, but as well.

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For medical professionals so making sure. So this in many places people say that the medical professionals do not have an awareness of rehabilitation is, and this becomes a problem when we're trying to advocate for rehabilitation trying to get rehabilitation services for

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People that need them. Okay. So these are the 4 key things for workforce challenges that have come up.

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And then within those themes there are some specific needs that are kind of worth mentioning, because these are the needs that again just keep getting talked about.

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So within, regulation. There's a need for standards.

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We've talked about the need for a standard around professional development.

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For instance, and there's also the need for strengthening associations within countries around academic institutions developing international standard curriculums but also, building the teaching capacity to deliver those curricula.

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We've talked about clinical practice now developing knowledge and skills and then advocacy.

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So for advocacy. People suggest that we need to develop leadership skills within our professions to enable them to influence policy to influence leaders at a higher level.

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To, you know. Talk to the medical professionals and have the confidence that they have this the qualifications to be acknowledged.

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I think in what they're saying, and the work that they're doing, and an E.

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And the work that they're doing to educate medical professionals about rehabilitation.

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And it's not just the medic, not the doctors and nurses, but it's also the public that gets mentioned as well.

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So advocating to the public for rehabilitation, and what rehabilitation is, and how it can help so you can sort of begin to see how there's a real complex and underlying need to develop many different pieces of rehabilitation and the system and the workforce and there are

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many challenges to overcome before rehabilitation.

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Really gets integrated into health systems alongside all those up.

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And this is just in the workforce workforce building block.

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There are all those other building blocks as well

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So? Oh! It's physi pedious work is aligned with online developing online resources and tools.

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And that's where our expertise really lies. That's what our team is good at doing, and and we can deliver those tools.

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Well. So to address these workforce challenges. We are developing a set of courses and resources that can be integrated into any regions, education and training initiatives, and this will support workforce development activities to hopefully build the rehabilitation capacity and then the quality of rehabilitation

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Care. So these courses and resources will match the needs that we've just talked about in the other slides

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So to date the work that we've done is we have done a really big piece of mapping of standards.

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So rehabilitation standards for all the professions.

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So physiotherapy where we've looked at physiotherapy, occupational therapy, speech, and language, therapy and prosthetics, and allotics.

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So we've mapped those standards and the education frameworks to together to the Rehab competency framework delivered by the who that came up with a framework of topics which we then mapped over a 100 curricula to that framework, and that has come up with this list of

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Topics that get gets taught to rehabilitation, Freshman's international internationally and into professionally.

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So it's a really long list of topics that kind of covers the knowledge of a re of all rehabilitation, professionals internationally.

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So what we're then doing is developing developing courses.

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That map to that list, and some of those courses at the moment are ones that are specifically coming up as a need.

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So amputee rehabilitation, cerebral palsy, stroke all these courses that are coming up as a need.

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We're kind of picking those ones out and making sure that we have online courses available for those

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And that will continue. We will continue to develop courses to map onto this framework of courses that has evolved

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So we've also identified within the curriculum, mapping 10 foundation topics came out as the ones that get taught to all rehabilitation, professionals.

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So we're talking about, you know, interprofessional topics here that all rehabilitation professionals, need to be able to practice in their profession.

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So we've got 10 topics there, and we're developing those courses as well.

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So that's where you know. That's around courses and and creating online courses that anyone can use through the digital platforms that I'll talk about in a moment but alongside that we're very aware that we'll also be developing some tools online.

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Resources that can support the other workforce challenges that are coming out as well.

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So around advocacy and regulation and entry level training the tools that we develop will be very much aligned with the work that W.

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H. Show is doing to support rehabilitation, professions, and also the work that the international professional associations do. So.

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We know that the world Federation of occupational therapy world physiotherapy.

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They all have resources, and they have the expertise to support regulation, entry level training within any country, so we'll be aligning with the work.

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That's already being done so, you know. For instance, world, physi therapy has the Webinar next week on curriculum development.

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Everything is very aligned, and all the tools and resources provided by all these organizations that are working to support the workforce together

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So I once we've developed these tools and resources we obviously have to deliver them online. For anyone to use.

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So the courses will be on the physiopia plus e learning platform, which I'm sure everyone's familiar with, and Eric has already mentioned.

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This morning. It's worth mentioning, and I don't know if Eric's still here.

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I think he might be that we've done some significant work on physiopia plus recently to make it more appropriate for use in low middle-income countries.

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So it is, being translated into multiple languages now, and we also have apps available, so that we now have an app, available so that people can do the courses offline so they do not need electricity.

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They do not need data. They do not need the Internet. You'll be able to download your course onto the app.

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Take it away, do it offline and then sync your account.

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Later on, when you have access and it's our understanding that it doesn't even take much data to download these courses.

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So so along that alongside the translated courses and we'll be doing at the moment we're doing French, Spanish.

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It's how Italian, German, and Ukrainian are the languages we're translating into at the moment, so that makes it more widely accessible to particularly the French and Spanish to people in more low resource settings so the courses will obviously be delivered through

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Physiopia plus we've also developed a rehabilitation, resource, repository.

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Now this has come about, because all over the Internet there are so many resources.

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Eric's mentioned many of them. This morning we we struggle to find those resources sometimes, so the rehabilitation resource, repository is simply a place that links to all those resources.

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So if you're thinking, oh, where's that resource that Eric talks about?

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I can't find it, and it's not coming up on my Google searches.

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Have a look on the resource repository. It may well be there, and it's simply simply link to those other resources, and these are resources that we also use within the online courses and then the other platform is the community is a practice platform so this is a platform where groups.

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Can get together to communicate network and also mental each other will be mentored in one place.

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So small groups of people on a platform around a specific topic.

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Either learning, sharing, or developing whatever work they're doing.

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So the community is a practice platform, and the mentoring is very much going to match toward together with the online forces that we already have available

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Now Eric's already mentioned this this morning as well.

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We all know that when you train you have to adapt to context.

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So the courses, all the courses and tools that we, as physiopia develop, are suitable for a global audience.

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So they are, we we specifically, make them so that they're suitable to anybody.

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They are the courses in particular they are courses of a standard that we would expect to rehabilitation professional to be.

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How and there are different level courses, of course. But however, you know they must be combined with in-person training that where there's an adaptation to context so these courses are alone won't help you to be a skill won't help us.

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To develop skill practitioners in those areas, because you have to adapt the training to the context.

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So we really do advocate for using the online courses and the tools that we develop in a hybrid fashion.

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And what that means is that you have have the online training, but they're combined with an in-person training event as well and it's that in-person event that you can adapt the training, to the context so you can do different language you can adapt do practical training training skills in person get

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Feedback. This is where the external guidance is missing in online training.

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You know you need to do that in person piece to get the external guidance to make sure you're doing the skills correctly and being able to discuss cases from your specific context with someone else that understands those cases so when we combine the online learning with the face-to-face training it

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Becomes a really kind of cost-effective and efficient way, and time-efficient way to deliver training, because when people are coming into the face-to-face, training, they're all coming with the same base level of knowledge if they've done the online course first and it just means you have more

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time in that face to face, training to adapt it to context, to make it really specific do practical skills training.

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So we're really advocating for you, using the resources and the courses that we develop in this hybrid fashion

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And on that note what I'm gonna do is hand over to Neelum.

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Now Neil has been using needle, is it team member is a busy Pd.

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Team member and has been working within the Relap project as our education focal point in Pakistan.

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She will tell you more about herself as she speaks, and Neelie's gonna describe how she's been using plus courses in a hybrid fashion at her university

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One. I hope I'm one of those.

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So. Thank you. First of all, I'm glad to say thank you to everyone for giving me the opportunity to come up and share the way we are using this digital learning and hybrid learning form for the occupational therapy student before we start I must let you know that we are working in

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Occupational type, 40 years in Pakistan. But unfortunately we never had the resources to update ourselves.

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I myself. Is here for 22 years, and it was.

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It's very, very difficult to get access to the resources they're not available in the country not to get a single book.

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Is published who I have the research papers, that is, the channels are not there, so it is not easy for us to develop the profession and provide the quality care service.

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As per the needs of the people, and this is the most challenge that we faced.

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But since we have been associated with physical media, and they are by the project of freely patches, and we used to get to the forum, too, before event, but we never were able to access to you know most of the information but now it is available to everybody and luckily since people believe it's

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A competition between Pto. But we believe that it's a complementing.

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Rehab facilities for the metment of the client, and that is what people are surprised, and we say occupational therapy is also using physical media.

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So that says it is promoting multi-d have professional team to work together for the better program process. So next slide, please

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So at jailing, college or free application sciences. We have different domains, of rehabilitation, speech, and ideology, rehabilitation, as saying, clinical psychology, physical health, education, for sciences and all of us are using it at this moment.

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I'll be specifically discussing about the occupation of therapy.

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So the first thing that comes up is students were newly enrolled, and even those who graduate they have role ambiguity, because the since that book is not there about the rehabilitation, so that we have professional themselves are not acquainted enough with the knowledge to tell somebody what would they do and where they can

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be used. So many of the courses, like global need of repetition, introduction to lean application, and the standard rehabilitation, and all these things help student in gaining the confidence and motivation, to pursue learning further and access to the resources within and actually contribute into the health care system where

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they're actually needed. So this is very important learning which we, despite of giving many times, was unable because we were limited a number.

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We are self-bound to limited resources, so our own knowledge was quite compromised.

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This actually gives them a bigger vision and horizon of the need of the perfection.

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Next slide, please, so I would like to share how we have integrated it into the curriculum.

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There are 2. Basically they are concept based and through article learning forces.

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At some other hand, a majority of them are, or the hands on skills.

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So what we what we do is we give them the prerequisite information right, which is required for the particular courses through the plus courses, the physical media courses they they go through that and then they related to that particular curriculum, objective which is taught in the class and then we have very

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Healthy discussion and student come up with innovative ideas. For example, if you see this next slide

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Leadership, leading change is one of a beautiful course honestly, I myself did it right, and it it made me to change and think in different ways.

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If I would like to quote over here one of the examples, which is very much close to my heart these days, for the very first time we explode substance use, rehabilitation.

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In Pakistan, and with the Anti-cortic Force Department, their drug rehabilitation center.

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We work there, we pick the community from there, and we actually you know what the change through the understanding, what the leadership is all about.

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It's not only about the political leaders that we have.

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It is about the we have leaders and the professional leaders, too, that we need, and we work for around 6 to 7 months with them and explore the professional needs and guided them and everything.

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They said. They announced around 6 positions for the occupational therapist, and this is one of the big achievement for us, because then they get to know about.

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The rehearsal, the confidence that come among the new that that was actually in the students for the finding year students.

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That was amazing because they were looking into it. How globally it is practice!

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And the courses were giving them the insight of exploring more, and actually delivering more in the country.

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Can we move ahead, please? Similarly, for the hands on scale, we have a little change.

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That is, the basic concept is developed in the glass, and then we integrated to the digital learning right?

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And once they are reinforced with that, then we actually do the lab work.

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The clinics and get them involved in the with the patients, and that is how they learn more.

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Despite this, only that we do this all in the class like we had the flat, and the some of the students were stuck at their own station, and they were unable to come to the city back and that was a big even in the Covid right that was the issue.

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But we were not able to resolve at that time, but at this time and we had a plan.

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So this integration actually helped us a lot because they were not lacking behind.

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They, one of my student. He lives very far away from the library, and that's the only place at the sound where he can get the Internet.

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So he used to go to the library and download the course right, and then go back to home and study it on his own, and when he came back so he was not very much lacking behind.

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He actually got a chance to move with the students and did not miss anything just a little reinforcement helped him, and he he based up with the rest of the students.

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So this is how we work for the hands-on skill looks like please

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Yeah, this is one of the format I just sharing with you regarding how we do the course breakup like we plan it before the semester start and this is one of the Kinesiology.

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Force breaker, and it is like when we have to do this Mmt.

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Of risk join, so we recommend them to you know. Do this course right, and then they get more learning, and then we go for the lab and the clinic.

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Similarly, the other. It is all pre-planned now, and it is really helpful from the student point of view I'll be sharing their perspective, to with you the next one, please.

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And this is a specifically with occupational therapy, you can see this is from applied to theatric, and you students are actually looking into the fall prevention through the exercises, and when and there is no you know still rehabilitation, sector is not being there for gerontology so the

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Old age, people the elderly, they still deprived of this facility.

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The quality of health is compromised, and they said: last year we picked the community of substance.

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Use this disorder and now we are picking up this community of geometry and working on it so by doing the courses that getting from the theory and even you know the research, paper everything is very much accessible.

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Now it is very easy for us to convince the health profession that the research is there.

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You can see it. You know we can port it in our proposal and everything.

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So it help us a lot, and this year we are picking up this geometric population and the old age houses, so that we can make some national guidelines for occupational therapy the way we did for the substance used to solve them hopefully.

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We will be able to do this this is one of the perspective of the student who did a lot.

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Of courses around 21 courses on her own. She was very much motivated honestly, and we we recommended, despite those courses.

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She did many of them. The other courses, too, and the Icf.

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Is one of the need right that we need to put up with through the documentation and still we do not practice at the clinic how to document it.

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We might be reading it as a model. And that is how I added right.

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But how to implement it, and how to use it in the documentation I learned recently from physiology after all these 20 years, but then there is learning never stops so I guess I I am.

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Thankful to the Forum and the project, and definitely the one who thought about the idea and promoting it.

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So this helped us a lot. And now for the supervised clinical practices and the manuals we have introduced, Icm.

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Into wet. So when the students will be going to different places or rotation, right and placements, they will be using these things.

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There, and we are spreading the world now, and and there's always a reference of those courses from where they're doing it.

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How it is linked, and that all we got from the Physiopia.

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The you know, the resource, repositories, thanks please.

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Sometime you think students are getting burdenized, so students are not.

01:43:50.000 --> 01:43:55.000
That's what students is. And sometimes you think the teachers are getting the facility data.

01:43:55.000 --> 01:44:17.000
But this is one of our faculty member, and she find it a amazing, since they they actually best fit to each other, and the more they're together, the more it is easy to transform the knowledge from one person to another and improve it further and because the courses are very much comprehendable and the video

01:44:17.000 --> 01:44:22.000
Is the the the assistance that is being provided during that is amazing.

01:44:22.000 --> 01:44:30.000
Similarly during the flood, we never had an opportunity, and we never knew that we have can actually play part and it's specifically occupational therapy.

01:44:30.000 --> 01:44:45.000
This time we had move, and that was how to rehabilitate the displaced people and the students make an event and event to the site, and they because they did the course they got to know what they can do and then they Bent over there with the supervisor.

01:44:45.000 --> 01:45:05.000
And they actually participated. So this was one of the amazing thing, and I think if we keep on working this way, so we will be able to reach the the you know, the golden standard practices, and that is very much needed the benchmark practice and he might be the global professional that right now at this

01:45:05.000 --> 01:45:15.000
Is just the beginning, and that's all. Thank you so much. Everyone

01:45:15.000 --> 01:45:16.000
Thank you, Neila. Thanks such great stories from Neil.

01:45:16.000 --> 01:45:21.000
We're gonna hear some more stories now from Ukraine.

01:45:21.000 --> 01:45:28.000
So it is. All is still with us

01:45:28.000 --> 01:45:34.000
I'm Hello, so my name is Olhakova Chuk.

01:45:34.000 --> 01:45:38.000
I'm education and workforce development consultant in Ukraine.

01:45:38.000 --> 01:45:48.000
I have very big pleasure to work with Rachel in the Philadelphia in Ukrainian team, in brain, of era, by chess project.

01:45:48.000 --> 01:45:58.000
I talked today about using online resources, the train rehabilitation professionals during times of war.

01:45:58.000 --> 01:46:09.000
Please. Next slides municipal house of Ukraine has identified the actually due to the Russian aggression and war in Ukraine.

01:46:09.000 --> 01:46:34.000
Many Ukrainians need rehabilitation, and minister of House of Ukraine has identified the former main priorities on Moira related injuries, it is the brain injuries the spinal cord interests burns invitation complex injuries, very

01:46:34.000 --> 01:46:45.000
big problem is complications related to lack of movements such as contractors, lots of range of movement and muscle strengths.

01:46:45.000 --> 01:46:46.000
Another very big problem is lack of rehabilitation.

01:46:46.000 --> 01:46:52.000
Professionals and understanding, of rehabilitation by medical professionals.

01:46:52.000 --> 01:47:10.000
You know that due to war a lot of rehabilitation professionals must move to a different region in Ukraine, or move to another country.

01:47:10.000 --> 01:47:35.000
So please, next slide, I would like to emphasize that physical media is doing very important a work in Ukraine, and I would like to thanks Rachel and love Hs Project was this important work for Ukrainian Rehabilitation profits, educators, students and people

01:47:35.000 --> 01:47:54.000
in need of rehabilitation, because courses the development physical media team is very important, and especially all Ukrainians, rehabilitation professionals are very encouraged the opportunity to have courses in Ukrainian.

01:47:54.000 --> 01:48:10.000
Enough already translated 64 courses. That is a very high priority for Ukraine, and Physiopia team, also very well cooperate with Ukrainian team to develop courses.

01:48:10.000 --> 01:48:33.000
That is highly priority for Ukraine. Right now, for example, a Ministry of Health of Ukraine kindly asked to develop Icf courses and full program

was developed by Zoo Pedia and already translated, into Ukrainian so It's very important

01:48:33.000 --> 01:48:44.000
Work, please. Next yes, and next, yes, how is the plus been used?

01:48:44.000 --> 01:48:53.000
So it's very important for continuing professional development for practitioners in rehabilitation, because we of course, have quite lack of knowledge.

01:48:53.000 --> 01:49:23.000
I mean up to date knowledge about rehabilitation, and I received a lot of messages, for from rehabilitation practitioners to have this free access to physiopia, plus and to also I plus is very important for entry level education for teachers and students in high educational

01:49:25.000 --> 01:49:49.000
institute institutions. We we have mammaran tomatoes, a lot of with many Ukrainian university, with many hospitals and practitioners in rehabilitation teachers and students in Ukraine have free access to physiopia plus courses

01:49:49.000 --> 01:49:56.000
it's very important, and it's very encourages for all Ukrainians professionals.

01:49:56.000 --> 01:50:00.000
So please, next

01:50:00.000 --> 01:50:01.000
Integration, interprofessional development is also very important.

01:50:01.000 --> 01:50:15.000
The plus plot for has been integrated with the National Health Service of Ukraine Learning Academy.

01:50:15.000 --> 01:50:23.000
This Academy platform is very big national platform for all professional of health, care and integration of plus is very important.

01:50:23.000 --> 01:50:33.000
Step. It's also a free access, a possibility of free access.

01:50:33.000 --> 01:50:59.000
There also plus courses have been recommended to all rehabilitation, professionals in Ukraine by the Ministry of House Minister, of calls sent a letter to all Health care Department all over the Ukraine with Recommendation, of plus courses at least next

01:50:59.000 --> 01:51:05.000
Very important work we do with in National University of Ukraine.

01:51:05.000 --> 01:51:15.000
In physical education and sport. Actually, it's starting from as a head of department or physical therapy and occupational therapy of National University Key of National University. Ask kindly.

01:51:15.000 --> 01:51:23.000
Ask of his Udia about possibility to help with mentoring on Burns.

01:51:23.000 --> 01:51:41.000
Course, for, say, your students and I would like, since Rachel and Karen Hall that they find possibility to organize a mentoring.

01:51:41.000 --> 01:52:07.000
Actually regarding Burns. We have quite difficult situation in Ukraine, because rehabilitation after Burns actually very well, is the west of Ukraine, but It's almost absence in the central Ukraine and East of Ukraine and of

01:52:07.000 --> 01:52:16.000
Course we need knowledge for students. It's very high, important up to date knowledge for students on Burns.

01:52:16.000 --> 01:52:32.000
So one head of Department of National University, of Ukraine on Physical Education currently ask so Rachel, and caring a whole, organize this possibility.

01:52:32.000 --> 01:52:33.000
Of mentoring of teachers in students after online course on Burns.

01:52:33.000 --> 01:52:42.000
Please. Next, actually we have very great platform community of practice platform.

01:52:42.000 --> 01:53:04.000
It's communication, networking and mentoring platform and to be organized a group you can see as a first group mentoring on Burns by the Mentor.

01:53:04.000 --> 01:53:19.000
Can help teachers and students. We so like not just call, but mentoring, and they have very good possibilities because it can be a question.

01:53:19.000 --> 01:53:48.000
It can be sharing the documents. It can be a Zoom Meeting, and all in one group, so it's very important that with starting as this mentoring group, and it's very highly priority enough for Ukraine so please send the next so I would like if you would

01:53:48.000 --> 01:53:52.000
Like to help Ukrainians to be a mentor.

01:53:52.000 --> 01:53:59.000
For example, in this community or practice, platform, please write to us.

01:53:59.000 --> 01:54:11.000
Please write to Rachel, all right to me. It's very good community or practice platform where we can share knowledge and to help each other.

01:54:11.000 --> 01:54:16.000
Thank you very much

01:54:16.000 --> 01:54:25.000

Thank you all. I'm so delighted. All this electricity stayed on for her presentation all has been having real electricity challenges recently.

01:54:25.000 --> 01:54:39.000
So thank you so much, Ola and Neil, I'm I just love hearing these stories from integrating the work that we're doing at physical media actually into the development of the workforce in these different situations.

01:54:39.000 --> 01:54:58.000
And it's really nice to start hearing these stories. So thank you both for sharing your stories, as Ola said, there are opportunities to to mentor more of the rehabilitation physiotherapist occupational therapist in particular or physiotherapist in particular actually in

01:54:58.000 --> 01:55:04.000
Ukraine there is, there are massive gaps at the moment, so please do get in touch if you're interested to join us in this journey.

01:55:04.000 --> 01:55:24.000
In Ukraine. And and if anyone's interested with integrating plus courses into curriculum will be happy to share her experiences, I'm sure. So yeah, so I'm gonna hand it over back to the team now the adapt team

01:55:24.000 --> 01:55:26.000
Thank you, Rachel. Thank you, so thank you, Rachel.

01:55:26.000 --> 01:55:34.000
Rachel, Neil and all her. Thank you. I think what you've you've brought an amazing wealth of different areas that physiopia is working in.

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And I have to say, Rachel, seeing your face when when these girls are talking, just to show how how proud you are and how how much you can see?

01:55:40.000 --> 01:55:52.000
What your work has contributed across the world is amazing, and how, Neil and I need Neil them to help me with my university courses, because she's she's she's surely got that absolutely down.

01:55:52.000 --> 01:55:53.000
And I'll have thank you, and really really difficult circumstances for coming and sharing.

01:55:53.000 --> 01:56:03.000
Your experience, and how important that is as well. Thank you all of you for that, and we've had a quite a few questions.

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That are sort of similar to say. Can you just explain a little bit, physiopia and physio plus, and what the payment walls are, and who that might?

01:56:11.000 --> 01:56:14.000
Could you just expand a look a bit for those with that aren't so sure

01:56:14.000 --> 01:56:19.000
Yes, of course. So physiopia is the original website that we created.

01:56:19.000 --> 01:56:20.000
That's the busy pages that charity. It's the free, open resource that you all use.

01:56:20.000 --> 01:56:33.000
I'm sure and see all the time funding. A charity is very challenging.

01:56:33.000 --> 01:56:37.000
Actually and so to keep physiopia free and open for everyone.

01:56:37.000 --> 01:56:51.000
We didn't go down the path of adverts or anything to cluster up the site, but we decided to use our expertise in e-learning to develop physiopia, plus so Physiopia plus is the online learning platform that has the courses.

01:56:51.000 --> 01:56:54.000
And other professional development opportunities that has a subscription to access via pdia plus.

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So there's a small subscription. Well, I don't.

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I shouldn't use the word small. There is a subscription fee of a ??149 50 per year.

01:57:03.000 --> 01:57:21.000
However, that is way, so it's free for people in low middle income countries there's a discount for students and those that do pay so in the high-income countries.

01:57:21.000 --> 01:57:40.000
Your membership fee goes towards funding the Physiopia charity, keeping physiopia open for everyone to access, but also funding those free accounts for people in low middle income countries on Physiopia plus So that is how the 2 sites work and how the funding works between them

01:57:40.000 --> 01:57:46.000
Thank you, Rachel, so we have a question from him, and you from India, saying, Is there any work going to for different languages?

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So, for example, he's saying Hindi, or for public access.

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So just any

01:57:50.000 --> 01:57:55.000
Yeah, at the moment. So it's very th.

01:57:55.000 --> 01:58:06.000
The translation has been a huge challenging piece of work to do so at the moment we are sticking to the most common languages and the languages that have been funded by other mechanisms.

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So we're staying with those 5 languages. It's just at the moment.

01:58:10.000 --> 01:58:11.000
I'm afraid

01:58:11.000 --> 01:58:17.000
And that's okay. So kind of the question here about let me find it.

01:58:17.000 --> 01:58:19.000
So do you. So. Physiopia? Do you offer a train?

01:58:19.000 --> 01:58:32.000
The trainer. So you've got wonderful resources and you've got ideally in-person resources that work alongside and needles given us really good example, of that do you have any train the trainer options within with.

01:58:32.000 --> 01:58:34.000
Any of the resources.

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That is one of the topics on the list, for the toolkit.

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Yes, so so we don't have it at the moment.

01:58:39.000 --> 01:58:42.000
But that's that's something that we're working on

01:58:42.000 --> 01:58:46.000
Okay, brilliant. Thank you. And I guess another question is the leadership modules as well.

01:58:46.000 --> 01:58:54.000
So I suppose that's a more abstract, slightly more complicated module to teach than sort of burns and specific therapy things.

01:58:54.000 --> 01:58:59.000
So again is how how you? How are you working through the leadership modules

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Yeah. So we already have actually leadership modules or leadership course on on plus on Busy Pdf.

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But there is the as part of Relab, and there is a leadership institute being created, and that is a that's also a hybrid delivery to rehabilitation.

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Leaders so this kind of 2 different approaches there. The leadership course on plus is for anyone, for rehabilitation, professionals.

01:59:25.000 --> 01:59:37.000
The Leadership Institute, which is some of the work that John Hopkins soon is doing as part of Relab is, will will also be available as part of that work

01:59:37.000 --> 01:59:41.000

Thank you have a question for Neil. How do you say?

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A brilliant that you've managed to get clinicians and leadership roles higher up in in your your place of work.

01:59:43.000 --> 01:59:57.000
How did you start broaching these discussions? How did you sort of start the foundations of bringing bringing more therapists and bringing more viewers, clinicians to the leadership table

01:59:57.000 --> 02:00:04.000
But sometime it is to pick up, but get to see the changes right, and that is actually the visible right.

02:00:04.000 --> 02:00:25.000
So they. The action speaks louder than the worst, and when you see the changes, they come up with, you know, with with their ideas and with the they want to get involved, and that is the reason we are having more users now and even just just recently like more more forgetty, is interested in actually adapting this type

02:00:25.000 --> 02:00:32.000
Of move, like pre-planned ahead of the semester, and then put it up there.

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And we discussed the law. So it's it's very obvious.

02:00:36.000 --> 02:00:40.000
In front of everybody, when actually, you see the more opportunity of work is growing.

02:00:40.000 --> 02:00:41.000
People are moving right to better opportunities and providing better services.

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So they think such courses want to make difference. So they're coming up

02:00:50.000 --> 02:00:58.000
Thank you. Last question about the mentoring, and then maybe that might it's a little bit more detail into that might then help us get more mentors for you.

02:00:58.000 --> 02:01:01.000
How is that process? You know? How would how would you start that process?

02:01:01.000 --> 02:01:05.000
And what's what would you need your mentors to be? And what would you want?

02:01:05.000 --> 02:01:09.000
Your mentees to to require you to do that

02:01:09.000 --> 02:01:14.000

Mentoring is very new for us, and actually the Burns group in Ukraine is the first time we will have ever tried this.

02:01:14.000 --> 02:01:20.000
So what I will say about mentoring is, if you'd like to experiment with us on how this works.

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Best. Then you're welcome to join us. We do not have a solid process at the moment, so we're kind of experimenting with methods that we can deliver in an effective way.

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I suppose

02:01:35.000 --> 02:01:38.000
I think a lot of different. A lot of Ngos are trying to work on mentoring.

02:01:38.000 --> 02:01:50.000
Aren't they trying to make sustainability and teaching and training in sort of make sure you leave in country, support and stuff like that so I think that's a probably a collaboration of lots of different areas and all need to get our heads together and thank you so much.

02:01:50.000 --> 02:01:56.000
I think the last question here is, How do physics from low, low middle income countries, access physiopia plus for free?

02:01:56.000 --> 02:01:59.000
It's more of a technical question. But

02:01:59.000 --> 02:02:14.000
I'll add a link to the chat, but there, it say, if you scroll to the bottom of the website there should be a link that says discounts or on the home on the join page, there should be a link to discounts you just go to the discounts page and ask for your discount and you will

02:02:14.000 --> 02:02:15.000
get it

02:02:15.000 --> 02:02:18.000
Brilliant, so Rachel Neelie and all her.

02:02:18.000 --> 02:02:28.000
Thank you so much. That was just inspiring and wonderful to hear all your different opinions, and just to see Rachel, how much you've built in this platform. You've done and then seeing it work in the world it's just incredible! Thank you

02:02:28.000 --> 02:02:30.000
Well, thank you, and it's and it's I must say that it's thanks to the community because we couldn't have done it without everyone else.

02:02:30.000 --> 02:02:45.000
So it is a community project. So thank you. Everyone.

02:02:45.000 --> 02:02:49.000

Thank you, Rachel, Ola and Milam so much it's just incredible to be able to share.

02:02:49.000 --> 02:03:10.000
Your experience with with so many people. Thank you so much for joining us, I wonder if it's good for everybody to have a 5??min break away from the screen and just have a leg stretch and we'll need to come back in 5??min time and listen to our next amazing speakers so thank you

02:03:10.000 --> 02:03:40.000
So much everybody for joining us so far, and we'll be back in 5??min time.

02:08:21.000 --> 02:08:28.000
And then everybody welcome back from the break. I wonder if hey, chair?

02:08:28.000 --> 02:08:36.000
We can get you on unmute. And Leslie

02:08:36.000 --> 02:08:38.000
Just to check. You can hear me, and I can hear you.

02:08:38.000 --> 02:08:40.000
Yes, Hello! How are you?

02:08:40.000 --> 02:08:52.000
Perfect great. Hello! There! Thank you. Hello, everybody else. I hope you've had a very quick glance away from the screen just before I introduce our next speakers.

02:08:52.000 --> 02:08:55.000
I just wanted to say, if you're interested in joining adapt.

02:08:55.000 --> 02:08:57.000
It's very easy. You can do it on our website I'll pop the link into the chat box and adapt members.

02:08:57.000 --> 02:09:10.000
Do remember that, thanks to our collaboration with physiopia, you get a great discount on Relab Hs and Physioplasts.

02:09:10.000 --> 02:09:15.000
So now we have Leslie anger, Malea, and you cheer Belmad.

02:09:15.000 --> 02:09:16.000
Both Physio rehab specialists for the International Committee for the Red Cross.

02:09:16.000 --> 02:09:26.000
Icrc. They'll be presenting the resources which have been developed by Itc.

02:09:26.000 --> 02:09:27.000
Between Leslie and each year they have so many experience.

02:09:27.000 --> 02:09:51.000
I think over 20 years. Humanitarian experience in the field, which collectively includes I think, Afghanistan, Pakistan, Iraq, Western

Central Africa, Sudan, Syria, the Dem Democratic Republic, of Congo, and Central African, Republic, and Gaza, Leslie, has a degree.

02:09:51.000 --> 02:10:06.000
In international public health at the University of Liverpool, and has been designing and delivering training courses on lower limb amputation and cerebral palsy that's included the design of a Mooc on lower limb amputation in collaboration with physio

02:10:06.000 --> 02:10:24.000
Pdf. And Leslie's currently working with the Ministry of Health in Columbia, with a plan to include wheelchair services in the National Health plan she presented at the 2,000 and 15 World Physio Congress in Singapore in a Session titled barriers

02:10:24.000 --> 02:10:29.000
To accessing rehabilitation services in Tongueo.

02:10:29.000 --> 02:10:35.000
Lucia Bellnard's background includes a masters in international corporation and development.

02:10:35.000 --> 02:10:46.000
Our experience includes pediatrics in Sudan, and then, interestingly, after the Islamic State crisis which created the displacement of thousands of Iraqi and Syrian people.

02:10:46.000 --> 02:10:50.000
She worked as the rehabilitation technical advisor.

02:10:50.000 --> 02:10:55.000
Blue chair has worked tirelessly for vulnerable people, following traumatic events.

02:10:55.000 --> 02:11:00.000
She's also developed courses with physiopia in cerebral palsy and reference manuals.

02:11:00.000 --> 02:11:02.000
In early rehabilitation and conflict, disasters, and is also part of Wh.

02:11:02.000 --> 02:11:11.000
So working groups, including the package of intervention and rehabilitation, so I feel very humbled introducing both of you today. Thank you.

02:11:11.000 --> 02:11:22.000
So much for sharing your time with us. I'll hand over to you from here

02:11:22.000 --> 02:11:29.000
I am just.

02:11:29.000 --> 02:11:33.000
Nice, and I mean we have a shared presentation.

02:11:33.000 --> 02:12:03.000
We pass each other the work because of we're putting them together. I don't have a bit more special domain

02:12:15.000 --> 02:12:39.000
The meeting, the chat box that also to introduce in the normal license Monday and work. So I invite you to have a look at that.

02:12:39.000 --> 02:12:49.000
Maybe some of your head already, otherwise you can have a look after so

02:12:49.000 --> 02:12:50.000
Lucia, just in case I think your audio is not really good.

02:12:50.000 --> 02:12:51.000
I don't know if it's only on my end.

02:12:51.000 --> 02:12:59.000
But okay. So Hello, everybody. Thank you for giving us the opportunity to present.

02:12:59.000 --> 02:13:06.000
So, we, I mean that's part of his Monday. Dcrc.

02:13:06.000 --> 02:13:14.000
Is a supporting rehabilitation of victims, of armed conflict and other violence.

02:13:14.000 --> 02:13:24.000
So this is part of the Monday. It's often we people are asking us, you know, if we are working only in low and middle-income countries.

02:13:24.000 --> 02:13:27.000
But the mandate of the IC. Is really armed.

02:13:27.000 --> 02:13:50.000
Conflict. So in our program we have a twin track approach, so we try to be person-centered, so we assist persons in need with prostheses or thezis physiotherapy wheelchair working aids, and social integration, activities, and but we are also working at system, level, so

02:13:50.000 --> 02:14:02.000
We try to in the countries where we are working, to strengthen the rehabilitation sector so often we use in collaboration with wh show, sorry the rehabilitation 2030.

02:14:02.000 --> 02:14:16.000
Initiative. We also provide education. So it can be by trainings, but also working with schools, therapy schools, or prosthetic and artists.

02:14:16.000 --> 02:14:26.000
School, and we also support Physiotherapy Association and association of a person with disabilities.

02:14:26.000 --> 02:14:31.000
Sorry this was not the next slide

02:14:31.000 --> 02:14:39.000
So just to give you an idea this is where we are working currently as a physical reputation program 200.

02:14:39.000 --> 02:15:01.000
We have around 304 project around the world, and every year we are assisting more than 350,000 people in the countries where we are working, and more precisely for physiotherapy we also providing more than 800,000 feature therapy sessions but through the centers.

02:15:01.000 --> 02:15:05.000
we are supporting, actually not as directly, necessarily

02:15:05.000 --> 02:15:10.000
Next

02:15:10.000 --> 02:15:15.000
Yeah. So.

02:15:15.000 --> 02:15:26.000
But also trainings developed with a collaboration with that organizations, and many of them have already been mentioned.

02:15:26.000 --> 02:15:43.000
So this would be a repetition. But then adjust the confirmation of how it is, and over time.

02:15:43.000 --> 02:15:46.000
Yes.

02:15:46.000 --> 02:15:47.000
Lucia, I'm sorry sorry to interrupt. Is it possible you could put your microphone a little closer to your mouth?

02:15:47.000 --> 02:15:53.000
It's just. It's a little difficult to hear

02:15:53.000 --> 02:15:58.000
Yes, let me know. Can you hear me that sure

02:15:58.000 --> 02:16:02.000
That's a little better. Just a little echoie

02:16:02.000 --> 02:16:06.000
I'm very sorry. I don't know if it goes on my collection

02:16:06.000 --> 02:16:12.000
I don't think it's the connection. Thank you.

02:16:12.000 --> 02:16:16.000
Okay.

02:16:16.000 --> 02:16:17.000
Let me know

02:16:17.000 --> 02:16:21.000
Thank you.

02:16:21.000 --> 02:16:25.000
Yes.

02:16:25.000 --> 02:16:27.000

Okay. Sorry for the

02:16:27.000 --> 02:16:32.000
Yeah, I think it's good, Lucy. It just also stay quite slow.

02:16:32.000 --> 02:16:37.000
Because there's a little echo when you speak more slowly, it is much easier

02:16:37.000 --> 02:16:42.000
Alright.

02:16:42.000 --> 02:16:59.000
So we present some of the manuals and the expertise in the team.

02:16:59.000 --> 02:17:05.000
But training is a lot external on training available for everyone.

02:17:05.000 --> 02:17:30.000
And we will not go into into the more internalizedcy training which we must start to do, that a lot instead of what in what we we

02:17:30.000 --> 02:17:57.000
And that we use in our

02:17:57.000 --> 02:18:27.000
They thanksgiving, relation pro . As part of an integrated packet approach to contribute to the protection

02:18:30.000 --> 02:18:55.000
See that supports in different ways

02:18:55.000 --> 02:19:10.000
Can be a direct

02:19:10.000 --> 02:19:20.000
Population is the care for weapon, one more we also do support.

02:19:20.000 --> 02:19:29.000
We also, and

02:19:29.000 --> 02:19:30.000
And so on.

02:19:30.000 --> 02:20:00.000
That is. Yes, that's slightly better. Thank you.

02:20:12.000 --> 02:20:13.000
I mean, we need to deliver

02:20:13.000 --> 02:20:14.000
Lucy, I'm I'm so sorry to interrupt again.

02:20:14.000 --> 02:20:15.000
But anybody who's got headphones. It's clearer to listen through headphones.

02:20:15.000 --> 02:20:16.000

If for those who don't have headphones, Lucy, there was a suggestion that's come from somebody who's much more technical than me.

02:20:16.000 --> 02:20:38.000
Suggesting, might it work if you take your head, set off and speak directly to the to the your laptop or computer

02:20:38.000 --> 02:20:39.000
We try. Sorry.

02:20:39.000 --> 02:20:40.000
And just keep would help the clarity. I'm so sorry for this

02:20:40.000 --> 02:20:48.000
It's very normal in all of our work forces. I think these days

02:20:48.000 --> 02:20:49.000
Okay, can you hear me better?

02:20:49.000 --> 02:21:00.000
Yes, would everyone else agree with that if you could just mention on the chat box? If you could speak a little bit more, Lisa, we can see

02:21:00.000 --> 02:21:06.000
Yes, so let's see if if you can hear me back to Lanes.

02:21:06.000 --> 02:21:07.000
Let me know. I cannot see your screen

02:21:07.000 --> 02:21:08.000
Yes, it. That's much better. And the cat.

02:21:08.000 --> 02:21:16.000
And now picking up as well. Thank you so much. Perfect

02:21:16.000 --> 02:21:20.000
Alright. I'm sorry, so I

02:21:20.000 --> 02:21:21.000
Shall I repeat anything, or shall I continue from here

02:21:21.000 --> 02:21:22.000
I I think it might be useful to repeat. We don't to waste a single thing of what you've said would if you wouldn't mind going back a bit we've got the lunch.

02:21:22.000 --> 02:21:23.000
Break where we can make up a bit of time, and we've got the break between you and our next speaker.

02:21:23.000 --> 02:21:39.000
So if you don't mind, and going back a little

02:21:39.000 --> 02:21:40.000
Alright, so are we from this slide. This is all right.

02:21:40.000 --> 02:21:46.000
Thank you so much

02:21:46.000 --> 02:21:53.000
I don't know. Right? Okay. I don't know what happened.

02:21:53.000 --> 02:22:04.000
Yeah, you Dave, I was presenting the the global licensing strategy in which they I did.

02:22:04.000 --> 02:22:11.000
I have an Education Department working in involved.

02:22:11.000 --> 02:22:18.000
The Asc. Has charged Gcd that the had needs of people affected by our conflict in other situation of violence.

02:22:18.000 --> 02:22:28.000
Health approach to contribute to the protection of life and human dignity, and to prevent analogy, suffering to present the the rule of the visitorities working in the Icrc.

02:22:28.000 --> 02:22:36.000
I was mentioning that we do have a hospital care program.

02:22:36.000 --> 02:23:04.000
There's your C. Supports, bankruptcy and part of indirect being indifferent countries we do support them in different ways or we dive in staff prices, stuff working hand in hand with with an authority workforce or sometimes with a run that work I am more gradually possible

02:23:04.000 --> 02:23:11.000
Hospitals and the functions of the care in hospitalizer.

02:23:11.000 --> 02:23:15.000
See is weapon one digital, but more than more about expanding.

02:23:15.000 --> 02:23:45.000
Also the care cool population, effective by different health conditions, but leaving in the care to the jackets, to maternity, dynamics, internal and so on. But historically, our our intervention is that for weapon wanted injury over the

02:23:48.000 --> 02:23:58.000
Years, and then

02:23:58.000 --> 02:24:09.000
Where we support the publication, centers again existing verification centers or

02:24:09.000 --> 02:24:20.000
Very important also in the collaboration

02:24:20.000 --> 02:24:31.000
In both acute, and which which we give you the number, quality, accessible and sustainable.

02:24:31.000 --> 02:24:43.000
On rehabilitation services, and they're driving towards the participation of this person involved.

02:24:43.000 --> 02:25:13.000
After also important concepts that we looks at the continuum of care, since we try to deliver to the particular as soon as the health condition is discard or is present, I'm a team later on the meditation navigating for people with disabilities

02:25:15.000 --> 02:25:20.000
And their ability, and integrate and reintegration.

02:25:20.000 --> 02:25:30.000
We also response to the different needs of the first of of that person.

02:25:30.000 --> 02:25:53.000
We don't have condition to get to the services offers on the ground, but also externally with that other services present.

02:25:53.000 --> 02:26:23.000
I mean so going to present some of the that are available, and they are accessible on the Internet 2020, and it's based on we are seeing better knowledge in parts of the therapy in 4 phases one I mean from a queue to

02:26:28.000 --> 02:26:46.000
Post, a huge

02:26:46.000 --> 02:26:51.000
And the the importance of the social culture, cultural adaptation.

02:26:51.000 --> 02:27:08.000
How do we represent her on your hand?

02:27:08.000 --> 02:27:30.000
Construction or innovation.

02:27:30.000 --> 02:27:40.000
Thank you, Lucia, so there is another resource that we develop that is freely available for the resources.

02:27:40.000 --> 02:27:41.000
There is not the links, but if you take the name you Google them, you will find them easily.

02:27:41.000 --> 02:27:49.000
It's it's in our bookstore, but it's it's free when you download this as a Pdf.

02:27:49.000 --> 02:27:55.000
So there is one which is called the Physical Rehabilitation Center.

02:27:55.000 --> 02:28:06.000
So this is an architectural handbook that was developed because we have 30 years of experience in building rehabilitation centers, and it's also interesting.

02:28:06.000 --> 02:28:07.000
I think, for a physiotherapist, because you have set up of physiotherapy departments.

02:28:07.000 --> 02:28:18.000
So in terms of how much space you have to consider what type of material that you might have, etc.

02:28:18.000 --> 02:28:27.000
So, and also depending on the number of physical therapists that are working in the department.

02:28:27.000 --> 02:28:39.000
So it can also be quite useful in that sense. Next

02:28:39.000 --> 02:28:45.000
So there is also I don't see it. Maybe you need to click one more time.

02:28:45.000 --> 02:28:51.000
We also develop another resource which is the prosthetic gate analysis for physiotherapists.

02:28:51.000 --> 02:29:10.000
So it's also a book which is focusing on the management of people with amputation it's aimed for physical therapy, but it can also be for the house professionals that are involved in gravitation of person with local limitation it's from the

02:29:10.000 --> 02:29:26.000
Surgical stage until functional recovery, and in fact it gives guidance, practical guidance, so that we can reach a good quality, of care and you have different chapters.

02:29:26.000 --> 02:29:29.000
So you have one on polypropyl and technology.

02:29:29.000 --> 02:29:46.000
I will also talk about this a bit later. So this is the technology to produce processes and ourotics that is low, cost and that we are using a lot in the the project where we are working it also has a chapter.

02:29:46.000 --> 02:29:54.000
On pre and past, fitting treatments, gate, analysis, and gates and deviations.

02:29:54.000 --> 02:29:59.000
There is also. Of course, this is our yeah car business.

02:29:59.000 --> 02:30:20.000
If I can say that, because, of course, when you are working in an arm conflict often you have a lot of people with lovely reputation or reputation in general, so, and we also notice that sometimes this topic which is not always included in training curriculum very much in details so for us

02:30:20.000 --> 02:30:25.000
It's very important to train the visit therapists that are working at the Icrc.

02:30:25.000 --> 02:30:29.000
But also partners, and in the countries where we are working on this subject.

02:30:29.000 --> 02:30:34.000
So there's also a training that I will talk about later.

02:30:34.000 --> 02:30:39.000
And of course, then this goes with it. There is another booklet that you can find.

02:30:39.000 --> 02:30:47.000
That's an exercise for lowerly ambitious which is specific exercises.

02:30:47.000 --> 02:31:03.000
That physiotherapist to physiotherapy assistance can do during the gate training of lowerly mappetis

02:31:03.000 --> 02:31:33.000
My turn again to talk about the from time to time. The is the one responsible for cluster of first application that we scored when they

02:31:42.000 --> 02:31:52.000
Instructions, and managing under functions and other technical mobilizations, nameologies, and so on.

02:31:52.000 --> 02:32:22.000
They are, is a really practical guide on how to apply, and then and give an overview on the type of mobilization with specific indications of type of structures for the type of mobilizations and step procedures of application with pictures and

02:32:22.000 --> 02:32:52.000
Description. So all master master's lars are presented for lower and uploading. What's the application of and the section on traction management and lowering defined for constructions, and so on.

02:33:03.000 --> 02:33:16.000
That we don't have to which which is, I think, the basic surgery war surgery that we we are.

02:33:16.000 --> 02:33:33.000
This also 2 vial books that have been revised in the 2 years, as well well is explaining the general relationship principles of war, surgery.

02:33:33.000 --> 02:33:44.000
She was

02:33:44.000 --> 02:33:51.000
He's really

02:33:51.000 --> 02:34:20.000
Consequences of its explosion, and then it describes the management for specific parts of the body, surgical management, just clinical features to treatments, complications of

02:34:20.000 --> 02:34:43.000
Brain injuries. It's not manual.

02:34:43.000 --> 02:34:55.000
This is training that is available

02:34:55.000 --> 02:35:25.000
A project that has been started in 2,016 and founded, in 2,016, because started to be implemented on this in 2,018 the the AIM

02:35:27.000 --> 02:35:57.000
We really hear a having a base traverse. As I said over 2 years in collaboration with we, we

02:36:05.000 --> 02:36:34.000
It comes out of the form of the it's a small manual, but what he's probably interesting to hear is that it's based on so how can we ensure quality it's it's one of the service. User related standards so how can we ensure quality that

02:36:34.000 --> 02:37:04.000
Procedure, structure related standard so and then processes work to do that.

02:37:04.000 --> 02:37:09.000
Oh, how do we

02:37:09.000 --> 02:37:17.000
And it's goes with the what set of tools and documents for its implementation?

02:37:17.000 --> 02:37:34.000
Because so, for instance, how to form, for how to set a situation of official therapy department wherever it is located, in which are content 2.

02:37:34.000 --> 02:37:57.000
To. For instance, also

02:37:57.000 --> 02:38:13.000
For outcome measurements it. It also has a

02:38:13.000 --> 02:38:18.000
Let me

02:38:18.000 --> 02:38:23.000
Yes, so this is something new that we are working on, of course, with the all the noncommittee cable diseases.

02:38:23.000 --> 02:38:32.000
Now but the burden we can say, and especially also in the countries where we are working.

02:38:32.000 --> 02:38:42.000
We we start to work on diabetes, especially on diabetic food, also because we are more and more service user attending the rehabilitation centers.

02:38:42.000 --> 02:38:46.000
We are supporting with amputation due to diabetes.

02:38:46.000 --> 02:38:56.000

So the first step of this was to develop this manual, which is the management of diabetic food.

02:38:56.000 --> 02:39:00.000
It's for rehabilitation, professionals, but also other house workers.

02:39:00.000 --> 02:39:17.000
And it's really to have house professionally when I would say is to encourage interprofessional approach to to this issue, and of course along the whole continuum of care.

02:39:17.000 --> 02:39:21.000
So it ranges from primary health care, and Cl.

02:39:21.000 --> 02:39:47.000
Also reduction centers, so it includes, for example, tools and illustration to to test and categorize diabetic patient with for complication, and there is also recommendation on orthotics or offloading devices that can be used used for a person with alceration for example or other

02:39:47.000 --> 02:39:54.000
Issues ready to food. We developed any learning. I will talk about it later on, which is accessible.

02:39:54.000 --> 02:40:05.000
It's accessible externally. It's on request, so you can write to us, and we we give. We'll give it access to you as well.

02:40:05.000 --> 02:40:10.000
You can, and next one

02:40:10.000 --> 02:40:11.000
So this is what I was talking about before, so that's not really aimed at physical therapist.

02:40:11.000 --> 02:40:37.000
But I still think it's important, because it's it's good to know how processes and orotics are manufacturers also to be able to collaborate more with pnos prosthetic and artists and so we developed for manuals that

02:40:37.000 --> 02:40:53.000
Are manufacturing guidelines on how to produce lowerly in prosthetics, apple in prosthetics, lowerly, Matthews, and upperlym autotics so with the polypopian technology so this is a a technology which is using plastic

02:40:53.000 --> 02:41:07.000
And and which is low custody of good quality that we are using in our in our projects

02:41:07.000 --> 02:41:08.000
Right so as you can see now we we shift to iser.

02:41:08.000 --> 02:41:22.000

See, there are a lot of resources with partners, and we have already been talking extensively about the second one, which is the early habitation in cost.

02:41:22.000 --> 02:41:34.000
With any doctor, and do not repeat myself. Maybe I can say being in more density responses, especially in the queue of power.

02:41:34.000 --> 02:41:59.000
We do the training on use of them for the response in a more coordinated manner to the big crisis that happened that I started 2 years ago.

02:41:59.000 --> 02:42:14.000
I'm better comprehensive. The program is the main conditions that we we'll normally treat in.

02:42:14.000 --> 02:42:28.000
Yes, computation, I'm sure, is not management of nerve injuries, not to brain injuries, applications, and birds

02:42:28.000 --> 02:42:55.000
They the first one the minimum technical standards and recommendation for as you can see, with different partners and we don't have the minimum standards for intervention in in an emergency, setting and the purpose of the is we need to be able to think together to strengthen the

02:42:55.000 --> 02:43:01.000
capacity to respond in our invitation in a coordination coordinated manner.

02:43:01.000 --> 02:43:11.000
So in knowing what kind of human resources workforce we have to deploy.

02:43:11.000 --> 02:43:32.000
Accordingly type of it's more disaster, setting much easier than the equipment that we do need to to have and deploy in order that I prevent basic complications.

02:43:32.000 --> 02:43:36.000
How it can be coordinated response ensuring patient.

02:43:36.000 --> 02:43:48.000
Yeah, patient care. Since the beginning of a crisis.

02:43:48.000 --> 02:43:56.000
This is also the resource that they see that are locked together with the age foundation.

02:43:56.000 --> 02:44:24.000
I mean, and we've it has been seen that, especially after they are.

02:44:24.000 --> 02:44:31.000
Why did you care? In in response to this school emergencies?

02:44:31.000 --> 02:44:37.000
Alright also is maybe more functioning. That seems in an emergency up 90% of the surgery.

02:44:37.000 --> 02:44:58.000
That workflow is really deeply injuries. So this is why we got all these. He guide the same to support the

02:44:58.000 --> 02:45:16.000
Sort of really presents, they also the logistic part of an intervention in a in a in a in such a setting, but also of a the the they, they, continuous scale.

02:45:16.000 --> 02:45:34.000
So how how very, how we respond in in the emergency room! Go patient with an injury, and then anesthetic care, surgery, compare nursing, rehabilitation care, and so on.

02:45:34.000 --> 02:45:46.000
Here. It's which are the Research Service Provision forests.

02:45:46.000 --> 02:45:54.000
The management of that we do treat in our different conference and projects.

02:45:54.000 --> 02:46:15.000
Now back to Nice.

02:46:15.000 --> 02:46:16.000
Yes, so that's the training I was talking about before talking about the guidelines.

02:46:16.000 --> 02:46:23.000
So so so we developed a training. It wasn't.

02:46:23.000 --> 02:46:29.000
What's several other partners? So there is, for example, the University hospital in Geneva.

02:46:29.000 --> 02:46:39.000
There is the food. We were a lot of collaborating and and other partners to develop this e-learning, so it's meant to be a blended learning so normally you do the e-learning and then there is a face to face.

02:46:39.000 --> 02:46:48.000
Component. Of course this is will be for Icrc.

02:46:48.000 --> 02:47:06.000
Staff and partners, but but the e-learning, as I said before, is accessible for externals without an issue, and so the idea is really to have a interrupt professional approach to prevent and respond to diabetic food.

02:47:06.000 --> 02:47:10.000
Patients need. So it's it can be about rehabilitation.

02:47:10.000 --> 02:47:16.000
But it's also clinical. It also takes has a part on a psychological.

02:47:16.000 --> 02:47:29.000

So along the whole continuum of care, and of course the idea is to strengthen the technical low-age, the skills and the attitudes to for diagnosed with diabetes.

02:47:29.000 --> 02:47:36.000
So as you can see here on the learning path, there are several online activities.

02:47:36.000 --> 02:47:43.000
So on non-communicable disease, also more on diabetes and diabetes foods.

02:47:43.000 --> 02:47:50.000
It also has a part on social distinctions of health, and then biomechanics, non pharmacological management.

02:47:50.000 --> 02:48:15.000
You also have a partner of floating and on functional rehabilitation on wound, care, mental health issues, motivational interviewing, therapy, patient education, interprofessional collaboration, assessment, and resultbake management, cycle, what international actors are involved so the idea is really to be able to

02:48:15.000 --> 02:48:35.000
Have in a given country, you know the way. Continue of care, and all the the services available for persons with diabetes

02:48:35.000 --> 02:48:40.000
Oh! And we thought I don't know if others choke about it or not.

02:48:40.000 --> 02:48:59.000
But there is also a lot of resources out there which we were not involved in developing, but that we find very useful, and I think can be very useful also for people listening to this Webinar I mean first there is Ubuntu which is the version 2 of getting to know cerebral policies.

02:48:59.000 --> 02:49:08.000
So these are this is a resource where you can train parents of children with cerebral palsy.

02:49:08.000 --> 02:49:13.000
We are using that blood in the field, and the we really found it very useful and then there is, of course, the Pon Seti Red book which exists.

02:49:13.000 --> 02:49:25.000
On. I don't know how many languages, but that gives you the whole technique and how to do serial casting on club food.

02:49:25.000 --> 02:49:42.000
Then there is also a muk, which is on spinal cord injury that is free, and that has also been translated in several languages and interbrance manual and trainings on burn care

02:49:42.000 --> 02:49:53.000
Next, and then more wual resources that are very useful to there is the emergency blue and red Book.

02:49:53.000 --> 02:49:54.000

There is a whole training package on wheelchair, and that you have the basic level.

02:49:54.000 --> 02:50:02.000
You have the intermediate, and you also have a package for trainer.

02:50:02.000 --> 02:50:11.000
So this has also been trusted in several languages, and is very useful, and then, of course, as I mentioned at the beginning, there is a rehabilitation, 2,000.

02:50:11.000 --> 02:50:12.000
And 30 guide for action and competency framework which we also use in the that is valuable for everybody to know where to find this

02:50:12.000 --> 02:50:26.000
That's that's definitely. See? Yeah. Thank you.

02:50:26.000 --> 02:50:30.000
So. Thank you, messy

02:50:30.000 --> 02:50:31.000
Thank you. That's okay.

02:50:31.000 --> 02:50:32.000
Thank you, messy. Thank you, Leslie, Lucy, thank you so much, and thank you, Lucy, for just getting through it, even with a slight difficulties at the beginning, and still being able to share all your wonderful knowledge.

02:50:32.000 --> 02:50:33.000
Thank you. I think I think we're all sitting here going you guys need a whole day, you you need.

02:50:33.000 --> 02:50:34.000
To tell us about all this stuff, don't you? This this you've kind of gone through so much stuff and shown so many manuals and so many resources in that 45??min.

02:50:34.000 --> 02:50:35.000
But actually we need more. We need to know more. How do we?

02:50:35.000 --> 02:50:36.000
How do we get more information from you? Thank you. So a couple of questions translation, wise.

02:50:36.000 --> 02:51:06.000
What languages are a lot of the manuals or the resources in

02:51:10.000 --> 02:51:11.000
Very good question, because I we did not mention it in the presentation, but listening to the our speakers.

02:51:11.000 --> 02:51:25.000
And I. They are all in English, and Leslie Patriarch. No, only English.

02:51:25.000 --> 02:51:29.000
Most of them are in French, some of them in our beach

02:51:29.000 --> 02:51:30.000
And some of them in Spanish, too. Yes.

02:51:30.000 --> 02:51:31.000
Okay. Thank you. And are they accessible through the links?

02:51:31.000 --> 02:51:32.000
So Julia is one of our who is joined. Just watching is doing an amazing job of keeping up with all of your your all of your data on here.

02:51:32.000 --> 02:51:33.000
So. Thank you, Juliet, and so is the. Presumably the language is changeable when you link into these links you can change the language there. Super.

02:51:33.000 --> 02:51:34.000
Thank you. So within the so with the manuals is there?

02:51:34.000 --> 02:51:35.000
Is that then an option of having cause? Obviously these are these are manuals that people go and read, and they self direct, and they self learn, and you've spoken about Icrc.

02:51:35.000 --> 02:51:36.000
Stuff having in face to face, in house, training but not necessarily with the manuals.

02:51:36.000 --> 02:51:37.000
Is there a way for clinicians using them to contact, or to like similar to the mental system we've spoken about before.

02:51:37.000 --> 02:52:07.000
So if they have any complications or confusions with the online? Stuff, is there a way to link in to discuss it further?

02:52:26.000 --> 02:52:39.000
Yes, of course this this can be done, but more at country level, because if we have 500 people linking in with us in Geneva, then I think I'm gonna commit suicide but of course, we have team on the ground.

02:52:39.000 --> 02:52:40.000
So yeah, of course. But I I think also that most probabilities your therapist working in the countries where we have teams.

02:52:40.000 --> 02:52:54.000
Make sense.

02:52:54.000 --> 02:52:55.000
We got to mention about training, we quickly. So some of the they go with some training.

02:52:55.000 --> 02:53:05.000
But at the moment most of their, but maybe for the war, surgery seminar.

02:53:05.000 --> 02:53:13.000
Yeah, they are. They are. They are related to our project, and somehow they are open.

02:53:13.000 --> 02:53:31.000
But through applications most of the time, so application

02:53:31.000 --> 02:53:38.000
Then also the audience is kind of selected. Starting from certain specific settings background and so on.

02:53:38.000 --> 02:53:39.000
So with the people we work on on the ground that it goes with practical training

02:53:39.000 --> 02:53:40.000
Thank you, thank you. And then she's put a question in in both of my chat, saying other manuals, professionals like physi and physi assistance, or any of them, free access or for the public to use

02:53:40.000 --> 02:53:41.000
They? They? They know them already. So. But yeah, of course it's possible to have a monitoring more on site

02:53:41.000 --> 02:53:42.000
So all the manuals that we have presented. They are open access

02:53:42.000 --> 02:53:43.000
If anybody who reads someone understands them. So I imagine they will be obviously very useful for professionals as well.

02:53:43.000 --> 02:53:44.000
That they will be more meaningful for professionals to sort of work alongside there.

02:53:44.000 --> 02:53:45.000
Of course. Yes. Yeah. Yeah.

02:53:45.000 --> 02:53:46.000
Yeah. Thank you. So: another of ongoing theme that seems to be throughout the day is is the importance of evidence-based practice, and Cpd.

02:53:46.000 --> 02:53:47.000
Across sort of global global health is and I think that's probably something that it needs more work I guess, than all the global platforms is to is to sort of show the importance of evidence base and Cpd work.

02:53:47.000 --> 02:54:17.000
But any thoughts from you guys about how how that can be embedded more at sort of ground level training in some of these institutions that are starting the training process

02:54:48.000 --> 02:54:59.000
But I think one of the 1 one thing that that is useful is to work closely, you know, with with schools with physiotherapy schools on the grounding.

02:54:59.000 --> 02:55:09.000
And because this is where you know, people start to study, and then they go out, and the and they work so, and and also Physical Therapy Associations.

02:55:09.000 --> 02:55:10.000
So I think this is how generally this is how we try to when we train people, or when we want a subject to be included, because we see on the ground that feature therapy is the lack of the scales for example we always work with the physiotherapy association and and also the

02:55:10.000 --> 02:55:11.000
Thank you. And another question: How do you develop your resources?

02:55:11.000 --> 02:55:12.000
So? Who is involved in the development? And and how do people get involved?

02:55:12.000 --> 02:55:42.000
Or would you want people to be getting involved with helping you develop most of

02:55:46.000 --> 02:55:49.000
Yes, I might jump in here, I think it's a continuous work.

02:55:49.000 --> 02:56:02.000
We are very much aware that our are limited, and we need much more to be developed.

02:56:02.000 --> 02:56:32.000
It's always a question of time and resources available. We didn't mention all the internal resources that we have but we also have to primarily work on that not only the external ones but in turn 100 protocols guidelines, that we internally, use free word and so on

02:56:41.000 --> 02:56:42.000
It's a hard work to keep up with the work on the field plus developing training material.

02:56:42.000 --> 02:56:45.000
Schools, or even a level of the ministry sometimes. So that's that would be my recommendation.

02:56:45.000 --> 02:56:46.000
Yes, as we do not have a dedicated section of someone who, if we have another material on rehabilitation, it comes from the habitation department when the support of the training, department but their resources are in turn on most of the time

02:56:46.000 --> 02:56:47.000
Well, we still try to collaborate a lot with, you know other partners.

02:56:47.000 --> 02:56:48.000
If they're interested, can be. Yeah, that's what you would show.

02:56:48.000 --> 02:56:49.000
It can be and as I mentioned, for for diabetic food, we we work with a lot of other partners to develop this so, and especially we do that when when we know that the know how in house is not very well flopped and that we so we we try to to work, and with others and even to have

02:56:49.000 --> 02:57:19.000

Our resources. Peer reviewed before we publish them.

02:57:37.000 --> 02:57:50.000
Also maybe to say that in the email we have an education specialist in the internal India that's training material and training practices on the feed. And so on. But she's not present here today.

02:57:50.000 --> 02:57:51.000
But this is also something that we do have in the vacation department.

02:57:51.000 --> 02:57:52.000
Thank you. There's another question with your resources. There's so many, so many stuff out there. Is there any is there any resources aimed for members of the public that have less medical terminology?

02:57:52.000 --> 02:57:53.000
Perhaps that aren't aimed at professionals

02:57:53.000 --> 02:58:12.000
I thought that might be the answer.

02:58:12.000 --> 02:58:13.000
There is a lot. No, because, of course, you know, like I see it doesn't work on the in the medical field, so you will find you have all type of other resources for general public so yeah, that that's gonna be if you ask us. To share.

02:58:13.000 --> 02:58:14.000
I've been arrested for the rest of the day.

02:58:14.000 --> 02:58:27.000
Yeah, yeah, I think I guess I think it's just sort of cause.

02:58:27.000 --> 02:58:28.000
These. It's gonna be very we we're gonna we're gonna send, you know, small links in the chat for 2 days

02:58:28.000 --> 02:58:29.000
Obviously we have a lot of people like globally coming in and joining this are just saying you know how others, but they're all accessible through your website.

02:58:29.000 --> 02:58:30.000
So 1 one, website and then you can go through those and sort of work out.

02:58:30.000 --> 02:58:31.000
Find which are for general public, which are more professional, based all that sort of stuff.

02:58:31.000 --> 02:58:32.000
So that that's the messages. Let's not have 2 days of this.

02:58:32.000 --> 02:59:00.000
Let's go to your website

02:59:00.000 --> 02:59:01.000
No, exactly. Yes, no, no, but there is a lot of the yeah.

02:59:01.000 --> 02:59:07.000
There is a lot of resources, even on low wax.

02:59:07.000 --> 02:59:08.000
That's a lot of things so. And then yeah, everything is accessible from Robert.

02:59:08.000 --> 02:59:12.000
Thank you. So regarding the training, so you said that you've in Icrc staff.

02:59:12.000 --> 02:59:13.000
So

02:59:13.000 --> 02:59:14.000
Get the face to face training, and then within your in country hubs our members of the country then able to come and get the face to face training from the Icrc. Stuff yeah

02:59:14.000 --> 02:59:17.000
Exactly. Yes. Yeah. Yeah. So we always also invite when we are training.

02:59:17.000 --> 02:59:18.000
People who are who are working in the country. So where we have rehabilitation center supported, and so on.

02:59:18.000 --> 02:59:19.000
Thank you so much. I think. Yeah, I think that you've covered so many things that we can say.

02:59:19.000 --> 02:59:20.000
Oh, question about prosthetic so fresh about bones?

02:59:20.000 --> 02:59:21.000
A question about Laura question about this, and you've covered all of them. We haven't got time to ask all those questions, so thank you so much.

02:59:21.000 --> 02:59:22.000
I think you know I it would be wonderful if we could offer a platform as well to to sort of extend this and give you give you the opportunity to do some of go a little bit into more detail about some of these manuals I think that'll be wonderful but can I just say

02:59:22.000 --> 02:59:23.000
Leslie Lucya, thank you so much for coming and showing this work, and again all the links in the chat, and Juliet for putting them all in here.

02:59:23.000 --> 02:59:24.000
You know this has gone to a global audience. So every person within country can take this information and share it with one or 2.

02:59:24.000 --> 02:59:25.000
So, of course.

02:59:25.000 --> 02:59:45.000
And this is everybody watching take it and share it with 1, 2, 3, 4 people, you know, and then the more people that share this the more this

information can get out and be usable across the countries across the world so thank you so much for this

02:59:45.000 --> 03:00:15.000
Thank you.

03:00:31.000 --> 03:00:42.000
Thank you. Thanks, Julia, for putting the one in the chat and apologies again for inconvenience.

03:00:42.000 --> 03:00:43.000
Thank you both so much. If you had a spare moment.

03:00:43.000 --> 03:00:48.000
I know there are some some other questions in the chat box, but we understand.

03:00:48.000 --> 03:01:07.000
You've got a full day ahead from here onwards, so so no, no pressure to do those just to say to to the audience out there, we will AIM to put as many of the links together that that both Leslie and Lucy have been talking about and and send them, off to you

03:01:07.000 --> 03:01:08.000
So we'll work on that. But thank you both so much.

03:01:08.000 --> 03:01:14.000
Leslie, and I hope you can join us for a bit more of the day.

03:01:14.000 --> 03:01:26.000
But thank you right from here onwards. We're gonna take a short break again, and then we're coming back at 20 past 12 for our next excellent speaker.

03:01:26.000 --> 03:01:32.000
So have a good break stretch of your legs, and we'll be back in about 15??min.

03:01:32.000 --> 03:02:02.000
Thank you.

03:11:02.000 --> 03:11:04.000
Good afternoon.

03:11:04.000 --> 03:11:05.000
Good afternoon. Good afternoon.

03:11:05.000 --> 03:11:10.000
Yeah. Great. Obviously, we're live but that. But that's fine.

03:11:10.000 --> 03:11:11.000
Yes.

03:11:11.000 --> 03:11:15.000
With just that 5??min until we was it 20 past? We're starting. Yeah.

03:11:15.000 --> 03:11:16.000
Yes.

03:11:16.000 --> 03:11:17.000
Thank you. Yes, we have some several minutes, I think, according to my

03:11:17.000 --> 03:11:24.000
Yeah, that's that's fine. Do you want to check about screen sharing, or you?

03:11:24.000 --> 03:11:25.000
Yeah.

03:11:25.000 --> 03:11:26.000
You'd be sharing a screen or some slot

03:11:26.000 --> 03:11:27.000
Yes, I will be sure

03:11:27.000 --> 03:11:33.000
Yeah, I know I would like to share my screen, and I will start, and then will be following my presentation.

03:11:33.000 --> 03:11:34.000
That's what we meant. This alone.

03:11:34.000 --> 03:11:38.000
Okay. Yeah. So that's just check for them. That's yeah.

03:11:38.000 --> 03:11:40.000
We just don't have the full

03:11:40.000 --> 03:11:43.000
So so I can share now. No, I I cannot

03:11:43.000 --> 03:11:45.000
Let me take 1??s

03:11:45.000 --> 03:11:48.000
Yeah, so long you just need to somehow change the setting slightly

03:11:48.000 --> 03:11:53.000
Yes, yes, yes, yes.

03:11:53.000 --> 03:11:54.000
Can you see my screen now

03:11:54.000 --> 03:11:55.000
I think that is

03:11:55.000 --> 03:11:58.000
That's yeah, that's perfect. How it's like Mary's good

03:11:58.000 --> 03:11:59.000
Yeah.

03:11:59.000 --> 03:12:04.000
Perfect. Okay.

03:12:04.000 --> 03:12:05.000

Hey? Up and I Yeah.

03:12:05.000 --> 03:12:21.000
Great here. Yeah, we'll we'll go that we can just have your title slide up and waiting for the with a few minutes until everyone joins us.

03:12:21.000 --> 03:12:24.000
Can you see my screen already?

03:12:24.000 --> 03:12:25.000
Yeah.

03:12:25.000 --> 03:12:26.000
Yeah. Thanks.

03:12:26.000 --> 03:12:29.000
Yeah, okay. Shall I leave it? Or do you want me?

03:12:29.000 --> 03:12:38.000
Yeah. Just just go up to the top. The your first, which is your first slide

03:12:38.000 --> 03:12:39.000
Yeah.

03:12:39.000 --> 03:12:41.000
This is said, oh, no, no, no! Sorry! This is my first light

03:12:41.000 --> 03:12:49.000
Great. Well, why did you just share? We'll have that up now as a full one, and we can just pause for them the 5??min until a few, and it comes up

03:12:49.000 --> 03:12:51.000
So I can leave this on

03:12:51.000 --> 03:12:53.000
Yeah, that's fine. Yeah. Just leave it like that for a minute.

03:12:53.000 --> 03:12:58.000
I think that's fine. Yeah, that's fine.

03:12:58.000 --> 03:13:07.000
Okay.

03:13:07.000 --> 03:13:11.000
No, it's life.

03:13:11.000 --> 03:13:12.000
Yeah.

03:13:12.000 --> 03:13:15.000
Good! Good! How are you? Are you paying for you, Travis?

03:13:15.000 --> 03:13:19.000
Yeah, more or less. Yeah, I know 10%. Sure. Yeah?

03:13:19.000 --> 03:13:24.000

Okay. Okay. Where are you living?

03:13:24.000 --> 03:13:28.000
I'm leaving a Sunday morning

03:13:28.000 --> 03:13:35.000
Okay. Okay. Yeah.

03:13:35.000 --> 03:13:36.000
Yeah.

03:13:36.000 --> 03:13:38.000
Yeah, yeah, and I'm I'm packed already, because you know I came yesterday back from Junior so it's a bit of busy time.

03:13:38.000 --> 03:13:40.000
I would say bits. Yeah, they're too busy

03:13:40.000 --> 03:13:43.000
Yeah, it. Yeah. Yeah. Yeah. And just

03:13:43.000 --> 03:13:50.000
And of the end of the year, and to seems to conference time as well

03:13:50.000 --> 03:13:55.000
Yeah.

03:13:55.000 --> 03:14:01.000
Was. It was nice to to have a face to face conference in Geneva

03:14:01.000 --> 03:14:05.000
Yeah, I saw your post. Yeah, it looks nice.

03:14:05.000 --> 03:14:06.000
Yeah. Yeah.

03:14:06.000 --> 03:14:12.000
Oh, hide in the background, and we'll we'll come back about 3??min

03:14:12.000 --> 03:14:21.000
Yeah, people were quite shocked when I was saying, you know what's around 50 medical model

03:14:21.000 --> 03:14:22.000
The yeah.

03:14:22.000 --> 03:14:29.000
Alan, where are. You you in Geneva as well.

03:14:29.000 --> 03:14:30.000
You's open. No Utopia. Yeah.

03:14:30.000 --> 03:14:36.000
Yeah. Oh, amazing! The troubles, if they settle down a bit like, is that right?

03:14:36.000 --> 03:14:37.000
Yeah. Yes. Yes. Yeah.

03:14:37.000 --> 03:14:40.000
Goodness. For that. Yeah, yeah.

03:14:40.000 --> 03:14:45.000
Yeah, this is nice. Yeah.

03:14:45.000 --> 03:14:53.000
I might have been not in Geneva anymore. I was there for the past 2 days

03:14:53.000 --> 03:14:54.000
Are, you but

03:14:54.000 --> 03:14:55.000
So what are you now? Cute.

03:14:55.000 --> 03:15:00.000
I'm based in off an underline which is 20 kilometers from the airport.

03:15:00.000 --> 03:15:01.000
The Netherlands. So yeah.

03:15:01.000 --> 03:15:05.000
And in the Netherlands. Yeah, yeah, we're really delighted to see.

03:15:05.000 --> 03:15:07.000
Okay.

03:15:07.000 --> 03:15:11.000
So I know that the wonderful benefits of having conferences.

03:15:11.000 --> 03:15:15.000
You know where we all face to face, which is what adapts used to do in the in the Uk.

03:15:15.000 --> 03:15:20.000
But you. We get 20, of us all Uk. Based. And the wonderful thing about what we can do.

03:15:20.000 --> 03:15:22.000
There are some great things on zoom, aren't there?

03:15:22.000 --> 03:15:24.000
Whereas this conference can go internationally, which is what it's done so

03:15:24.000 --> 03:15:31.000
Yeah, no, it's definitely the benefit actually of of based conferences.

03:15:31.000 --> 03:15:36.000
Yes, no doubt about that. If you see where people are coming from basically from a few parts of the world.

03:15:36.000 --> 03:15:39.000
Yes. Yeah. Yeah.

03:15:39.000 --> 03:15:44.000
Yeah, I think I need to get Luke to send me a slide.

03:15:44.000 --> 03:15:45.000
Yeah.

03:15:45.000 --> 03:15:50.000
He's put it together where everybody is, which is great, right fee we'll hand over to you for introductions in a moment.

03:15:50.000 --> 03:15:54.000
Thank you. Thank you both so much for your time again. I'm really.

03:15:54.000 --> 03:16:00.000
We're all really grateful for it, so, as you know, this is a subject close to my heart as well.

03:16:00.000 --> 03:16:02.000
So thank you for being here

03:16:02.000 --> 03:16:09.000
So so so my focus will be slightly different than the presentations this morning, because they were very much focusing on resources only, which I will do as well.

03:16:09.000 --> 03:16:15.000
But in a different way. I start with the concept actually and and focus on Cdr as an important resource.

03:16:15.000 --> 03:16:38.000
Then we call. Then I go into the rehab for some time, and then the folks actually on human resource, resources and discusses actually how Western universities or organizations like server policy Africa do work together with the University of color yeah.

03:16:38.000 --> 03:16:53.000
Excellent. I think that's wonderful. I think everybody brings a different angle from the speakers, which is which is refreshing, and I'm so welcome to have different angles so that sounds perfect

03:16:53.000 --> 03:17:04.000
No, I like some of the presentations, and say I, I met some as well, but I haven't heard him yet.

03:17:04.000 --> 03:17:05.000
Oh!

03:17:05.000 --> 03:17:08.000
So yeah, and I know him for a long time because he, you know they are using also the rehab.

03:17:08.000 --> 03:17:16.000
And so we have been developing material for them, and they have done some translations, and he has been false right from the beginning.

03:17:16.000 --> 03:17:23.000
Also in refueling some of the work that we have been doing. So. That's a good relationship with anybody

03:17:23.000 --> 03:17:29.000

It's interesting good to know. Thank you.

03:17:29.000 --> 03:17:30.000
Honestly you happy to

03:17:30.000 --> 03:17:31.000
Yeah.

03:17:31.000 --> 03:17:32.000
But yeah, we're on time. Let's go live again.

03:17:32.000 --> 03:17:39.000
So wonderful. I'm chiefy

03:17:39.000 --> 03:17:54.000
Thank you. Welcome back everyone. If you're joining us just now we've had an incredibly useful and important morning listening to the vital work of specialists and low-resourced, and often fragile rehabilitation systems.

03:17:54.000 --> 03:18:00.000
Further to this. I think it's good to mention that one third of the world which is over 2 point.

03:18:00.000 --> 03:18:05.000
4 billion people live without any form of rehabilitation, and maybe more.

03:18:05.000 --> 03:18:11.000
Who need, but will never receive physiotherapy. I think it was just last week that the Wh.

03:18:11.000 --> 03:18:18.000
So claimed the world's population has just reached 8 billion people, and we know this increases the need for rehabilitation.

03:18:18.000 --> 03:18:38.000
Not just because the world's population increasing, but also due to aging populations, urbanization, natural disasters raised Ncds along with better diagnosis, which is obviously great but the great, question continues is what can we do, as professionals in this area of global health to support.

03:18:38.000 --> 03:18:47.000
These billions of people with no access to rehabilitation, because if we here today our group of people audience adapt members, all of us.

03:18:47.000 --> 03:18:58.000
If we're not striving to resolve this, then who and when we know that projects have been raised and dropped, such as our shooting?

03:18:58.000 --> 03:19:16.000
Sort of poorly trained and non-supervised physiios systems which resulted in governments bypassing qualified, videos indirect diagnoses being made and poor, treatments so what do we do obviously retaining our professional standards are crucial as we know but they're simply not

03:19:16.000 --> 03:19:24.000
the funding to provide qualified videos to every single rural area, especially in low middle income countries.

03:19:24.000 --> 03:19:34.000
And these countries is Professor and Mosley and Professor Tom Shakespeare pointed out last year are often where the greatest rehabilitation needs are found.

03:19:34.000 --> 03:19:52.000
Well, the system, community based rehabilitation known as Cbr Aims, to meet the needs of this population and there's one man who's devoted his life to physical therapy in Cbr for low resource Settings so her corn Neilch I hope i've

03:19:52.000 --> 03:19:59.000
Pronounced it right is the founding director of enablement cerebral palsy, Africa, and the editor of DC.

03:19:59.000 --> 03:20:07.000
Id: journal: Eric is a Dutch physiotherapist who started his international experience in South Africa.

03:20:07.000 --> 03:20:14.000
Facilitating the development of a huge Cbr program and pioneering the urban primary health center in Alexandra.

03:20:14.000 --> 03:20:19.000
I saw the immense ongoing need to build the Cbr workforce.

03:20:19.000 --> 03:20:24.000
He's lectured at the University of Applied Sciences, and directed enablement.

03:20:24.000 --> 03:20:32.000
The charity for the last 25 years, and I can personally thoroughly recommend the enablement website for the excellent Cpr.

03:20:32.000 --> 03:20:48.000
Is that are. There. I'll pop a link into the chat box if that's useful just now to personally, I can't think of anyone more qualified or diligent to take the reins of cerebral palsy Africa which Herg has now done he's

03:20:48.000 --> 03:21:03.000
Joined today by Zella I'm deniki from Ethiopia, and if you think you can't rival any of our incredible speakers so far, Zella lem is both a physiotherapist and an occupational therapist with years of experience working with children with

03:21:03.000 --> 03:21:08.000
Neuro developmental disabilities, particularly those were cerebral palsy.

03:21:08.000 --> 03:21:16.000
He's currently the head of department for the occupational therapy at the University of Gondar, Ethiopia.

03:21:16.000 --> 03:21:23.000
Both his research and clinical interests are within areas related to cerebral palsy, rehabilitation and assistive technology.

03:21:23.000 --> 03:21:29.000
In low middle income countries. Thank you both so much for joining us today and sharing your time.

03:21:29.000 --> 03:21:34.000
I know we're gonna learn loads from you, and so how may I hand over to you from here

03:21:34.000 --> 03:21:39.000
Yes, thank you very much. Fiona and Alice, for inviting us.

03:21:39.000 --> 03:21:43.000
We feel a preference actually to be with you this morning.

03:21:43.000 --> 03:21:47.000
We heard already a lot about resources, and maybe for your background.

03:21:47.000 --> 03:21:52.000
I think, in terms of our 2 presentations we or I start.

03:21:52.000 --> 03:21:56.000
Actually with giving a presentation a short presentation about Cbr.

03:21:56.000 --> 03:22:00.000
Bits I see, as a very important resource for official therapy as well.

03:22:00.000 --> 03:22:19.000
Then I will tell a bit about our latest development, and that's it has been a long-term development of 7 years by now of developing a smartphone application called the Rehab and then salem will take over from me and he will be talking actually about the importance of collaboration

03:22:19.000 --> 03:22:28.000
Between Western universities and African universities, but also he's making also the example of a small organization called Server policy.

03:22:28.000 --> 03:22:38.000
Africa was working very closely together with the University of Kombar, and maybe for your information Sailan is the country representative for saver policy. Africa.

03:22:38.000 --> 03:22:43.000
I have no idea how he's combining all his tasks.

03:22:43.000 --> 03:22:46.000
I think he must be working 24??h a day, 7 days a week.

03:22:46.000 --> 03:22:49.000
But he's he's just doing it. Let me go to the next slide.

03:22:49.000 --> 03:23:04.000
Maybe to get something straightforward for me beginning, and I was introduced in some of the efforts about this training program as an able or this this conference.

03:23:04.000 --> 03:23:10.000
Enablement is a multimensional, but we are not a multinational sorry for that.

03:23:10.000 --> 03:23:20.000
I know that our output is is quite a bit, and some people are always amazed when they hear actually that enablement is just a very small not-for-profit concrete.

03:23:20.000 --> 03:23:24.000
But 3 people, are working, and a number of associates, members around them.

03:23:24.000 --> 03:23:29.000
So we are small now. I took some screenshots sexy from our website.

03:23:29.000 --> 03:23:50.000
Fiona was already referring to our website call, visit our website, and you will find out that all that we made during the past couple of years is open source open access so it's all for free except some hard copies of some books that we developed but what we see actually in terms.

03:23:50.000 --> 03:24:11.000
Of our our fission is, or mission is that we feel that enablement that is, in the name as well, enabling people that we want to optimize the potential of the people and in our case we focus very much on people with disabilities, so when when we talk about rehabilitation and I

03:24:11.000 --> 03:24:33.000
Should set that right from the beginning. I often have a conflict with quotation marks because there's a lot of discussion about Cvr. There has been a lot of discussion about Cbr and people tend to forget that Cbr has been developed to ensure that people with disabilities have access to a

03:24:33.000 --> 03:24:44.000
Rehabilitation. So so we we deviate sometimes in terms of what we are saying from what he wrote health organization is saying, I come back to that issue, and then a lot of what we are doing.

03:24:44.000 --> 03:24:46.000
Is not so special. It's it's not a hard rock sign.

03:24:46.000 --> 03:24:56.000
Hard science. It is all ways that we try to do in in in all things that we try to do in new ways.

03:24:56.000 --> 03:25:04.000
Let me go to them next slide, so I believe that we, as therapist I've been trained in the seventies long time ago.

03:25:04.000 --> 03:25:14.000
I'm a bit at the end of my career. We as therapist, but especially as people living in low resource settings, cannot do without Cbr.

03:25:14.000 --> 03:25:18.000
And I hope that most of you are familiar with Cbr.

03:25:18.000 --> 03:25:24.000
That Cbr is about the differing, essential or basic forms of rehabilitation.

03:25:24.000 --> 03:25:29.000
If limited and local, available resources to as many people as possible, so the focus of Cbr right from the mid seventies, when Cbr.

03:25:29.000 --> 03:25:46.000
Was developed by now to some extent by devote health or recognition, but at the same time by people like David Werner and others, was fairly much on cover, it's trying to make sure that Cvr.

03:25:46.000 --> 03:25:50.000
Comes at the doorstep of people that people do have access to rehabilitation.

03:25:50.000 --> 03:25:55.000
I mean Cpr. Is an approach specifically introduced for low resource settings.

03:25:55.000 --> 03:26:00.000
Keep that in mind spontaneously, and Cpr. Has been promoted internationally for over 40 years.

03:26:00.000 --> 03:26:07.000
As a course strategy for the improvement, inequality of life of people with disabilities and their families.

03:26:07.000 --> 03:26:10.000
So it causes so beyond official therapy. It's more comprehensive.

03:26:10.000 --> 03:26:14.000
We talk about comprehensive rehabilitation.

03:26:14.000 --> 03:26:34.000
Not Cbr: it's on the slit, I can tell you I was the past couple of days I was in Geneva, and I was asked to give a presentation about the the the role of Cbr in the current role of Cbr.

03:26:34.000 --> 03:26:38.000
Because people felt actually we don't read so much about Cbr anymore.

03:26:38.000 --> 03:26:44.000
And that's correct because new approaches have been developed over the past couple of years.

03:26:44.000 --> 03:26:48.000
Cbid is one of them community-based, inclusive development, and you are often familiar.

03:26:48.000 --> 03:26:53.000
If the Ws. Are approach, we have 2,030.

03:26:53.000 --> 03:27:02.000
Now Cbid community-based, inclusive development in my fuel is actually the outcome of what you do with Cbr.

03:27:02.000 --> 03:27:03.000
Inclusive development. That's basically what we are heading for with.

03:27:03.000 --> 03:27:32.000

If Cbr. And then because of some allergic reactions from the global disability movement, as I may say, so, alertsic reaction with regard to the term rehabilitation, because they were connecting rehabilitation and associating rehabilitation with the medical model so there was a version, towards

03:27:32.000 --> 03:27:37.000
Cityr as well, and a new model was a developed community based inclusive development.

03:27:37.000 --> 03:27:46.000
Just a few years after Cbr. Guidelines were being launched by the World Health Organization in 2,010 in Abu Cha.

03:27:46.000 --> 03:27:47.000
It's hard to swallow for a lot of people in the Cbr movement.

03:27:47.000 --> 03:27:51.000
It was difficult for people in the field because they got confused, and I'm a bit afraid that the confusion is getting bigger and bigger.

03:27:51.000 --> 03:28:18.000
If there is a large international organization currently giving training programs in Africa, if the title out of surface delivering into community mobilization I'm getting very worried and people pointing at me and they say yes, but you were biased because you were efficiently, at least, of course, i'm biased, was not biased.

03:28:18.000 --> 03:28:24.000
And I personally feel that medical rehabilitation remains extremely important.

03:28:24.000 --> 03:28:26.000
Then I can tomorrow in a traffic accident, a spinal cord injury.

03:28:26.000 --> 03:28:31.000
I want to see the best neurologist in, the Netherlands.

03:28:31.000 --> 03:28:38.000
I want to see the best physiatrist, and I'm not so concerned about my my rights.

03:28:38.000 --> 03:28:46.000
I'm not so concerned about inclusion. Now I want to get the best meal of a car at that moment, because I know it's a final importance.

03:28:46.000 --> 03:28:55.000
And it is death, care, and Fiona has been referring to it to with many people in low resource settings don't have any access at all. Not at all.

03:28:55.000 --> 03:29:01.000
Now, when I'm reading the title, of Shots, scores and people inform me about this.

03:29:01.000 --> 03:29:06.000
Then I think wow! Great. Prehabitation for all, so that has become a reality.

03:29:06.000 --> 03:29:12.000
Fantastic paradise on Earth. Everything is available. Okay about this.

03:29:12.000 --> 03:29:15.000
You know I do a lot of ef elevations for all sorts of ironclos and Ncos, and the reality is very often very different.

03:29:15.000 --> 03:29:32.000
I'm going into the field. I'm standing with my feet in the mud, and that's very different from all the nice policy papers developed in i 3 towers in Geneva, in in Washington, in the hey?

03:29:32.000 --> 03:29:35.000
Can you name it?

03:29:35.000 --> 03:29:45.000
We have 2030, I think that's a great approach rehab as part of universal health coverage, but I see some ups, and I see some downs.

03:29:45.000 --> 03:29:50.000
I'm a bit afraid that the focus is too much on profits increasingly.

03:29:50.000 --> 03:29:58.000
Number of professionals, especially official therapist. Now as official therapist, I'm not saying this is not important.

03:29:58.000 --> 03:30:15.000
Yes, this is important. But that is the long term that's something we can achieve in a country like Sierra Leone, up with 800 fisher therapies working on a population. Of 8 and a half 1 million people that's something we are not going to achieve in the forthcoming future

03:30:15.000 --> 03:30:25.000
So I think, on the short term in the short run. I think we need to focus on alternative models in discussions with world health organization.

03:30:25.000 --> 03:30:44.000
They tell me. Don't worry. You know we are working on the basic rehabitation packets, and we are going to train doctors and nurses at the primary health care level in one week and 20??h online training and they are going to keep themselves busy with some essential elements of rehabitation

03:30:44.000 --> 03:30:49.000
I'm thinking. Okay, on top of all the other tasks that they are having.

03:30:49.000 --> 03:30:53.000
Think about a country like Nigeria, 220 million people?

03:30:53.000 --> 03:31:00.000
How many occupations do you have there? 20, I think how many official therapist? Okay, they are more lucky.

03:31:00.000 --> 03:31:03.000
They are more efficient therapist in that year. But what about the status?

03:31:03.000 --> 03:31:04.000

The condition of primary health care in Nigeria.

03:31:04.000 --> 03:31:11.000
It's usually not functioning. You don't find nurses.

03:31:11.000 --> 03:31:29.000
You are lucky if you find community health focus, and you were lucky if you find medicines in stock that and that, and 220 million people on the population in the African continent, or 1.2 billion people that's 20% is it really better in the other African countries yes, in some

03:31:29.000 --> 03:31:35.000
Other countries, like South Africa. It is better, but there are many countries where it is even worse than in Nigeria.

03:31:35.000 --> 03:31:44.000
So I'm a bit afraid. That's 330 is still having many challenges to overcome

03:31:44.000 --> 03:31:57.000
Now out of surface, Neliferie. I think it's so completely misplaced because it economically poured us 2 billion in this world have hardly any access to reapplication the rehabilitation serves in many countries.

03:31:57.000 --> 03:32:00.000
Are not well accessible, and if available, are limited to the happy.

03:32:00.000 --> 03:32:17.000
Fuel, living in urban areas, how to get it in the periphery, how to cut it in the rural areas in the mountains, in slums, and you name it the quality of rehabilitation is often very poor I will show you some pictures in the short moment, there disappointing results of the

03:32:17.000 --> 03:32:24.000
Poor interfaces, obviously, if you're poor expenses, what can you expect out of the pocket cost of such services?

03:32:24.000 --> 03:32:33.000
Are very high at people in the African continent, and the Asian continent, in order to catch services in order to get assistive defices.

03:32:33.000 --> 03:32:52.000
They have to pay it themselves, and there's lack of textualized training of therapist and sometimes shocked by seeing the critical of some universities in African countries, and I see old-fashioned outdated curricula which have been developed in the West many years ago, and I think it it this particular

03:32:52.000 --> 03:32:55.000
In my fuel have hardly any meaning for many African situations.

03:32:55.000 --> 03:33:18.000
I'm working a lot with Salem as chairman of Syracuse, Africa, and we try at the University of Poland to introduce a 3 week module focusing on cerebral palsy alone I'll be practical away from therapy and trying to

03:33:18.000 --> 03:33:21.000

Change mindsets of people, in terms of what approaches needed actually to deal actually with these large numbers of children.

03:33:21.000 --> 03:33:25.000
With cable policy to deal with the parents, to deal with the very few poorly trained Cb.

03:33:25.000 --> 03:33:36.000
R workers. Sailan is, for we going to tell a bit more about it.

03:33:36.000 --> 03:33:37.000
Strategic approaches are being used to narrow developmental conditions.

03:33:37.000 --> 03:34:00.000
You know how many times you know if a coming ghana in a contact in Buddha refugee camp variables last year, and I see children with cable policy being threeed by official terrorists, rains, of motion exercises in a child which is this kinetic and

03:34:00.000 --> 03:34:02.000
I'm surprised, and I ask the official therapist.

03:34:02.000 --> 03:34:10.000
But what are you doing? And why are you doing this? The lack of recognition of the immense influence of traditional health, of people don't forget, you know.

03:34:10.000 --> 03:34:11.000
Before people come to you as a faculty, at least they first go to a traditional doctor.

03:34:11.000 --> 03:34:15.000
They first call to a faith healer, and they spent a lot of money on it.

03:34:15.000 --> 03:34:32.000
So so make sure actually that you know what the context is before you pretend that you can make any meaningful difference actually in many African countries.

03:34:32.000 --> 03:34:42.000
Discourse at attention, and it's in line with the previous part of Scar's attention for cultural and religious ways of hearing, disease, disaster, and disability in the mindset of many people.

03:34:42.000 --> 03:34:48.000
It's still I call it the spiritual, the model, or the religious model.

03:34:48.000 --> 03:34:57.000
I'm having a disability, or I got a child with a disability because court is passing me. I did something wrong, and we give out therapy.

03:34:57.000 --> 03:35:04.000
This is needed. Of course I think we don't take care of that mindset of people.

03:35:04.000 --> 03:35:12.000
Now the situation in some countries is getting worse instead of getting better, and you know, I think I I call it these days.

03:35:12.000 --> 03:35:35.000
The 3 C's call for 19 at the tremendous effect on rehabilitation surface delivery extremely difficult circumstances this enablement to be developed for a line for the built a whole series of held out actually hand out should be given to parents on how how to deal with a child having

03:35:35.000 --> 03:35:43.000
Epilepsy how to deal with a child having difficulty eating because tip sheets you can find them on our website climate change.

03:35:43.000 --> 03:35:45.000
What is climate change doing actually in terms of the needs of people with disabilities.

03:35:45.000 --> 03:35:52.000
They are the first ones who are being affected, and then I'm even not thinking about conflict.

03:35:52.000 --> 03:35:56.000
You know it's incredible. Email I do a lot of work in my Omar access to rehabilitation.

03:35:56.000 --> 03:36:11.000
Serves in me, on my spiritually absent. I mentioned already we have twenty-thirty, so I'm not going to elaborate on that my velocity television in Ethiopia.

03:36:11.000 --> 03:36:22.000
No sorry, for he has been reading it. There was one therapist who, before I had the discussion, and I was saying: You know there is some.

03:36:22.000 --> 03:36:26.000
There's a cap between what people need and what is available.

03:36:26.000 --> 03:36:28.000
And this person was saying a gap. It's an ocean.

03:36:28.000 --> 03:36:34.000
It's an ocean in terms of what is needed. So where to start?

03:36:34.000 --> 03:36:37.000
Tell tell them tell us that's a supervision.

03:36:37.000 --> 03:36:41.000
Let's let's be realistic. Yeah.

03:36:41.000 --> 03:36:49.000
You all know the stars, methodology from the real health organization, I suppose so that's an assumption.

03:36:49.000 --> 03:36:57.000
I do realize the tool for the systematic assessment of rehabilitation, saturation in countries that's being widely used.

03:36:57.000 --> 03:37:00.000

I wrote that in Geneva as well. I was asking in Geneva how many stars do we need before we know what the situation is on the ground?

03:37:00.000 --> 03:37:02.000
Don't we know actually already what is on the ground?

03:37:02.000 --> 03:37:11.000
Why are our old, this resource being done? Let's start doing something.

03:37:11.000 --> 03:37:17.000
No! Just a quote from that report, and I think that tells us a lot at peripheral level.

03:37:17.000 --> 03:37:27.000
Rehabilitation is almost an available. I need to get rid of the photographs on my right side you always have difficulty reading in the public sector.

03:37:27.000 --> 03:37:32.000
There is no rehabilitation available at health. Centers entered primary healthcare Default.

03:37:32.000 --> 03:37:54.000
This State hospitals clearly like capacity for outpatient rehabilitation, and despite national Cpr program guidelines which are available in that country in Rwanda, little rehabilitation in the community is happening that's, the situation and then that's very happy

03:37:54.000 --> 03:38:03.000
With this recommendation made by this assessment establish an essential packets for the application at the prime.

03:38:03.000 --> 03:38:09.000
We have a level either through task sharing or with newly established free application personal.

03:38:09.000 --> 03:38:19.000
And I hope and I risk that we start believing again in the importance of an alternative rehabilitation personnel.

03:38:19.000 --> 03:38:23.000
Next to all you people who are official therapist and via some.

03:38:23.000 --> 03:38:32.000
Oh, please, in our myths as well, I think for the time being we really need also, and other category of people

03:38:32.000 --> 03:38:51.000
We are involved with the University of Melbourne with the Catholic Health Association in India in a program where the rehab is going to be rolled out, they are training there on and yearly basis annual basis 1,000 cbr workers then you were going to make a difference.

03:38:51.000 --> 03:39:07.000
And I'm very happy. That that is happening. Okay, the picture on your left side that's in me, on Mars and in mind and exit, and then victim from and mine, accident and I don't know the name of this this this guy and on your right site.

03:39:07.000 --> 03:39:15.000
You see also in blue a beautiful 12 year old girl. I will tell later a bit more about her

03:39:15.000 --> 03:39:19.000
Now? What what is needed to reach the unreached.

03:39:19.000 --> 03:39:24.000
And now I'm going to make that link. If the rehab the smartphone application of it.

03:39:24.000 --> 03:39:30.000
You see here the screenshot. I think we need top-down steering governments need to become in control.

03:39:30.000 --> 03:39:48.000
They need to be made. They they need to take the lead in developing a viable public rehabilitation system for all rehabilitation should be part of public services and should not be left to private enterprises to if not to I and Ceos, governments you're becoming control, and

03:39:48.000 --> 03:39:53.000
I think it should be a mixture of rehab, 2,030 plus cvr.

03:39:53.000 --> 03:39:55.000
I hope that one day I can still convince the little telephone.

03:39:55.000 --> 03:40:00.000
Organization to go back to Cbr. That's a bit better.

03:40:00.000 --> 03:40:05.000
I think we need at the same time a bottom-up development.

03:40:05.000 --> 03:40:14.000
So top down, steering and bottom up development. It's so development embedded in the community for people with disabilities in the economically poorest 2.

03:40:14.000 --> 03:40:34.000
1 billion and they and their families to the community and their families with people with disabilities and the families would benefit from acquiring basic knowledge and skills and assistive technology if it's they could make an easier life if they're important parent we need to empower people we need to empower people with

03:40:34.000 --> 03:40:38.000
Disabilities. They need to have information now in the react.

03:40:38.000 --> 03:40:43.000
The first idea for the rehab started with the book from David Werner.

03:40:43.000 --> 03:40:48.000
Disabled for the children. We felt it was outdated, and we said, You know we need to update it, and let's go for disabled for the children.

03:40:48.000 --> 03:40:53.000
2 point. 0. Now we had to get permission for that.

03:40:53.000 --> 03:40:54.000
And we we decided. Now let's let's not call that.

03:40:54.000 --> 03:41:20.000
That's a legal way to get permission. That's just start with a new name, and then the name rehabilitation applications start the way for or written originally what we had in mind is have 21 conditions disabling conditions and pro and develop information and make that information available to people with

03:41:20.000 --> 03:41:33.000
Disabilities and to field workers, simple information, accessible information, and preferably in many different languages.

03:41:33.000 --> 03:41:49.000
Now we did field, test it in different parts of the world, and it was a big desire from the field to add also an interactive component in which client information or patient information could be uploaded.

03:41:49.000 --> 03:42:03.000
So with the rehab, if if oh, well, if if certain levels of security, protection of client data, you can also get rid of all your pay.

03:42:03.000 --> 03:42:08.000
Performs, and you can actually upload your information from your assessment.

03:42:08.000 --> 03:42:13.000
The the it's a logical system before in the rehab continuously the Icf.

03:42:13.000 --> 03:42:16.000
In the different chapters, but also in the interactive part.

03:42:16.000 --> 03:42:19.000
And you can better make your goal set calls, decide actually about interventions, make your follow up.

03:42:19.000 --> 03:42:32.000
There's a calendar in it. And we are trying to connect it to.

03:42:32.000 --> 03:42:41.000
So to information systems of programs. So this is the the reap which is some offline a tool.

03:42:41.000 --> 03:42:47.000
So when you are online you can do call it, synchronize your your patient.

03:42:47.000 --> 03:42:52.000
That data from instance and upgrades you can single nice.

03:42:52.000 --> 03:43:00.000
But when you are in a remote area, vendor, where there is poor Internet connection, can still use the app.

03:43:00.000 --> 03:43:19.000
Take a country like Myanmar. 85% of the population in the Omar is having a smartphone, so it offers lots of opportunity actually and we see it as

a tool that can empower the masses on the right side of your screen you see actually what we call flesh

03:43:19.000 --> 03:43:27.000
Cards and a flesh cart is actually a a hard copy of a chapter out of the rehab.

03:43:27.000 --> 03:43:30.000
So the people would. Don't have smartphones, can copy actually the material on flashcards.

03:43:30.000 --> 03:43:36.000
We, we make them you know I'm calling on Sunday.

03:43:36.000 --> 03:43:48.000
I'm going to Ethiopia. I'm going to meet Ceylon, and we are going to give together a training, and I'm bringing a box with copies of the server policy chapter.

03:43:48.000 --> 03:43:54.000
Because the training is on server policy, and it's finale so it's it's sturdy.

03:43:54.000 --> 03:44:03.000
It can last for a long time. I'm not sure if it can last for a life, but for a very long time, and I I bring a few English copies but most of them are Amheric we value the importance.

03:44:03.000 --> 03:44:21.000
Of access to low to information through local languages, and currently we are, with teams of people trying to go for for for suffering languages.

03:44:21.000 --> 03:44:31.000
At this moment most of the material has been translated already in Spanish, in Portuguese, in France, so in the main European languages.

03:44:31.000 --> 03:44:42.000
But we have now material, favorable in Amharic Nepali, Vietnamese, Tachik, Kiswahili, a few few more.

03:44:42.000 --> 03:44:49.000
And that's you know. Months by months we try to increase actually the number of translations.

03:44:49.000 --> 03:44:51.000
The the smartphone app is currently having 14 chapters, and soon more chapters will be uploaded.

03:44:51.000 --> 03:45:09.000
So a total of 22 will be by the end. The number of chapters that we have now, when we talk about rehab also in the context of the rehab, I think it is about 3 invitation in broad sense taking the Icf.

03:45:09.000 --> 03:45:13.000
And the Cbr matrix as its conceptual framework. I read it.

03:45:13.000 --> 03:45:24.000

The Cbr matrix in this forum, and you see that empowerment is there in the middle, because I think empowerment is like the the basis of everything.

03:45:24.000 --> 03:45:32.000
It's it's it's not a domain in my fuel, but it is a principle that's a tool that will help field workers and professionals to do divert better.

03:45:32.000 --> 03:45:36.000
It's a tool that if informs and empowers people with disabilities.

03:45:36.000 --> 03:45:59.000
So it's not a narrow way of looking at disability and narrow quotation marks, and I hope that I'm not creating for by saying that narrow because Fisher therapy is not narrow but but in that our way, let me put it like that of house rehab is being

03:45:59.000 --> 03:46:10.000
Seen I'm going to go to a next slide, because I hope we have some time for discussion as well, Ken Rehab contributes to solving the needs of people with disabilities.

03:46:10.000 --> 03:46:18.000
I think that if information technology offers new opportunities also in the resource, I think we can reach the units better inform people.

03:46:18.000 --> 03:46:23.000
And this is a tool that truly can make a change in our fuels.

03:46:23.000 --> 03:46:37.000
We have embarking next year on a number of outcomes, studies to find out if the competencies or field workers are improving when they start using the rehab this is the fission of the rehab.

03:46:37.000 --> 03:46:39.000
Yeah and here is also I can maybe I'm not going to say something about this, because I probably take too much time.

03:46:39.000 --> 03:46:52.000
Then this is the goal of the reap. Field workers are well equipped to adequately respond to the needs of people.

03:46:52.000 --> 03:47:03.000
If disabilities and the families you see the objectives or rehab is integrated in the daily vertical field, because our field worker cannot do without the rehab anymore. That's.

03:47:03.000 --> 03:47:23.000
The idea behind it, or organizations involved in disability and development are strained and if announced competencies of their workforce, and people with disabilities are access to essential information about their own condition, objectives now here you'll see also sitting and I told you already the official therapist was

03:47:23.000 --> 03:47:27.000
Doing rains of motion exercises with Elsa also is having some hand function, sees a bright curl.

03:47:27.000 --> 03:47:32.000
She is not able to talk. Let's see, communicating at the moment.

03:47:32.000 --> 03:47:41.000
That you approach, or she starts immediately. I contacted her. The official therapist had never been thinking about.

03:47:41.000 --> 03:47:57.000
For instance, the importance of making a communication board that would have been far more important in my fuel than all these fisher therapeutic interventions, thinking about Elsa, 12 year old girl beautiful pearl in her puberty I was walking into the in the in the

03:47:57.000 --> 03:47:59.000
Refugee camp, and I didn't feel very safe.

03:47:59.000 --> 03:48:03.000
No what about Elsa? So think about child protection.

03:48:03.000 --> 03:48:08.000
Think about how she is able to take care of her personal needs when she starts menstrating and so on.

03:48:08.000 --> 03:48:16.000
So I think we need a far broader approach from Fisher to your past, working in low resource settings.

03:48:16.000 --> 03:48:37.000
We're sitting now this is a picture, and I show you here what is being done with. This and this is concerned by official hundreds of these small small pictures and

03:48:37.000 --> 03:48:40.000
If you know I I know how many, can you?

03:48:40.000 --> 03:48:41.000
So to tell you. Actually you know what they've done with this boy.

03:48:41.000 --> 03:48:46.000
It's actually your own useless rains of motion, exercise painful.

03:48:46.000 --> 03:48:58.000
It's harming it's torture at the setting in a very poor wheelchair, and and that's our only wheelchair which was available a few years ago.

03:48:58.000 --> 03:49:12.000
Now this picture I call yesterday from Malavia. Sailan has been a few weeks ago in Malavi, and he had kept on the training in a more functional approach towards staining children with Cerebral palsy.

03:49:12.000 --> 03:49:25.000
And this picture I cut from someone else. Salon even doesn't know this person, this person from whom I called it, and here you'll see a fisher therapist working with a child in a far more functional way I was so pleased to see?

03:49:25.000 --> 03:49:35.000

This picture. This is what is needed in my field here you see, Peter, Peter, in Cameroon was lying and rolling over to move to go from one place to another.

03:49:35.000 --> 03:49:41.000
Place with this wheelchair. He's sitting upright.

03:49:41.000 --> 03:49:45.000
He's got able to come out to school. He's able now to attend shorts.

03:49:45.000 --> 03:49:49.000
He's able to play. He's able to communicate.

03:49:49.000 --> 03:49:50.000
His life has changed dramatically, just by giving this wheelchair.

03:49:50.000 --> 03:49:57.000
That's the type of services that we meet

03:49:57.000 --> 03:49:59.000
Okay. I mentioned these things. I think already having information at your fingertips.

03:49:59.000 --> 03:50:09.000
Instead of happy books and manuals. That's the benefit of the smartphone easy updates.

03:50:09.000 --> 03:50:15.000
If every Internet connection, less paperwork, and we hope. And that's the challenge.

03:50:15.000 --> 03:50:26.000
For next year that we can make sure that the Rehab can company so with existing information systems, because then the reapp is for manages of some of importance.

03:50:26.000 --> 03:50:30.000
This is a start, but not yet the end. We continue working on it.

03:50:30.000 --> 03:50:37.000
We call continuously do field test. You're doing outcome studies next year, and we hope that we can get a Phd.

03:50:37.000 --> 03:50:38.000
Student who is interested to what doing in impact study and we are currently working on new aspects of the rehab.

03:50:38.000 --> 03:51:05.000
He developed a milestone tracker. That is a face in a better version, and soon as it will be uploaded we are working on chapter focusing on assistive technology and one on adaptive tools in agriculture because we see there's a big need to afford it now settings where the

03:51:05.000 --> 03:51:27.000
Rehab will be used now from San Diego, Napoleon to to Indonesia, Kelly, Monton, tool chats to. I've come now where this photograph was made to Bangladesh the the charge in Bangladesh in the in the big

03:51:27.000 --> 03:51:34.000
Jamuda refer to chat. So basically in many parts of the world.

03:51:34.000 --> 03:51:39.000
Thank you very much of 2 sealen

03:51:39.000 --> 03:51:42.000
Okay. Thanks. So much. Help. Yeah.

03:51:42.000 --> 03:51:45.000
I need to put that. I need to stop sharing Yup

03:51:45.000 --> 03:51:51.000
Yes, thank you so much. For participating this conference.

03:51:51.000 --> 03:52:09.000
I will start to sharing my screen

03:52:09.000 --> 03:52:23.000
Sorry

03:52:23.000 --> 03:52:24.000
Yeah, that's perfect. That's great.

03:52:24.000 --> 03:52:31.000
Okay. Can you see my screen? Okay. Perfect

03:52:31.000 --> 03:52:39.000
Okay. Thank you so much as mentioned by Hub. My focus of presentation will be on human resources.

03:52:39.000 --> 03:52:44.000
So I will share my experience, working at the University of Contra Cvr program.

03:52:44.000 --> 03:53:00.000
So the University of Congress. CIA. Program is one of the oldest Cdr programs you needopia which is operating in Fourth district as it in Gandhara since 2,005 for the last many years who have been working with many international partners including individual volunteers from abroad

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Angels and academic institutions. So since the focus of the conferences on resources for features working in low associating sounds, stopped by describing the role of physiology, obviously particularly in severe programs so as you know that physical therapist has a key role to play in Cv services

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Team. Believe the role of physiotherapes.

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The Ccb program should be to serve as resources person and coaches and mentors for the Cbr workers.

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So the challenges in Cvr program. So speaking from experience, there is a series scarcity of email resources and knowledge in many Cv.

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Programs in low settings in lower source ratings. Often there is not enough use with therapist, as mentioned many times, and as most pt curriculums in low in middle come countries are highly influenced by Western modes visual therapy.

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Professional education may not take cubes. There are business with appropriate knowledge in this case to work in a variety of settings, including Cvr.

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Another challenge is low. Professional involvement in Cpr. Programs.

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For example, in our program there has been no clear structure for physiology in that we have professionals to be involved within providing support for Cpr.

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Workers. As a result they're involvement in engagement.

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In this program is low and often Cdr workers or this middle level pre approximately, do not receive support from therapist.

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This might be due to lack of capacity structure in the awareness.

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So what? What? What is the solution? So I, as it's agreed by many a solution to this challenges license capacity building initiatives, so capacity, development programs, are highly needed to support the professionals and maximize the ruling to maximize their role in cpr programs.

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I by this I mean to develop the and other repetition professionals and the cube them with appropriate knowledge, and the kids to work in Cbs.

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So if that's the keys. What have the best approaches for K.

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Capacity, development. So from our experience we found out that more structured, continuous mentorship and supervision for local capacity development approaches are more helpful and sustainable.

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Time, for example, therapist. The same expenses from upload or high resource settings to provide short term ratings and services, because oftentimes expose just comes a predetermined idea same solutions about how to solve a problem or may only concept is a small group of

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People. So without the full involvement in input from the local therapist.

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Such programs are unlikely to reflect the needs and experiences of the recipients, and therefore are not sustainable in the in the long run.

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So, therefore I strongly believe that capacity, development, program, or initiatives anchored in context is key to supporting, visit their business in low resource settings so the key here is that capacity development, if it should be uncertainties this means that it does not just only entail offering a training, or

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Record a short term course, for example. But it should start with a sorrow understanding of the participants, realities, and the identification of knowledge and the skills they already process as well as the gaps in their knowledge and skill and from their activities can be created that provide participants with a new knowledge skip and understanding

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That become invaded in their daily work activities and in Hans a couple of the organization within the which they operate.

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So I would like to emphasize again that training initiatives should protest, prioritize the acquisition of competencies to call activities, mentorship and provision rather than acquisition of knowledge through short term lectures and seminars this also has the application in terms of effective usage of

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Resources. So what are the best practices in this capacity?

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Development, initiative. So it's very critical for capacity development to be aligned with local priorities, and you should be done with doing planning and coordination as otherwise it only be sustainable and capacity building requires creating trust which is very crucial and can be achieved by having a

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Clear, insured understanding of the purpose of the capacity, building, and also capacity, will linguistic time in long-term commitment to the process.

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And it's important to recognize as an artist short term activity.

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For example, with our CPU work. It's it's been ongoing.

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So the capacity building mentorship and coaching has been ongoing, and is not very short term activities very long, and it takes time in commitment so I would like to share examples of 2 capacity development things that youog so that focused on Cbr.

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The first one is Ug and Cpa. Partnership.

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So you have already heard about Cpa. So the University of Gondar is one of those oldest institutions in Ethiopia, and, as you know, subproblems, Africa is a Dutch charitable organization working in many countries, South Africa to improve the lives of children we serve both policy and current recipes

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collection with your gene implementing A/C Bar program for children.

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Recipiented families. So just to describe the structure of the project I'm working as a country representative for Cp.

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From your side, and supported by senior staff at Tcpa, with many self experience in working in Africa. So the motive Cpa follows in this program is as follows: so we initially had the training of trainers workshop organized by experts from cpn is a land for a

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group of therapist after that training constant in mentorship coaching is being provided by experts to the trainers.

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And now locally as a master trainer, I'm working with and providing, taking care of support for Cvr workers at Eugene.

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They update to the activities. So in addition, Cp.

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Is also working. To build Linux of local expertise who is and support other program in initiatives locally and regionally.

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So, for example, the Mallory example is one of the DC.

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One of the examples, and now we are currently expanding this model to involve more, said therapist to to increase their capacity, so that they can act as a resource person for the Cpr.

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Workers, so the second part example is ug. Increased.

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University partnership, so international center for the advancement of community-based repetition at Queens University in Canada is in collaboration with the Mastercard Foundation are working together.

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To, we, 2 are just an overall goal of creating a regional rehabilitation or center of excel, and sat emoji.

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So one of the outcomes of the partnership is the development of a new curriculum introduction of a new health profession group in the country which is occupational therapy.

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So the approach for this partnership has also been capacity, development, so to describe a little bit about the background so initially when this partnership was in initiated Ott wasn't part of the original proposal, but this become a key component in the partnership as you did want

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To be a regional lab for rehabilitation, and disabled in collusion.

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And function as the center of excellence in the rehabilitation.

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So the first approach that that was done was to train future faculty of the BCC.

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Ot. Program at Queens University in Canada. So a number of people have been trained in the masters of science in occupational data at Queens University in Canada, and during their studies most clinical placement is were held in different African contexts countries for more contextualized relevance

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Compared to being held in in Canada, and after that a co-creation approach was implemented in the development of the newt curriculum to bring the fishing into the country.

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So the first several workshops, information sessions, and consultation with government, interavitation, stakeholders, as well as a formal leads.

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Assessment. We speak with disabilities, their families and relevant community stakeholders to based identify priority needs support same services that may be based field Bytopian.

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We're all conducted. So the results from the community consultations and also aut curriculum benchmarking against other African contexts and the curriculum guide lens informed all decisions related to the format delivery and content of the

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Category. So in this process we can see that both partners, engagement process of cooperation by activity and effectively involving partner stakeholders and dataopian society, so that the undergraduate of the curriculum would not only meet the expected international standards but also reflect

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The Ethiopian realities. So both partners engage in the corporation process with clearing lines, operatings of communication among partners

in users and the community to foster understanding of differences, the values thread female priorities of each this has promoted from our experience mutual

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Learning, in grows by expanding the scope of possibilities beyond confessionally accepted standards and an addition mentorship supports from queens.

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To the new. Of these that's aligned with the goals of the the new.

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This has been provided. So this is what one example of a capacity, developmental sound got in in call text.

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So in conclusion, I would like to end my presentation with just 2 messages.

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So the first one is similar that there is a serious lack of copper.

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Still low end, resource limited settings in terms of post materials, and know-how, and but there is a strong need and will for collaboration that has, as I mentioned partnership in collaboration, should be uncurring call take us and focus on strangers and local capacity and as last I would like to

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Set you to take recent tutorial help, educate loin income countries to save their own priorities in solutions by my my colleague, Mr.

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Hub, in the Journal of disabled T Cvr. And inclusive development.

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So you can see the picture here so this informed my presentation.

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Thank you so much

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Thank you. Solemn. Yeah. Amazing. Thank you.

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Yes, yes, thank you. We are open to questions.

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Questions. Well, thank you so much. I think I think if you look at the chat as well, a lot of us are set up and sort of started again, paying a lot of attention to your your the way you've articulated some of these problems in the way that you've heard you showed your

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Advance knowledge and experience of working in this area. And, and, Zalam, you've brought to us.

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You know how it is feels to be in country and have things done around you, but not necessarily engaging you.

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Within it, and we've also got some Emily Emily and Senegal would really like to be in touch with you guys about some work that they're doing in Senegal She's in Senegal We've got Mario in Haiti and Sibyl in Saint Lucia who again

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Lots of people saying, Thank you so much for representing us as well in thinking about nothing about us without us, from crippers here as well.

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So, you know. Thank you so much. You certainly sort of embodied as well.

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What's why we want this conference to be globally.

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We want everybody from all over the world to be involved in it, and how we can not just sort of do unto and be part of that capacity building and groundwork.

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So thank you so much. There are so some certainly some questions.

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I I should imagine I'm so. Some of the questions just about how to access your rehab app, and is it free?

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And is it other other resources that you have on your website?

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That can be shared, and that are free for access, and which ones are not free.

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And how do we so you know, direct people to them

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The the rehab is is for free, so so people can just.

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I think, go to the cook hole or the apple store, and to download the rehab, and they can start playing with

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Okay.

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And then you need to cut a password and the special code PIN code.

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So this double protection on it, because I think it's a it should comply with European law in terms of privacy and currently the surfer is based in Germany.

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We we are talking now with some governments already about where the data should be placed in some countries for instance, in Ethiopia, the government doesn't allow to have a healthy late data being stored actually at the forum server so those are the hiccups.

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We still have to to discuss. But yes, the material is is free.

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Still free. You know we, if if the rehab is really going to be rolled out on a massive scale, then we need to start thinking about asking a small fee actually for maintenance offers the server and updating the app

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So through the app store. I think, is what you were saying for the app yeah.

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Absolutely. Yes. Yeah.

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Definitely and Mario who is in Hi T. Is saying, is it?

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Do you need Internet or can use it without Internet

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You have to download it on the Internet. But then you can use it without the Internet.

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That's the beauty of it is an offline system.

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So in if you, if you're in the most remote place, you can still at your patient data, you can actually access all your information about the different disabilities.

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So yeah, it's yeah.

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Oh, fine! Thank you! So I think again a lot of us sort of here who have an interest in working and supporting a falseative again.

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Set up and gone okay, capacity building is so important. How can we who do we who do we need to talk to?

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If we have a voice, how can we support, how can we?

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And for those in country who, you know also sort of been really motivated by your talk today.

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Who can they talk to? How can we I think, for use the word lobby? Who do we lobby?

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How do we make this happen for you? Who can we it, mobilize us

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So so is that an invitation to start working together with enablement and and

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I think you have plenty of people here plus that team that are all here for you absolutely

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I think I think that's that's great, because I I a.

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And A. And I'm also already referring to it that we try to build a pool actually of.

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I'm gonna say immediately of African trainers, because we, you know, although we see the importance of for instance, Western trainers going to to the African Continent, I'm calling.

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Myself as well, so so we am, I to say we should not do that, but I think we have.

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We really need to make sure. I see that the local African capacity is being built, and there are very good African therapists as well.

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So so we are looking for the cult birds in African countries and and develop a pool.

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But if you're interested to work with Cpa.

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Be welcome. Right to me. I'm the I'm still the chairman.

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Maybe for your information and enablement is a limited liability company.

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I'm at the end of my career. I hope to work for another year.

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If everything goes well in terms of health by that time I'm turning 67 end of next next year, beginning of 2024, and we are now trying to see if

he can merge enablement if cpa one plus one is 3 to together we are stronger and make one strong

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Foundation, called the foundation enablement, because you you'll refer to lobbyists, and that's how I got tricked by by you.

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Because we feel that we have something to say, and I saw that someone was saying.

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I think, I've got a name. But someone was saying, Yeah, but what you were saying, you know we are.

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We are saying for 30 years already

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That was that was Leslie who is big part of adapt as well.

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Yes.

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She's, you know, and I think a lot again. People that have been, you know, plugging away it like you have for a whole career that have been.

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Saying this for a long time. It's like lots of stuff.

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You kind of notice it, but unless everybody says it, or unless it's picked up higher, you can kind of know it, and you can note yourself.

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But then you just take that through your career, and you know, yeah, we need to be lobbying guys

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To to me. It's becoming high time that that's C.

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Be our mind that people are coming together. I can, and start forming a strong coalition, but we need to to to have the debate actually with organizations for developing the policy from within their I free to Tower with lots of theoretical backgrounds and i'm not saying that everything is

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wrong, but it's not always realistic, I would say

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And I think that at least answer another question here. How much will is there in lower resource communities who have no access to rehab and to implement Cbr.

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So understanding of it. How how much will is that to implement it

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I think there's a lot of interest in the in the rehab, and I think there's still a lot of interest in the field of Cbr.

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You know I I I I to actually about the topic exhibits I had to deal with in Geneva at it was because the the the the the leadership was concerned that Cpr.

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Is, we don't read so much anymore about Cbr. I'm the chief editor of the DC.

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Id journal, and my question is actually and my brief is actually to make sure that we start talking about this and that we are becoming yeah, that will be coming false in the debate.

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So I'm continuously trying to profile people and say, you know, come up with your ideas alright. Me!

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It's it's it's a hard Europe, I can tell you as well

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I'm sure of it. So again, another question: any thoughts about how we can better link the online resources to on the ground training.

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And I guess Ellen, this is also, for you, you know, for your you're in country.

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You're in there doing this and to further increase sustainable and high-level training.

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So online apps are really great and like we talked to the Icrc. And the other ones.

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You know the manuals are brilliant, but then we're reading a manual, and having you know, face to face training is very different.

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So any thoughts about that

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Yeah, it's really important. Yeah. But yeah. Should be continuous.

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And, as I said, and more structure to that is really important, having the tools and these online tools are and also trainings are very, very important

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Nice

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And can I as well in enablement? We had for a long time and we still have a discussion shoot.

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We next to the development of the rehab, start with e-learning training programs that are building up on the rehab.

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So when people need more information, or the tools, I think then they can call actually to the website and training in it, and and we do have already some materials developed here.

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We have a module on Cbr an online module developed for Cambodia.

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We founding from Kanye Toas, Germany, early vaulting, I saw her name also X, under the I've worked a lot with her about.

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This. So there are developments, but funding is very often an issue.

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We work on the show string, I can tell you. You know I'm we are a business.

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I'm not earning an awful amount of money, but that's that has never been. My!

04:12:49.000 --> 04:13:01.000
Intention. It's fashion and to trying to. Yeah, trying to to, to to make this world a little better in the in a small way

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I think we can all feel that from from the talk you've done, and and what you've spoken about.

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And Rollerly is here, and she's got a question she's I know from experience, many therapists not interest in working in the community.

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What can we do to change this, and how can we train therapists to become coaches and mentors for Cbr workers

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Yeah. Yeah, very, very good question. I I I think also that and implicitly was already referring to it.

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I think a new role for official therapies would be to play a role in coaching field workers supporting them.

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Train, yeah? And supporting also family members. You know fisher therapy should not have that white code, and that's stethoscope.

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I was a while ago I was in Bangladesh and fishery piece, and Bangladesh can even give medicine, so they're called. Doctors, and I was shocked actually to meet a young official therapist white coat stethoscope working with a child I ask her actually what's wrong with the child

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That, said the child's having a week back. I said, Okay, is that the diagnosis?

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Can I see the chance walking? I saw the child walking at the sock.

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Obvious and so you know I I could sometimes so discourage them when I see this, but I think we need fisher therapists.

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Who are not yeah, not too busy with themselves, but they see actually with people when they are surfing

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I think, and I think I'm rarely as person as well.

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Therapist come coaches. Maybe they'll be not so much white coats.

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I Iraqi as well, and I think and refunds, has a really good question.

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That might sort of sum up your talk and just thank you for such an important talk.

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Could the presenter summarize what they would say at the top 3 barriers, and their view to rehab for all in Lmc's

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It's sorry. Can you? You know? Yeah.

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Alright. I'll read that again for you. So could you summarize what you would say?

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Are the top 3 barriers in your view to rehab in low middle income countries all low resource settings.

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Say, love them. I think that only

04:15:03.000 --> 04:15:04.000
But I'm on the smoke.

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Yeah. Okay. Yeah, there are a lot of bodies. So as we say that we don't have enough.

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Enough number of databases, and also the quality, and also the I mean the economy challenges.

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So there are a lot of challenges for to achieve.

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We have for all in Lloyd, middle income country.

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So it all comes down to the resource. C. My resources and yeah.

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Okay, can I? At 1 point? Because you're already saying this in your question?

04:15:36.000 --> 04:15:58.000
I think your previous question how to get facial therapist working in the slums of the big cities, how to get them working actually in in the rural areas in the mountains, in in Nepal in the desert in in in in Botswana you don't find them so so we can talk

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For a long time about adding more efficiency.

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At least, you know, I think that's not the only solution.

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That's why I feel we should have a different workforce coming from those communities and train them.

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They are. They are not mobile, they are not going to move.

04:16:13.000 --> 04:16:16.000
How many Canadian therapists are working in the United Kingdom?

04:16:16.000 --> 04:16:19.000
How many Ethiopians are working in the United States.

04:16:19.000 --> 04:16:24.000
So give them a proper academic training, and they call for clean up posters, and they are gone.

04:16:24.000 --> 04:16:27.000
I'm not not. I'm not saying everyone, but but quite a number.

04:16:27.000 --> 04:16:31.000
You'll go, and I cannot blame them even. But

04:16:31.000 --> 04:16:41.000

I think, yeah, that was one of the things I'd written down is, how do you ensure if you go if you send someone to kind of just be trained that they come back and use the training in country and I guess it's another one of the barriers isn't it you know and actually having in country like

04:16:41.000 --> 04:16:47.000
Zellerm, like you're doing like building capacity in country, from people in country training, people in country.

04:16:47.000 --> 04:16:53.000
And you understand the the cultural changes. You understand the language you understand, and all the things that you know.

04:16:53.000 --> 04:16:56.000
We've talked about again all morning. But how do we embed it?

04:16:56.000 --> 04:16:57.000
Grassroots that we need. You guys, don't we?

04:16:57.000 --> 04:17:03.000
We need you guys and we need we all need to be empowering each other to to sort of get this message out.

04:17:03.000 --> 04:17:10.000
Thank you so much. Thank you.

04:17:10.000 --> 04:17:14.000
Yeah. Thank you so much.

04:17:14.000 --> 04:17:22.000
I think this discussion from what I've seen in the chat box, and what's going on between the adapt committee needs so much attention.

04:17:22.000 --> 04:17:29.000
And we are a big group here listening to you today who really do want to see this put forward.

04:17:29.000 --> 04:17:41.000
So I think that's keep in touch about it, and if you can, can guide us from here, we can forward this on to the participants on on what we can do.

04:17:41.000 --> 04:17:51.000
To as I say, help lobby, help! Push this forwards, and just keep the keep it moving forward and and keep hope as well, because there is progression and there, has been huge.

04:17:51.000 --> 04:17:54.000
Leaps and forwards globally over the decades, and we just need to keep pushing for that, and not get burnt out and not get tired of it.

04:17:54.000 --> 04:18:03.000
So let's keep our hope and and and keep going with it.

04:18:03.000 --> 04:18:04.000
Thank you both so much it's such an important subject.

04:18:04.000 --> 04:18:12.000

We look forward hearing you both talk more, I hope, in the future I think it's probably good to get away from the screens again.

04:18:12.000 --> 04:18:20.000
Now, and we have a lunch break coming up for everybody which is going on, and I think, until 1 50.

04:18:20.000 --> 04:18:25.000
So there's about half an hour a lunch break, and then I'm going to hand over to Alice.

04:18:25.000 --> 04:18:34.000
Will be taking over the introductions to the our speakers from there.

04:18:34.000 --> 04:18:38.000
So. Thank you very much, everybody. Please keep the chat coming in any comments.

04:18:38.000 --> 04:18:56.000
Any resources, any thoughts that all so welcome, so useful and so please keep them coming in during lunch, and after thanks so much, and see you all in half an hour

04:18:56.000 --> 04:18:59.000
That's great, and right. So you've just joined.

04:18:59.000 --> 04:19:09.000
Jump to share anything before we just stop for lunch, or be happy to just hide and come back

04:19:09.000 --> 04:19:10.000
Okay.

04:19:10.000 --> 04:19:11.000
Hi! Hi!

04:19:11.000 --> 04:19:12.000
I know you're on my head as well. So just checking you on the time right

04:19:12.000 --> 04:19:13.000
Hi! I'm

04:19:13.000 --> 04:19:19.000
I know I've been panicking all day thinking I'm I always get it the wrong way, around, which is very straightforward.

04:19:19.000 --> 04:19:21.000
But anyway, so no, I'm here, and I don't.

04:19:21.000 --> 04:19:24.000
I don't think I need to share anything else. Share my screen

04:19:24.000 --> 04:19:27.000
Okay. That's fine. Be too much. We've been gonna get lunch.

04:19:27.000 --> 04:19:28.000
Are you happy to

04:19:28.000 --> 04:19:30.000
Yeah, definitely. No, no, I'm I'm gonna go and have my lunch, too.

04:19:30.000 --> 04:19:31.000
I just wanted to make sure I was here and

04:19:31.000 --> 04:19:36.000
Yeah, yeah like: that's what we'll need everything running, because otherwise it just this calls chaos.

04:19:36.000 --> 04:19:40.000
If we stopping. But yes, you need everything running. We'll just put everything on, you know, meet and close videos.

04:19:40.000 --> 04:19:41.000
And then yeah, lovely thanks, everybody.

04:19:41.000 --> 04:19:45.000
Yeah, perfect. I'll do the same. Yeah, okay, bye.

04:19:45.000 --> 04:19:52.000
I know it's great to meet you after all our chats by by by technology.

04:19:52.000 --> 04:19:53.000
Yeah. Thank you for coming along today and for sorting out your your daughters off the contest appointment.

04:19:53.000 --> 04:19:54.000
Yeah. Yeah. Thank you.

04:19:54.000 --> 04:19:57.000
Oh no, I'm really sorry. I even asked yeah.

04:19:57.000 --> 04:19:58.000
That was no, no, absolutely ask. It was yeah, completely

04:19:58.000 --> 04:20:04.000
Sometimes as as lots of people juggling, too, from the end.

04:20:04.000 --> 04:20:14.000
Whatnot: yeah.

04:20:14.000 --> 04:20:15.000
Okay.

04:20:15.000 --> 04:20:16.000
You can just see my right screen. You break.

04:20:16.000 --> 04:20:17.000
Yes, we do. Yeah, excellent. Alright.

04:20:17.000 --> 04:20:47.000
Have you got the screen out now cool. Okay, yeah, everyone will be happy to go on top of that

04:47:05.000 --> 04:47:06.000
Okay. We'll just give it the final minute, Emma, and then we'll get going.

04:47:06.000 --> 04:47:36.000
Assume that people are there

04:47:48.000 --> 04:47:59.000
Great! So welcome back from lunch. Everybody hope you've had a little break from the screen, and as either as a rehabilitation for physiotherapy occupational therapy professionals.

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I hope you've moved a little bit as we all know that.

04:48:00.000 --> 04:48:06.000
's so important for us anyway. Delighted to be carrying on this afternoon.

04:48:06.000 --> 04:48:12.000
So we've Emma, Tebet has very kindly joined us from who so?

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Emma has been a technical officer at the who in the W. H. O.

04:48:17.000 --> 04:48:32.000
Assistive technology team in particular. Hasn't December since about 2,015 and she's responsible for coordinating the teams work in relation to sort of workforce and and service delivery and this includes the development of our sort of normative guidance

04:48:32.000 --> 04:48:48.000
And practice tools, such as the training and assistive products, as well as supporting countries, to improve access to assistive technology and as a physiotherapist by background and she's been a member of that for well over 15 years along with many of us and Emma.

04:48:48.000 --> 04:49:03.000
We know you've published some papers, and and if you know, was recommending to our members, I think one of your recently published papers of training the sort of mid-level rehabilitation workers at a community-based Cpr based programs or something recently so we'll

04:49:03.000 --> 04:49:07.000
Try and link people to a few of those as well, which I think fits with some of what Hub was saying.

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Maybe before before lunch anyway, we're delighted for you to be presenting and letting us know what?

04:49:08.000 --> 04:49:17.000
Who are doing at the moment

04:49:17.000 --> 04:49:21.000
Thanks. Thanks, Alice. Thanks. Adopt team it's yeah.

04:49:21.000 --> 04:49:24.000
Really lovely to be here, and I feel like it's coming full circle.

04:49:24.000 --> 04:49:34.000

Having benefited so much from adapt study, days, and support and resources over the years, so really happy to be here.

04:49:34.000 --> 04:49:45.000
I am going to share my screen

04:49:45.000 --> 04:49:49.000
Sec

04:49:49.000 --> 04:49:50.000
Stop!

04:49:50.000 --> 04:49:53.000
Yeah, that looks good looks perfect

04:49:53.000 --> 04:50:00.000
Excuse me if I'm looking left sometimes I'm just just checking my notes on on my left, so

04:50:00.000 --> 04:50:05.000
I think. We can hear you? There might just been a moment where you had to jump for something of your mic, so

04:50:05.000 --> 04:50:06.000
Okay, let me know if if my sound is not good.

04:50:06.000 --> 04:50:10.000
Yeah. No they will let you let you know. I'll wait at you or something.

04:50:10.000 --> 04:50:11.000
If yeah sounds good sounds good at the moment.

04:50:11.000 --> 04:50:15.000
- I I can't see you now. I know.

04:50:15.000 --> 04:50:16.000
Just give me a sec

04:50:16.000 --> 04:50:18.000
I'll I'll call out that if there's a problem

04:50:18.000 --> 04:50:19.000
Oh, no, I can see you okay. Perfect right? Let's go so.

04:50:19.000 --> 04:50:48.000
Yes, I'm going to focus. Today's the time today on training in assistive products which is our newly available online learning resource and just go into a bit of detail on that for people who aren't familiar and it's nice to be here today as well, actually with

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colleagues from Hi and Icrc.

04:50:51.000 --> 04:50:57.000
And Physiopia, who have all contributed in different ways to the development of tap.

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Amongst lots of other lots of other contributors. And yeah, if there's anyone here today who has been involved in tap development, let us know in the chat, it'd be really nice to to hear from you as well so i'm going to spend the time this is the overview of the

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session so very briefly to set the scene and talk about what assistive products are very brief background.

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But sort of context for this resource, and then spend most of the time talking about what tap actually is.

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So it's objectives and target audience. The content how it's presented, how it's delivered resources for what we call coordinators, and I can touch on the module development process for people if if there's time.

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At the end and give you a tour of the of the platform.

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Itself right? So what is assistive technology and assistive products.

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So I'm going to start with assistive products which often called assisted devices.

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Technical aids, helping aids. So any any devices which maintain or improve somebody's functioning and independence and promote well-being.

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So examples that we'll all be familiar with our hearing aids, wheelchairs, and glasses, prostheses, pill organizers, memory aids, for example, an assistive technology is who defines as the application of organized knowledge I'm skills related to the products but including the systems and

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The services. So we talk about assistive technology as the whole ecosystem that's needed in order to make sure somebody gets their assistive product and can make best use of it.

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Rather than just, it being distributed with no services, and assisted products, make up one of 4 groups of health products, and so by health products.

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They need medical devices, medicines and diagnostics.

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For example, and the reason that I've put the little sustainable Development goals diagram here with goal 3 for health at the center is because health products are a very important fundamental component of ensuring good health and well-being and a part of universal health coverage so I

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Think the the framing of tap is very much within achievement of goal 3 and an important part of universal health coverage, and I think talking today to a rehab audience.

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You all will very much appreciate assisted products as part of rehab services and providing corruption, toilet chairs, for example.

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But what we often don't think about as rehab providers is the broader application of assisted products across other services, as well such as vision services, such as diabetic services.

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So somebody with diabetes first needs their diagnostic to identify that they've got diabetes.

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Then they need their medicines to control their blood, sugar, and they're likely to need assistive products to manage the complications of diabetes.

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Unfortunately, so it's a whole package. Yeah. So that's that's sort of where where we're our framing of assisted products.

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Why is tat relevant to you? What's it got to do with you?

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So in a nutshell, it's an open access online training tool to support countries to build health, workforce capacity to provide simple products at community and primary health care level.

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And I think there are 2 ways that it might be helpful to, and the people here today.

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First, as a teaching or training resource in your work. Often as as rehab workforce, we have a role in in training and teaching colleagues in service, training training mid-level cards like Cbr workers or rehab assistants or maybe there are people here.

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Working in, on, bachelors or masters programs where there might be an element of delivering content and curriculum on assistive technology so I think tap could be a really helpful resource for you, in that role but also I think I we hope that it could be useful to you

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To also add competencies to your own skills, and I think many of us when we work outside of a high-income country health system, do not have the luxury of working in a multidisciplinary team and we often have to wear lots of haps and take on physio.

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Ot speech therapy even roles as one person, and so I think, for the physios out there you will find content, which you might think is more traditionally comes under oath which you you might find useful and and vice versa, and we'll we'll come to that in

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More detail in a little while.

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So I just I just want to quickly on this slide.

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Explain where tap fits into who's overall work on 80.

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So the work on 80 supports a systematic approach to strengthening access to 80.

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That is framed by what we call fivep. So we have people at the center, and we hope that we're advocating for people centered provision.

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But then the other elements of the ecosystem which all need to be in place are access to quality, affordable products, provision or services with trained personnel and policy frameworks that support people and on the who website you can find more information about the other resources and tools that we have available to support

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strengthening access to 80 in those areas where obviously tap focuses on the the provider and the personnel piece and tap supports the implementation of whs priority assisted products list which for people who aren't aware already is a list of 50 assisted products similar to the

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essential medicines list which many countries are now starting to use as a model to develop their own national lists, and is often a first step to start embedding assistive products into policy and programming at a country level

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So on to tap. I hope I'm not talking too fast.

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No. Okay. So I've already said it. It's to increase access to 80 at a primary health care level, and within that we've got 2 overarching objectives.

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So firstly, to equip the primary health care, level personnel with the knowledge and skills to provide assistive products.

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But then a second objective to equip the broader workforce, to recognize who may Need referral into 80 services, and of course that's super important, because you can set up a new service, but if there's not good

awareness in the community, about not only the service, but who might need the service, then then

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You might miss miss a lot of people who who could benefit from that service

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This slide shows where tap fits into the whole service.

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Delivery, system, so here we've got a a typical triangle showing primary secondary tertiary services, and tap is really focusing on the bottom layer.

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But really to make the point that the problem that have been selected are those that are are simple.

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Some people don't like the word simple or basic, but simple in terms of their service delivery and and there's also a focus within the training on flagging and being able to identify who may need referring into secondary or tertiary services for for related problems or for more products

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Which would need provision by specialist providers, such as prosthetics and orthotics.

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So it. It very much builds in that that referral and kind of red flag safety net. So that we we've got that's that's that's safeguarding in place

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So that the the sort of primary target learners for tap are primary health care personnel likely to be based in a health facility and in a position to provide assistive products.

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For example, nurses or nursing assistants, but could be Cbr.

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Rehab workforce as well, and also pharmacy, workforce.

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So we've we've in in the countries where we've implemented tap.

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So far we've had people people involved from all of those all of those professions, all of whom have have found the modules relevant, and useful, to them.

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And then, as I said before, the second is the broader workforce who will identify and refer into the services.

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For example, people who are doing door door visits for health, promotion, etc.

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Or Community, Cpr. I've forgotten the word now, but the people who mobilize their communities in Cbr.

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Programs, and as I mentioned at the beginning, tap can also be useful to educators.

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Managers, policymakers, and there's quite a bit of content that that actually people who use assistive devices themselves can find helpful

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And so the the content itself is organized by 4 steps of service delivery.

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So so we've organized these steps as first. Select.

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So, selecting the most appropriate product for the person which to the rehab professionals amongst you will probably cover assessment and screening prescription.

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Would all come under that that number one select number 2 fitting so adjusting and fitting the product suit the person, and depending on the product, there might be quite a large fitting element and for some products, that there's not much fitting that's needed thirdly, teaching the person how to use

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And take care of their product, very important, and then finally follow up.

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So reviewing their needs, reassessing, for example, but also maintenance and repairs, and I think we found so far that it's been very helpful to really strongly embed the maintenance and repair follow-up part into this 4 steps as that's that's a step which very

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Frequently doesn't happen, gets ignored and is a big big reason for people abandoning their their assisted products or or sort of not not really making the best use of them.

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The content covers just the right amount of information to do knowledge and skills to carry out these steps safely, and local trainers can add additional training to adapt and and extend the training as as appropriate to their setting

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So the design you'll see soon is on a website and it's blended learning so there's the online component followed by clinical skills practice.

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The modules are interactive and include text in plain English, so by plain English I mean quite simple.

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I think the reading age is approximately age 12, when we've done tests.

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There are illustrations. There are lots of case studies with character examples, and we've we've worked hard to make sure they're very globally representative, and also across children adults.

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Older people. There are questions and activities there are videos and there's also a discussion for him.

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There are pre and post module quizzes, and if the learner gets 60% or more in their post module quiz, they then get to download the all-important certificate with their name on it there are supporting documents for downloading in pdf

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Format which I'll talk about in a little more detail in a moment, and there's also guidance and resources, for in-country implementers or coordinators as well as clinical mentors, and we'll talk about them a little bit more in a minute

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So implementation and mentored practice. So the the blended part we feel is very important, and and we've put plenty of on the platform to support in country teams with that with the face-to-face learning that's needed to consolidate knowledge and skills

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And and we're really actively trying to advocate for tap to be implemented within systems, and it's open access.

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People are welcome to use it as they like, but we have lots of content, really trying to support and promote, promote that.

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So you'll see a bit more when I give you a tour of the website, but there are resources for the managers or implementers, for example, a planning template for delivering tap training setting up new services and thinking about all those all the elements that are needed for that there are resources for the

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Clinical mentors, including tools for assessing competence.

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And and evaluating whether people are ready to practice independently.

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And then there are tools to support service. Delivery itself, such as screening and assessment forms and tables to help with a selection of the best assisted product for for an individual

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So the the in-country mentors, who who would they be?

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So they would be healthcare personnel with proven experience in the module content area.

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And who can? Who have the availability to take on a mentoring role?

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And and these these people are absolutely integral to the success of Tab in the next slide.

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I'm going to give some more details on on on the journey to competency, as we call it, but in our in our implementing, so far the mentors have been from different professions, including physios Otis but also nurses, and they they don't necessarily need to

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Have experience in assisted products, provision before. If it's an area that is still related to their work.

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So we found that if if the're quite a senior person within the health system and they're used to delivering training and supervising people, then that they can quite quickly take the tap modules themselves get themselves up to speed to be able to then support the the people

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Who will end up being a service providers who are likely to be a sort of next level down in in Cadre

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So this slide shows the sort of typical journey to competency that we have feel tested and and found works really well.

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So there are 3 stages, for on the on the road to being competent and and being able to practice independently.

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So first the the learners take the online modules.

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So self-paced, which they could do at home in their own time.

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But in lots of settings we found people actually like coming together in a group and sitting together in a training space, doing the online content either on individual devices or sometimes on a shared screen and

for a lot of primary health care workers that's been it that they've preferred that sometimes because of

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Connectivity issues, but also because of lack of protective study, time outside of work, so they're juggling busy families and and actually we all know we've got been straight and we've meant to have done the pre-reading. And we haven't done.

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It so sometimes it's helpful. You know that all your learners are in one place they've all taken the modules together, and as and and it also means that you can make the learning a bit more interactive by pausing the modules and making some of the online activities using them

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As face-to-face activities.

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So next after the online part is some face-to-face learning which is run by the mentors so that they can add some contextualization to to the content for their setting and start building the skills aspect so I've got some examples here.

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Such as talking about referral pathways, so that when you identify that somebody has a foot also, for example, where do you refer that person to?

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And then also role, play practice. So practicing doing, screening, practicing assessments, practicing, fitting, for example, adjusting elbow crutches, and then also becoming familiar with the assisted products that are that are going to be available for you to provide in your service, and then

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Thirdly, the the learners go off back to their workplace, and they start practicing, and the mentors ideally are available for a 3 to 6 month period, to support the learners, as if they've got questions but also to carry out visits, and and check their competence

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So onto the modules themselves. So Taps got a modular structure which is in 3 layers, and we've got the first, and there's a a graphic here showing the module structure with lots of green and yellow smiley faces on it so I should first explain that

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The green, smiley faces are the modules that are already on the platform and available, and have been field tested and and are ready to use the yellow, Smiley faces are modules that are nearly there and will be on the platform within, the next 6 months and you will see that there

05:12:10.000 --> 05:12:30.000
Are 3 functioning streams that have no smiley faces on yet, so we haven't started developing modules for hearing communication or cognition, and we're hoping to start the cognition and hearing in 2,023 and if possible, the communication as well, depending

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On are the capacity of our small team. So we have one overarching module across the whole of the program, which is an an introductory module to assistive products, and then the next layer we have introductions to each functioning area and then we have our

05:12:55.000 --> 05:13:17.000
Product modules which focus on the 4 steps of service delivery, and the so when I talked before about some modules being tap being relevant for wider health workforce to sensitize them to be aware of referring into health services then the first 2 layers would be

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Relevant to those to that group, and then obviously the service providers would take the product modules themselves.

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So people can take any modules. They like.

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It's not that that's up to people to tailor depending on their own needs and priorities, but we do recommend people go through the modules through the Las.

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So if you wanted to take the walking Aids module, you would start with introduction to assistive products, followed by the mobility introduction, and then the walking aids module and you'll see on the side the little link to the w-h-o wheelchair service training packages, and I just

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Want to give a shout out to them, because they're another fantastic resource that's available for for everyone to use.

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They are in Pdf format, and can be downloaded from the Who.

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Website and I think you'll be getting the link in the chat.

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They. The title is Wheelchair Service Training Packages, and with a focus on less resource settings.

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But they are. They teach the principles of seating and wheelchair provision which is relevant to people working in all set of things.

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I know when I used to work in the Uk Health Service that I found them.

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They found them highly useful, and in my training as a physio.

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That that was a that was a real gap in my training, and the so the the yeah I can't.

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I can't recommend them highly enough

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And so just briefly now to go into the tap content, and what's it?

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What the modules cover. So the first module introduction to assistive products covers what they are, how they can support people across the 6 areas.

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Vision, hearing, communication, etc. What type of people need assistive products, and it gives an introduction to the 4 steps of service provision.

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Then you get into the second layer, and each module gives a more in-depth introduction to the types of assisted products within that stream, and how they support people, and they also include some simple screening tools, to help to identify if a person may need an assistive product so we've

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Put vision, screening here as an example, but also in them mobility, module.

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There's a foot screen to carry out a simple foot screen to identify.

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If somebody may have at-risk feet and benefit from therapeutic footwear, if they have reduced sensation because of diabetes, or for any other reason, and then also what actions to take with those findings, and then the product modules, as I said are

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Teaching the how to provide the product. Following the 4 steps

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There's some important considerations for country implementation to go with.

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Tap, so I think so far we've really focused on the training and mentoring another very important consideration is the assisted products.

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So the supply of products, the quality of the products, stock, management, and storage of the products, and then also the facilities.

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Are they set up for providing assistive, put so clinical space space for user training privacy, particularly for monoles, such as incontinence

products, and then referral networks and service provision which I've already talked about and the all-important monitoring and

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Evaluation. And so we've been doing some work to try and develop some digital ways of collecting data on the service delivery.

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So? Who who the products are being provided to what sizes, etc.

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But but we don't have any tools available to support that at the moment.

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So I'm just going to the out of the presentation into the tap. Website.

05:17:54.000 --> 05:18:01.000
Hey!

05:18:01.000 --> 05:18:02.000
Alice, please let me know if it's keeping up

05:18:02.000 --> 05:18:11.000
Right. Stop this screen share, and then maybe do another.

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Oh! Is it not

05:18:12.000 --> 05:18:13.000
I think, and then they ask them up. Yeah, no, that has come up. That's good

05:18:13.000 --> 05:18:17.000
It? Is it? That? Okay?

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Great. So this is the website up here in the right hand corner is I'm already logged in but sorry.

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There there would be a registration and login button here.

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So when you first visit the website, you would need to register an account, and then you will be sent an activation email and then you would need to log in.

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We found that some people aren't getting the links, so you need to check your spam and if you're still not getting the link, then please email us because we do don't want people to face that barrier and then down the bottom of use I used saying let me just move that out of the

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Way sorry so down.

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And we can see it. Yeah, perfect.

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Down here, can you see? I don't know. Can you see my rooms?

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Yep. Yep. Yeah, we can see? It yep.

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Yeah. Yeah. So down here there's a button with English and the Uk flag.

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So if we click on that we can see all the languages.

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That tap is currently available in not all the modules are available in all the languages, but we're working to do more translations.

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As we as we go and we're hoping to add more languages next year as well.

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So currently we have Swahili, Ukrainian, Georgian, Chinese, Portuguese, French, Spanish, Arabic, Russian, and English.

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So we we're on the homepage now.

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So this just gives you some introductory information, and across the top here we have the homepage about page using tap modules.

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Videos coordinators. So I'm going to go into the about page.

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And this page gives you an overview. Of what tap is about, as you would expect who it's for a little bit on accessibility.

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The development process. It's you'll find the contributors on this page, and also importantly the copyright and disclaimer.

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And so it is available under a creative commons license, and that means that it's freely available to use and reproduce, and you may also adapt the content as well but if you're interested in using reproducing adapting.

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The content. Then do read this page because it gives a bit more information on the the sort of cave apps around that, particularly if you're adapting to please remove the who look so now we go to using tap.

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And we have some videos to teach you how to navigate around on the website and actually all of these pages are available without needing to register for an account, and it so gives you a little bit of an overview.

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A bit like I have done today and tells you about the certificates.

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So next we're going to go to modules

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And we have the full list of available modules on this page, organized under the functioning streams.

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You'll see wheelchairs in emergencies, but that I can see that that you won't be able to access that at the moment, because it's still being field tested for Ukraine so I'm going to go into the walking Aids module to show

05:22:07.000 --> 05:22:08.000
You how the modules to look. So this is the landing page of the module.

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It tells me here what resources I will need, and there are some documents that I can download and print.

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So a list of keywords or definitions. Key messages is a very top-level summary of the module content, for for sort of quick reference, and then there's an assessment and selection form there's a discussion for him where you can post questions

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And comments, and then we have the module lessons. So, as you can see, we've got the 4 steps here, and I'm gonna go into fit

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So we have under fit. We have some topics, so let's go into getting ready.

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So for all the physios here, this will be very familiar to you.

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This is now going through what we're gonna do. If we're gonna fit.

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Someone with a walking aid, so explaining how they should be standing with their shoulders relaxed, and talking about the hand grip being level with the person's wrist.

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If we carry on.

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We'll now come to Kret fit for a walking stick, and here's a nice example of how the case studies are used.

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So we've got a lady here who's had a stroke and a little case study box followed by a video.

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And I'm going to carry on scrolling down.

05:23:49.000 --> 05:24:13.000
So we've now got elbow crutches, and we have a series of video tutorials which I'm gonna play with no sound and carry on talking so through the product modules we have videos like this one which are filmed in a studio with a

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new neutral background, with people in whoosh! Ships from all around the world, and they are mostly videos showing particular aspects of either assessment, screening, fitting, and user training and they've all been made without any voice over or words apart from the in introductory introducing

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the people at the beginning, so they do hopefully be accessible to people regardless of what language they speak.

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They are also all available through the video button at the top of the platform for quick access so you don't need to go back into the modules and try and remember well where was that video and we hope these videos will also be helpful to people to people who use assistive products

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Themselves, to help them to get best use out of their product.

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So

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I think this one we're done with us. Good right?

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So that's that's an example of the content.

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Here's the content also showing you how we have questions and activities presented in these yellow boxes, and then you can click and you see the answer within the box, so I'm going to show you now the video.

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Page. So this is where we've got our sort of repository of videos so we can click and and access all of the video links very quickly.

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Here, and as well as the video tutorials.

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We have another type of video which are mostly in the introductory modules which are showing people in real life settings, and really what their assisted products mean to them, and how they help them to go about their daily lives and those are really nice videos if you're doing any advocacy or

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Awareness, raising.

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So the coordinators page we we we we've tried calling this page lots of different things, coordinators, implementers, project managers.

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But this is the page. If you're going to use tap to run, training, and this has got a wealth of resources to help you to do that.

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So it we have a template for making a project plan.

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Some resources for preparing tap training including checklists of the sort of resources you need for a training room and delivering face-to-face training and a list of all the funds and documents that you might need to print for your training and then some background information on tap

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More details on how to make a project plan with a list of all that types of information you might need.

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So the outcome that you're aiming for the stakeholders and their roles, the who the learners will be and identify what what health facilities they might be coming from and and so on and and we have here you can see more information on all of those so these

05:27:55.000 --> 05:28:22.000
These menus open up, and we are planning next year to make a principal sort of manual of all of this content, so that people can download and have sort of in one book a manual of how to how to use and and deliver tap and set up services alright

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I'm gonna go out of this page now and back into

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Yeah, that's good. You just need to flick through your slides quickly. I think

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Next 3, bye

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Yeah, am I? Gonna I'm really sorry. I'm gonna have to.

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Yeah. Okay. Right? So just for people who'd like to know how the modules are developed.

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We, we, it's the the development led by someone from our team.

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But with support from experts in the content, and the context tap will be used.

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So we start by doing some desktop research to see what existing training content there might be available on on the on the assistive product.

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We develop a product description. So that we're very clear about.

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What are we talking? About we talk about walking aids you know what's included what's not so for the walking aids module for example, we decided to exclude rear pediatric rear walkers or caywalkers because we decided that they were beyond the scope of

05:29:40.000 --> 05:30:03.000
Tap. Then we, as is typical for online learning, we developed a content map with a task analysis and then we develop something called an instructional design plan, and we develop all the illustrations and videos it gets uploaded onto the tap platform we identify external reviewers to

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From from different settings and different expertise, and and then we revise the content based on feedback.

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And then we you deliver the content in with one of the country implementations, and and we because it's online the lovely thing is that we can carry on updating and upgrading the content based on feedback so would be really thrilled we're always thrilled to have more

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Reviewers. So if anyone here today would be interested in reviewing future tap modules, or even field testing modules that are in development.

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Do do get in touch with us would be. We'd be pleased to hear from you

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And last slide, just to say a bit more about the country implementation.

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So far before the launch tap had been used to train 400 people in 11 countries since the first pilot in 2,017.

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The content is available in 10 languages, and since the tenth of November we've had over 500 people register on the platform and take part in the massive open online course which ran for 2 weeks, and finished yesterday but it's now available it's live and you're welcome

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To to go and take the modules and share the the website link with with other people, and this a few links here which I think are going to be in

the Chat if they're not already, if you're not familiar with wha's, work on assistive technology and you'd like.

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To follow follow the work, and also discussion on 80 in general.

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There's a discussion Forum called the Gate Community, and you can sign up to that to receive email notifications and discussions and post discussions yourself as well.

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So you can ask questions there of the community. You can share resources.

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You'll you'll often see calls for funding opportunities for jobs and funding opportunities as well, and that's the link with the which is called mednet communities at the bottom of this slide okay, so I'm gonna stop sharing my screen and hopefully there's a bit of time.

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Left for questions.

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Brilliant. Yes, thank you so much. I'm a I made huge platform, so much information, easy to click through so beautifully explained and so clear and again.

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So, if people from all over global audience here saying, Thank you so much, this will be really useful like to be involved in being reviewers like to be involved in work.

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So I think certainly we'll share your email address and share collection.

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That at the end, for anybody wants to get involved in all the projects and all the things we've been speaking about today.

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Great

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Got some. Oh, yes, lots of people want him to participate.

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Got a couple of questions coming through, so I will, I think, is in Nigeria, and says: When one's done the modules and is certified does that give you the right to train or mentor others.

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So

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That we don't. We don't. We're not able to offer any accreditation or validation beyond giving you a certificate of completion.

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And so as with all w-h-oh resources, they're very much out there as a global public good and it's at your discretion really to decide.

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If you think that you're that that you have the knowledge and skills to go out and be a mentor, or a coordinator, and and we're always available for support as far as our small team, can manage but we're always really happy to answer questions and actually questions are really helpful

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Because that helps us to understand better. Maybe what information is missing or what what's not clear and to improve the content as well

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Thank you. A couple of questions and again from sorts of people coming in.

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Lena is in Columbia, and I think this was part of ours question as well.

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A couple of others saying, What about accessing the devices?

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So this training provided but is, is, if you got any advice or any suggestions, where they could then start accessing the devices?

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The training is about big question

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Hmm: yeah. So accessing access accessing devices is the big challenge everywhere for everyone.

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I I didn't really mention today, but we have got.

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We've published a procurement manual to support, to guide, to give guidance on procurement of assisted products, which is aimed more at national procurement agencies, and we've also developed product specifications for 27 assistive products on the who

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Apl procurement is something that you need to look at locally and look at what's available in your local market.

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You can use the assistive product specifications from Who to help you to quality check those products, and see if they might have the features that the who has has said are sort of the minimum requirements, in a product and there are I think also lots of other initiatives out there trying to support a procurement

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Of assisted products, and I, Ngos, also supporting procurement of assisted products.

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So, for example, Latter-day Saints, charities do a lot of procurement of assisted products, and often link with Ngos and I, Ngos, and governments now to donate their products to services that have a problem with product supply but but we work we've worked with the

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Ministry of Health in Papua, New Guinea, and they have all their workforce trained in their national prosthetics and orthodox service, who are now providing not only prosthetics and athletics, but walking aids, and even toilet and shower chairs.

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following tap training and their budget for assisted products is solo, that they often are refurbishing and recycling.

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What they have, and relying on donations from organizations like Latter-day Saints.

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So I think it's, an it's an ongoing.

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It's an ongoing challenge. But we're we're working on it.

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Thank you.

05:36:58.000 --> 05:36:59.000
And just lastly, assisted products are now also available in the Unicef supply catalog.

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So that's been a huge initiative, and they can now be ordered. Wheelchairs and hearing aids can now be ordered through the Unicef catalogue, and there'll be more the range will be bigger next year

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Yeah, I think.

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Jump in. I have a question directly for Emma.

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Have it

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There's a list of them here. Go on

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Anyway, you know chess progressive ever you've come so far since you know.

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Hmm.

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Obviously I remember the occasion where we, you know, had the discussion and debate at who, about what the 50 assisted products products should be, and then it was back in 2,016 or something on the basis it's a list of 50 and I remember that was this huge sort of you know discussion on unfortunately what had

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to get dropped out. Is there any basis of reviewing it?

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Hmm.

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Yeah. Yeah.

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At some point, or even increasing it to the 100 essentially products, because of the 100 central medicines, and I think most of us in rehab.

05:37:57.000 --> 05:38:01.000
Look at the list. It's brilliant, but we all know it's limited. Good point

05:38:01.000 --> 05:38:05.000
Yeah yeah and yeah. It, it. It's coming. It's coming.

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Oh! Amazing!

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So the the next iteration of the list is already been started.

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There's a technical advisory group which has been convened, and it's being developed.

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Much more following the methodology of the essential medicines and diagnostics lists.

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Now so they're just in the process of looking at the criteria and weightings for how to decide what products go on the list, and and I don't know how many there will be. On.

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It but I think that there probably will be more than 50, and I think it's important to say that 50 is not.

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We're not trying to limit countries who have the capacity to provide more than 50.

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But it's a model list, so and as you might have noticed from Tap, we've actually started, including some products in tap that aren't on the apl

so transfer boards, because they just fit so well, with with the other range of products that are there so transfer boards.

05:39:01.000 --> 05:39:14.000
Is coming soon and also in catheters. Because if you're providing absorbent in continents products, then you really should be also offering catheters, as a you know, in terms, of you knowre not going to provide crutches.

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If you're not gonna make sticks and rollators available as well

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Nice. Yeah, that's great to hear. Yeah, I'm sure everyone here will be really pleased to yeah to that as well.

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I'm sorry, Amy, back to you

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Yeah. Thank you. Yeah. And I think so. Some of it sustainability as well as it.

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So let's see just sudden chat is Zoom's British charity physio net that we sax and refurbishes assistive devices and but also I know the Icrc do also have some manuals on how to make some assisted devices, don't they so also

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It's you know, to be aware that we don't just want to be sending stuff out also if it can be sustainably made in country that would be good.

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If the if it's possible for obviously not all devices can be so.

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Juliet asked, Would you say, these trainings are mostly basic knowledge.

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Know how, or they designed specifically for professionals with experience

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No, absolutely bait for basic. So they're not.

05:40:06.000 --> 05:40:13.000
They're not designed for that. They're relevant and accessible for professionals, but we're trying to keep the bar really low.

05:40:13.000 --> 05:40:39.000
So anyone who's already working in a clinical role, but they could be a community health worker, a nursing assistant, an any any sort of you know, someone who's done a one year graduate training would be able can can manage to take them onto some new problem

05:40:39.000 --> 05:40:49.000

Thank you, and I think probably double as questions this one. So Juliet saying, Would you be able to give us announcer to when all the module Will be available. But I think others are saying how can we support you.

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If you would you want some support in developing those, and how you know, how how can people get involved in helping do that so?

05:40:57.000 --> 05:40:58.000
Hmm.

05:40:58.000 --> 05:40:59.000
Is there a timeframe can kind of as assistant speaking. It's up fee

05:40:59.000 --> 05:41:04.000
Yeah. Oh, thank you. Yeah. Certainly. For reviewing and field testing.

05:41:04.000 --> 05:41:24.000
That's really helpful, and for actually developing the modules, we can only manage to develop a certain number at a time, because in order, although we have you know there's plenty of people with the expertise to provide that the the actual raw content but turning that content into the format it's in

05:41:24.000 --> 05:41:28.000
On tap to present it very simply, and with the case, studies, etc.

05:41:28.000 --> 05:41:30.000
Etc. That's where we have a little bit of a bottleneck, and we really want to keep the quality up there and to keep it really consistent.

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So we've got funding for 2,023 to start developing the hearing modules, and and we actually already have a module available for pill organizers.

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But it was developed specifically for Tanzania, and we want to expand that and make it a bit bigger, and we don't have our cognition introduction module yet.

05:41:55.000 --> 05:42:03.000
But we'll yeah, we'll. We'll go as fast as we can.

05:42:03.000 --> 05:42:11.000
They want more. And the question here from Leslie say, what do you think about?

05:42:11.000 --> 05:42:12.000
I know

05:42:12.000 --> 05:42:14.000
Applied paper-based technology. Is that what that is, Leslie?

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Hmm.

05:42:15.000 --> 05:42:17.000
For everybody, but but I don't think Leslie can't.

05:42:17.000 --> 05:42:24.000
Somebody wants to explain, applied basically I'm I'm assuming it's where you use cardboard and to sort of produce seating and sort of manage

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Cardboard and paper, I I know that there's lots of people in this Forum who are really keen on it and have lots of experience in it.

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I've I I personally don't have any experience in it, but I have also heard the the sort of counter argument that from a longevity point of view that it maybe isn't that durable.

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Especially in humid and and wet climates, I think, rather than answering the question directly.

05:42:58.000 --> 05:43:12.000
I'll probably just say more. That tap is really focusing on ready-made off-the-shelf products because you know as a team we're really trying to promote better access to ready-made off-the-shelf products and start getting governments to

05:43:12.000 --> 05:43:13.000
Start procuring them, and including them in their health services and in their health.

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Financing schemes, but I think that a lot of the tap content is very relevant to homemade and locally made products.

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In many cases. So, for example, the module that's coming soon on portable ramps focuses on aluminium port ready-made, portable ramps but the principles of providing them and how to assess and work out what the steepest ratio the ramp.

05:43:51.000 --> 05:44:11.000
Should be, how long it should be. Other aspects for placing it are absolutely applicable to somebody making a ramp out of wood or bamboo, or even a concrete ramp to help. Access so hopefully there's still lots of useful content for locally made solutions

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Oh, I'm absolutely sure. Yeah. In the beginning of this you'd mentioned about referral into Sis assistive technologies as sort of a spoke.

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I don't know and how any thoughts about how to further develop pathways, to actually have clinicians understanding the need for it, referring into it

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Space, too. I think.

05:44:33.000 --> 05:44:46.000

I think that when you're using yeah, I think I think that, and when you look at the project planning template for tap it, I think it's very important to think about when you're when you're organizing training for people who are going to provide the assisted products also thinking

05:44:46.000 --> 05:44:51.000
About who might be referring into the services and organizing training for that group, as well.

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So we've just run training in Tanzania for people working in primary healthcare centers and about 50 people in primary health care.

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Centers have taken the modules to to become providers.

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But then over a 100 community workers have taken the modules to send people into the services.

05:45:11.000 --> 05:45:12.000
Yeah.

05:45:12.000 --> 05:45:18.000
But but then also the referral pathways on up are so important that they're all kind of mapped out, and and they should be.

05:45:18.000 --> 05:45:20.000
You know they're going to be there already, aren't they?

05:45:20.000 --> 05:45:29.000
But it but it might be that the person working in that primary health care center doesn't know where to send somebody with a diabetic foot wound or an eye infection.

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For example. So it's making sure that they've they've got that knowledge so that they can, so that they can practice safely

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I once said down the module of more understanding as to who to refer on for these facts as well, I suppose, is that

05:45:39.000 --> 05:45:44.000
Yeah. Yeah. Exactly. So. It's lots of flagging, and there's loads of flagging to rehab services.

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You know, we recognize that often people who need assistive products need rehab as well, but not always so there's lots of flagging to, you know.

05:45:51.000 --> 05:45:53.000
Send them to a rehab service

05:45:53.000 --> 05:45:59.000
I think we've got quite a few. Well, quite a few other sort of not not questions, but people just who just want to say thank you, Fiona.

05:45:59.000 --> 05:46:11.000
Crook is works for handcuffs and's actually in Iraq, and is sort of saying, Thank you so much for your work, and it was great to see it's available and pleasure working with you they've continued to support a number of the phcc's both products and mentor

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Support and want to continue so. I think a thank you from Fiona in Iraq for that the another fear, Fiona from I'm using South Africa so she's saying, do you know about the Timian Reverse.

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Collater, which is made from wood instead of a K. Walker, so I suppose just again saying some different produce different products that might not be the specific well known ones, but there are other things out there.

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So perhaps feeling you could share that with us, and then we could share that with the group, because I don't know about it.

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Do you know about it, Emma? That we didn't know about?

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So yeah, please share it stuff that works just stuff that works in country for you.

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Nope, no, no, I don't know about that. Hmm: yeah.

05:46:49.000 --> 05:46:50.000
Please.

05:46:50.000 --> 05:47:08.000
And and also also, if people feel that they're modules on other assisted products, that that you think are really really important for us to add to our module list, then you know we really welcome feedback on that and the way, it's to set up as you know in the modular structure is that we can always add

05:47:08.000 --> 05:47:13.000
more more modules for more assistive products. As time goes on.

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Brilliant, and that would be to come back to to you. I think someone's asking for your your last page with your your last slide of the contacts on.

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It's just pop back up on the screen as well so they've got your contact details.

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What what I could do is put. I'll copy it into the chat

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And yeah perfect. And we've got Kath Barton who she's currently setting up apt workshops in Kenya for specialized seating and standing frames.

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Saying the process is quite cheap. Our rematerials but very time intensive, but working really well for all communities with children.

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As for their Cp. So I just, I think probably sort of highlighting how much this work from the World Health Organization and these assisted device work is actually filtering out so 500 people that you've got signed up doesn't feel that big but actually it looks like it's bigger and

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Getting bigger and bigger and again this forum hopefully will be, you know, almost see you on.

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Hmm.

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Do on. Teach one, see this, share it, tell your colleagues and sort of spread these things around, isn't it so?

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And I think there's sort of 2 other questions, Mario saying is, it is a resources available in French, but I think you've covered that it is available in front, isn't it?

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On the website

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The yeah, the the first module is available in French, and the the sort of web pages, but we now need to look at starting to translate.

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So we translated some more the first module for for the launch into French, Spanish the sort of UN languages. But but now next step is to really get get those translations for more modules yeah

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And I was just saying about communication and straight patients.

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But I think again, communication is one of your next channels of yeah one of the one of the ones that didn't have a smiley, face on it yet so I think

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Hmm, yeah, no, and and we've got speech therapist in our team actually, so but you just doesn't ever have time to work on it.

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But we're going to develop a module on communication boards and books, and that module will be on local making communication.

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Boards and books locally, but there's actually quite a lot of great open access content that unicef have developed and the global symbols project as well where there's now a bill growing repository of open access symbols that you can take to make bespoke communication.

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Boards, and for different cultures and context, so there's a whole set of symbols for Croatia and Serbia.

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India. So yeah, if people are making a working communication that those are really helpful

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And thank you. I think this I think again you've sort of mentioned Juneicef. I see Rc.

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You know huge talked about, you know, so everybody's kind of linking to each other, and I think it's really important to say actually none of us are stand nobody standalone players in this everybody is sort of aiming for the 2,030 you know whether we get there we're not at that speed

05:49:52.000 --> 05:49:55.000
But everyone's aiming for for that, aren't they?

05:49:55.000 --> 05:50:01.000
So actually, there's a lot of platforms here. But you know you guys are sort of saying, Well, Icrc have got something for this unicef support.

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That's actually having everybody working together, if at all possible, and sort of pulling these things in also is really important, and what's so lovely as we put in our chatter people linking in from I'm in Kenya I'm in tanzania let's solve in cup as

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Well. So forums like this are really important for clinicians across across the world to link up as well

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Yeah. Yeah. Yeah, that's right. And there's a huge amount of work going on around 80 in Kenya with a lot of funding.

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So who is working with the Ministry of Health to build the Ministry of Health will be building the first ever national 80 Center in Kenya, which will become a regional resource hub it's.

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It's not a tertiary center. It's going to be a training center a sort of center of excellence and expertise but then there's also a lot of work being done in Kenya also with other partners like 80 scale and the global disability innovation hub so for anyone in kenya

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I think it's quite an exciting time. Yeah.

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And all link together. Please do you know, share contact, share links from this? Emma.

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Yeah, and the person messaging me about Tanzania.

05:51:01.000 --> 05:51:04.000
Thank you.

05:51:04.000 --> 05:51:07.000
Please please send me an email, and I'll I'll talk to you more about tons in there

05:51:07.000 --> 05:51:10.000
Yeah, so all, please all, please, all everybody all linked together

05:51:10.000 --> 05:51:14.000
Well, if I've missed any other, if I missed any other messages, please feel free to email me.

05:51:14.000 --> 05:51:25.000
I'm rushing through quite quickly on there. Yeah, and yeah, so for everybody watching as well, and if you're looking at this on catch up, you know we're gonna be sending out the details we're sending out all the links we're gonna send out people's contact details as well so

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please do use this as an opportunity to connect with each other to network and work.

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You know, work globally and share share things like Walker share all this information. It's, you know, so important to do this and the thank you so much

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Hmm! Well, thanks so much. It's so lovely.

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Everyone's so interested. So yeah, it's great thanks for having me.

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And yeah, look forward to now having another flurry of registrations on the tap website.

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Oh, yeah.

05:51:55.000 --> 05:51:58.000
Oh, and Luke just reminded me to plug adapt as well, so make sure as well if you're not a member, join adapts because he'll have access to one of these wonderful things.

05:51:58.000 --> 05:51:59.000
As well. Thank you.

05:51:59.000 --> 05:52:05.000
Okay. Which I will plug it in the we're gonna take this to 5 quick 5 when it break everybody.

05:52:05.000 --> 05:52:06.000
If you want to just run away from your computers, grab a cup of tea.

05:52:06.000 --> 05:52:17.000
Before. Let's say we, Leslie then joins us for our last session of of this afternoon.

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Yeah. Thank you. All fine.

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But I'm Emma again. Thank you so much. Yeah, it would be great great that shopping person again at some point would be lovely cool.

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Yeah. Definitely. Nice to see you, Leslie. This

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Yeah.

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So it's gonna share the screen, which is that?

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But yeah, and then I'm actually gonna yeah, take 2??min.

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But yeah, we'll be. We'll be back in a few minutes. Everybody

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Alice.

05:52:43.000 --> 05:52:47.000
Everyone can hear. That's fine.

05:52:47.000 --> 05:52:53.000
No is. Can you get the pathlet up?

05:52:53.000 --> 05:52:54.000
They are both of them, both of them.

05:52:54.000 --> 05:52:58.000
Yup, ready, both ready to go on your presentation.

05:52:58.000 --> 05:53:02.000
Okay. Perfect.

05:53:02.000 --> 05:53:03.000
Okay.

05:53:03.000 --> 05:53:33.000
I'll be. I'll be 3??min. I'll be back

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Can you still see your slides? So they disappeared something different

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I can see the palette front page

05:57:38.000 --> 05:57:42.000
And I hey, that's what was off to the that better.

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That's better.

05:57:43.000 --> 05:57:44.000
But so I started, went share screen, and then I needed a different screen, and all these things happen.

05:57:44.000 --> 05:57:45.000
Great okay. Thanks for that little break everybody, actually those of you who are who are the audience of this, I think, get a little bit more moving around because they those of us that are obviously hosting I have to with our computers.

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So it's thank you very much that opportunity to run and grab a drink.

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So we have such amazing speakers so far, talking about, you know all the amazing resources that the provided out there by by many different sized organizations which is just amazing.

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And oh, just mute! Sorry about that!

05:57:48.000 --> 05:57:49.000
Just to ensure. We don't have any echo, anyway, and then our in-house is where we're going next to be able to bring you the resource that we as adapts have put together along with communication therapy international and Ot frontiers.

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So Leslie Gillen will be presenting, and she's I've I have to fill out great shoes.

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Because Leslie's been a previous chair of adapt and has guided many of us, you know, through our some developing careers into into global health here in the U in the Uk as Physiotherapists so She's got board experience clinically and globally specializing

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In pediatrics and neurology and and she's a physiotherapy lecturer for 11 years, and they're possibly passionate about teaching, and and training on Leslie's worked in all sorts of places Middle East Yemen Jordan Syria

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Palestine and Tanzania, and is really aware of the sort of importance of and provisioning sort of culturally relevant and sustainable, training, particularly when we do short visits from from overseas and I think we

all agree that we you know that listening to cube earlier talking about that culturally appropriate being

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so important, yeah. So Leslie's work tirelessly on producing this document along with with colleagues, and it's just gonna take us through it.

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And really it's asking: Yeah, we have. We have an ask of of the audience as well.

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So, Leslie, I'll let me know when you need me to change between different screens and

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I will do. Can you all hear me

05:59:53.000 --> 05:59:57.000
Yup!

05:59:57.000 --> 06:00:00.000
Perfect. Good afternoon morning or evening, or wherever you are. Thank you very much for asking me to do this.

06:00:00.000 --> 06:00:09.000
I must say I'm in all of all the speakers that we've had today.

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Working on this project has all been volunteers from very parts of the world, and it has been now almost 8 years since we had the first addition.

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Way back in 2,001 when adapt. Well, wasn't to that then.

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But when the network started it was just a group of physios meeting together to try and support members by facilitating exchange between information to help develop physiotherapy and rehab, services but also to support each other because if you've never been abroad.

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Particularly to these lowing low resource settings.

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It's very difficult to know what to expect. So that's where we're in effect started.

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So we have the next slide, please

06:01:13.000 --> 06:01:21.000
So oh, good back! Thank you. Next one. So it wasn't originally a book.

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So I say the title, name. The reason we called less resource settings rather than countries was speaking, because I'm sure it has been noted before that there are some areas of the world that could be very rich but have areas or settings that are less resource so there was a big debate as to what we should

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Call it. In the first place, I want to give you a brief history of the document.

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Who's it for? And the process of the third edition, and then ultimately some feedback.

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Next, please.

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So way back in 2,012 we had a joint workshop in New York.

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This was with the occupational purpose and speech and language, therapist.

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These will all people who are interested in or had worked abroad, and we wanted to get together to to see how we could work more effectively and support therapists working abroad now each network had its own information but we actually decided we had more similarities than differences so we set about doing a

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Survey a joint survey as to what would we want?

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As therapists. If we're going to work abroad and unsurprisingly 90 over 90% of the information that people wanted was the same, and I I I personally was advocated a a joint therapy degree.

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But that's another story, anyway. So the survey came out.

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So we decided to do this first addition on the first edition was 73 pages, and essentially what we were doing was looking at.

06:03:32.000 --> 06:03:38.000
Do you really want to go abroad? Is it right for you?

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If you do, how do you find work abroad? Predecessor, your survival, guide to health and safety and travel.

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What happens upon arrival. We did a lot on cultural awareness and sustainability of the role, and often missing out getting back.

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You get back from a country. You're very excited. You talk to people, and they're really not interested because they can't relate to you.

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So it was really important to have something that we could discuss as a team.

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So in 2,014 we had a workshop in lease.

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We actually had this at the Rugby ground. We must have had 60 to 70 people attending all people who had well, the most hadn't been abroad, but some had and wanted just to gain better knowledge and as you can see from the slide the Angel of the day to work to be able to

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Make informed decisions as to whether to seek work, what type of project to join, to develop critical thinking, to know where to find information and support? But probably and I think this is going to be the same at the end. Of this not to have all the answers but to know where to ask the questions next please

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So after that it got bigger, and in 2,017 we had second edition.

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Now the second edition was a 152 pages, and this now increased to specific rehab.

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We had a different group of people, all wanting to share.

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Then expertise. So we had extra chapters, for example, moving and handling evidence-based practice emergency settings, communication, eating and drinking difficulties, equipment and assistive divisive.

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We just had this brilliant talk from Emma on that, and this was a massive expansion.

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Now the first addition, what we wanted to do is make it available to as many people as we could.

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Now I have to admit our big. Failing is, of course this is very much.

06:06:06.000 --> 06:06:22.000
A Uk based book. Initially it was, for as it was set up here, so we wanted to try and expand it a little bit, so it it was much more relevant to other countries.

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But the first edition cost ??9. The second edition cost ??18, and that was cost price.

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That was not making any money at all. Can we have the next slide, please

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So? Who is it for? Well, it is a practical aid, and that's all.

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It is every subject that we have mentioned. You could write a whole book on, but the 3 networks wanted to share their knowledge and we hope.

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It's a useful resource and reference for those currently working in the field, and I think it was mentioned earlier that you know we often go abroad, and you might be the only physio you might be the only speech in language therapist you might be the only occupational therapist.

06:07:12.000 --> 06:07:29.000
And you have to wear a different house. So it was very important that every chapter we wrote was relevant to every therapist

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Next, please.

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So producing the document. There were many authors over the 3 editions.

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I would probably say 20 to 30 different people from the 3 professional groups help for produce documents.

06:07:51.000 --> 06:08:04.000
The latest edition has got 4 main sections. The practicalities, the students, corner specific areas of practice and different ways of working.

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Our first edition was essentially the practicalities. So what I mentioned before I tried really hard to keep everybody to 10 pages per chapter.

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This proved not terribly easy, and we had lots of discussion in the end.

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I had to edit it and try and do as best I can.

06:08:28.000 --> 06:08:32.000
Otherwise we'd have had a book that was 500 pages.

06:08:32.000 --> 06:08:53.000
But we collaborated on chapters, and we if, for example, a physio had written a chapter, we would send it to an occupational therapist or speech, a language therapist to agree that it was relevant and the other way around okay, thank you next one

06:08:53.000 --> 06:08:55.000
So as I mentioned earlier, we wanted to publish the document.

06:08:55.000 --> 06:09:05.000

Originally to go to run alongside our workshops.

06:09:05.000 --> 06:09:15.000
The cost clearly started, becoming prohibitive. As this third edition was costing ??25.

06:09:15.000 --> 06:09:28.000
It was a an awful lot of pages, so we then had to rethink, and and how could we actually best provide

06:09:28.000 --> 06:09:32.000
Allow the document to be seen by as many people as possible.

06:09:32.000 --> 06:09:38.000
I looked at online publishing that just became very very complicated.

06:09:38.000 --> 06:09:47.000
And then, thanks to my daughter, who is a consultant in college of Care, she said, why don't you write a tablet?

06:09:47.000 --> 06:09:53.000
So I then had to look and see what a padlet is.

06:09:53.000 --> 06:10:07.000
So a padlet essentially is an online post. It wall, it's allows individuals large and small groups to post the comments questions and resources in one place.

06:10:07.000 --> 06:10:10.000
That is easily accessible to everyone. You can upload videos.

06:10:10.000 --> 06:10:27.000
Podcasts, etc. Onto the paddle. You can have 3 free padlets, but once you start going into adding: videos there is a small cost.

06:10:27.000 --> 06:10:36.000
So all first one is a free one, so if we could go into the next page and then go into the document itself.

06:10:36.000 --> 06:10:42.000
So that's what it looks through. Look like when you go into it, and if you could get into it, please, Alice.

06:10:42.000 --> 06:10:49.000
Yeah. So. Everybody this is, gonna be a little bit of it sorting as I go on to.

06:10:49.000 --> 06:10:55.000
That's this one here. So here's the live documents

06:10:55.000 --> 06:11:05.000
Okay. So this is the live document. So essentially this is a book that is online.

06:11:05.000 --> 06:11:06.000
You can click on. For example, let's click on contents.

06:11:06.000 --> 06:11:11.000

Pages.

06:11:11.000 --> 06:11:16.000
And what should come up

06:11:16.000 --> 06:11:26.000
Is exactly what's in the documents and telling you the pages

06:11:26.000 --> 06:11:36.000
The beauty of this using a tablet is the anyone can

06:11:36.000 --> 06:11:42.000
Download or upload any chapter, and printed if they wish.

06:11:42.000 --> 06:11:50.000
But they don't have to print the whole thing. We can go back out of that into another one

06:11:50.000 --> 06:11:59.000
So if we go into the practicalities again, what we do is we encourage

06:11:59.000 --> 06:12:04.000
We encourage anybody who's never worked abroad to read through this section.

06:12:04.000 --> 06:12:16.000
First, because really what it does it just gives you the pros, the cons, what you might need to prepare, and so on and so forth.

06:12:16.000 --> 06:12:20.000
So they we've just got up preparing to work abroad.

06:12:20.000 --> 06:12:39.000
It is so important that we get ourselves. We understand what we're going to, because we do want to make everything as sustainable as possible, and I hope that we've got we've done this in the document if you can go out of that please.

06:12:39.000 --> 06:12:47.000
And then you can see that we have a students section specific areas of practice.

06:12:47.000 --> 06:12:52.000
If you just go into the first one first one top, no top above that doubling.

06:12:52.000 --> 06:12:56.000
Thank you.

06:12:56.000 --> 06:13:01.000
So these are the new editions, or some of the new editions.

06:13:01.000 --> 06:13:09.000
In this third addition we could go on and put more and more in, and I hope we will someday.

06:13:09.000 --> 06:13:15.000

So we've got working with displaced persons, survivors of torture, positive care.

06:13:15.000 --> 06:13:22.000
HIV and Aids, etc. Along with the original ones that we have chapter 7.

06:13:22.000 --> 06:13:35.000
So 11. Thank you. Now. What I would like is if you go to the next slide, we can go back into the slide.

06:13:35.000 --> 06:13:36.000
This is: okay.

06:13:36.000 --> 06:13:40.000
Nope, Susie's page, and it is fine.

06:13:40.000 --> 06:13:45.000
Let me go up to. I just need to pull here we are

06:13:45.000 --> 06:13:48.000
Okay. So next slide, so the most important thing to stress that this is guidance.

06:13:48.000 --> 06:13:55.000
It is not instructions we're not trying to say.

06:13:55.000 --> 06:14:01.000
This is what you must do, but it's really to get you to think about. To reflect.

06:14:01.000 --> 06:14:21.000
Is this what I want? And if you're working, for example, with survivors of torture or with displaced persons, it's giving you some guidance to what to expect there are a lot, I'm sure greater articles and books on what to do exactly so please note that this is what it is

06:14:21.000 --> 06:14:36.000
Guidance, and not instruct. We've tried to adapt the current, the the content to current and emerging global context, and it was correct at the time of publication.

06:14:36.000 --> 06:14:42.000
And I say was because you know yourself as soon as you publish anything, you buy a new iphone.

06:14:42.000 --> 06:14:44.000
You buy a new computer. It's already out of date.

06:14:44.000 --> 06:14:51.000
So we do rely on people helping us to say this is where you know.

06:14:51.000 --> 06:14:57.000
Maybe this isn't correct anymore. This is what you need to think about.

06:14:57.000 --> 06:15:01.000
Do you go to the next slide

06:15:01.000 --> 06:15:09.000

So just again. The most important thing it cuts across all professions, and that's what we really wanted to do.

06:15:09.000 --> 06:15:24.000
Clearly you will find when you read each chapter you will probably guess who has written it, because I think a physi therapist tends to be a little bit more physi biased, a speech and language therapist does.

06:15:24.000 --> 06:15:33.000
Etc. But we have tried really hard to make it accessible to all professions, and I personally believe to other professor's as well.

06:15:33.000 --> 06:15:41.000
I don't think it should be just the Otis H.

06:15:41.000 --> 06:15:48.000
Chapter does vary in length and depth, even though I did try to keep using to 10 pages, and you can see at the bottom.

06:15:48.000 --> 06:16:00.000
There, we even introduced tele rehabilitation and chopped 20 is sharing skills through training.

06:16:00.000 --> 06:16:25.000
And we really stress that word sharing, because if we don't share knowledge and use the knowledge of the local people, we we will never learn, and of course, everything we hope it's been underpinned by evidence based practice but what I would like to show you now is another paddle to show you what

06:16:25.000 --> 06:16:29.000
Can be done.

06:16:29.000 --> 06:16:44.000
So ours is very much a very simple book. Now this is my daughter has allowed us to share this one, so you can see a padlet, can have everything from simple writing.

06:16:44.000 --> 06:16:49.000
You can, insert podcasts you can insert videos, anything you wish.

06:16:49.000 --> 06:16:58.000
You can have question and answer sessions, and I think it's a brilliant way of disseminating knowledge.

06:16:58.000 --> 06:17:11.000
I said, very, very minimal cost, and at any point any of the articles can be downloaded and printed separately.

06:17:11.000 --> 06:17:17.000
So if we go back now to I said that'd be brief.

06:17:17.000 --> 06:17:24.000
The final slide

06:17:24.000 --> 06:17:32.000
So what we really want now is your feedback on this resource, so we can improve it for your needs.

06:17:32.000 --> 06:17:45.000
As I said, there were 20 odd volunteers who've written to the best of their ability to help each other, and we especially want therapists.

06:17:45.000 --> 06:18:09.000
Working in low resource settings to get involved. If you can do that, please contact us as adapting queries at gmail.com or fill in the form on the paddle which is the last section where it allows you to give feedback the more feedback we have the better we

06:18:09.000 --> 06:18:20.000
can make it, and the more we can share this link with everybody. And it is now owned, I believe, by adapt is that right, Fiona

06:18:20.000 --> 06:18:23.000
He's not here at this. It's me. Yeah.

06:18:23.000 --> 06:18:24.000
Oh, sorry! Alice.

06:18:24.000 --> 06:18:27.000
At the moment. I'm just great blessing. I'm going to come off.

06:18:27.000 --> 06:18:30.000
Jump off this again, and just go back to the public.

06:18:30.000 --> 06:18:36.000
So this is version this is the rest. This is addition 3.

06:18:36.000 --> 06:18:37.000
Yes.

06:18:37.000 --> 06:18:40.000
Isn't it so, anyway? Here that it's that it's referenced, and everybody we've.

06:18:40.000 --> 06:18:47.000
We've shared the link to this in in the chat today, because even if you're not an adapt member, but you're listening to this talk.

06:18:47.000 --> 06:18:52.000
We'd really like your feedback because also those of you that are overseas in low resort settings.

06:18:52.000 --> 06:18:55.000
We need to know if we're telling our therapists in the Uk.

06:18:55.000 --> 06:19:01.000
Who are coming over. If we're giving them the right information, and you'll see that we've made it interactive.

06:19:01.000 --> 06:19:15.000
So you can either thumbs up, or even thumbs down but we're not gonna get too many of those on a particular area and add comments, but specifically where we'd like your feedback is in this in these yellow beige boxes or yellow sort ofish boxes at the end where you can give us your

06:19:15.000 --> 06:19:20.000
Comments on the on the different sections, and then what we're planning on doing cause.

06:19:20.000 --> 06:19:28.000
Obviously, you know this is the first online version is then we've we've got the next version sort of ready to get to go live once once we've made any edits or additions or answered.

06:19:28.000 --> 06:19:31.000
Your your comments. So yeah, please do engage and have a look at our materials.

06:19:31.000 --> 06:19:52.000
So that we can improve it really for the for the benefits of of all you know, and it's very much a multidisciplinary aspect, and any name improve improve it for everybody would that be right Leslie

06:19:52.000 --> 06:19:56.000
Indeed, and the other good thing about using a paddle.

06:19:56.000 --> 06:20:05.000
Say, for example, you wanted to expand on the tele rehabilitation or any chapter.

06:20:05.000 --> 06:20:06.000
We, the people who have access to it can take it out.

06:20:06.000 --> 06:20:13.000
We can change it. We can add things, and we can put it back in.

06:20:13.000 --> 06:20:28.000
So? What if we have a book? Unfortunately, you've gotten you have the book as it is, we can be changing this all the time and adding different things as we well, them, or as any as all of you want them?

06:20:28.000 --> 06:20:32.000
So we genuinely. We know we'd love your feedback on this

06:20:32.000 --> 06:20:37.000
Yeah, absolutely. And I think in in relation to you know, as we've we've said to many of you listening.

06:20:37.000 --> 06:20:43.000
We we are pretty tiny. As an organization, and it's all volunteer ledge from physiotherapists here, and you this isn't quite like the Icrc.

06:20:43.000 --> 06:20:47.000
Sort of, you know, but we have the ability to change this quickly.

06:20:47.000 --> 06:20:50.000
It's just owned by, you know that sort of small group.

06:20:50.000 --> 06:20:52.000
So yeah, it can be very responsive, as as you need.

06:20:52.000 --> 06:21:01.000

And as you, as you give feedback, so I don't know any other any questions, or comments in the chat about this at the moment

06:21:01.000 --> 06:21:15.000
Half. Yeah, I've got a couple of questions. So Juliet, who will do the final layout and editing, and do you have a timeline deadline? Chef the review in the project in general

06:21:15.000 --> 06:21:16.000
Yeah big questions.

06:21:16.000 --> 06:21:17.000
Oh, anyone!

06:21:17.000 --> 06:21:21.000
Well, I mean I think this. This is a the first final.

06:21:21.000 --> 06:21:24.000
Document the people can read following on from feedback and reviews.

06:21:24.000 --> 06:21:36.000
Then, you know, when we have time, when people have time, we will edit and and review it as appropriate

06:21:36.000 --> 06:21:42.000
Okay. Thank you and then is this: Are there any other languages?

06:21:42.000 --> 06:21:44.000
No, not at the moment now

06:21:44.000 --> 06:21:45.000
Absolutely not. We're probably not quite in that resource.

06:21:45.000 --> 06:21:48.000
This is in what was good

06:21:48.000 --> 06:21:58.000
If anyone would like to take the time to translate it, we would be delighted to put it into to to host the tablet, but we don't have the translation abilities ourselves.

06:21:58.000 --> 06:22:04.000
Apart from Amy, who, posted in Spanish in the chat incredibly well earlier so I don't speak Spanish, so I don't know how accurate you were.

06:22:04.000 --> 06:22:05.000
But never mind.

06:22:05.000 --> 06:22:11.000
Moderately. I think, and I I think the I I I suppose I think what we're saying from adapt to we're saying.

06:22:11.000 --> 06:22:13.000
And you know, Leslie, amazing! So much work has gone into this is that this is kind of for for Uk physios as it stands.

06:22:13.000 --> 06:22:19.000
But to spread that way for us to go. Not this, you know.

06:22:19.000 --> 06:22:30.000
This is for us to go, and what what can we do? No harm, you know.

06:22:30.000 --> 06:22:31.000
Yeah.

06:22:31.000 --> 06:22:35.000
What can we, what what is required from us if we're going out to so different countries and and offering support, isn't it so you know that's what we're that's what we're asking what what can we do?

06:22:35.000 --> 06:22:41.000
To help and do something well, and not do it badly, and I think we've sort of discussed sort of on and off throughout the day.

06:22:41.000 --> 06:22:44.000
About how things could be done well, and how things could be done differently, and what the barriers are.

06:22:44.000 --> 06:22:49.000
And I guess this is for us as adapt, and you know I can't say I've done no work and whatsoever.

06:22:49.000 --> 06:22:50.000
But you guys all the work you've put in to say, how can we?

06:22:50.000 --> 06:22:56.000
What can we, as a very small organization, do to support therapists in this country?

06:22:56.000 --> 06:22:57.000
And who wants to come and do support in in low resource countries?

06:22:57.000 --> 06:23:04.000
And how can we do it? Well? So I think ultimately, for everybody, you know who's watching is involved in this.

06:23:04.000 --> 06:23:06.000
That's what that's what we're looking at from this.

06:23:06.000 --> 06:23:09.000
So it's not translated yet, because that isn't quite the focus of it, is it?

06:23:09.000 --> 06:23:10.000
Yeah.

06:23:10.000 --> 06:23:12.000
I think so. Fees got a question here. About how what does Leslie think about shorts and placements from H.

06:23:12.000 --> 06:23:22.000
Ics to low middle income country so short term versus long term placements

06:23:22.000 --> 06:23:44.000

Well, I think my view is because I have only had the opportunity to do short-term placements is the the points we've made in the paddle that are in the in the book, are even more relevant because it's very easy and particularly we put this in the students chron it's very easy to go to a

06:23:44.000 --> 06:24:02.000
short-term project. Think you've done something amazing, and as soon as you leave, they no idea what you've done, and just reverse so everything we do you must be able to say you know can you carry this on i'd rather do less, and try to achieve a little bit more and let them

06:24:02.000 --> 06:24:04.000
take control. We'll take that

06:24:04.000 --> 06:24:08.000
And send them the important things to sustainability and the long-term effects. And actually, even if it's a short term project, what else are you leaving behind?

06:24:08.000 --> 06:24:11.000
Okay. Yes.

06:24:11.000 --> 06:24:15.000
If you're, if nothing is behind this useful, is that?

06:24:15.000 --> 06:24:16.000
Absolutely.

06:24:16.000 --> 06:24:26.000
Is it worth going out? In the first place, I think, and Fee sort of followed that up with what's a lower resource countries think about short-term placements versus long-term and I guess I don't know that you know the answer but I suppose you know literature.

06:24:26.000 --> 06:24:27.000
Sort of suggests that it can be good, and it can be not good.

06:24:27.000 --> 06:24:47.000
I think if any of us have been looking and doing some meeting into that is that you know, as long as it's sustainable and like Zlm was talking about capacity building so in country capacity building a lot of the focus of today, has been offering support and training out to to

06:24:47.000 --> 06:24:50.000
therapist globally or people globally, not just having people go out and do.

06:24:50.000 --> 06:24:58.000
Training is actually having at this free free access free content for in-house in country staff to access themselves.

06:24:58.000 --> 06:24:59.000
So you know that would be a sustainable capacity.

06:24:59.000 --> 06:25:14.000
Building project as well, and I guess it's how all of these organizations can then help support the face-to-face training, because you know, that adds to the online resources that there is available.

06:25:14.000 --> 06:25:18.000
And I think that's probably a head scratch for all of us, isn't it?

06:25:18.000 --> 06:25:23.000
It is I? I certainly will never cause. I specialize in pediatrics.

06:25:23.000 --> 06:25:43.000
Whenever I was doing a session, for example, on on play, I would get them to make their own toys, so that well, rather than me bringing toys out, they made them, and they kept them, there and they could use them, and remove them and the same with it you know any basic equipment that

06:25:43.000 --> 06:25:48.000
They needed in the in the Rehab area

06:25:48.000 --> 06:25:49.000
Yeah, thank you. So there's a question from Jb: and I from humanity.

06:25:49.000 --> 06:26:00.000
Including just to say, Alice has mentioned in the chat, but again, just to get your feed on it, Leslie, and how many of the writers actually have worked overseas in low resource settings

06:26:00.000 --> 06:26:03.000
Everyone, everyone.

06:26:03.000 --> 06:26:11.000
Yeah. So I think I think that's really important again for us as a you know, for adapt to be saying actually this isn't just, you know, been done from a Desk.

06:26:11.000 --> 06:26:25.000
In the Uk. Everybody involved in it has been into low resource settings, probably more than one, and has sort of brought that and I guess all of us that have been out of kind of met up colleagues and we've got links and we keep hold those links and we you know we we're continuous. Links.

06:26:25.000 --> 06:26:31.000
Aren't they that we we bring in? You know we have, an ahead, and we bring into things that we do in when we work in the Uk. As well.

06:26:31.000 --> 06:26:34.000
So I think it's really important to say that it's done

06:26:34.000 --> 06:26:41.000
Yeah, we had them. We had people from America to the Philippines to Africa.

06:26:41.000 --> 06:26:56.000
And most of our the preparation, particularly for the third edition, was on Zoom because of the Covid crisis, and to get the right time to fit everybody in was very difficult.

06:26:56.000 --> 06:26:59.000
So we balanced around about 4 Pm. 5 Pm.

06:26:59.000 --> 06:27:03.000

Uk time and people were coming in at midnight.

06:27:03.000 --> 06:27:15.000
People were coming in 6 in the morning, but everybody contributed, and it's brilliant, and every single one of them had spent time working in low resource settings

06:27:15.000 --> 06:27:29.000
Thank you. It's a question from Fiona from South Africa saying, what is short term, versus long-term understanding question mark I've worked with amazing therapists from abroad and probably in the category of more long-term I suppose I guess the question is is it is

06:27:29.000 --> 06:27:33.000
Short term a project that you go in and do, but I guess we you know I don't know.

06:27:33.000 --> 06:27:35.000
From Fiona's point of view. But again, like I said, I keep contact.

06:27:35.000 --> 06:27:41.000
So I work alongside. Yeah, I still link in to my go on, and colleagues, my believing colleagues.

06:27:41.000 --> 06:27:42.000
Yes.

06:27:42.000 --> 06:27:46.000
They still share their knowledge, share skills, and you know, go back and do sustainability and offer those things.

06:27:46.000 --> 06:27:49.000
So. Oh, she's saying months or years.

06:27:49.000 --> 06:27:50.000
I yeah.

06:27:50.000 --> 06:27:52.000
Well, I'm talking I'm sorry I'm talking short time.

06:27:52.000 --> 06:28:00.000
Sort of 3 weeks to 6 weeks, 2 months, and then obviously long term 6 months, plus, I guess, is what I would say

06:28:00.000 --> 06:28:03.000
Yeah, I think, how long's a piece of string?

06:28:03.000 --> 06:28:04.000
It's it's so variable, isn't it? So?

06:28:04.000 --> 06:28:11.000
You know I've done, and 3 week projects in Kenya, but I've done the 3 week projects twice a year for 10 years, and and kept especially with zoom and things.

06:28:11.000 --> 06:28:18.000
Now you keep the contact, and I'm you know I'm doing teaching online and while I'm here, so yeah, what is short time, what is long?

06:28:18.000 --> 06:28:19.000
Term I think it's a it's always a debatable issue, isn't it?

06:28:19.000 --> 06:28:27.000
But yeah. But we you know we realize that this is very varieties

06:28:27.000 --> 06:28:34.000
I think throughout again throughout today different different speakers that we've got of all touched on tele rehab and telemedicine.

06:28:34.000 --> 06:28:37.000
But also you know what we've done today. Telecommunications.

06:28:37.000 --> 06:28:52.000
So I think we've you know the we've had people joining from literally all over the world today, and that's made possible by by Telly telling and obviously appreciating Internet connection blackouts you know that sort of stuff but at the same time.

06:28:52.000 --> 06:28:59.000
You know it does open those dialogues up, and it does make it easier in some ways to keep those connections and keep those links doesn't it?

06:28:59.000 --> 06:29:05.000
I think so. It's really important as well to acknowledge that you know we're asking for support from low resource settings to develop this.

06:29:05.000 --> 06:29:11.000
You know we we need your help. Help us. We we're asking for your support to come and help us do this properly.

06:29:11.000 --> 06:29:20.000
You know, and to share that, and and be aware of where our limitations are and where we need support as well

06:29:20.000 --> 06:29:21.000
So much

06:29:21.000 --> 06:29:22.000
Really any more questions on here. I don't think so.

06:29:22.000 --> 06:29:25.000
Yeah. Thank you.

06:29:25.000 --> 06:29:26.000
Session

06:29:26.000 --> 06:29:30.000
That's great. I do so that brings us pretty much.

06:29:30.000 --> 06:29:32.000
Hi sha! Fees

06:29:32.000 --> 06:29:41.000
Yeah, Amy, I was gonna say, so. Amy's got a last couple of things to just highlights, everybody, and I just noticed Juliet in the chat is just recent.

06:29:41.000 --> 06:29:48.000
A couple of other resources, as well, so going to point everybody to the chat, to have a quick look at those and we, will make sure that we collate.

06:29:48.000 --> 06:29:57.000
Somehow somebody collect all the different links and resources that have been shared during today.

06:29:57.000 --> 06:29:58.000
And put them on a sort of single document to send out.

06:29:58.000 --> 06:30:05.000
Obviously, we've got the email list of everybody that registered for this for this conference.

06:30:05.000 --> 06:30:13.000
So I can't promise it'll be this weekend, but it will be in the next week or 2

06:30:13.000 --> 06:30:14.000
Yeah. Yeah.

06:30:14.000 --> 06:30:18.000
So am I sharing the correct screen here. Ya! You see, developing fiscal one here

06:30:18.000 --> 06:30:19.000
Yes, so

06:30:19.000 --> 06:30:23.000
I am so Fiona Fiona, who is engineered?

06:30:23.000 --> 06:30:40.000
This conference, organize all of it, and so much right behind the scenes and organized everything, and has unfortunately kind of couldn't stay right to the end, was too modest to actually talk about her own project which she's been working on here alongside lots of other wonderful conditions looking at developing

06:30:40.000 --> 06:30:55.000
Physiates just wanted to quickly. Also just draw we're going to put the link in the chat for Fiona's module as well, which again is got some wonderful artwork is a online resource for physios and therapists working in low resource.

06:30:55.000 --> 06:31:00.000
Countries it's all. If there's no physio, it's sort of teaching with pictures.

06:31:00.000 --> 06:31:07.000
So without words or language, or anything like that required just pictures of how to sort of do very basic health care.

06:31:07.000 --> 06:31:14.000
Very basic management. And just again alongside all these other resources you know something available out there that is viewable.

06:31:14.000 --> 06:31:23.000
That is easy to follow. That is use with, videos and pictures as opposed to text.

06:31:23.000 --> 06:31:28.000
So not requiring part so much translation as well through these modules.

06:31:28.000 --> 06:31:36.000
So I know that Fiona and her team are working on different modules, and just to show some of the ones that are available already

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They've got respiratory. Amputee is viewable in life.

06:31:37.000 --> 06:31:48.000
Spinal cord injuries, so these ones, all these ones here are viewable, they say, viewable, and they are viewable.

06:31:48.000 --> 06:31:52.000
And if I just flick through the Npc. One because

06:31:52.000 --> 06:31:53.000
Okay.

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Cause I so fees I'm pretty with them, so penny as well, penny is one of the Uk.

06:32:00.000 --> 06:32:01.000
Leads and Ipt. We have so again eat sort of to link through and ask me options.

06:32:01.000 --> 06:32:14.000
Physiology notes so bones pictures as well as wording, very, very clearly diagrammatic information.

06:32:14.000 --> 06:32:21.000
Here sort of what Latin, what Latin things might mean if you're looking at these in different languages.

06:32:21.000 --> 06:32:22.000
Physiology, pathology, and clinical guide.

06:32:22.000 --> 06:32:45.000
So I think yeah. So again arrows, directions so not needing too much word, not needing too much language, iterations just really clear formatted pictures that hopefully will be another really excellent resource for people to use and to share with colleagues and again, if we've got

06:32:45.000 --> 06:32:53.000
Therapists that are working across Visio and Ot, and sort of generic therapists in the in our different settings, that we are in across the world.

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These should be applicable for everybody as well. So just wanted to highlight this great work, that fee and her team have been doing as well to, everybody. And we'll put a link in the Chat for Fiona as well

06:33:07.000 --> 06:33:11.000
I have just popped in the chat top

06:33:11.000 --> 06:33:14.000
Thank you.

06:33:14.000 --> 06:33:18.000
Great, so I think it's time to wind up. But thank you.

06:33:18.000 --> 06:33:33.000
So much for those of you in the chat. It's really lovely, especially a couple of years of comments that you have no idea that there were communities such as ourselves in adapt doing this and we're so delighted that you've been able to join us today and the thank you because it's

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actually made our day, that we've got such a international representation in the audience.

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That's so important to us, even though we might be ultimately running this from the Uk.

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I think all of us on the committee, and I must thank my amazing committee of there's at least 10 of us in the background, and then other adapt members who still continue to you know be involved.

06:33:55.000 --> 06:34:02.000
So itively of the work. So you know you can look at the adapt website for information. As we said.

06:34:02.000 --> 06:34:03.000
We've had the links up to the things on Twitter.

06:34:03.000 --> 06:34:12.000
We've had the links up to the benefits of being and adapt member, particularly for those of you in the Uk.

06:34:12.000 --> 06:34:17.000
We are a professional network of the charted society of Physiotherapy.

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We're in close touch with world physiotherapy.

06:34:18.000 --> 06:34:23.000
I will be going and speaking in Dubai.

06:34:23.000 --> 06:34:28.000
And actually, that's also to look at the sense of the evidence that's so generated often in high-income countries.

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And we're going to be talking about how that can be applied, or the adapted to sort of that that sense of using it in low-income countries, on low low resort, settings.

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But yeah, I mean there's a ability to have a discount code to physio, plus so yeah, many different benefits to it.

06:34:48.000 --> 06:34:53.000
But anyway, just to say, Thank you so much for joining us today we will get resources to you.

06:34:53.000 --> 06:35:06.000
The recording link to you, and if you we will, we've realized that there's a slight hiccup with the certificate in the sense that we've used a free version of being able to get you an automatic certificate which just means there's a there's

06:35:06.000 --> 06:35:13.000
A number per day, which are able to so if you haven't managed to give your feedback or get your certificate today, please keep that link.

06:35:13.000 --> 06:35:14.000
I will ask one of my teams just repost that in the chat now, so it's available.

06:35:14.000 --> 06:35:17.000
Keep that link. We on it tomorrow, and we're fairly sure that everything will be okay.

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If by any chance it isn't just email us at adapt inquiries at Gmail, Com, and we will be able to follow up with you.

06:35:30.000 --> 06:35:46.000
But thank you so much for for joining, and I am about to hit end on the Webinar, and hope you will have a lovely, lovely day or evening, or even start the day wherever you may be in the in the world and thank you so much to all our speakers, I look forward to listening to

06:35:46.000 --> 06:35:49.000
The recording cause. Yeah, I feel I need to hear everything again.

06:35:49.000 --> 06:35:59.000
So. Thank you very much, everybody, and yes, they will

06:35:59.000 --> 06:36:29.000
Yeah, we need to just say so to save our questions and stuff