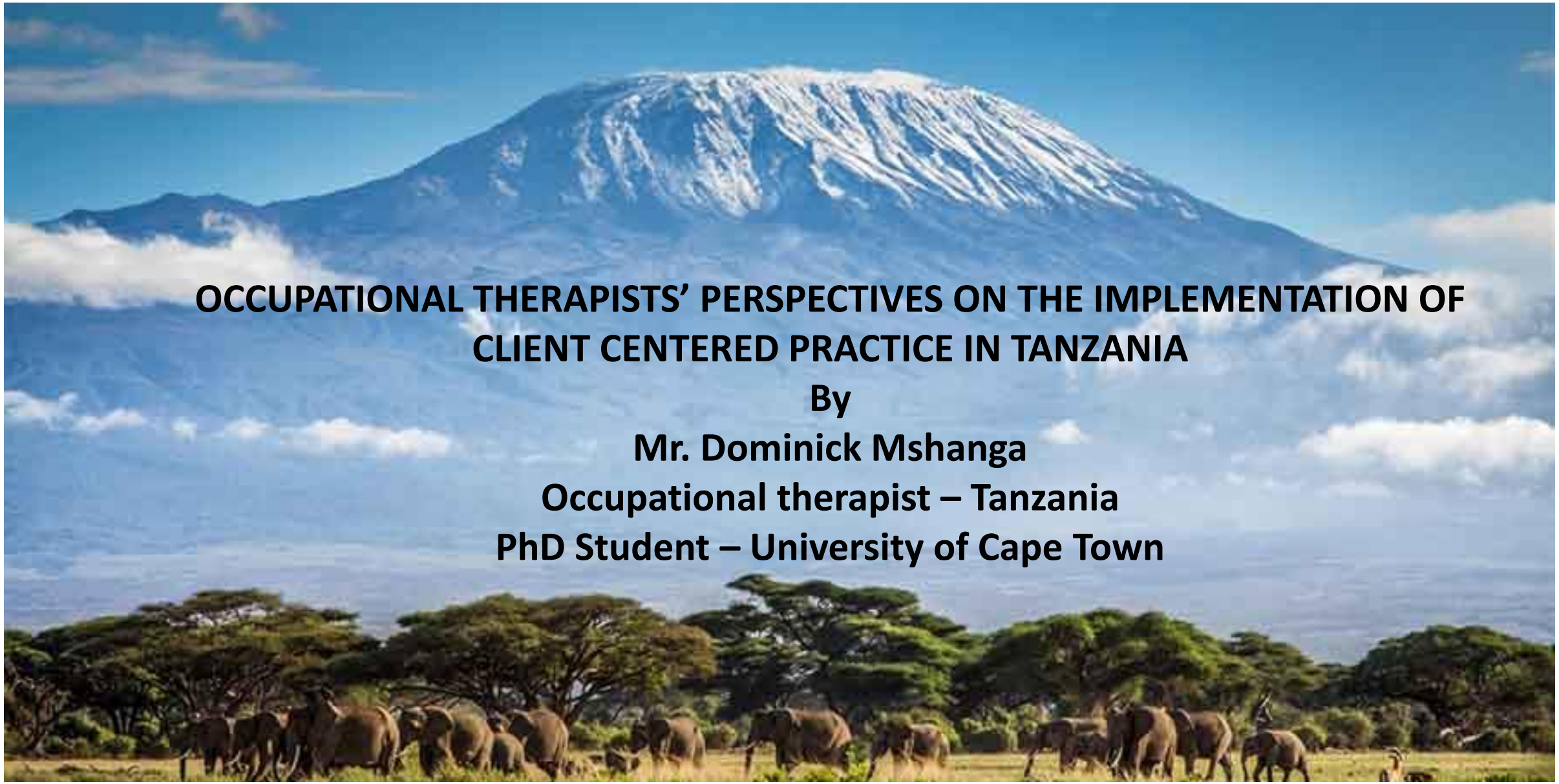

OCCUPATIONAL THERAPISTS' PERSPECTIVES ON THE IMPLEMENTATION OF CLIENT CENTERED PRACTICE IN TANZANIA

By

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Outline of the presentation

- Introduction
- Aim of study
- Purpose of study
- Research question
- Objectives of the study
- Findings
- Conclusion

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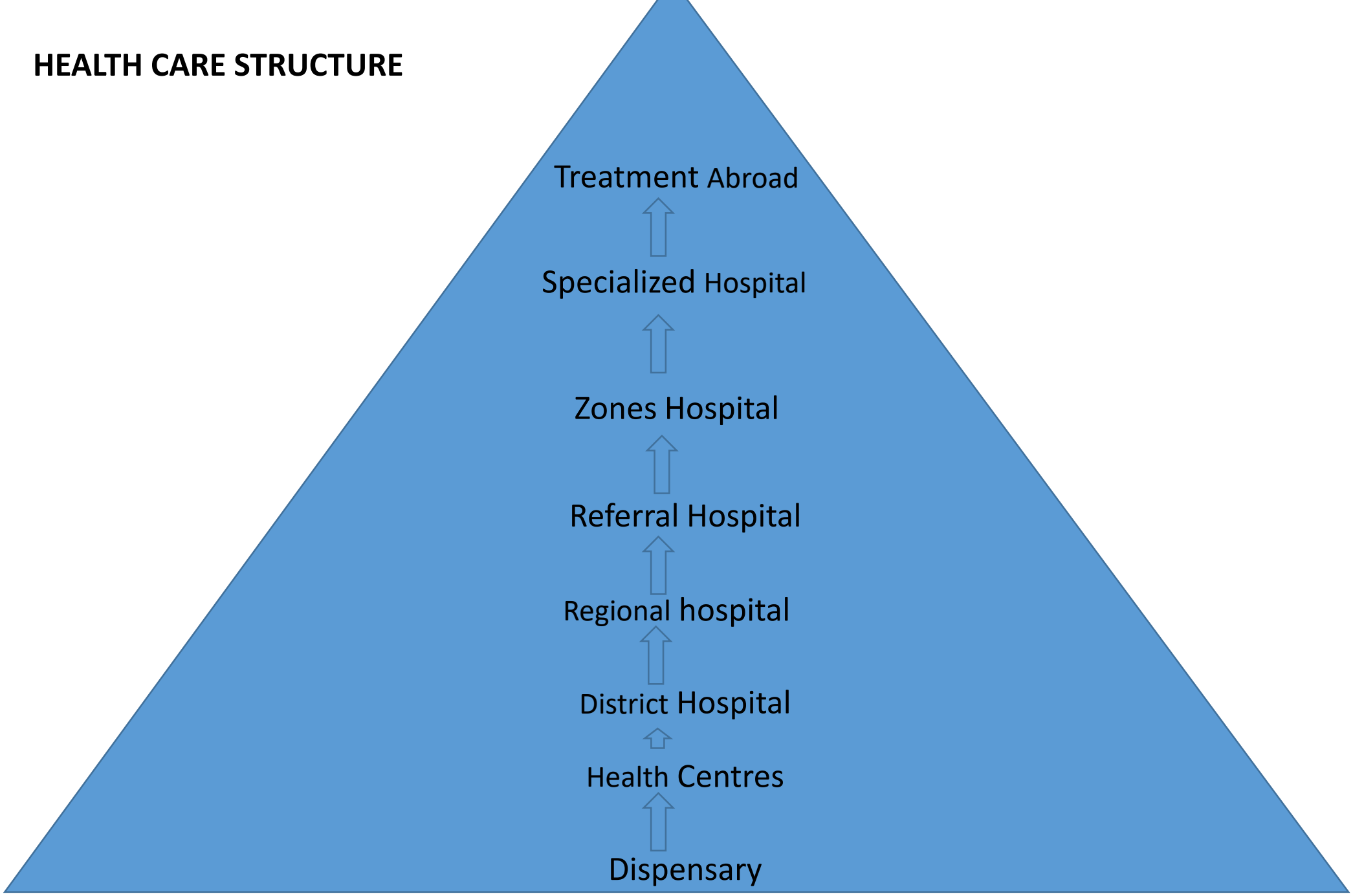
Introduction

- United Republic of Tanzania (URT) is located in Eastern Africa, bordering the Indian ocean, Burundi 589 km, Democratic Republic of Congo 479 km, Kenya, 775km, Malawi 512 km, Mozambique 840 km, Rwanda 222km, Uganda 391km, and Zambia 354
- It has a population of about 44,928,923 (Population and Housing Census, 2012).
- The health services in Tanzania are delivered by government, parastatal organizations, voluntary organizations, religious organizations, private practitioners and traditional medicine provider (URT/MoHCDGEC, 2013).

- The health system in Tanzania follows the pattern of government structures of leadership in the form of hierarchy.

HEALTH CARE STRUCTURE



- The Occupational therapy services in Tanzania started around 1950s by expatriate OTs
- The training of occupational therapist started in 1998
- Training is recognized by WFOT.

Introduction

- The World Federation of Occupational Therapists (WFOT) describes occupational therapy as ‘a client-centred health profession’ (WFOT 2012, p1).
- Client-centred practice (CCP) advocates shared power between clients and professionals (Chan, 2002) and that the client’s perspective forms the focal point around which occupational therapy revolves (WFOT, 2010a; Maitra and Erway, 2006).
- The use of the CCP approach may vary across countries because of differences in culture and service contexts (WFOT, 2010b).

Intro cont….

- The Canadian Association of Occupational Therapists (CAOT) was the first professional body to formally adopt CCP as its official intervention approach (Townsend, 1983).

- The American Occupational Therapy Association (AOTA) and the British College of Occupational Therapists (COT) subsequently integrated CCP into their codes of professional conduct (AOTA, 1995; COT, 1995).

- Occupational therapy is a relatively new profession in Tanzania with the first, and currently the only, education program being launched in 1998. The diploma level curriculum was based on practice approaches developed by the Canadian Association of Occupational Therapists (CAOT).
- The concept of CCP was introduced into the program by international volunteer educators most of whom held Eurocentric perspectives on occupational therapy practice.
- The relevance of the CCP approach within Tanzania has not been investigated to date.
- This study therefore aimed to determine the understanding and use of CCP by Tanzanian occupational therapists.

Aim of study

- The study aim was to determine the understanding and use of CCP by occupational therapists in Tanzania.

Research purpose

- The study may promote the advancement of practitioners' CCP competencies by guiding the Tanzanian Occupational Therapy Association (TOTA) on the development of continuous professional development (CPD) courses.

Research question

- *What is the understanding of Tanzanian occupational therapists on CCP, and to what extent are they implementing CCP?*

Objectives of the study

1. To determine perceived understanding of CCP.
2. To identify the perceived barriers to implementing CCP.
3. To identify the perceived enablers to the successful implementation of CCP.
4. To determine if there are any significant associations between demographic characteristics and barriers/enablers to CCP

Methods

- It was descriptive cross sectional study
- Population and sampling – all qualified and registered OTs working in TZ from 2002 – 2014
- They were 70 OTs in number
- Sample size 67
- Sampling method – non-probability convenience sampling was used
- Data collection – Questionnaire was used
- Data analysis – SPSS version 20.0 for quantitative data and For the open ended responses, responses were captured verbatim in *Microsoft Excel* and a thematic content analysis was conducted

Ethical approval

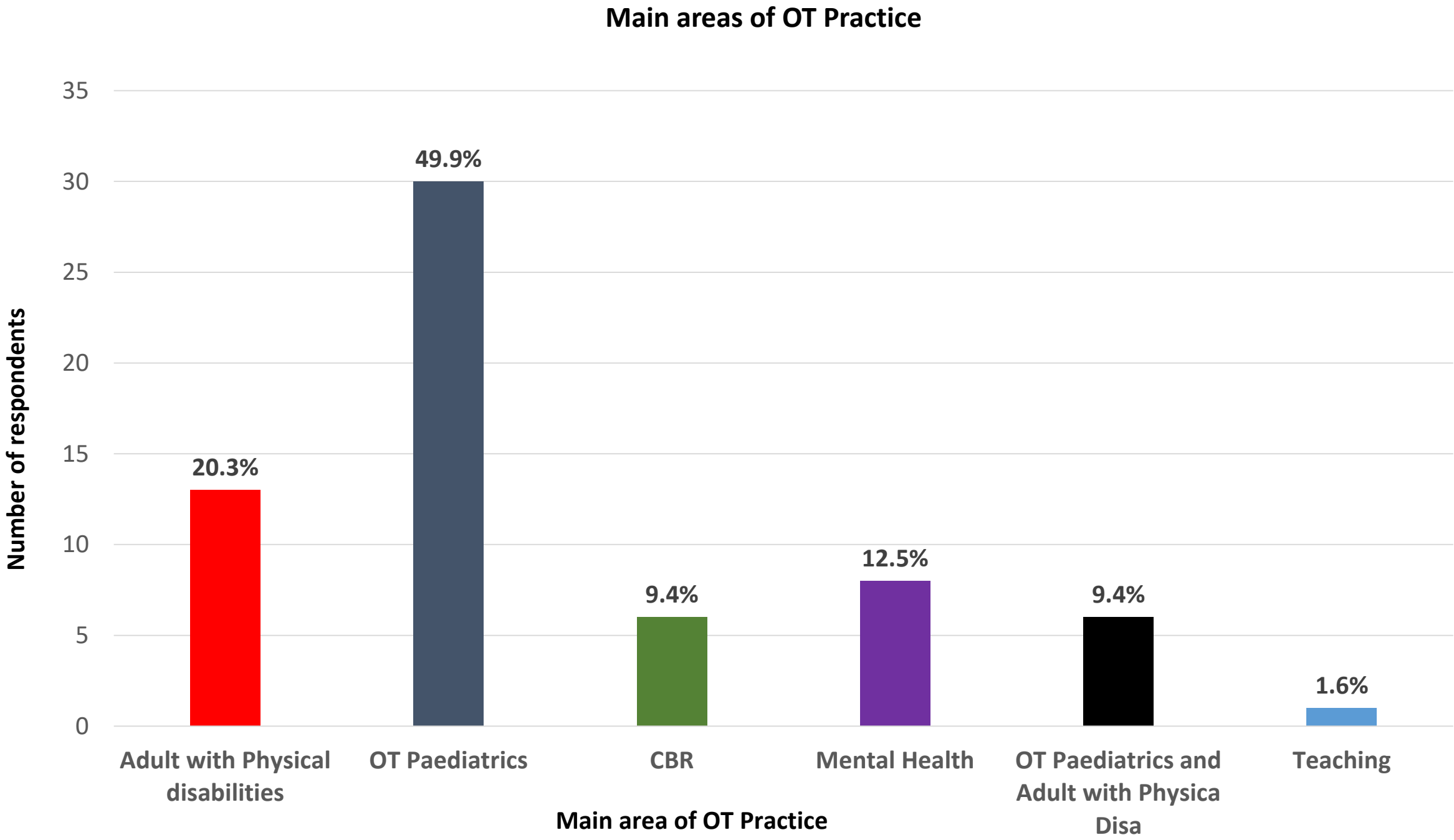
- Ethical approval to conduct the study was obtained from the Faculty of Health Sciences Human Research Ethical Committee of the University of Cape Town and the National Institute for Medical Research Tanzania (NIMR)

RESULTS

Profile of participants

Variable	Median	Range	IQR
AGES	28.0	28.0	25.0 – 35.0
EXPERIENCES	3.0	13	2 – 8.5

GENDER	Frequency	%
MALE OTS	27	42.2%
FEMALE OTS	37	57.8%


Main areas of OT Practice
35
30
25
20
15
10
5
0
Number of respondents
49.9%
20.3%
9.4%
12.5%
9.4%
1.6%
Adult with Physical disabilities
OT Paediatrics
CBR
Mental Health
OT Paediatrics and Adult with Physica Disa
Teaching
Main area of OT Practice

Occupational therapy education

- Diploma 62 (96.9%)
- Masters 2 (3.1%)

Understanding of CCP (n=64)	Responses		Total
	Yes	No	
Do I:	No.%	No.%	No.%
1. Consider my clients as individuals?	63 (98.4)	1 (1.6)	64 (100.0)
2. Listen to what my clients say?	61 (95.3)	2 (3.1)	63* (98.4)
3. Inform them about what I am doing in a way they will understand?	61 (95.3)	3 (4.7)	64 (100.0)
4. Educate my clients about occupational therapy?	60 (93.8)	4 (6.3)	64 (100.0)
5. Naturally approach my clients in a genuine and honest manner?	62 (96.9)	1 (1.6)	63* (98.5)
6. Treat my clients with respect and value their opinions?	59 (92.2)	4 (6.3)	63* (98.5)
7. Cut down barriers to ensure my clients feel welcome in your OT service?	59 (92.2)	5 (7.8)	64 (100.0)
8. Engage my clients actively in partnership throughout the occupational therapy process?	55 (85.9)	9 (14.1)	64 (100.0)
9. Negotiate with my clients about goals and outcomes?	53 (82.8)	9 (14.1)	62* (96.9)
10. Treat my clients politely and equally?	58 (90.6)	5 (7.8)	63* (98.4)
11. Respect my clients when they change their minds and re-focus their goals?	56 (87.5)	5 (7.8)	61* (95.3)
12. Ensure my clients understand about risks, safety issues and resource limitations?	59 (92.2)	4 (6.3)	63* (98.5)
13. Demonstrate confidence in using CCP practice?	54 (84.4)	10 (15.6)	64 (100)
14. Am I client centred?	59 (92.2)	3 (4.7)	62* (96.9)

Potential barriers to client-centred practice (n=64)

Barriers	Minimal barrier	Substantial barrier	
	No. (%)	No. (%)	Total
1. The therapist is short of time	13 (20.3)	51 (79.7)	64 (100.0)
2. The therapist is under financial pressure	29 (45.3)	35 (54.7)	64 (100.0)
3. The therapists level of stress is high	24 (37.5)	40 (62.5)	64 (100.0)
4. The intervention is dominated by the medical model	17 (26.6)	47 (73.5)	64 (100.0)
5. The therapist does not know enough about CCP	22 (34.4)	42 (65.6)	64 (100.0)
6. The therapist does not have enough self-knowledge	21 (32.9)	43 (67.2)	64 (100.0)
7. The therapist had difficult taking risks in order to support the clients goals	15 (23.4)	48 (75)	63*(98.4)
8. CCP is too great a change from current practice	32 (50.0)	31 (48.5)	63*(98.5)
9. The therapist and client are of different culture	30 (46.9)	32 (50)	62*(96.9)
10. The therapist and client are of different gender	47 (73.5)	17 (26.6)	64 (100.0)
11. The therapist has difficult assessing the clients ability to choose their own goals	19 (29.7)	45 (70.3)	64 (100.0)
12. The therapist has difficulty facilitating the clients identification of their own goals	19 (29.7)	45 (70.3)	64 (100.0)
13. The therapist thinks that CCP is too demanding for the client	14 (21.9)	50 (78.1)	64 (100.0)
14. The therapist is uncomfortable letting the client choose their own goals	19 (29.7)	45 (70.3)	64 (100.0)
15. The therapist and client have different goals	15 (23.8)	49 (76.6)	64 (100.0)
16. The therapists values and beliefs prevent them accepting the clients goals	24 (37.6)	40 (62.5)	64 (100.0)

Enablers to client-centred practice (n=64)

Enablers	Substantial enablers	Minimal enablers	Total
1. Education about CCP while still a student	63 (98.5)	1 (1.6)	64 (100.0)
2. Education about CCP while a practicing Therapist	55 (86)	7 (11)	62* (97)
3. Education which is not disease centred	42 (65.6)	15 (23.5)	57* (89.1)
4. A clear definition of CCP	56 (87.5)	8 (12.5)	64(100.0)
5. More explanation about and elaboration of CCP	60 (93.7)	3 (4.7)	63* (98.4)
6. Case examples showing how to practice in a client- centred manner	61 (95.4)	3 (4.7)	64(100.0)
7. Education about how to grade CCP for different capabilities	60 (93.7)	2 (3.1)	62* (96.8)
8. Education to increase knowledge of other cultures	55 (86.9)	7 (10.9)	62* (97.8)
9. Training to increase self- knowledge as an OT	59 (92.3)	2 (4.7)	61* (97)
10. Interpersonal skills Training	61 (95.3)	3 (4.7)	64(100.0)
11. Assertiveness training	55 (85.9)	7 (12.5)	62* (98.4)
12. Negotiation training	53 (82.8)	8 (12.5)	61* (95.3)
13. Involving people with disabilities in training to increase disability awareness	58 (90.6)	6 (9.4)	64 (100.0)
14. Client involvement in planning services	62 (96.9)	2 (3.1)	64 (100.0)
15. Client involvement in evaluating services	59 (92)	4 (6.3)	63* (98.3)
16. Management and peer support for use of CCP	58 (90.2)	6 (9.4)	64 (100.0)
17. Involvement of all staff & service providers in CCP training	62 (96.9)	2 (3.2)	64 (100.0)
18. Dedicated staff education time to learn how to practice in a client-centred fashion	61(95.3)	3 (4.7)	64 (100.0)

Conclusion

- Tanzanian occupational therapists showed ambivalence towards CCP.
- They reported that therapists have too little time to implement CCP; that CCP is too demanding for the client to appreciate and that therapists and clients have different goals.
- They believe that CCP could be advanced through education about CCP while still students, the involvement of all staff and service providers in CCP training, and client involvement in planning their occupational therapy Qualitatively, Tanzanian occupational therapists believe that CCP enriches the occupational therapist-client relationship, CCP is difficult in Tanzania and CCP needs to be supported in Tanzania.

Conclusion cont…

- Tanzanian occupational therapist would best benefit from introducing a range of occupational therapy practice models besides CCP because the health service context is resource-constrained, hospi-centric and regulated by the medical model. It does not, therefore, allow for the optimal implementation of CCP.

Thank you for listening

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