

## **Airing Pain Programme 128: Back Pain And Pain From A Global Perspective With The International Association For The Study Of Pain (IASP)**

*This edition has been funded by the Plum Trust.*

*Back pain is one of the most common types of pain that people report. It can arise due to any number of causative factors and can occur in any part of the back. Lower back pain and sciatica are particularly common and affect approximately 577 million people globally.*

*In this episode of **Airing Pain**, we have collaborated with the International Association for the Study of Pain (IASP) who are dedicating their global year 2021 to back pain. [2021 Global Year About Back Pain – IASP \(iasp-pain.org\)](https://www.iasp-pain.org/2021-Global-Year-About-Back-Pain)*

*We also dedicate a portion of the episode to useful pain management advice that will benefit anybody living with pain, including those with back pain.*

**Issues covered in this programme include: pain from a global perspective, pain in developing countries, Global Alliance of Partners for Pain Advocacy (GAPPA), chronic condition management, back pain, IASP Global Year about Back Pain, self-management approaches, physiotherapy, therapeutic exercise, pain in rural areas, physical strategies, pharmaceutical strategies, psychological strategies, the ‘3 P Method’, masking pain, pain psychology.**

This is **Airing Pain**, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain, and for those who care for us.

I’m Paul Evans and this edition of **Airing Pain** has been funded by the Plum Trust.

Chronic Pain has no geographical boundaries, so this edition of **Airing Pain** is truly a global effort.

**Vina Mohabir:** It’s not just the pain that we cope with, it’s how it impacts our entire life, how it impacts our relationships, our careers, our energy levels, our sleep. It impacts everything.

**Otieno Martin Ong’wen:** In Africa, and in Kenya, if you look at our education system, it’s more or less the old British system of education where, ‘What I say is rule of thumb, you need to do this.’ There’s not a lot of empowerment in our patients to self-care, or self-manage themselves.

**Evans:** The International Association for the Study of Pain, IASP, brings together scientists, clinicians, health-care providers, and policymakers across the globe to share experience,

knowledge and best practice in pain management. And if you think there's one missing component to that list of professionals, that is, the *millions* of us across the globe who live with chronic or persistent pain, under IASP's umbrella is GAPPa, another acronym I'm afraid, for the Global Alliance of Partners for Pain Advocacy.

Mary Wing in Adelaide, Australia, is a peer educator and patient advocate who's lived with neuropathic pain for many years. She holds a Post Graduate Diploma in Chronic Condition Management and facilitates chronic condition self-management programmes locally and online in America and Canada. As well as sitting on numerous chronic pain policy panels at state and national levels, she's a member of the *international* GAPPa taskforce.

**Mary Wing:** GAPPa started, in a very small way, in Boston in 2018 at their World Congress, and it expanded in 2019 to twenty-one members. Some of the people are what I call, 'Plain patients,' like me [laughs]. Some people are health professionals who also have pain and some are researchers who also have pain. They're trying to incorporate the patient voice into research and make sure that there's always a patient voice in everything, and hoping that the rest of the world follows suit. It makes a huge difference. I think they've done some studies and they've found out that when they involve patients in the planning of research projects and the conducting of [them] as well, they find they get a different result. And interestingly, a lady, a researcher from one of their universities here, asked me last year if I'd go in there and help her with some questions that she was organising for a research programme she was doing. When I got in there-, I don't know how many you would have filled out, Paul, but I have filled out numerous research projects and often you get to one and you just don't have an answer for it. And you think, 'Now, if that wording had been slightly different, I could answer that.' So, it was very interesting. We went through that and she quite happily changed some of the wording. I had someone else coming in after me and I've no doubt that he did the same. So, that's before they've even got started and, you know, if you're going to ask questions that are more user-friendly, obviously you're going to get a better outcome. And that's just one small part of the research before you really get going. The last thing you want to be is the patient that they have to have. You want to be included because they can see the value in having patients included, not because they have to include you.

It's the same with the congress, the IASP gives us things to do at the conferences [such as] presentations, [a] lived experience area. They're also trying to make sure that other chapters that they have have patient involvement in their areas as well so that this is a, sort of, ongoing

thing and it starts to grow. Instead of being a novelty for a year or two, they want it to keep going.

**Evans:** IASP, the International Association for the Study of Pain. How important is this international link up of people with pain?

**Wing:** I think it's very important because we've had, sort of, pockets of people who've been keen to include patients in activities, and to have it on a global level means that so many different countries know about it and are involved in it. You know, we have a researcher from Queensland and another one from New South Wales, so we've got three people from Australia there, and so there are other countries that have one or two people as well. I think it's really good to hear other people's perspectives on things from different countries. It's amazing to be able to discuss things with other people on that global scale. I've found it fascinating. Mind you, you'd be surprised how similar the problems are from country to country. But I don't think we can really begin to complain when you start to think about developing countries and the major problems that they have accessing pain care.

**Evans:** That's Mary Wing in Australia.

The International Association for the Study of Pain has designated 2021-, that's the year we're recording this programme-, as its Global Year About Back Pain. Do go to their website at <https://www.iasp-pain.org/GlobalYear> where you'll find excellent articles for managing back pain, including Mary's article, Back Pain: Myths versus Reality.

According to the World Health Organisation, 'low back pain is the single biggest cause of years lived with disability worldwide,' occurring, 'in similar proportions in all cultures.' So, in this edition of **Airing Pain** we'll be crossing continents and cultures to focus on universally accepted self-management approaches, not just to back pain, but to all chronic pain conditions.

Otieno Martin Ong'wen is a physiotherapist and educator in Nairobi, the capital of Kenya, in East Africa. He's a member of the Kenya Society of Physiotherapists and the Physiotherapy council of Kenya as well as the Physiotherapy ambassador for Kenya in the global Physical Therapy project. He's [a] mentor to students and graduates across Kenya and a clinical instructor at the Kenya Medical Training College. He's also a champion for the advocacy of exercise as medicine.

**Ong'wen:** We pretty much have the same musculoskeletal problems. You know, lower back pain is very common in our out-patient and in-patient clinics. We have patients with rheumatoid

arthritis, osteoarthritis, all those musculoskeletal conditions that we do know of. Most of the out-patients are usually just musculoskeletal conditions from foot and ankle pain, knee pain, hip pain, shoulder pain as well. Physiotherapists are a lot more generalist in Kenya, so in the in-patient hospitals you get to see stroke patients. They're in the ICU department, they're in the orthopaedic department, where we've had people with road traffic accidents. It's the same problems [as] we [do] have all over the world.

**Evans:** Tell me about the people you teach.

**Ong'wen:** I started teaching five years ago. It was more or less like a baptism of fire. I got selected as one of the trainers who were being trained in a programme that was run by the Jackson's Foundation, so it was almost like a residency programme in orthopaedic manual therapy where we had different lecturers from the US come to Kenya to teach and advance skills and physiotherapy skills. I started teaching because I was enjoying every aspect of being part of that class, so I thought the best way that I could enhance myself, from a knowledge base, was to teach others. I started teaching physiotherapists mostly, so whatever I learnt in class, whatever I learnt either from a podcast or out of my listening to other physiotherapists from different parts of the world, reading research, I thought that would best fill the gap. Because there is a very big gap, in terms of knowledge, of evidence-based medicine's latest research in Africa. So, we thought, 'We could do that.' I teach mostly physiotherapists but over the years we've been teaching all sorts of other clinicians; nurses, clinical officers, doctors who attend some of the CMEs that we provide in different rural areas. We teach patients as well. Whenever we go for the medical counts in the rural areas, we tend to have an educative session for the patients, mostly targeted towards non-communicable diseases where it's more or less a preventative approach rather than a curative approach. Those are my students; patients, medical professionals, and the Kenyan population in general.

**Evans:** Let's start with the professionals. You mentioned there's a gap, or there was a gap, in knowledge.

**Ong'wen:** If you look at the model of training that we [had] for physiotherapists, it was pretty much 100 years old and the curriculum kind of stayed that way. It was more or less very heavily targeted towards the bio-medical aspect rather than the bio-social aspect, so a lot of the information in relation to psychology, social aspects and social determinants of pain, as well as other musculoskeletal conditions, were missing from our training. For a long time, I felt that we were mostly technicians because you got a referral from a doctor and you were told to do

TENS, to provide a heat pack, to provide an ultrasound. [Those were the only things] physiotherapists used to do. The element of getting to talk to your patient to understand what brings them into the clinic, or the element of having a clinical reasoning base and doing a proper assessment on your patient was not there. [You] were handed over a sheet by the doctor and that sheet had instructions. So, the patient would hand you the sheet and say, 'The doctor told me I have osteoarthritis and these are the things that you need to do for me to get better.' A lot of the physiotherapists who finished school did not bother to go back to school anymore. None of them were participating really in aspects of continuous medical education. So, there was a gap. And there's still a very big gap in and around East Africa that we are trying to fill by either providing online CMEs-, because right now, the world has kind of, you know, moved from in-contact sessions to an online platform where I feel there's access to a lot more people, especially in the urban areas. It's a little bit of a different story in the rural areas.

**Evans:** You talk about that patient-doctor relationship, it's a doctor's job to prescribe how you get better. How do they take the business of giving a patient his or her own voice?

**Ong'wen:** A lot of the time, in Africa, and in Kenya, doctors like to take a lot more of an instructor role, or a teacher role. If you look at our education system, it's more or less the old British system where, 'What I say is rule of thumb. You need to do this.' There's not a lot of empowerment in our patients to self-care or self-manage themselves. A lot of times I've had patients who've had rheumatoid arthritis, and rheumatoid arthritis, for example, is a condition that patients really need to know how to self-manage. But you have a patient who is diagnosed with rheumatoid arthritis and they're very dependent on their doctor. They come to you and they don't have any education whatsoever, [don't know] what rheumatoid arthritis really is and how to best manage it. Most of the educated patients tend to navigate their own way in terms of understanding what the problem is. But I can tell you that a lot of times, since physiotherapists spend a good amount of time with patients, patients get a lot more education from physiotherapists and nurses because that is where they spend a lot of their time together. So, if you get a good physiotherapist who's really keen on looking at the evidence, who's really keen on finding out information about, you know, how certain diseases are managed, then you get a lot of better outcomes as a patient compared to just any other physiotherapist who's finished school, they show up at work and that's it. There's not a lot of information out there that is provided to patients, that can help them grow, or that can help them self-navigate or find out [how] to help themselves. So there is a lot of misinformation, you know, because they want to

go onto Google, for example. You get information but you don't get the best answers out of Google.

**Evans:** Otieno Martin Ong'wen from Nairobi in Kenya. So, from Africa to Canada.

Vina Mohabir works in patient engagement and pain research at The Hospital for Sick Children in Toronto, Canada. She's lived with chronic pain since her teens and has been through two pain management programmes, one for adults and a paediatric or 'sick kids' one when she was in her teens.

**Mohabir:** The Sick Kids chronic pain clinic really focused on using the 'Three P' method to help with pain management. So, physical strategies, pharmaceutical strategies, and psychological strategies. The pharmaceutical strategies allowed me to have enough control over my pain that I could pursue the psychological and the physical strategies. The psychological shift was probably the biggest change. Coming to the realisation that I was fifteen and I had no idea what the rest of my life would look like with pain, but coming to the realisation I could make an impact on my pain, and I didn't have to let it take away who I am and who I wanted to be, completely changed things for me. Realising that chronic pain is its own condition and that, although a lot of times I heard from doctors, 'We can't see anything physically wrong with you,' knowing that there *were* neurological changes in my brain and feeling validated from that almost, that there were things happening, it was definitely this big shift in my mindset about how pain could play out in the rest of my life.

Originally, when I was first referred, I was probably in one of the deepest depressions of my life because I really thought I was insane; I really thought that there was no logical explanation for what I was feeling and maybe something in my brain went wrong and I was imagining the whole thing. You know, you question everything around you. So, all of a sudden, being able to trust myself again was so powerful. Instead of looking at life as, like, a five-year plan, or a ten-year plan, or whatever that may be, the way you think before you have an illness or you have pain, learning to shift my thinking into what today looks like and surviving the day, the next day, and the day after that, recognising smaller changes while, you know, my pain was constant, it wasn't stagnant. It was dynamic, it was changing day to day, and recognising that experience... I had a physio tell me-, and she was brilliant in my recovery process-, she told me, 'You know Vina, part of changing your mindset is recognising that yes, your pain goes up, but it also comes down. You have the power to help calm down your body enough to go back down to your baseline level.'

**Evans:** So how do you do that?

**Mohabir:** That's a great question. So, this was in 2010. I think mindfulness and meditation was making its way into healthcare. But it wasn't, you know, part of that traditional CBT process that you would normally have. I began, actually, with hypnotherapy, funnily enough. So, I had my psychiatrist, who had a wonderful accent like you, kind of guide me through [these, like] getting down into a state of relaxation and being able to relax other parts of my body, and almost, like, find a vacation spot in my body that didn't hurt as much as the rest. Having a mental break by just focusing on that spot. So, I began with that hypnotherapy element. Then we shifted more into meditation and mindfulness, and mindfulness CBT, and using things like acceptance commitment therapy as well, and that's really where I found peace again. You're so uncomfortable in your body, like, all the time. It's so hard for people to understand what it's like, I mean, you really feel like you want to crawl out of your skin at every point and you'd rather be anywhere else. But it taught me that I can exist in my body and have it be a comfortable experience. I can be in pain and I can also be comfortable, and I can also find joy and relaxation and all these other things. Being aware of that and being aware of these, like, changing bodily sensations, gave me hope and it helped me stop existing in an all-or-nothing plain. It really helped me exist in my new reality which was that it wasn't pain or no pain, but it was really finding the techniques that gave me a level of power over what I was experiencing.

**Evans:** Helping patients get the 'power' Vina talks about, to have a role in the management, the *self-management* of their pain, is not always an easy concept for the healthcare professionals to get over to their patients.

Otieno Martin Ong'wen:

**Ong'wen:** I tend to try and engage my patients in a manner that makes them feel and own this. I tell them, 'Consider me as a teacher who's helping you through your journey, not as an instructor. You only have a limited amount of time with me. But what happens when I am not around?' So, there is usually-, there's a book I read when I was, you know, just new in the medical field, of where there is no doctor. This is a conversation that I usually tend to bring to the table a lot with patients because I've had instances where I ask my patients, 'Can I do a physical examination on you?' Or, 'Can I [even] take a proper history from you?' And the patient tells me, 'How do you not know? The doctor already gave you a prescription. You should know.' You know, you're considered a magician or a god of sorts, like, 'You already know from seeing me. You should already know what to do to me [for me] to get better.' But of course, I try to

bring in conversations of, you know, the right foods to eat, simple exercises and measures to help them. So, it's usually difficult, especially with patients who don't have education, like higher education levels. It's difficult, but since I spend a lot more time with them, it's a matter of getting them to trust me enough, but also getting them to trust themselves enough with their care to the extent that they change. And you know, changing belief systems is one of the most difficult processes. As a clinician myself, changing my own beliefs is not easy, so trying to really put emphasis on a self-management approach on patients is usually not the easiest way to approach things. But, it's a collaboration of sorts. I try to show them, I ask them, you know, 'Can you read?' I try to translate, depending on the languages that they speak. A lot of the time I tend to involve the family as well. So, you might get that there's a generation of Kenyans who did not get proper education, but whenever they come to the clinic I ask them, 'Do you have children?' and if the children are educated, I educate them to educate the patient in a language that they can understand.

**Evans:** Children teaching parents is an interesting turnaround but not confined to Africa. Vina Mohabir, in Toronto, again.

**Mohabir:** When I used to go the doctors my mom would come with me to an appointment. She'd say, 'Show what the pain is doing to you. Don't laugh. Don't brush it off.' It was a big issue because I learnt how to cope with my pain so well that I would go to the doctor's, or I would see other healthcare professionals, and they'd be, like, 'Oh she's fine, she's coping well.' And then I'd go home and I'd be crying or, you know, I'd be in a lot of pain, and my mum was, like, 'Now you're not going to get help.' But it shouldn't matter that I can laugh and I can smile, and I can have consideration of other people. I can have manners and say, 'How are you?' and things like that. Pain doesn't take away those things. It's almost this idea of what a pain patient has to be, and I stopped doing that because I want them to know that yes, I can cope with my pain. But I can also live with a tremendous amount of pain and just because I'm coping well doesn't mean that treatment should stop, or that I don't deserve adequate medical care, or that I don't deserve a referral to see somebody to help lower my pain. Just because I *can* cope with what I have doesn't mean I should, and it doesn't mean that I have to stop being myself either.

**Evans:** The visibility of pain-, do I look like I'm in the pain I say I'm in? Is it OK to smile, laugh even, what sort of message does that send? Many people living with pain will have experienced that dilemma, I certainly have. It's also the case that when psychological therapy is recommended for what is obviously, well, obviously to you anyway, a physical problem, wires can get crossed.



Mary Wing.

**Wing:** I'd been told two things. One, that I would be better in twelve months, and then I was told that it was all my fault when I wasn't. So, by the time it got to 2006, I was really in a dark place because every solitary person in the world that I knew was working, except for me, so I didn't have anyone to catch up for a coffee or a lunch with, or to talk to on the phone. So, by the end of winter I was pretty down. But then in 2007 all these different things happened to me. I had a doctor who I see, who has nothing to do with pain management, who had been trying to see if he could come up with a solution for me. When he couldn't, he said to me, 'How would you feel about seeing a pain psychologist?' I said, 'Well, that's okay with me, but why?' And he said, 'Because you're so frightened.' And I said, 'Well, yes I am, actually.' She was an amazing help.

I also had my eye on a postgraduate university course on chronic condition management that I wanted to study. I knew that I had to do something to distract myself because I was sitting there just wrapped up in this pain day in and day out, and I thought, 'I like to study', so I thought if I could study something-, it was distance [education] so it was online, so therefore I wouldn't have to worry about, sort of, traipsing around massive university campuses. She encouraged me to apply for that, because I'd been too gutless to do that up until then, and once I applied, I got in and that kept me busy for a good two and a half years. That was really fantastic. I also attended a six-week self-management course for chronic conditions which was run, at the time, by a local not-for-profit here in Adelaide. Those three things together that year not only kept me very busy, but I noticed that my pain levels were much better at the end of it. I learned how to pace myself, I learned how to set goals, I learned how to do all those self-management techniques. Plus, I had the distraction of [university] and the psychologist to talk to if I needed her.

**Evans:** Tell me how the psychologist helped you.

**Wing:** She helped me to realise that pain doesn't necessarily equal harm. She taught me to relax. That was the first thing that she taught me to do. She taught me self-hypnosis and gave me some recordings to listen to. She suggested I do that several times a day and I did, and it helped. When I got up in the morning, my pain levels would be a reasonable level. Then it would just, sort of, go up and up and up and by the evening I was just a mess. But, when I started to do all these other things, and in particular the relaxation, I found that the levels were going up and down more in the daytime. So, when it got to the evenings, it was actually much more pleasant for me and obviously then much easier to go to bed and get to sleep.

**Evans:** Mary Wing.

Now, how psychological therapy for chronic pain is broached depends very much on the patient's culture.

Otieno Martin Ong'wen in Kenya.

**Ong'wen:** It's actually considered a taboo to have mental health problems. When I was undergoing my training and we were talking about mental health screening tools, one of the questions on the mental health screening tool, which was the PHQ-9, was, 'Are you depressed?' That was the first question, and the second question was, 'Are there things in life that you used to do that you don't fancy doing anymore?' The first question, when I tried it out in the clinic the first time[s], I got into so many problems with most of my patients because they were, like, 'What makes you think, or what makes you decide that I am depressed?' Then I was, like, 'No, no, this is not me saying that you're depressed. This is me trying to find out a little bit more about some of the psychology aspects of contributors [as] to why you're in pain.' So, I needed to figure out how best to ask that question because of the traditional aspect that you're not supposed to be depressed, you're supposed to be a man, you're supposed to be strong, be a warrior. It's not been an easy journey. It's been a lot of learning on the way. And you know, sometimes it's difficult to incorporate research that is considered evidence-based practice and considered the guidelines on how to manage certain aspects. Yet, the research did not include some of the cultural aspects of African communities. How do you go about some of those problems in terms of addressing them? It's been a journey of really trying to pick what actually works, kind of like juggling in between trying to make my patients understand these approaches of therapy that could benefit them.

**Evans:** It's a very difficult bridge to cross, isn't it? Somebody might come in with back pain and you explain the role of the mind, the psychology, in pain. Because many patients, in the UK and probably everywhere else in the world, would come away from that conversation saying, 'The doctor thinks I am mad. I am not. I have a bad back.'

**Ong'wen:** Yes, I would say me trying to highlight some of the social contributors to some of the symptoms that we feel has been a difficult journey for me. But the beauty of it is the patients, as they move on, and as they journey on, they tend to realise or pick up some of those determinants or contributors to their pain, or contributors to the symptoms of their pain. So, it's usually a journey of patients, and [then] they come to that self-realisation and self-actualisation that there are certain things in the environment that are actually contributing to the symptoms that they have. And of course, I've run into so many problems with patients about patients telling

other patients, or their doctors, that, 'My physiotherapist said I was crazy.' Because if you look at how a lot of the pain science was taught, it was, you know, 'Pain is in the brain.' You try going to tell an African that pain is in their brain. It'll not go well. [laughs]

**Evans:** Well, the other thing is that you talk about exercise as medicine. Well, medicine is tablets.

**Ong'wen:** Yes, I try to really approach that topic in so many different ways. We do know the benefits of exercise and physical activity. I try even not to talk about exercise. I try to address it as physical activity and movement, so the patients get surprised that actually some simple movements can be solutions to [their] problem[s]. I usually tend to lean towards the African culture of movement. You know, Africans have been very keen at moving from one point to another, from the nomadic ways, us living in environments where we needed to walk from one point to another because there was no technology for us to have the luxury of sitting on a motorbike or sitting [in] a car. But if you look at technology, [and] everyday technology one way or another is designed to make work easier for us, but it also takes away a lot of the movement aspects of being human, right?

I try to encourage my patients to, you know, think about grandma. They use [a lot of the] grandparents as examples a lot in a clinical set-up. So I say, you know, 'Grandma never needed to go to the hospital, and I guess these are the reasons why. First of all, she was very fit. She still cooks while squatting.' You know, we have, like, a three stone kind of thing where you have one stone at the end, another stone, and a third stone, and you have wood put in between. The only way for you-, you can't cook while standing, so you need to get into a squatting position to cook, or a kneeling position. I use examples of such movements to encourage that, because sometimes I ask my patient, 'Is it possible for you to get in and out of a squat?' Most of them realise that this is a movement [they] haven't done in so many years, for example. Or it's a movement that [they] only do when [they're] in the rural areas because it's a pit latrine. You don't have the luxury of having a toilet but we've since developed to the extent that you find that in the rural areas. But also, since we are religious, I use a lot of religious examples. So, pick Elijah for example. Elijah used to walk from one point to the other. Moses had to go up Mount Sinai, which is some sort of serious physical activity and also, he needed to carry the stones back down. So, some simple examples from a religious perspective. And dance. Africans like to dance, from a traditional perspective. Dancing at weddings, dancing at marriages, dancing when [we] have certain ceremonies. I don't tend to use the gym as an area where you are going to get all of your exercise as medicine. I use simple movements that we tend to do on a day-to-

day basis. Once they get comfortable moving, I can start the discussion [on], 'What do you feel about transitioning to a gym set-up? What do you feel about moving, or advancing or increasing, your levels of physical activity? But it's difficult to convince patients, especially those who've never been to a physio, that movement can actually help you feel better.

**Evans:** I'm just looking at some of the conferences you've spoken to around the world. What do people outside Africa-, in America, in the UK, in Europe-, what can they learn from you in East Africa?

**Ong'wen:** Africans are very resilient people, and the pain culture in Africa is a little bit different, to the extent that sometimes it can be dangerous. You need to be strong no matter what. It's a resilience culture, which is great. But when it so happens that you have a medical condition that is serious and needs immediate attention, for example, or needs to be looked into, it becomes problematic. Whenever we go to the rural areas, we ask patients, 'Do you get hip pain?' [They reply], 'Why are you asking me that? It's normal to have hip pain. It's not a bother for me. Actually, it wasn't even a bother for me until you asked about it.' They want to come to the clinic when they cannot move anymore or when there's actually too much pain. So, on a scale of zero to ten, it's probably a twenty [laughs]. There's the elemental resilience, but to what extent? What we can learn is-, and I don't know whether this is a lack of access to immediate healthcare provision-, but in general, we tend to be very resilient in our journeys, or in our *pain* journeys. The beauty about it is, of course, our patients are going to move regardless because they don't have a choice. In some ways you find that that movement in itself actually heals them of the pains that they had. This is not documented. There's no research in and around that to say that because of this, then that. But I want to believe that the elements of resilience, and the elements of keeping [moving], are beneficial, but they can also be detrimental at the same time because maybe what we've transitioned [to] now is to try and teach patients that this looks like a red flag. There are certain pains that are actually not normal pains. 'It's not that you're bewitched, it's not that you have some cultural connotation to it, but it sounds like this is cancerous pain,' for example. So, we tend to teach our patients red flags so that they understand when to come to hospital, especially for the men. If you look at the population of men in Kenya who have some sort of cancer, they die early as compared to the females, because, first of all, they never really talk about it. Maybe it's the cultural thing, to the extent that when you say you're in pain you're told, 'Take it as a man. Brave it on. Warrior on.' It's too painful, and the man in you does not want to bother the rest of the family with a pain that [makes you look weak]. If that is the case, where do they go? I've tried on so many levels to encourage men to come out or speak about

their pains, because maybe you getting to speak to somebody else or you getting to interact with somebody else who has the same problem makes that problem less of a burden than thinking that you're in this alone. So, I like to go to patient gatherings and just sit there and listen to patients having [a] conversation.

There's a group of cancer patients who are female. Whenever they meet, they're talking, they're reaching out to one another, they're encouraging one another. They're figuring out things, 'Oh, how did you grow your hair? How did that happen? Your hair looks nice.' There's that interaction that makes you feel that [you're] not in this alone. It makes you feel that [you're] strong and we're strong and there's nurture, and there's somebody I can reach out to. So, pick a group of men and, you know, tell them, 'Let's talk about prostate cancer.' You can have up to ten minutes of silence before somebody says something. It's a culture that-, I don't know how long it will take to change it. I am also learning how to open up, to my friends for example, or even to my patients. Or even having open conversations and feeling vulnerable, or feeling weak, as a man myself. So I guess it's going to be a journey that we get to understand with a lot more education, but also just understanding, or helping the men understand that we can also share our problems, and by sharing our problems it becomes easier, first of all, to really navigate, but it also becomes easier to understand that we are not in this alone.

**Evans:** Otieno Martin Ong'wen.

I'll just need to remind you that whilst we in Pain Concern believe the information and opinions on **Airing Pain** are accurate and sound based on the best judgements available, you should always consult your health professionals on any matter relating to your health and wellbeing. They are the only people who know you and your circumstances and therefore the appropriate action to take on your behalf.

Do check out Pain Concern's brand new shiny website at [www.painconcern.org.uk](http://www.painconcern.org.uk) where you can download all editions of **Airing Pain** and find a wealth of support and information material about living with and managing chronic pain.

The International Association for the Study of Pain and Global Alliance of Partners for Pain Advocacy Taskforce has a really good website that brings the latest scientific developments into simple language for the understanding of patients and the wider public at <https://relief.news>, very simple. And to remind you about the International Association for the Study of Pain Global Year about Backpain, it's at <https://www.iasp-pain.org/GlobalYear>

Last words in this edition of ***Airing Pain*** go to Vina Mohabir in Canada.

**Mohabir:** There's not one part of my life that is untouched by my pain. So, I would encourage anybody who doesn't have pain, or doesn't cope with pain, to just talk to the people they know who do. You just have to say, 'How can I be a better support to you? What would make today easier for you?'

### **Contributors**

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### **More information:**

- [IASP Global Year About Back Pain 2021](#)

### **With thanks to:**

- IASP, International Association for the Study of Pain – <https://www.iasp-pain.org/>