Perspectives of occupational therapists on the implementation of client-centred practice in Tanzania

Student: Dominick Michael Mshanga

Student number: MSHDOM001

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Supervisor: A/Professor Madeleine Duncan

Co-Supervisor: Dr Helen Buchanan

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DECLARATION

I, ***Dominick Mshanga,*** hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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LIST OF ABBREVIATIONS

CAOT	-	Canadian Association of Occupational Therapy.
CCP	-	Client-Centred Practice
CMOP	-	Canadian Model of Occupational Performance.
CMOP-E	-	Canadian Model of Occupational Performance and Engagement
COPM	-	Canadian Occupational Performance Measure
COT	-	College of Occupational Therapists
CPD	-	Continuing Professional Development.
CPE	-	Continuing Professional Education
IBM	-	International Business Machines
ICF	-	International Classification of Functioning and Health
KCMUCo	-	Kilimanjaro Christian Medical University College
MOHSW	-	Ministry of Health and Social Welfare
NIMRT	-	National Institute for Medical Research Tanzania
OT	-	Occupational Therapy
OTs	-	Occupational Therapists
PPS	-	Prospective Payment System
PQACCP	-	Professional Questionnaire for Assessing CCP
SPSS	-	Statistical Package for Social Sciences
TOTA	-	Tanzania Occupational Therapy Association
URT	-	United Republic of Tanzania
WFOT	-	World Federation of Occupational Therapists
WHO	-	World Health Organization

DEFINITIONS OF TERMS

Barriers

> Factors in a person's environment that, through their absence or presence, limit functioning and create disability (WHO, 2001, p. 214).

Client-centred Practice

> Client-centred practice refers to collaborative approaches aimed at enabling occupations with clients who may be individuals, groups, agencies, government, corporations or others. Occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients in meeting clients' needs, and otherwise recognize clients' experience and knowledge (CAOT, 2002. p. 49). The terms client-centred practice and client-centred approach are used interchangeably in the literature.

Client

> A Client is an individual who may have occupational problems arising from medical conditions, transitional difficulties or environmental barriers. Clients may also be organizations that influence the occupational performance of particular groups or populations (CAOT, 2002. p 50).

Collaborative practice

> Involves the continuous interaction of two or more professionals or disciplines, organized into common effort, to solve or explore common issues with the best possible participation of the patient (Herbert et al., 2007)

Culture

> The knowledge, beliefs, values, assumption, perspectives, attitudes, norms and customs that people acquire through membership of a particular society or group (Hammel, 2009a, p 7).

Developing country

The main classification system used by the World Bank is based on gross national income (GNI) per capita. This system categorises countries into low-income, middle-income or high-income based on their GNI. Low- and middle-income countries are sometimes referred to as 'developing countries' (The World Bank Group, 2015).

Enabler

Person or thing that makes something possible (Oxford Dictionaries, 2013)

Health promotion

The process of enabling people to improve and increase control over their health (World Health Organization, 1986).

Patient

A person who is receiving medical treatment, especially in hospital (Oxford Advanced Learners Dictionary, 2010)

Practice

'The carrying out or exercise of a profession, especially that of medicine or law' (Oxford English Dictionary, 2011b)

OTseeker

An occupational therapy evidence database developed in Australia that contains systematic reviews and randomized controlled trials of interventions. Trials are rated to enable users to judge their quality (Bennett *et al.*, 2003a, McKenna *et al.*, 2004).

ABSTRACT

Background: The concept of client-centred practice (CCP) was first developed and implemented by occupational therapists in Canada during the early 1980s and subsequently transferred into the Tanzanian occupational therapy curriculum by international volunteer educators. Currently, the occupational therapy curriculum at the Kilimanjaro Christian Medical University College (KCMUCo) in Moshi, Tanzania covers CCP using assessment tools and models developed by the Canadian Association of Occupational Therapy. To date, no occupational therapy research has been conducted to investigate the relevance of CCP for Tanzania, or to document the perspectives of therapists in applying the principles of CCP. This study was indicated to inform the occupational therapy curriculum at the KCMUCo and the Tanzania Occupational Therapy Association (TOTA) about occupational therapy practice realities related to the implementation of CCP in Tanzania and to guide the alignment of the occupational therapy curriculum towards a local understanding of CCP or an alternative (non-Western) perspective**.** This study, therefore, aimed to determine the understanding and use of CCP by occupational therapists in Tanzania.

Methodology: The study used a descriptive cross-sectional design. All qualified occupational therapists working in different regions in Tanzania were approached to participate in the study (N=80). A questionnaire, the Professional Questionnaire for Assessing CCP (PQACCP) was adapted for the study. The questionnaire consisted of five sections: 1) demographic and practice information; 2) an adaptation of an existing checklist on understanding CCP (Parker, 2006); 3) potential barriers to CCP; 4) enablers of CCP; and, 5) therapist opinions on the relevance of CCP for the Tanzanian context. The checklist of potential barriers and enablers was adapted from Sumsion & Smyth, (2000). Data were analysed using the SSPS software program (version 20.0). Numerical variables were checked for normality and the appropriate measures of central tendency and dispersion calculated. Frequencies and proportions were determined for categorical items. The Chi-square test of association was done to determine whether there were any observed associations between demographic variables and barriers/enablers.

Results: The top three barriers were *'the therapist is short of time' (n*=51, 79.7%), *'the therapist thinks that CCP is too demanding for the client'* (n=50, 78.1%), and '*the therapist and client have*

different goals' (n = 49, 76.6%). The top three enablers were '*education about CCP while still a student'* (n = 63, 98.8%), *'client involvement in planning of services'* (n = 62, 96.9%), and *'involvement of all staff and service providers in CCP training'* (n = 62, 96.9%). There were no statistically significant relationships between demographic characteristics and understanding of CCP, barriers to CCP and enablers to CCP. There were statistically insignificant but interesting gender differences in the identification of enablers and barriers that warrant further exploration.

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. 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.

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CHAPTER 1: INTRODUCTION

This chapter presents information about why this study was undertaken, background about client-centred practice (CCP) including the concept of CCP and challenge to CCP in Tanzania, research context, research problem statement, research purposes, research question, aims of study, and study objectives.

1.1 Introduction

CCP is a process in which the client is the focal point around which occupational therapy interventions evolves (Maitra & Erway, 2006). It is a cultural concept based on the shared power between clients and professionals (Chan, 2002) and as such, the application and interpretation of its principles varies from country to country and context to context. Although CCP is a key principle in many areas of occupational therapy within current international occupational therapy models (Sumsion, 2006), to date no study has been done to verify the relevance of CCP in Tanzania.

1.2 Background

Occupational therapy (OT) is a relatively new health service in Tanzania. The occupational therapy training was launched in 1988. The Tanzanian School of Occupational Therapy training is located in the Kilimanjaro Christian Medical University College (KCMUCo) in Moshi. There are currently 80 occupational therapists in the country, many of whom have been trained through the KCMUCo occupational therapy curriculum which endorses client-centred occupational therapy practice. The concept of CCP was introduced into the Tanzanian occupational therapy curriculum by international volunteer educators. The occupational therapy curriculum in Tanzania covers CCP using assessment tools and models developed by the Canadian Association of Occupational Therapy (KCMUco, 2006). However, the relevance and usefulness of this approach to occupational therapy practice in Tanzania has not been investigated to date, nor is there any information about the extent to which practitioners understand, endorse or implement this way of working. This study set out to gather descriptive, quantitative information from Tanzanian occupational therapists on their perspectives about and use of CCP.

1.3. Research context

Tanzania is located in Eastern Africa of the coast of the Indian Ocean. The country has a population of 44,928,923, with almost 75 percent living in rural areas (Tanzania Population and Housing Census, 2012).Tanzania is considered a low-income country (World Bank, 2012). The health services in Tanzania are delivered by government, parastatal organizations, voluntary organizations, religious organizations, private practitioners and traditional medicine providers (United Republic of Tanzania (URT), (2013). The health system of Tanzania, and especially the government's referral system, takes up a pyramidal pattern. The organization of health services starts at the primary level of village health services and dispensary services and continues to secondary and tertiary levels of healthcare at health centres, district hospitals, regional hospitals and referral/consultant hospitals. Referral hospitals are the highest level of hospital service, and offer specialized health service in the country (URT, 2013). Where further treatment is not available at referral hospitals, a patient is usually sent abroad.

There are no occupational therapists employed at village and dispensary level. The Ministry of Health and Social Welfare (MOHSW) employs occupational therapists at district, regional and referral level hospitals. The majority of occupational therapists in Tanzania are currently working in regional and referral hospitals where the biomedical model[1] is dominant. The occupational therapy services within MOHSW are not currently featured on the ministry organogram but the training of occupational therapists is under the human resources development section sub-division of allied health sciences training. The social welfare division is responsible for addressing issues of people with disabilities.

The health sector in Tanzania has been facing a serious human resource crisis that is negatively affecting the ability of the sector to deliver quality health services (URT, 2013). There is a severe shortage of human resources at all levels. This shortage is more severe in rural districts due to the fact that most workers are reluctant to work in rural areas (URT,

[1]Biomedical model is an approach to pathology that aims to find medical treatments for diagnosed symptoms and syndromes and treats the human as a complex mechanism (WHO, 2001).

2013). Nevertheless, if basic employment rights are provided for, this model can work. (URT, 2013). For example, the Benjamin Mkapa HIV/AIDS Foundation Initiatives[2] have been recruiting nurses and doctors (not rehabilitation professionals) and posting them to rural areas where their basic needs are being met (for example housing) and their salaries are paid on time.

Differences in the distribution of human resources exist at urban and rural facilities level. The staff shortage is aggravated by financial shortages and the expanded population as well as the HIV/AIDS pandemic, malaria and tuberculosis (MOHSW, 2008; URT, 2013).The MOHSW has slowly been employing qualified health professionals including Occupational therapists in some of the district's referral and regional hospitals (MOHSW, 2008). The Abuja Declaration[3] (WHO, 2001) recommends the allocation of 15% of a national budget to the health sector. However, the budget allocation for health in Tanzania has been decreasing and is currently well below the Abuja recommendation as indicated in Table 1.

[2]Benjamin William Mkapa HIV/AIDS Foundation is a trust, non-profit making organization, established in 2006 by previous President Benjamin William Mkapa of Tanzania. It aims to supplement and complement the development efforts of government by enhancing the delivery of quality HIV/AIDS care, treatment and other related services (Mkapa HIV/AIDS Foundation, 2015).

[3]In April 2001, African Union countries meeting in Abuja, Nigeria, pledged to increase government funding for health to at least 15%, and urged donor countries to scale up support (WHO, 2001). Only Rwanda and South Africa have achieved the Abuja Declaration target of 'at least 15% (WHO, 2011). Twenty six countries have increased the proportion of government expenditures allocated to health and 11 have reduced it since 2001 (WHO, 2015).

Table 1: Allocation of National Budget for Tanzania. Source: United Republic of Tanzania (2013 – 2014)

Year	% of Budget
2001-2002	11.00%
2003-2004	9.70%
2004-2005	10.10%
2005-2006	11.60%
2006-2007	10.60%
2009-2010	9.60%
2010-2011	10.60%
2011-2012	8.50%

The budget fluctuations affect financial allocations to human resources in particular in terms of recruitment, incentives, retention and capacity building (United Republic of Tanzania, 2013). Other challenges the Tanzanian government has been facing include: low human resource management capacity in the councils; limited allocations for personal emolument; poor working conditions (bad roads, unreliable communication networks and electricity supply; limited recreation facilities and lack of potable water; ;suitable schools for children) especially in rural areas; limited ability of the health sector to meet the basic employee personal needs (including pay for extra, heavy workloads, workplace hazards allowance and opportunities for self-development); and, brain drain within and outside the country (United Republic of Tanzania, 2013). This means that the few health professionals that are employed carry a very high patient load. The working conditions raise the question as to whether the ideals of client-centred occupational therapy practice are in fact possible, or even relevant, hence necessitating the current investigation.

1.4. The concept of client-centred practice in Tanzania

Client-centred practice models and tools are part of the Tanzanian occupational therapy curriculum at the School of Occupational Therapy at the KCMCo in Moshi. The three-year occupational therapy course leads to a Diploma in Occupational Therapy. The majority of occupational therapy staff at the school holds a Diploma in Occupational Therapy and

some have done short courses in teaching methodology. Two staff members have a Master's degree in occupational therapy. The school used to receive volunteer educators from overseas who came on a contract basis to assist with teaching and the supervision of students in fieldwork. The use of volunteer educators stopped in 2008. The occupational therapy curriculum includes teaching on the importance of client-centred practice using assessment tools and models developed by the Canadian Association of Occupational Therapy. Students learn about the Canadian Model of Occupational Performance (CMOP) (CAOT, 1997), the use of the Canadian Occupational Performance Measure (COPM) (Law et al., 1991) and the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend & Craik 2007). The CMOP-E positions the profession beyond the medical model, and envisions health, well-being and justice as being attainable through occupation. It introduces engagement as an important construct in understanding human occupation (Polatajko, Townsend & Craik, 2007). According to Clarke, (2003) these models allow the use of other frameworks in practice and can be used across age groups, applied to various diagnoses; and to promote client-centredness in multicultural settings. However, the validity of this statement warranted further investigation within the Tanzanian context.

The Code of Ethics for Tanzanian Occupational Therapists was revised in June 2008 (TOTA, 2008). Section I addresses the occupational therapists' responsibilities towards patients/clients and their care providers and contain two statements that relate to client-centred practice:

- 'Practitioners shall respect the patient's uniqueness and right to self-determination, to make choices and decisions about their own health and welfare, to refuse treatment and to seek a second opinion'
- 'Occupational therapy personnel shall respect the autonomy of the patient/client throughout all phases of the intervention process'.

Another motivation for the study arose from observations made by educators during practice learning evaluations of third-year students. Occupational therapy students in third-year field practice placements reflect on client-centeredness by answering the following questions stipulated in the field manual:

- How do you define client-centredness?
- How do you try to be client-centred in your practice?
- What are the barriers that limit client-centeredness in the fieldwork setting?

Lecturers who engage with student reflections have identified discrepancies between the ideals of client-centred practice and the realities faced by students in the field. Although the client-centred approach seems to be encouraged by occupational therapists throughout the world, CCP is demanding, requiring the therapist to deal with many challenges. To date, no specific documents, guidelines or courses on client-centred practice have been provided to assist Tanzanian occupational therapists to broaden their knowledge about or skills in, client-centred practice after graduating from the occupational therapy program at the KCMCo.

1.5. Challenges to client - centred practice in Tanzania

Although no research has been conducted to examine the relevance of the CCP concept for practice in Africa, several challenges may be hindering the implementation of CCP in Tanzania, namely:

- *Limited resources (manpower, time and funds):* Tanzania has a shortage of 89,000 healthcare workers including occupational therapists. The WHO (2006) projected that without intervention the gap is expected to exceed 100,000 by 2019. There is lack of evidence for use of staffing ratios for allied health practitioners including occupational therapy. Staffing and resourcing for the rehabilitation professions lag behind the fields of nursing and medicine (Cartmill et al, 2012). The therapist to patient ratio in Tanzania is likely to be similar or more than the doctor: patient ratio which was estimated to be 1:30,000 people (Tanzania Service Provision Assessment Survey, 2006). The WFOT Human Resources Project data from 2014 reported the number of occupational therapists per 10,000 head of population = median 0.9 and mean 2. Inadequate funding can also contribute to failure to implement CCP (Sumsion,2006). The financial budgets in Tanzania are donor dependent due to a weak economy, low capacity for economic development, failure in governance and organization for development (corruption) and ineffective implementation syndrome (Tanzania Planning Commission, 2013).

- *Impact of poverty on service delivery* – Poverty impacts service delivery and also the type of services provided and it has a major influence on the burden of disease. Essentially, poverty is defined as 'a denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or clinic to go to; not having the land on which to grow one's food or a job to earn one's living, not having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence, and it often implies living in marginal or fragile environments, without access to clean water or sanitation' (UN, 1988).

  The World Bank defines extreme poverty as living on less than $1.25 per day and moderate poverty as less than $2 per day (World Bank, 2014). Tanzania is an example where a large proportion of the population live below the poverty line set at US$1.25 per day person (World Bank, 2015). It was reported that 'as many as 40% live in abject poverty, that is in a situation where their income is insufficient to buy food to cover minimum nutritional needs' (United Republic of Tanzania, 2001). 'The majority of occupational therapists working in Africa work within communities that are impoverished' (Crouch, 2010, p. 98). The difficulties arising from a poor country include: lack of funds and resources, lack of adequately trained personnel and very large distribution of people living in rural parts of countries. The World Bank's 'Voice of the Poor' study (Narayan et al, 2007) conducted a survey of the opinions of 20,000 poor people in 23 countries about the implications of poverty. They reported the following concerns, which occupational therapists working in Africa should take into consideration when using CCP: precarious livelihoods; excluded locations; physical limitations; gender relationships; lack of security; abuse by those in power; disempowering institutions; limited capabilities; and, weak community organizations.

- *Illiteracy among patients:* Literacy is one of the key elements needed to promote sustainable development, as it empowers people so that they can make the right decisions in the areas of economic growth, social development and sustainable environments (UNESCO, 2009-2014). Literacy is considered as a human right

(UNESCO, 2009-2014). The former United Nation (UN) Secretary General Kofi Annan states that: 'Literacy is a key lever of change and a practical tool of empowerment on each of the three pillars of sustainable development, social development and environmental protection'. All people, whether disabled or non-disabled, poor or not poor deserve the right to equal opportunity for education. Illiteracy leads to low levels of health literacy (Levasseur & Carrier, 2012). In Tanzania the majority of patients, particularly those in rural areas, lack access to education. They are, therefore, semi- or completely illiterate, especially women and persons with disabilities (UNDP, 2011). Low literacy makes it difficult for these patients to understand and explain their health problems to a therapist and this may impact on CCP.

- *Therapists as expert:* Patients in Tanzania believe that health professionals, including occupational therapists, know everything about their health problems. The patients see therapists as experts to solve their health problems and expect them to take a leading role in setting goals and implementing interventions. The basic ideal of a problem-solving partnership assumed by the client-centred approach is unlikely because of entrenched beliefs about the power and expertise of the health professional.

- *Cultural attitudes:* Every culture has beliefs about health, disease, treatments that have effects on healthcare, and medical education (Vaughn, Jacquez & Baker, 2009). Although there is no published evidence, there is experiential evidence in Tanzania that most local cultures believe that when you are sick someone will take care of you so there is no need to worry. Some African cultures, including those amongst people groups in Tanzania, are based on the Ubuntu[4] ideology (Chaplin, 2006; Mnyaka & Mothilabi, 2005 and Wiredu, 2004). Ubuntu worldview places emphasis on the commonality and interdependence of the members of the

[4] Ubuntu is the term in some Southern African languages for a way of being in the world that places the highest value on one's relationship to other people. It is found in the Zulu language which says:'*Umuntu ngumuntu ngabantu', meaning 'a person is a person through other people'* (Van & Nefale, 2005).

community. It recognizes a person's status as a human being, eligible to unrestricted respect, dignity, value and acceptance from the members of the community of which a person may be part. Ubuntu speaks to the inter-connectedness, common humanity and the responsibility of each person that flows from their connection to others (Mnyaka & Mothilabi, 2005; Wiredu, 2004). Ubuntu shares natural resources on a principle of equity among and between generations (Chaplin, 2006). Ubuntu philosophy has given rise to the Ubuntu therapy (Van & Nefale, 2005). Ubuntu therapy involves three dimensions namely: a psychotheological dimension that views God as creator who breathed life into all people; secondly, an intrapsychic dimension that signifies the human essence of enabling a person to become abantu (humanized being); and thirdly, the interpersonal dimension that emphasizes relationships with others (being kind, good character, generosity, hard work, discipline, honour, respect, ability to live in harmony with others (Van & Nefale, 2005). Therefore, the goal of Ubuntu therapy is to address conflicts within the three dimensions mentioned above as they relate to Ubuntu values which differ from western culture. In the western world independence is considered a central concept in rehabilitation (Tamura, McColl & Yamasaki, 2007). There is, therefore, likely to be a contrast between the assumed independence of the client in CCP and the way in which Tanzanian citizens engage with healthcare service providers, including occupational therapists.

- *Individualism:* The Western client-centred practice literature tends to concentrate on individualism[5], analysis and problem-solving as opposed to being, collectivism[6] and acceptance (Lim & Iwama, 2006). CCP assumes that the client enters the

[5] Individualism entails valuing personal independence and it involve putting an emphasis on personal responsibility and freedom of choice, personal autonomy and achieving self-fulfillment (Oyserman, Coon, & Kemmelmeier, 2002). Individualists tend to see themselves as unique from others (Shulruf, Hattie and Dixon, 2005).

[6]Collectivistic societies are characterized by extended primary groups such as family, neighborhood, or occupational groups in which members have diffuse mutual obligations and expectations based on their status or rank. In collectivistic culture, people are not seen as isolated individuals. People see themselves as interdependent with others, where responsibility is shared and accountability is collective (Oyserman, Coon, & Kemmelmeier, 2002).

helping partnership as an autonomous, independent person capable of making personal choices. In the developing world people are interdependent so no one stands on their own (Yang et al, 2006). CCP would therefore be a strange concept to convey to persons who believe that decisions are collective acts.

- *Language barriers:* Over 156 different (tribal) languages are spoken in Tanzania, (Lewis, 2009; Muzale & Rugemalira, 2008). Swahili[7] and English are the official languages. Swahili is seen as the unifying language of the country between different tribes while English serves the purpose of providing Tanzanians with the ability to participate in the international issues that might be related to education, health and socioeconomic matters. Some tribes in Tanzania only speak their local language especially those who are illiterate (Lewis, 2009). So if the therapist is not familiar with the local language of his or her clients, then it will be difficult to communicate with the client in a way essential for CCP.

- *Institutional challenges:* The International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) was developed as a framework to consider the medical, functional and social aspects of people with health problems (health condition, impairments of body structures and body functions, activity limitations, participation restrictions and contextual factors of the environment and as well as personal factors). The ICF is not followed by Tanzanian occupational therapists or by the health service in general. The health service in Tanzania follows a curative rather than a comprehensive approach to health (WHO, 1998). The focus is on fixing the impairment or healing the illness. There is little attention to preventing health problems or to rehabilitating the activity limitations and participation restrictions associated with body function and structure impairments. High rates of under-five mortality, maternal mortality and prevalence of other major diseases like HIV/AIDS, malaria and tuberculosis have led the healthcare service in Tanzania to focus primarily on curative care according to the biomedical model (MOHSW,

[7]Swahili language or Kiswahili is a Bantu language spoken by various communities inhabiting the African Great lakes region and other parts of Southeast Africa, including Tanzania, Kenya, Uganda, Rwanda, Burundi, Mozambique and Democratic Republic of Congo. It is a national language in Tanzania (Lewis, 2009; Muzale & Rugemalira, 2008).

2008). The scientific, reductionist nature of the biomedical model focuses on core mechanisms to study cause and effect; and ignores the relationships between mind and body and between the person and the environment (Kielhofner, 1983). Knowledge about the interaction between impairments, activity limitations, participation restrictions and personal and contextual factors is crucial for a comprehensive treatment plan. Therefore, the assessment tools used by occupational therapists need to be holistic, considering the medical and social aspects of client. However, some hospitals in Tanzania dictate the type of assessment tools to be used by occupational therapists, some of which are not comprehensive or client-centred.

- *Lack of continuing education on CCP:* Therapists in Tanzania had no opportunities for further training in CCP after completion of the occupational therapy course. The importance of educating health professionals in order to keep them up-to-date with the changing needs of society has been advocated by different authors (Kasvosve et al., 2014; Goulet et al., 2013; College of Occupational Therapists, 2007; Medical Federation for Medical Education, 2015). The WHO (2006a) noted that healthcare workers who lack the necessary training and knowledge, may be a major obstacle for health systems in the world. The WFOT (2011) recommends and encourages all members to engage in Continuing Professional Development (CPD) in order to maintain currency in terms of knowledge and professional skills. Article 6 of the Constitution of the Tanzanian Occupational Therapy Association, (2008) states that TOTA shall 'promote the development of occupational therapy through conducting postgraduate courses'. This objective hasn't yet been adequately achieved due to financial constraints that the association has been experiencing. There is also a lack of motivation among therapists to contribute towards enabling CPD.

  In some countries, especially developing countries such as Tanzania, CPD opportunities are scarce to non-existent (Griscti & Jacono, 2006) and if such opportunities exist, they tend to be expensive and may not be at the breadth or depth needed. The CPD in Tanzania is not compulsory, it is only recommended. The lack of CPD activities impacts healthcare practices, limits access to evidence-based

practice, and essentially threatens entire health professions (Ameriah, 2013). CPD should comprise post-graduate clinical education aimed at engaging the practitioner in a lifelong learning process (Health Professions Council of South Africa (HPCSA) (2010). Other associations such as the Occupational Therapy Association of South Africa (OTASA) have considered the issue of CPD in their constitution to be mandatory among members as stipulated by the HPCSA. They consider CPD as a lifelong learning with a goal of maximizing the wellbeing and care of clients and also to maintain and increase competencies in the rapidly changing fields of health development, and to reflect on professional practice experiences (OTASA, 2014). South African health professionals are by law compelled to accumulate 30 Continuing Education Units (CEUs) in any 12-month period (HPCSA, 2011). The non-compliance, or failure to accumulate 60 points, results in suspension of registration. A similar mandatory CPD system in Tanzania may affect the application of CCP in the country.

1.6 Research problem statement

There is no occupational therapy research documenting the use of CCP by qualified occupational therapists in Tanzania, including the challenges in applying its principles. One study has been conducted in South Africa focusing on how to incorporate a client-centred approach in the development of occupational therapy outcome domains for mental healthcare settings (Casteleijin & Graham, 2012). Some research on this subject has been conducted in non-western countries such as Taiwan, Singapore and Korea (Krizaj & Hurst, 2012; Kang et al 2008; Yang, Shek, Tsunaka & Lim, 2006; Chen, Rodger & Polatajko, 2002). The findings of these studies are reported in the literature review. Occupational therapy graduates in Tanzania are expected to implement CCP when they start working; however, there have been no continuing education opportunities for therapists to update or further their knowledge and skills in implementing CCP after graduating, nor have any studies been conducted in Tanzania to critique its appropriateness for the context.

1.7. 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.

1.8. Research question

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

1.9. Aim of study

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

1.10. 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

1.11. Summary of Chapter 1

This chapter has provided background information about CCP globally and in the Tanzanian context. It was noted that according to the CCP approach, occupational therapists are required to treat service users with respect and dignity at all times, working in partnership with them and their carer(s), putting them at the centre of practice whilst protecting the service users' rights to make choices over the care they receive and the plans they wish to make. However, there are numerous factors in the context of a resource-constrained country such as Tanzania that may make it difficult for occupational therapists to adhere to the ideals of CCP. The research problem statement, research questions, aim of the study, and the study objectives were stated.

CHAPTER 2. LITERATURE REVIEW

This chapter presents a review of the key literature relating to and supporting the practice of client-centred practice (CCP), in particular its impact on the way occupational therapy is practiced globally. The researcher reviewed published and unpublished literature related to CCP in occupational therapy. EBSCOhost (full text) was used and the databases selected were CINAHL and MEDLINE. Other sources were PubMed, OTDBASE, OTseeker and the WFOT website. Google Scholar was used to locate other articles which were not identified from the above-mentioned sources. Much of the literature reviewed originated from Canada, the United Kingdom and the United States of America. The literature which was not published in English was excluded. The databases were searched using the following keywords: 'client perspective', 'client understanding', 'therapist perspective', 'client centred practice', and 'therapist understanding'. One hundred and thirty articles published between the years 1980 and 2014 were located and considered for their relevance to the research topic. Thirty articles were selected because they focused on occupational therapy and client-centred practice. The information located in the selected articles covers the historical development of CCP, defining CCP, assumptions about CCP, barriers to CCP and ways to resolve barriers.

There is considerable evidence in the literature that supports the use of client-centred practice as one of the fundamental underpinnings of occupational therapy (Law, 1998). A lot of research has been conducted on client-centred practice in developed countries such as the United Kingdom (UK), the United State of America (USA), Canada and Australia (Maitra & Erway, 2006; Mortenson & Dyck 2006; Sumsion & Law, 2006; Duggan, 2005; Sumsion, 2004; Wressle & Samuelsen, 2004; Wilkins, Pollock, Rochon, & Law 2001; Sumsion & Smyth, 2000). Some research on this subject has also been conducted in oriental countries such as Taiwan, Singapore and Korea (Krizaj & Hurst, 2012; Kang et al 2008; Yang, Shek, Tsunaka & Lim, 2006; Chen, Rodger & Polatajko, 2002). One study has been conducted in South Africa focusing on how to incorporate a client-centred approach in the development of occupational therapy outcome domains for mental healthcare settings (Casteleijin & Graham, 2012). No studies have been done to date on CCP in Tanzania.

2.1. History of client - centred practice.

The basis for CCP derives from the work of Carl Ransom Rogers, an American psychologist and one of the architects of the humanistic approach to psychology, who developed and articulated the person-centred approach (Rogers, 1950). Rogers (1950) identified some of the key constructs of person-centred practice, which emphasized the importance of cultural values; the dynamic nature of the person and therapist/educator/counsellor interaction; the need for persons seeking help to have an active role in approaching their problems; and, the need for honesty and openness in the helping relationship. Rogers stressed the importance of empathy, respect, active listening and an understanding of the person's self-actualization and goal-directed behaviour. Since the 1950's the person-centred approach has been used by various disciplines in healthcare (client-centred therapy), education (student-centred learning), organizations, and other group settings.

Historically the practice of healthcare in Canada and the United States was guided by the medical model in which the health professional was directive and seen as the authority in making decisions about the health needs of clients. During the 1980s in Canada, an alternative model to the more traditional disease-centred method of patient care was suggested because it undermined patient involvement, empowerment and decision making (Levenstein et al., 1986). In America much of the debate about the medical model also started in the 1980s and 1990s. Critique focussed on the extremes of autonomy and paternalism in the doctor-patient relationship (Emanuel & Emanuel 1992). The medical model endorsed the physician's dominance and it was felt that this caused conflict among patients. Three alternative models for the doctor-patient relationship were proposed: the informative model, the interpretive, and the deliberate model, all of which reflected patient involvement and empowerment and were supportive of patient autonomy (Emanuel & Emanuel 1992.). Government policy in the United Kingdom (UK) during the 1990s initiated the process of recognising the patient element in healthcare with the publication of the Patient's Charter in 1991. The charter set out the goals of listening to and acting on people's opinions and needs and set clear principles of service for meeting those goals (Department of Health (DOH), 1991).

Occupational therapists in the countries mentioned above were uncomfortable with the top-down approach of the medical model and wanted to reflect a practice orientation during the occupational therapy process that was based on shared decision-making. During the 1980's therapists struggled to integrate the idea of CCP into their practice, as client-centred practice represented a shift in the way healthcare was delivered (Law and Mills, 1998).

2.2. Client-centred practice in occupational therapy

The Canadian Association of Occupational Therapists (CAOT) was the first professional body to formally adopt client-centred practice as its official intervention position when it published the Guidelines for Client-centred Practice of Occupational Therapy in 1983 (Townsend, 1983). The American Occupational Therapy Association and the British College of Occupational Therapists integrated client-centred practice into their codes of ethics and professional conduct in 1995 (AOTA,1995, College of Occupational Therapists, 1995). Other countries that have since adopted CCP include Sweden and Slovenia (Švajger, Piškur, 2006; Piškur, 2001 and Pihlar, 2003). The Slovenian Occupational Therapists (SOTA, 2000) Code of Ethics emphasizes client participation in the occupational therapy decision-making process and occupational therapists' respect for client choice, even when it differs from the professional opinion. The Code of Ethics of the Swedish Association of Occupational Therapists (SAOT, 1998) included the following statements that reflect CCP; 'the client should be treated with respect'; 'necessary information should be given to the client', 'treatment should be based on the wishes and needs of the client' and, 'interventions should focus either on the individual or on the environment by relating therapy to the client's life'.

The WFOT developed a position statement on CCP in 2010 which intended to inform all occupational therapy members to embrace CCP. The statement starts by defining occupational therapy: 'Occupational therapy is a client-centred health profession concerned with promoting health and well-being through occupation' (WFOT, 2010 p**.** 4). The document emphasizes that occupational therapy should aim at enabling clients to participate in occupations that they want to do personally as well as the things they need or are expected to do socially and culturally (WFOT, 2010). During the occupational therapy process occupational therapists are supposed to respect and partner with clients,

value peoples' subjective experiences of their participation and appreciate peoples' knowledge, hope, dreams and autonomy (WFOT, 2010).

Different countries in Africa, including Tanzania, have incorporated the issue of CCP in their professional Code of Ethics. In South Africa the Occupational Therapy Association of South Africa (OTASA), (2005) included two statements in section A of its Code of Ethics that address the responsibilities of the occupational therapist towards patients/clients and their care providers and capture the CCP approach; 'occupational therapy personnel shall respect the autonomy of the patient/client throughout all phases of the intervention process' and 'practitioners shall respect the patient's uniqueness and right to self-determination, to make choices and decisions about their own health and welfare, to refuse treatment and to seek a second opinion'. To date CCP has been aimed at enabling occupations with clients who may be individuals, groups, agencies, governments, corporations or others (CAOT, 1997). The therapist listens to and respects the client's standards and adapts the intervention to meet the client's needs (Sumsion, 2000).

2.3. Basic concepts of client - centred practice

In CCP, patients are motivated to manage their own healthcare through prevention and lifestyle alterations (Lau, 2002). Patients are considered to have the right to know and the right to decide (Eijssmen, 2012). The World Health Organization's Declaration of Alma-Ata proposes that people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare (WHO, 1978). Fundamental concepts of CCP in occupational therapy include respecting the patients and the choices they make: respecting an individual means taking into account that person's views, choices and beliefs (Filardeau & Durand, 2002). Choice is an important component in an effective partnership (CAOT, 1991). The choices made by a client can be influenced by the stage of an illness/disability and the capabilities of the client (Sumsion & Law, 2006). Another CCP concept is facilitating patient participation. It focuses on the person-environment-occupation relationship by providing flexible and individualized service delivery, incorporating the patient's values into clinical decision making, and patient-centred communication (Law, 1998). CCP enables clients to partner with service providers and to take responsibility for decision-making and choices. By doing so it does not prevent the therapist from taking responsibility in informing clients about risks and dangers that might

be associated with a particular decided action (Law et al., 1997). For partnership to happen, effective listening and communication is important (Sumsion & Law, 2006). The characteristic of an effective partnership involves taking in the other's experiences (Rogers, 1939) and being flexible and aware that the relationship can change (Banks et al., 1997). The philosophy of CCP is translated into practice through processes of enablement. Enablement differs from treatment and care-giving in the sense that things are no longer done to or for patients but in full collaboration with them.

2.4. Defining Client- Centred Practice.

There are at least three different definitions of CCP in the literature all of which highlight partnership and client participation in decision making (CAOT, 2002; Sumsion, 2000; Law, Baptiste and Mills, 1995).

The three definitions are as follows;

The Canadian Association of Occupational Therapy (CAOT, 2002) defined CCP as;

> 'Client-centred practice refers to collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others. Occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients in meeting clients' needs, and otherwise recognize clients' experience and knowledge…..(Where,) enabling refers to process of facilitating, guiding, coaching, educating, prompting, listening, reflecting, encouraging, or otherwise collaborating with people so that individuals, groups, agencies, or organizations have the means and opportunity to participate in shaping their own lives'(CAOT, 2002, p. 49-50).

Sumsion, (2000, p. 308) reported a definition based on a project using the Delphi technique with 63 therapists. The resulting draft definition highlighted the defining elements of CCP as follows:

> 'Client-centred occupational therapy is a partnership between the therapist and client. The client's occupational goals are given priority and are at the centre of assessment and treatment. The therapist listens to and respects the

client's standards and adapts the intervention to meet the client's needs. The client actively participates in negotiating goals for intervention and is empowered to make decisions through training and education. The therapist and client work together to address the issues presented by a variety of environments to enable the client to fulfil their role expectations'

Law, et al 1995 p. 253 defined CCP as;

'…an approach to providing occupational therapy which embraces a philosophy of respect for and partnership with people receiving services. It recognizes the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strength clients bring to an occupational therapy encounter and the benefits of the client-therapist partnership and the need to ensure that services are accessible and fit the context in which the client lives'.

The original Canadian definition included the key concepts of partnership, respect, choice and involvement. The Sumsion definition took context more into account, acknowledging the influence of the current pressures on health in the Canadian context at that time. Sumsion, (2000 p. 308) began with a preamble which says:

'There are many factors that influence the successful implementation of client-centred practice, including a clear determination of who the client is and the recognition of the impact of resources.'

This research report uses the Canadian Association of Occupational Therapists CAOT (CAOT, 2002) definition because it views the word 'client' not necessarily as an individual but also defines it as groups, agencies, government, corporations or others. A broad definition is relevant to the African context where people are considered to be interdependent[8] (Eaton & Louw, 2010) on each other and where occupational therapy practice covers the occupational and functional dimensions of individual, group and population health. Interdependence means that the 'client' is part of a collective decision-making system about their health choices including participation in the occupational therapy process. The African continent is one of the continents of the world that shows a

[8]Interdependence refers to the degree to which members of the group are mutually dependent on the others. Interdependence emphasized on harmonious relations with others, promoting sensitivity to social cues, and encouraging behaviors that affirm relatedness to others (Kitayama, Duffy & Uchida,2007)

rich diversity of traditional and cultural activities that are done collectively (Crouch, 2006, p.50). The core skills of CCP on enablement of occupational therapy practice has shifted the paradigm to include both the traditional medical model of remediation (therapy done to/on client) and prevention, promotion, development or maintenance of occupational performance established collaboratively (therapy done in partnership with person) (Law et al., 1990; Law, Baptiste and Mills, 1995).

2.5. Benefits of Client-Centred Practice

The following are the benefits of incorporating CCP in practice:

- Improves satisfaction with occupational therapy services (Sumsion & Law, 2006)
- Increases adherence to the therapy recommendations (Sumsion & Law, 2006)
- Improves functional outcomes and increased client comfort and satisfaction ((Sumsion & Law, 2006; Cott, Teare, McGilton & Linecker, 2006).
- There is also some evidence to suggest that 'reorganization of services based on client-centred theory can increase efficiency and cost-effectiveness and decreased length of stay' (Cott, Teare, McGilton & Linecker, 2006).

2.6. Assumptions about Client-Centred Practice

The basic assumptions of a client-centred approach, according to Law et al., (1998, p.9), include:

> 'respect for clients and their families, and the choices they make. Clients and families have the ultimate responsibilities for decisions about daily occupations and occupational therapy services, provision of information, physical comfort, and emotional support with an emphasis on person-centred communication, facilitation of client participation in all aspects of occupational therapy service, flexible, individualized occupational therapy service delivery, enabling clients to solve occupational performance issues and focus on the person-environment-occupation relationship'.

On the basis of these assumptions, clients and therapists are presumed to be able to: (Law, Baum &, Baptise, 2002, p. 18):

1. Build a client-centred partnership by each focusing on their roles and responsibilities with the client leading the decision-making process
2. Work together to identify occupational performance problem areas, the type of intervention needed and the expected outcomes. Here clients are considered able to request information and define their treatment priorities.
3. Access resources to help solve problems. Clients participate at different levels, depending on their capabilities. Therapists encourage clients to recognise and build on their strengths and clients are able to understand the scope of the therapists' knowledge and access to resources. It is assumed that the clients have insight into their own conditions and a mutual understanding of the formulated goals. By focusing on occupational performance, occupational therapy practitioners assist clients and families in becoming actively engaged in their life activities.
4. Work collaboratively with people in the clients' environments to assist them in acquiring skills and making modifications to remove barriers that create a social disadvantage.

These assumptions about client independence in decision-making and ready access to resources for goals setting have been contested elsewhere (see footnote 8 and 11 above).

2.7. Barriers to Client-Centred Practice

Although the client-centred approach seems to be encouraged by occupational therapists throughout the world, CCP is demanding, requiring that a therapist deals with many implementation challenges. The following studies report and identify different barriers in implementing CCP that are faced by occupational therapists.

The therapist is uncomfortable letting clients choose their own goals (Sumsion & Smyth, 2000; Wressle & Samuelsson, 2004; Krizaj & Hurst, 2012). This can happen when clients lack the education or insight to engage due to cognitive limitations. Most patients with acute and severe illness have no or restricted insight into their illness so it becomes difficult for them to make informed decisions (Krizaj, Hurst, 2012; Maitra & Erway, 2006; Law, 1988; Sumsion, 1999, 2005; Toomey, Nicholson & Carswell, 1995; Ende, Kazis, Ash & Moskowitz, 1989). Some client*s* may lack an understanding of the rationale behind CCP and therefore may make unrealistic goals that might conflict with the therapist's clinical

judgement or lead to possible risk/harm (Krizaj, Hurst, 2012; Sumsion & Smyth, 2000; Law et al., 1995). Poverty and illiteracy especially health literacy[9] among patients is higher amongst the majority of people in Tanzania. Health literacy is one of the foundations of individual health because it will enable clients to take an active role in understanding and make decisions regarding the management of their health problems (Levasseur, 2010; Rootman & Gordon, 2008).The majority of patients, particularly those in rural areas are poor and semi- or completely illiterate, especially women (UNDP, 2011). This makes it difficult for these groups to understand and explain their health problems to a therapist. Those clients who are young, well-educated and come from the higher social classes are more likely to be involved in the decision-making process with therapists (Krizaj & Hurst, 2012; Krupat et al, 2001; McKinstry, 2000; Law, et al, 1995; Deber, 1994). The educated clients and higher social classes have access to health literacy that enables them to make informed decisions. Other issues might be the therapists' reluctance to take risks in supporting the clients' goals (Hobson, 1996), clients unable to identify the risks (Parker, 2012), high levels of tension created by unworkable caseloads and performance expectations, as well as the ever-expanding knowledge that must be incorporated into practice (Coulter & Dunn, 2002).

Therapists and clients have different goals (Sumsion & Smyth, 2000; Wressle & Samuelsson, 2004 and Krizaj & Hurst, 2012 & Parker, 2012). Gateley & Borcherding, (2012 p. 49) reported that

> 'goals used in a treatment plan must be written in occupation-based, measureable, observable, action-oriented terms, must be realistic for the client and be able to be achieved in a reasonable amount of time, and goals must be formulated from the problem identified with collaboration with client.'

[9]Health literacy is defined as the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings over the life-course (Levasseur, 2010; Rootman & Gordon, 2008). Rehabilitation professionals are often uninformed about and neglect health literacy in their interventions (Levasseur, 2010).

Rosa (2009, p. 289) indicated that occupational therapists have an ethical responsibility to take into account clients' discussions regarding their own care and to provide them with the opportunity to share in the decisions that affect them. Since occupational therapy is a client-centred profession (WFOT, 2011) it requires therapists and clients to work together in setting goals but if the goals of therapist and client differ, CCP is hindered.

The therapist does not know enough about CCP. The implementation of CCP requires a theoretical knowledge of its principles, skills and experiences. Parker, (2006 in Sumsion, 2006, p. 55) and Wressle & Samuelsson (2004) suggest that a knowledge gap when implementing CCP into practice will make it difficult for therapists to practice it effectively. Not understanding or being trained in CCP can lead to failure in applying the principles of CCP appropriately to clients. When therapists try to use CCP they will lack confidence, experience stress and it can cause misunderstanding with clients (Wressle, Samuelsson, 2004; Fraiser, 1995, Law et al 1995; Corring & Cook, 1999; Sumsion & Smyth, 2000; Wilkins et al., 2001).

The therapists' values and beliefs prevent them from accepting the client's goals. This barrier was reported in studies by Sumsion & Smyth, (2000) and Wressle & Samuelsson (2004). Townsend & Polatajko (2007) categorized the therapists' values and beliefs into five areas namely; i) occupation; ii) person; iii) environment; iv) health, wellbeing and justice; and, v) client-centred practice. For client-centred practice the therapist's values and beliefs consider that clients are experts regarding their own occupations and that clients must be active partners in the occupational therapy process. Shafaroodi et al., (2014) reported that a therapist's values and beliefs are essential factors affecting collaboration with clients and evaluation and planning for intervention. Therefore, when differences or misunderstandings exist between the values and beliefs of therapists and clients, then CCP will be difficult to apply.

Therapists' inability or lack of desire to give up or share power with their clients: Healthcare systems tend to be characterised by professional power. Health service providers, including occupational therapists, have power to control who receives services, what is provided to clients and how much intervention is offered (Sumsion & Law, 2006; Duggan, 2005; Chan, 2002). Power shift and sharing in CCP is very important (Sumsion & Lencucha,

2007). Therapists sometimes disempower clients by not allowing a client-therapist relationship that enhances more partnership to develop. Partnership involves listening and communicating with the client, working together during the assessment, goal setting, and intervention and reflecting on the client's needs in relation to their environment and the roles which the client undertakes. The therapist needs to become a facilitator rather than a director of setting goals and executing intervention (Parker, 2006; Hugman, 1991; Corring, 1999). The issue of power between therapist and client/patient is particularly difficult to manage in the African context because of the challenges of illiteracy, poverty; health inequality and social injustice. The profession itself in Africa hasn't achieved its professional power similar to other health professions such as medicine and nursing. Clark, (2010) explained that a powerful profession has the capacity to obtain leadership positions, advocate successfully in the policy arena, and secure the resources necessary to achieve their professional goals. Therefore, in the occupational therapy profession, cultivating power and confidence among our practitioners is essential to realize our full capacity for meeting society's occupational needs (Clark, 2010). She recommended that occupational therapy practitioners analyse their individual sources of power and evaluate opportunities to develop confidence and secure power for their professional work in venues both in and outside the workplace.

Therapists lack critical reflections about CCP. Failure to critically examine the client-centred claims of the occupational therapy profession is symptomatic of an overall dearth of critical thinking in the rehabilitation professions (Hammell, 2013). Critical thinking is defined as '*an intellectual practice that challenges assumptions and taken-for-granted ways of thinking, and that seeks to expose linkages between ideologies and power*' (Hammell, 2013, *p.174*). The Tanzanian occupational therapy curriculum in Moshi faces challenges because it trains students at diploma level which may not adequately prepare them to become critical thinkers. However, Pithers & Soden, (2000) argue that, due to increased economic competition demands, education and training enables learners to now think 'smarter' than in the past, no matter in what discipline or at what level. Occupational therapy practice is becoming increasingly complex as intervention occurs in healthcare systems and with individuals and populations who present needs that range from multidimensional health conditions to prevention, health promotion and maintenance of health (Valde, Wittman&

Vos, 2006). Valde and others urged that demonstrating an ability to think critically must be fundamental to occupational therapy education. Julius Nyerere's education philosophy[10] during the 1970s served as the foundation for the development of higher education in Tanzania (Matekere & Kiondo, 2007). He believed that universities in Tanzania and other higher learning institutions should prepare people who are critical thinkers and who are able to question the government on its day-to-day activities (Matekere & Kiondo, 2007). According to Nyerere, students at universities must be developed into critical thinkers so that they can be the source of new ideas or alternative development ideas that will be used to challenge policy makers on issues of national interest (Matekere & Kiondo, 2007). Similar calls for higher education and training to develop critical thinkers that challenge government policies, employers' desires and the pace of globalization have been made in South Africa (Lombard & Grosser, 2008).

Institutional influences: At an institutional level, concerns may be lack of time, lack of multidisciplinary team involvement, an existing biomedical model, lack of motivation and funding issues. Employers want occupational therapists to attend to an increasing number of clients to reduce waiting lists and to ensure they continue to receive funding (Sumsion, 2006, p.50; Pettersen & Svilaas, 2003). Limited occupational therapy staffing resources restrict the amount of time therapists are able to spend with their clients. At the beginning of CCP more time needs to be spent because clients need to understand the issues related to their health problems and be enabled to work in partnership with the therapist to devise an intervention that they can own. When working with people who are elderly, illiterate and from low socioeconomic status, more time will be required as they may lack problem solving skills (Sumsion, 2006).

Lack of funding: Funding is important to ensure adequate availability of resources e.g. manpower and equipment needed by therapists and patients. (Krizaj, Hurst, 2012; Wilkins

[10]Julius Kambarage Nyerere was a Tanzanian politician who served as the first President of Tanzania and previously Tanganyika, from the country's founding in 1961 until his retirement in 1985. One of his great quotes was saying *'...intellectuals have a special contribution to make to the development of our nation, and to Africa. And I am asking that their knowledge, and the greater understanding that they should possess, should be used for the benefit of the society of which we are all members.* 'Julius Kambarage Nyerere, from his book Uhuru na Maendeleo (Freedom and Development), 1973.

et al., 2001; Harrison, 2001; Sumsion, 1999). A study by Kjellberg et al., (2012) on the myth of participation in occupational therapy indicated that the concept of participation is connected to concept of CCP. They identified barriers to participation as being clients' inability to participate due to financial problems. In some African countries such as Tanzania, funding for health has been a big problem. The allocation within the Ministry of Health and Social Welfare (MOHSW) has been inadequate to meet the cost of public health services required by the population.

Manpower shortage. The issue of health-worker manpower in Tanzania is a huge problem. In 2013 there were a total of 6,876 health facilities in the country (URT, 2014). According to the staffing level guidelines (2014), the minimum number of health workers required to provide quality health services in these facilities is 145,454. The actual number of health workers available is 63,447 with a shortage of 82,007 which is about 56.3% (URT, 2014). In the training institutions the number of workers required is 4,325 but only 2,820 are available with a shortage of 1,505 equalling 34.79% (URT, 2014). The shortage is more severe in rural districts (URT, 2014). Differences in the distribution of human resources exist at various places including urban and rural facilities, leading to inequitable access to health services (URT, 2014). The reasons for these problems include the low rates of recruitment imposed through structural adjustment programmes, as well as the increasing burden of disease due to HIV/AIDS, both of which increase the demand on the health system and contribute to worker attrition rates (URT, 2014; URT, 2008). Other problems include the poor organization and management of the health workforce and poor working conditions, which cause educated people to seek employment outside the Tanzanian health sector (such as Botswana, Namibia, South Africa). The remaining workers become de-motivated (URT, 2014; URT, 2008). There is also the great challenge of a rapidly aging workforce, which exacerbates the crisis (URT, 2014).

Decentralization policy in Tanzania: A study by Munga et al., (2009) showed that recruitment of health workers under a decentralized[11] arrangement in Tanzania has been characterized by complex bureaucratic procedures, severe delays and sometimes failure to get the required health workers. The study also revealed that recruitment of highly skilled health workers under decentralized arrangements may be both very difficult and expensive (Munga et al., 2009). Decentralized recruitment was perceived to be more effective in improving retention of the lower cadre of health workers within the districts. In contrast, the centralized arrangement was perceived to be more effective both in recruiting qualified staff and balancing their distribution across districts, but was poor in ensuring the retention of employees (Munga et al., 2009). A recent study by Manzi et al., (2012) on human resources for healthcare delivery in Tanzania confirmed the following problems: inadequate staffing of health facilities, a high degree of absenteeism, low productivity of the staff who were present and inadequate supervision in peripheral Tanzanian health facilities.

Cultural issues. Culture is revealed in a person's beliefs, values, attitudes and daily activities (Chiang & Carlson, 2003). Occupational therapists in multicultural[12] contexts need to be culturally sensitive or competent (Chiang & Carlson, 2003). Cultural competence involves an awareness of one's own cultural beliefs and behaviours; cultural variables; health and disability issues relating to culture; and strategies for developing culturally sensitive practice (Chiang & Carlson, 2003). Language or poor linguistic skills can be a barrier when therapists communicate with clients from different cultural backgrounds whose language differs from their own. Tanzania is a multilingual country where about 156 native languages are spoken by different tribes (Muzale & Rugemalira, 2008). The worthy thing is, however, that Tanzania is unified by one national language - Swahili - which the majority of the population can speak. The issue of language is just one aspect within cultures that occupational therapists are supposed to consider as they embark in an occupational

[11]Decentralisation has been defined as a process that involves one or all of the following aspects i) the shifting of workload from centrally located officials to staff or offices outside the national capital (*deconcentration*), ii) the transfer of management from the centre to semi-autonomous organisations and agencies within the public service structure (*delegation*), iii) the transfer of political and decision-making powers and authority for managing public services to independently elected local governments (*devolution*), and iv) the transfer of management and financing functions to a private organisation (*privatisation*) (Rondinelli, Nellis & Cheema, 1983)

[12]Multicultural' is a term used to describe cultural and ethnic diversity(Chiang & Carlson, 2003)

therapy intervention process. Each culture has its own unique characteristics which usually are best understood by indigenous people (Kisanji, 1995). For example it is important to understand beliefs around the cause of diseases or disability and to frame treatment so that it is culturally acceptable, especially when selecting and using occupation as therapeutic means. Sumsion & Lencucha, 2007; Yang et al, 2006; Sumsion, 2006, Chen et al, (2002), reported that the acceptance of how sick people behave and encouragement of the sick role exists in some cultures which may hinder CCP as the clients will tend to remain passive when asked to share goals because they are expecting to get support from the family.

Lack of desire or motivation: Motivation has been recognized as an essential component in managing medical issues and adjusting to physical disability, cognitive impairment, returning to work, and improving psychosocial functioning (Mabin, 2014). Clients may have no wish or inspiration to contribute to setting their goals and may expect their therapist to do this for them (Parker, 2012; Maitra & Erway, 2006; Wressle & Samuelsson, 2004; Fraiser 1995; Law et al., 1995). Some studies on rehabilitation have reported causes of de-motivation and include factors such as; personal factors, clinical factors, family factors, cultural factors, the rehabilitation environment and the professional's behaviour (Maclean, 2002).

Perceptions of other health team members: Therapists who adopt a client-centred approach to practice have been perceived by other team members as working more slowly (Williams et al., 2001) and being less skilled and less effective (Wanigaratne & Barker, 1995; Jaffe & Kipper, 1982; Schroeder & Bloom, 1979). At stake in this perception is a clash of values: time is money. Despite the rhetoric of patient rights, the ultimate value driving health services is the cost benefit of time: intervention ratio.

Ethical dilemma[13]*:* Brockettt & Dick, (2006) said ethical occupational practices require occupational therapists who are: reflective, sensitive, mindful and who encourage people; who understand laws and rules, professional codes of ethics and standards of practice;

[13]Ethical dilemmas are those in which behavioural choices depend on interpretation of rights and responsibilities of therapist and client given the legal and moral expectations of the situation (Townsend, Brintnell & Staisey, 1990).

who work towards or maximize occupational performance of clients and who are respectful of all other people involved in a professional encounter, despite struggling to have everyone work together in a mutually beneficial relationship. Notwithstanding the fact that client-centred approaches have been shown to be effective in a variety of settings and with different client populations, ethical challenges and treatment obstacles can impede its successful use. There is a lack of recent studies reporting on ethical dilemmas in occupational therapy. A study by Barnitt, (1998) identified the following ethical dilemmas in occupational therapy and physical therapy: difficult/dangerous behaviour in patients; unprofessional/incompetent staff; lack of respect for vulnerable patients; difficult or risky decisions about patient discharge; unfair allocation/lack of resources; lack of confidentiality/privacy for the patient; and, lack of respect for the therapists' opinions. If these dilemmas are not addressed they may interfere with or affect CCP. Sumsion, (2006) reported that occupational therapists are often caught between the demands of their professional roles, the institutions/organizations' goals and the client's needs. Sometimes clients determine goals that therapists think are unsafe or that entail unnecessary risk so it is challenging to maintain CCP approach. (Law et al., 1995).

2.8. Ways to resolve barriers to CCP.

Several studies have reported various ways of resolving barriers to CCP. The suggested ways may or may not be relevant to the Tanzanian context. Further studies might be needed in order to ensure the recommendations provided are adapted to be applicable in the Tanzanian context.

Involvement of staff in CCP training: Sumsion and Smyth (2000) recommended staff training in client-centred practice. Training may address specific CCP skills such as how to grade CCP for different client capabilities. The WFOT (2011) recommended all members to engage in continuing professional development (CPD) to maintain currency of knowledge and professional skills. This applies to Tanzanian occupational therapists since the Constitution of the Tanzania Occupational Therapy Association, 2008 article 6, stipulates clearly that the association should promote the development of occupational therapy through conducting postgraduate courses.

Client involvement in education and service provision: The identified barriers can be addressed by involving persons with disabilities in training and education to increase disability awareness and to amplify their understanding and acceptance of clients' wishes Krizaj, Hurst 2012; Samuelsson, 2004; Sumsion, Smyth, 2000 & Hobson, 1996; Wressle; Tommey, Nicholson, Carswell., 1995 & Waters, 1995; Law et al., 1995; Johnson; 1993; Slater, 1990 & Johnson, 1993). Levasseur & Carrier, (2012) also emphasize the need for occupational therapists to integrate health literacy in their daily practice as this will improve the level of understanding by patients in regard to their health problems.

Education about CCP while still a student was recommended by Wressle & Samuelsson, (2004) and Sumsion, Smyth, (2000). A study by Ripat et al., (2014) on the internalizing of client-centredness in occupational therapy students reported the need for educators of healthcare professionals to deliberately focus on client-centredness in the uni- and inter-professional curricula. By so doing students will be enabled and prepared to enact inter-professional collaboration for CCP.

More explanation about and elaboration of CCP. According to Wressle & Samuelsson, (2004) and Sumsion & Smyth, (2000) a focus on CCP in training, client involvement in education and service provision, and education about CCP while still a student, enables its use after graduating. Other strategies that can be added include the use of reflective practice (reflective diary), regular case presentation, networking, performance review, availability of training materials, mentoring, supervision and personal development plans (Parker, 2006)

Client involvement in planning services. Service user involvement is an active collaboration between professionals and clients concerning the planning, implementation and evaluation of services and goes beyond CCP because it implies the transfer of power or control over aspects of service delivery (Wright & Rowe, 2005; Wressle & Samuelsson, 2004; Sumsion, Smyth, 2000). Furthermore, Braye, (2000) added that user involvement sums up a range of different ideas from active participation at the micro-level of individual decision-making to more macro-level involvement in service planning and evaluation, and increasingly in the training and research arenas. Client involvement is reported to have several benefits. For example in a study conducted by Tait & Lester (2005) on encouraging user involvement in mental health services, the followings benefits were identified: users are experts about

their own illness and need care; users have different but equally important perspectives about their illness and care; user involvement increases the existing limited understanding of mental distress; users are able to develop alternative approaches to mental health and illness; user involvement may be therapeutic in itself, and user involvement may encourage social inclusion. I have decided to use the example from mental health because it is a group which is considered to have less ability to take part in the treatment process.

Using case examples to demonstrate how to implement CCP. Case examples can be used to illustrate how to apply the principles of CCP (Wressle & Samuelsson, 2004; Sumsion, Smyth, 2000). The case examples can be generated from experienced occupational therapists and can be used during training of occupational therapy students and sharing with other qualified occupational therapists. Parker (2006) indicated that case presentations can be done regularly to explore difficult issues, to solve problems and to discuss approaches further in detail. Doing presentations and sharing with others will help to boost confidence and confirm standards of practice.

Management and peer support for using CCP. Sumsion, (2006) reported that implementing any change in practice requires not only time and commitment from staff but also support and encouragement from occupational therapy and service management. Different levels of organization should also be committed (Krizaj & Hurst, 2012; Sumsion, 2006; Wressle & Samuelsson, 2004; Sumsion, Smyth, 2000). The management needs to provide therapists with approved time, or time out of clinical work, for discussion, reflection and the provision of training resources e.g. purchase COPM (Sumsion, 2006). The provision of research opportunities and putting into place a framework for strategies for CCP was also recommended (Sumsion, 2006 citing Restall et al 2003, p. 104).

Training in interpersonal skills. Research has found that good interpersonal skills are a prerequisite for a helping relationship be effective during the initial interview with clients (Lloyd & Maas, 1993). So occupational therapists implementing CCP approach require this important skill (Sumsion & Smyth 2000).

Institutional support: Institutional support means that occupational therapists will be supported and encouraged by the authorities to develop and integrate CCP practice within an institutional system (Krizaj, Hurst, 2012; Sumsion & Smyth, 2000; Townsend, 1998; Toomey, Nicholson, Carswell, 1995). The biomedical model is dominant in Tanzania.

Partnership with clients. The issue of partnership is also important in enacting CCP. Sumsion and Law (2006) identified partnerships as one of the core elements of CCP. Partnership involves moving away from traditional authoritarian therapeutic styles of relating to the client. It respects the clients' experiences and affords them similar status in the therapeutic relationship. The occupational therapist is supposed to work in co-operation with the client and family through the identification of goals and ensuring that the focus of the intervention is on the client's or family issues to achieve the goals set together (Casteleijin & Graham 2012; Sumsion & Lencucha, 2007). The aspect of partnership with clients in Tanzania is possible despite some limitations addressed earlier

Power sharing: The occupational therapists intending to practice CCP must consider the balance of power between themselves and their clients (Sumsion, 2006). The transfer of power to the client is warranted and this will bring changes to the interaction from a medical perspective to one that is focused on the client's needs (Falardeau & Durand, 2002). The use of simple language (avoiding medical terms and jargon) is mandated during provision of information to clients as it is considered to be a medium of power (Sumsion, 2006). Therapists are supposed to avoid exerting power over clients; rather, therapists should be attempting to empower, particularly in a client-centred interaction, and work toward shared power where each person involved in the process respects the other's expertise (Falardeau & Durand 2002). Law et al., 1995 outlined the core concepts by defining power as a process which the client and therapist achieve together what neither could achieve alone. Clients' empowerment can be enhanced through the provision of the information and education is needed to make decisions. Taylor (2003) outlined four ways of empowering clients namely: clients should be active participants, clients should be supported to increase personal control over their own health and become less reliant on professionals, clients should be supported to increase control over accessing community resources, service should be built on a strengths-based approach where participants are encouraged to recognize, use and build on their own strengths and existing resources to accomplish their goals.

Multidisciplinary team approach: Client-centred practice needs to involve all team members caring for clients so that each member follows the same procedure. (Krizaj, Hurst 2012; Sumsion, 2006, Dyck & Mortenson, 2006). A team approach allows difficulties to be

shared, concerns discussed and individual strengths to be used in decision making. A team approach promotes motivation among members and doing so will provide more acceptance of CCP among clients. (Wressle et al., 2003; Wilkins, Pollock, Rochon & Law 2001, Pollock, McColl, 1998). In Tanzania occupational therapists are not working alone; they usually work with different health professionals such as nurses, doctors, physiotherapist and social workers.

Cultural diversity: Understanding how to relate well with clients without violating their culture norms, beliefs and customs will foster CCP. Hammell, (2009) said that no people today live in a single monoculture and this is true in the African context which is considered to have multi-linguistic diversity. Human beings learn from their own cultures how to be healthy, how to define illness, what to do to get better and when and from whom to seek help (Munoz, 2007). Culture permeates every clinical encounter in occupational therapy and each person seeking care brings their own personal and familiar cultures. The context where care is provided also adds yet another layer of culture (Munoz, 2007). Lynch and Hanson, (1998), defined cultural competence as 'the ability to understand and address a person's needs within a socio-cultural context'. Iwama (2005) introduced the Kawa model as a culturally relative approach to understand the person as a socio-cultural context in the Japanese context. In realizing the importance of culture and diversity in occupational therapy, the World Federation of Occupational Therapy (WFOT), (2010) developed a position statement entitled 'Diversity and Culture.' The WFOT position statement recommends four strategies and actions to promote adherence to the diversity and culture (Kinebanian, 2009) as the following: to be cognisant of diversity and culture; respect each individual's culture; and to competently respond to the previous and incorporation of these principles into the knowledge, skills and attitudes of occupational therapy education and research. The WFOT Code of Ethics has also included statements that address culture and diversity which declares that 'occupational therapists have a responsibility to consider the cultural diversity, lifestyles and perspectives of the people they serve'. Therefore, increasing therapists' knowledge of other cultures will help to provide cross cultural, client-centred services (Elliot, 2007; Iwama, 2004; Sumsion & Smyth, 2000; Paul, 1995). Occupational therapists need to be aware of their own cultural background and personal values to ensure they do not influence their approach to clients

(Fitzgerald, 2004). Occupational therapists must familiarize themselves with the cultural occupations of their clients, considering their social environment before and during the intervention process. Voce and Ramukumba, (1997) reported that:

> 'Some cultures associate certain activities with gender. For example, cooking is viewed as a feminine activity. While assertiveness is acceptance in some cultures, it could be viewed as aggression in others. This example is very true in Tanzania context where cooking and even washing and cleaning are seen to be the tasks of women.'

Therefore the clinical judgments and cultural competence of the occupational therapist in relating to patients is very important as a means of overcoming barriers to CCP.

2.9. Summary of Chapter 2

This chapter reviewed the literature about CCP in order to support the findings of the study aimed at describing its application by Tanzanian occupational therapists. The review has outlined the definition of CCP, assumptions about CCP, barriers to the implementation of CCP and ways to resolve these barriers. The next chapter discusses the methodology used in the study.

CHAPTER 3. METHODOLOGY

This chapter describes the methodology used to collect and analyse the data in order to answer the research question and meet the study aim and objectives.

3.1. Study design

The study used a descriptive cross-sectional design which is often referred to as non-experimental research because no variables are manipulated. One of the main purposes of descriptive research is to discover some basic characteristics of a population as it exists (Kothari, 2004; Payton, 1994. p. 47). As no previous research has been done on this topic in the study context, this study design was an appropriate choice.

3.2. Study Setting

This study was done in the United Republic of Tanzania with occupational therapists working at various hospitals and centres within different regions of Tanzania. Detailed information on the context is provided in section 1.3. The sampling frame for the study is shown in Table 2.

Table 2: Settings from which participants were recruited

Name	Region	Urban rural	Focus	No of OT's
Muhimbili National Hospital (Referral hospital)	Dar es Salaam	Urban	Mental Health, Adults & children's with Physical disabilities	6 OTs
Vikuruti Psychiatric Rehabilitation Village	Dar es Salaam	Rural	Mental health	1 OT
Comprehensive Community based Rehabilitation Tanzania	Dar es Salaam	Urban	Children's & Adults with disabilities	4 OTs
Al Muntazari School (School for children's with learning disabilities)	Dar es Salaam	Urban	Children's with Learning disabilities in school	1 OT
SAMRS Occupational Therapy Clinic (Rehabilitation for children's with disabilities)	Dar es Salaam	Urban	Children's with physical and learning disabilities	1 OT
Kilimanjaro Christian Medical Centre (Referral hospital) & OT school(Referral hospital)	Kilimanjaro	Urban	Adults & Children's with disabilities	8 OTs
Kilimanjaro Christian Medical University College	Kilimanjaro	Urban	Teaching	1 OT
Gabriella Children's Rehabilitation Centre (Rehabilitation centre for children's)	Kilimanjaro	Rural	Children's with learning disabilities	6 OTs
Young Women Christian Centre Moshi (YWCA) (Rehabilitation centre)	Kilimanjaro	Urban	Children's with physical and learning disabilities	4 OTs
Mbeya Hospital(Referral)	Mbeya Region	Urban	Children's and adults with physical disabilities	1 OT
Mirembe Hospital (National Psychiatric Hospital in Tanzania)	Dodoma Region	Urban	Mental health	7 OT
Mawenzi Regional Hospital (Regional hospital)	Kilimanjaro	Urban	Adult and Children's with physical disabilities & Mental Health	7 OTs
Comprehensive Community Based Rehabilitation – Kilimanjaro	Kilimanjaro	Semi-urban	Adults and Children's with disabilities in the communities	3 OTs
Longuo Psychiatric Rehabilitation Village	Kilimanjaro	Semi-urban	Mental Health	1 OT
Faraja Diaconic Centre (School for physically handicapped children)	Kilimanjaro	Rural	Children's with physical disabilities	1 OT
Irente children's home (Children's with disabilities)	Tanga	Rural	Children's with physical and learning disabilities	2 OTs
Young with Disabilities Community Program (YDCP)	Tanga	Urban	Children's with physical and learning disabilities	3 OTs
Selian Lutheran Hospital (Private Hospital)	Arusha	Urban	Children's and adult with physical disabilities	5 OTs
Sekou Toure Hospital (District Hospital)	Mwanza	Rural	Children's and adults with physical disabilities	2 OTs
Paloti Rehabilitation Centre (Childrens and adults rehabilitation centre)	Arusha	Urban	Children's and adults with physical disabilities	1 OT
Bukoba hospitals (Regional Hospital)	Bukoba	Urban	Children's and adults with physical disabilities	1 OT
Sibusiso Children's Rehabilitation Centre (Childrens rehabilitation s centre)	Arusha	Semi-urban	Children's physical and learning disabilities	2 OTs
Mbulu Hospital (District hospital)	Manyara	Semi-urban	Children's and adults with physical disabilities	2 OTs
Mtwara regional hospital (Regional hospital)	Mtwara	Urban	Children's and adults with physical disabilities	2 OTs
Kahama Hospital (District hospital)	Shinyanga	Urban	Children's and adults with physical disabilities	2 OTs
Morogoro Regional hospital (Regional hospital)	Morogoro	Urban	Children's and adult with physical disabilities	2 OTs
Kasulu Hospital (District hospital)	Kigoma	Semi-urban	Children's and adults with physical disabilities	1 OT
Mara Hospital (Regional hospital)	Mara Region	Urban	Adult & children's with disabilities	1 OT
Siuyu Children's Rehabilitation Centre	Singida	Urban	Children's with physical and learning disabilities	2 OTs
			Total	**80**

Figure 1 shows the selected regions from which occupational therapists were recruited.

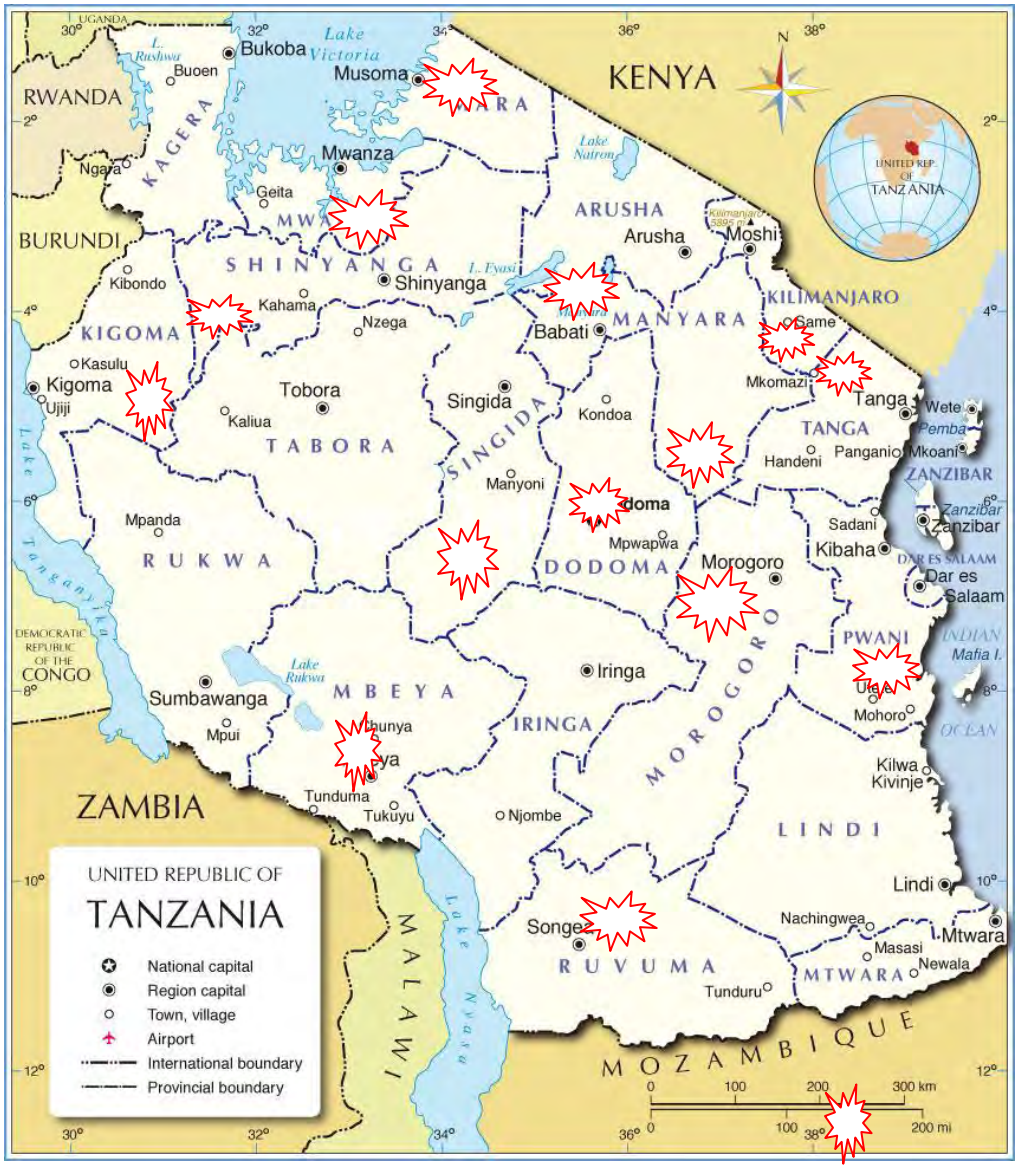

Figure 1: Map of Tanzania showing the regions from which occupational therapists were recruited for the study (regions indicated by red flashes)

3.3. Population and sampling

The study population included all qualified and registered occupational therapists working in Tanzania from 2002 - 2014. In 2012 there were 70 qualified occupational therapists in Tanzania who were registered in the member association (WFOT, 2012) but according to the statistics available at the occupational therapy school in Moshi, the total number of

qualified occupational therapists in Tanzania in 2013 was 80 (Mallya, 2014). Therefore, the population for this study was considered to be 80.

3.3.1. Inclusion criteria

The only inclusion criterion was that participants had to be graduate occupational therapists practicing in Tanzania with more than six months' practice experience. This criterion was set because the researcher wanted only those who potentially had some experience in using CCP in their practice.

3.3.2. Exclusion criteria

The only exclusion criterion was occupational therapists volunteering from overseas. This group was excluded as their education was likely to have differed from that in Tanzania. In addition, as volunteer occupational therapists come to Tanzania via different organizations, the TOTA and the School of Occupational Therapy have no records of volunteers.

3.3.3. Sample size estimation

The sample size was calculated using *OpenEpi* (Dean, Sullivan, Soe, 2014). With a population of 80 occupational therapists, and the following parameters:

- confidence limit of 5%
- estimated prevalence of 50% of occupational therapists claiming to use CCP; and,
- a confidence level of 95%,

A sample size of 67 participants was required.

3.3.3.4. Sampling method

Non-probability convenience sampling was used to enrol all consenting occupational therapists in Tanzania who met the inclusion criteria.

3.4. Instrumentation

Permission was received from the authors to adapt and use the Professional Questionnaire for Assessing CCP (PQACCP) (Sumsion & Smyth, 2000; Parker, 2006)(see Appendix D p.109). The PQACCP consists of the following five sections: **Section I:** Demographic characteristics

This section gathers demographic information on the study participants. Items from the original questionnaire include: age, years of experience, main area of occupational therapy practice and type of practice.

Section II: Understanding of CCP

This section contains a checklist on participants' understanding of CCP developed by Parker, (2005). The checklist consists of 13 statements, numbered alphabetically, that are answered by ticking either 'yes' or 'no'.

Section III: Barriers to CCP

This section is based on the questionnaire developed by Sumsion and Smyth (2000) for assessing barriers and solutions to implementing CCP. The questionnaire consists of 16 statements on possible barriers to CCP. Responses are recorded on a five-point scale with options ranging from 'completely prevents CCP' (score of 5 points) to 'does not prevent CCP' (1 point). The changes made to this section are reported in Section 3.6 (Pilot testing of questionnaire).

Section IV: Enablers of CCP or ways to resolve barriers to CCP

This section is also based on the questionnaire developed by Sumsion & Smyth, (2000) for assessing barriers and solutions to implementing CCP. It consists of 18 statements that are rated on a five-point scale ranging from 'Completely effective' (5 points) to 'Not effective' (1 point).

Section V: Opinions on the relevance of CCP for Tanzania

An open-ended question was added in which participants were asked to comment on the relevance of CCP for Tanzania and to justify their opinions. This question allowed participants the opportunity to reflect more about CCP and to provide subjective information that may have been missed. It also allowed them to make additional suggestions regarding the relevance of CCP to occupational therapy practice in Tanzania.

3.5. Reliability and validity

The reliability and validity of the PQACCP has been confirmed in previous studies based on CCP as a construct that addresses autonomy/choice, partnership/responsibility,

enablement, contextual congruence, accessibility, empowerment, goal negotiation and respect for diversity (Donney & Carswell, 2002; Sumsion, 1997 & Peloquin, 1997; Law et al 1995,). Therefore the content validity of the questionnaire was based on the experience of occupational therapists in the United Kingdom as well as expert knowledge from a literature search (Sumsion & Smyth, 2000). The first study to confirm content validity was conducted in the United Kingdom to identify barriers and solutions (Sumsion & Smyth, 2000). The highest barriers identified were that therapists and clients have different goals, the therapists' values and beliefs prevent them from accepting clients' goals and therapists are uncomfortable with allowing clients choose their own goals. The methods to resolve barriers were management and peer support for CCP, involvement of all staff in CCP training, and staff education time to learn how to practice in a client-centred fashion. A similar study was done in Sweden (Wressle & Samuelsson, 2004) where the questionnaire was translated into Swedish and yielded similar results to those reported by Sumsion and Smyth (2000). The highest ranked barriers were that the therapist does not know enough about CCP, therapists and clients have different goals and therapists' values and beliefs prevent them from accepting the clients' goals. The highest ranked methods to resolve barriers were management and peer support for use of client-centred practice, involvement of all staff in CCP training, and staff education time to learn how to practice in a client-centred fashion.

The following steps were taken to reduce the variation in responses between participants thus improving the reliability of the results

- A pilot testing of the questionnaire was conducted to ensure the operational definitions were presented using clear language and that the layout was logical (face validity). It was also used to check that the sequence of sections was coherent and the written instructions on how to complete each section were clear to ensure it was user-friendly (Rattray, 2007; Boynton, 2004; Bourgue & Fielder, 2003).
- The importance of the study was explained to participants in an information letter (Appendix C p. 106) which all participants were required to read prior to completing the questionnaire.

3.6. Pilot testing of the questionnaire

The aim of the pilot was to provide feedback on the clarity of the questions, user-friendliness of the layout and format, and time taken to complete (Boynton, 2004).

3.6.1 Pilot test procedure

The pilot test involved 15 third-year occupational therapy students at the Kilimanjaro Christian Medical University College. The students were 18 years of age or older. The information letter (Appendix C p.106) was used to obtain their consent to participate in the pilot testing of questionnaire. Participants were informed of the purpose of the pilot and that they would not be included in the main study. The pilot study was completed two weeks before the full-study data collection was done. The pilot study procedures were based on the recommendations of Peat et al, (2002) and consisted of the following steps:

- the questionnaire was administered to pilot test participants in exactly the same way as it would be administered to the main study participants;
- participants were asked for feedback to identify ambiguities and difficult questions;
- each question/statement was assessed to determine whether it gave an adequate range of responses through observing how the questions were completed, and by obtaining feedback from the focus group discussion among some of the pilot group participants and feedback from the research supervisors;
- an assessment was done to establish whether written replies could be interpreted in terms of the information required; and,
- questionnaires were checked to ensure all questions were answered and that there was no missing data.

3.6.2 Pilot test findings

Of the 15 third-year students, ten returned the questionnaire during the allocated time despite efforts to follow up those that were outstanding. Follow up of participants was done via mobile phones and e-mails. Information gathered was used to make corrections on the specific areas of the questionnaire. The identified problems, mentioned in the preceding section, were addressed before embarking on the main study (Appendix R p.131). Data capturing was done to check the entry process and the appropriateness of the data capture sheet and analysis steps. Also, the time taken to complete the questionnaire

was recorded and it was decided that the average time of 30 minutes was reasonable for busy clinicians. The unnecessary, difficult or ambiguous words or statements were corrected (see Appendix R p.131)

3.7. Procedure

3.7.1 Gaining access to participants

Once ethical clearance was obtained, participants' contact details were sourced from the TOTA and the School of Occupational Therapy Moshi databases. The Tanzania Occupational Therapy Association and the School of Occupational Therapy were approached for their assistance in providing the registration and contact details of occupational therapists in Tanzania.

3.7.2 Recruitment of participants

Potential participants who met the inclusion criteria were contacted individually by the researcher by visiting local occupational therapy departments, or contacting them via mobile phone or e-mail to explain the study and request their participation.

3.8. Data collection

The process of data collection was started after obtaining ethical approval from the National Institute for Medical Research Tanzania (Appendix B, p.105). The period during which data collection occurred was 1 October 2014 until 13 December 2014 (ten weeks). There was limited face-to-face contact between participants and the researcher to ensure confidentiality (see 3.11.4 for further information). The participant information letter (Appendix C, p.106) was distributed with the questionnaire (Appendix D p.109) either by hand, the postal service or electronically. In cases where participants were unsure of the best way to receive the questionnaire, it was sent via post and e-mail. Participants were asked to complete both documents at a convenient time and return it to the researcher by hand, electronically or via the postal service using post office stamped return envelopes. Participants recorded their responses directly on the questionnaire. Electronic questionnaires were sent in Microsoft Word format, and participants were requested to download the forms, type in their responses, save the changes in Word format and return it to the researcher via the same e-mail address. Participants were requested to place a tick (√) or cross (X) beside the appropriate response. The following methods were used to

achieve the best possible response rate from participants (Edwards, Roberts, Clarke, et al. 2007; Leece et al, 2004);

- participation was requested from respondents in advance (when possible) through personal visits, telephone contact and emails, and information about the purpose of the study, how the results would be used, and issues related to anonymity and confidentiality were addressed
- respondents were given a sufficient amount of time (two months and two weeks) to complete the survey
- electronic and telephonic reminders for mail surveys were sent out during the data collection period thanking the respondents who had already completed the survey, while reminding others about the deadline for completing the survey
- clear verbal and written instructions were provided on how to complete and submit the survey
- the questionnaire was designed as easy to read and follow
- an incentive in the form of a book was offered on completion of the study to those who had participated. The book will be awarded through a lucky draw at a TOTA annual event to be held on September 2015
- participants were assured that confidentiality would be upheld when disseminating the study findings.

3.9. Data Management

Confidentiality of the data was ensured by numbering questionnaires rather than using participants' names. The use of numbers on the questionnaire helped in counter-checking whether the participants had returned the questionnaire or not. The lists were kept by researcher. Completed questionnaires were stored in a secure location to which only the researcher had access. Information from completed questionnaires was captured using *Statistical Package for Social Sciences (SPSS)*, *version 20.0* (IBM, 2011). Accuracy of data entry was ensured by double-checking the data that had been captured (William & Trochim, 2006).

3.10. Data analysis

Data were analysed using *SPSS, version 20.0* (IBM, 1989-2011). For numerical variables, data were checked for normality using the Shapiro-Wilk Test and the appropriate measures of central tendency and dispersion calculated. Frequencies and proportions were determined for categorical items. The Chi-square test of association was used to determine whether there were any significant differences between demographic variables (gender, year of experience, area of practice, and level of education) and barriers and enablers to CCP. For Chi-square Tests, categories were collapsed as follows to avoid including variables with too many categories in the analysis, or too few responses in some cells, thereby making the results easier to interpret (Vaus, 2002):

- Categories for 'children with physical disabilities in general hospital and rehabilitation centres' and 'children with physical and learning disabilities in schools' were collapsed (renamed 'paediatrics')

- Categories for barriers in implementing CCP were collapsed into two by combining 'completely prevents CCP', 'prevents CCP a great deal' and 'prevents CCP moderately' (renamed 'substantial barriers') and 'prevents CCP slightly' and 'does not prevent CCP' (renamed 'minimal barriers').

- Categories for enablers in implementing CCP were collapsed into two also by combining 'completely enables CCP', 'enables CCP a great deal' and 'enables CCP moderately' (renamed 'substantial enablers)' and 'enables CCP slightly' and 'does not enable CCP' (renamed 'minimal enablers)'

- With regard to the multiple analyses for the chi-square test, the Bonferroni correction was applied (Armstrong, 2014; Goldman, 2008). The purpose was to adjust probability (p) values because of the increased risk of a type I error, i.e. concluding that a significant difference is present when it is not when making multiple statistical tests. Therefore, instead of setting the critical *P* value level for significance, or alpha, to 0.05, the lower critical value is used. For example, in Table 3, 14 analyses were done, therefore applying the Bonferroni correction as follows: 0.05/14 = 0.004, the p-value that would be significant would be $\underline{<}$ 0.004.

For the open ended responses, responses were captured verbatim in *Microsoft Excel* and a thematic content analysis was conducted (Boynton, 2004). The quantities of qualities approach (Saldaña, 2013, p. 24) to counting instances of similar codes was used because the open-ended responses were mostly single sentences rather than descriptive narratives. The researcher looked for patterns of responses for each statement and grouped similar units of meaning into categories that captured the main themes. (Hosking et al., 1995).

3.11. Ethical considerations

Ethical approval to conduct the study was obtained from the Faculty of Health Sciences Human Research Ethical Committee of the University of Cape Town ((HREC REF 242/2014, Appendix A p. 104) and the National Institute for Medical Research Tanzania (NMR/HQ/R.8a/Vol.IX/1829, Appendix B p. 105).

3.11.1. Informed Consent

The participant information sheet (see Appendix C p. 106) was written clearly and provided sufficient information for participants to understand what was required of them. The study purpose, procedures involved, risks and discomforts were declared in simple language in the information letter. Participants were asked to voluntarily participate in the study, and informed consent was ensured by having the participants sign the information letter (Appendix C p. 106) before data collection. Participants were given the opportunity to ask questions verbally or electronically. The researcher was able to respond to all concerns raised by participants on how to complete the questionnaire and the procedure for sending it back. All the participants' information letters were signed and returned with the completed questionnaires to the principal investigator. The signed participant information letters are stored by the researcher and will be kept for two years.

3.11.2. Autonomy

Autonomy was upheld by stating that participants were free to choose whether to complete the questionnaire or not. The participants were assured that participation was completely voluntary and that they had the right to withdraw from the study at any instance. Refusal to take part or withdrawal would not have affected them in any way and their choice would be appreciated by the researcher. All participants contacted were willing to take part in the study. The researcher kept the linked list of names and

questionnaire numbers in order to be able to track back and identify those participants who completed the questionnaire or not. The list was destroyed immediately after completing the process of data collection.

3.11.3. Beneficence

Beneficence was upheld by informing participants of their rights and the procedures involved. The possible benefits of participating in the study were to help Tanzanian occupational therapists to understand on how CCP is being implemented in Tanzania and to inform the School of Occupational Therapy and the TOTA in restructuring occupational therapy practice in the country to benefit the profession as a whole. No payment was made to participants and the cost of postal return of the questionnaire was carried by the researcher.

3.11.4. Confidentiality and anonymity

Questionnaires were numbered to ensure anonymity. Each participant was approached individually to maintain privacy. A list of the names linked with participants' study numbers was used to check which participants had returned questionnaires so that reminders could be sent to participants who had not returned the questionnaire by the due date. This list was destroyed immediately after stopping the collection of questionnaires so that participants names could not be linked to their study number. The questionnaires that were sent and received via e-mail were downloaded, printed and mixed with the others so respondents could not be identified. One participant returned his/her answers via mobile phone. The researcher transferred the responses from this participant onto a hard copy questionnaire and mixed it with the others to ensure anonymity. The questionnaires were kept in a locked drawer. The data were then entered into SPSS software for analysis. Only the researcher and statistician worked together. Data will be maintained securely for a year or more before destroying them or in case of publication in future.

3.11.5. Justice

All Tanzanian occupational therapists who met the inclusion criteria were given the opportunity to participate in the study.

3.11.6. Potential risk

The nature of the topic under the study posed minimal risk leading to distress. Some discomfort may have been evoked in some occupational therapists who are not

implementing CCP. The minimal distress did not necessitate referral. The risk will be offset by the provision of in-service training in CCP (if indicated following the study).

3.12. Summary of Chapter 3

This chapter has described the methodology procedures and processes which research has used to collect data and analyse the data. The following chapter 4 presents the results according to the aims and objectives of the study.

CHAPTER 4: RESULTS

This chapter presents the research findings of this study. The results are organised according to the objectives of the study. The chapter starts by providing information on participants' demographic characteristics. This is followed by responses on the level of understanding of CCP and analyses of statistically significant relationships between understanding of CCP and demographic characteristics. The barriers and enablers to implementing CCP are then presented along with analyses to determine whether significant relationships with demographic characteristics exist. The last section provides information to the open-ended questions on the relevance of client-centred practice in Tanzania.

4.1 Response rate

Sixty-four participants (n=80) returned the questionnaire giving a response rate of 80%. Twenty-six questionnaires had no missing data. Data was missing on 38 questionnaires. Missing data for the items ranged from 1.5% to 10.9%. The item '*education which is not disease centred*' (section IV of PQACCP on enablers to CCP) had the highest amount of missing data. Details for missing data per item are stipulated in Appendix S (p. 131).

The methods of disseminating and returning questionnaires were as follows:
Ten questionnaires were sent using post-office stamped return envelopes and seven were returned the same way. Three participants decided to scan and send the completed questionnaire via the researcher's e-mail address. Forty questionnaires were handed out directly (face to face) by the researcher in Dar es Salaam and the Kilimanjaro region and collected the same way by researcher. Twenty questionnaires were sent using participants' e-mail addresses and 17 returned the same route. One participant decided to copy the answers in her mobile phone and sent them to the researcher as a text message. The researcher used a blank questionnaire to record her answers. Ten questionnaires were sent by combining two ways, once by postal method and once by e-mail.

4.2 Characteristics of participants

Table 3 presents the demographics and practice domains of the participants. The data for ages and years of experience were not normally distributed. The medians for age and years of experience were 28.0 years and 3.0 years respectively. There were slightly more females than males. A large proportion of participants (45.3%) worked with children with physical disabilities in general hospitals and rehabilitation centres. The primary source of funding for settings where occupational therapists worked was from the public sector 26.6%. Most (96.9%) respondents had a diploma level of education.

***Table** 3: Profile of participants (n=64)*

Variable	Median	Range	IQR
Age (years)	28.0	28.0	(25.0 – 35.0)
Experience (years)	3.0	13.0	(2 – 8.5)
		No.	**%**
Gender:			
Male		27	42.2
Female		37	57.8
Total		***64***	***100.0***
Main area of occupational therapy Practice			
Adults with physical disabilities		13	20.3
Paediatrics		30	46.9
Community based rehabilitation		6	9.4
Mental health		8	12.5
Combination of children and adults with physical disabilities		6	9.4
Teaching		1	1.6
Total		***64***	***100.0***
Primary source of funding			
Private		15	23.4
Public		17	26.6
Donor		11	17.2
Private companies		3	4.7
Combination			
Private and public		7	10.9
Public and donor		4	6.3
Private and donor		4	6.3
Private, public and donor		1	1.6
All sources mentioned above		2	3.1
Total		***64***	***100.0***
Occupational therapy qualification			
Diploma		62	96.9
Bachelors		0	0.0
Master's		2	3.1
Total		***64***	***100.0***

4.3 Understanding of CCP

Table 4 shows the results for understanding of CCP. The majority of participants indicated that they had an understanding of the different aspects of CCP, with c*onsidering my clients as individuals* being rated highest (n=63, 98.4%) and *negotiating with them about goals and outcomes* rated as the lowest (n=53, 82.0%).

Table 4. Understanding of CCP (n=64)

Variable	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 occupational therapy 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)

*Missing data for these items.

4.4.1 Relationships between understanding of CCP and demographic variables

Chi-square Tests revealed no statistically significant differences between understanding of CCP and gender, years of experience and main area of occupational therapy practice (refer to Appendix G–I, p. 117-119 for details).

4.5. Potential barriers to client-centred practice

This section reports the results for perceived barriers to CCP. As described in section 3.11, categories were collapsed into two for the purpose of analysis. Detailed analyses for the original categories are available in Appendix E (p 115).

4.5.1 Barriers to CCP

Table 5 shows participants' responses on potential barriers to CCP. Shortage of time was the leading barrier (n = 51, 79.7%), followed by the therapist thinking that CCP is too demanding for the client (n = 50, 78.1%) and the therapist and client having different goals (n = 49, 76.6%). The therapist and client being of a different gender (n = 17, 26.6%) received the lowest rating as a barrier to CCP.

Table 5. Potential barriers to client-centred practice (n = 64)

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

* Missing data for these items.

4.5.2 Relationship between barriers to CCP and demographics

Chi-square Tests revealed no statistically significant differences between barriers to CCP and gender; years of experience and main area of occupational therapy practice (see Appendix J–M, p.121-124, for details).

4.6. Enablers to client-centred practice.

This section reports the results for enablers to CCP. As described in section 3.11, categories were collapsed into two for the purpose of analysis. The detailed analyses for the original categories are available in Appendix F p. 116.

4.6.1 Enablers to CCP

Table 6 represents enablers to CCP. The highly rated enablers were education about CCP while still a student (n=63; 98.8%), involvement of all staff and service providers in CCP training (n=62; 96.9%) and client involvement in planning of services (n= 62; 96.9%).

Table 6. Enablers to client-centred practice (n=64)

Enablers	Substantial enablers No. (%)	Minimal enablers No. (%)	Total No. (%)
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)

*Missing data for these items

4.6.2 Relationship between enablers to CCP and demographics

Chi-square Tests revealed that there were no statistically significant differences between enablers to CCP and gender, years of experience and main area of occupational therapy practice. Details of the results for the Chi-square test are available in Appendix N to Q p 125-128.

4.7. Relevance and opinions of client-centred practice in Tanzania

Three themes emerged from the analysis of the responses to the open-ended questions, namely: CCP enriches the occupational therapy-client relationship, CCP is difficult in Tanzania, and CCP in Tanzania needs to be supported. Table 7 provides an overview of the themes and categories after which the findings for each theme are presented under separate sub-headings.

Table 7. The relevance of CCP for Tanzania

Themes	Categories	No. (%)
1. *CCP enriches the occupational therapy-client relationship*	CCP increases client participation	16(32)
	CCP allows clients to take responsibility	11(22)
	CCP encourages partnerships	9(18)
	CCP empowers clients	8(16)
	CCP leads to client satisfaction	8(16)
	CCP helps clients to understand his/her health condition	6(12)
	CCP tends to focus on intervention supporting client's needs	8(16)
	CCP values client goals	6(12)
	CCP enables therapists to set realistic goals	6(12)
	CCP can be used across different clients	5(10)
2. CCP is difficult in Tanzania	Limited resources	16(32)
	Cultural barriers	13(26)
	Clients consider therapists as experts	10(20)
	CCP is time consuming	9(18)
	Clients lack knowledge about CCP	6(12)
	Following medical model	8(16)
	Reluctance of therapist to share power	5(10)
	Therapists lack knowledge about CCP	4(8)
	Clients set unrealistic goals	2(4)
	Illiteracy among patients	2(4)
	CCP is a more westernized practice	2(4)
	Lack of institution support	1(2)
	Clients are reluctant to change	1(2)
	Therapists have different goals from that of client	1(2)
3. *CCP in Tanzania needs to be supported*	Improving resources	16 (28)
	Postgraduate training	15(23)
	Education of clients	8(13)
	Education on CCP amongst occupational therapy students	3(5)
	Involve other health professionals in CCP education	5(8)
	Facilitate attitude change among clients	3(4)
	Increase the enrolment of occupational therapy students	2(3)
	Skills training on how to empower clients & power sharing	1(1.6)
	Support from TOTA	1(1.6)

Theme 1: CCP enriches the relationship

Ten categories were identified within this theme as shown in Figure 2. Collectively the ten categories depict the various ways in which Tanzanian occupational therapists believe that CCP enriches their relationships with clients.

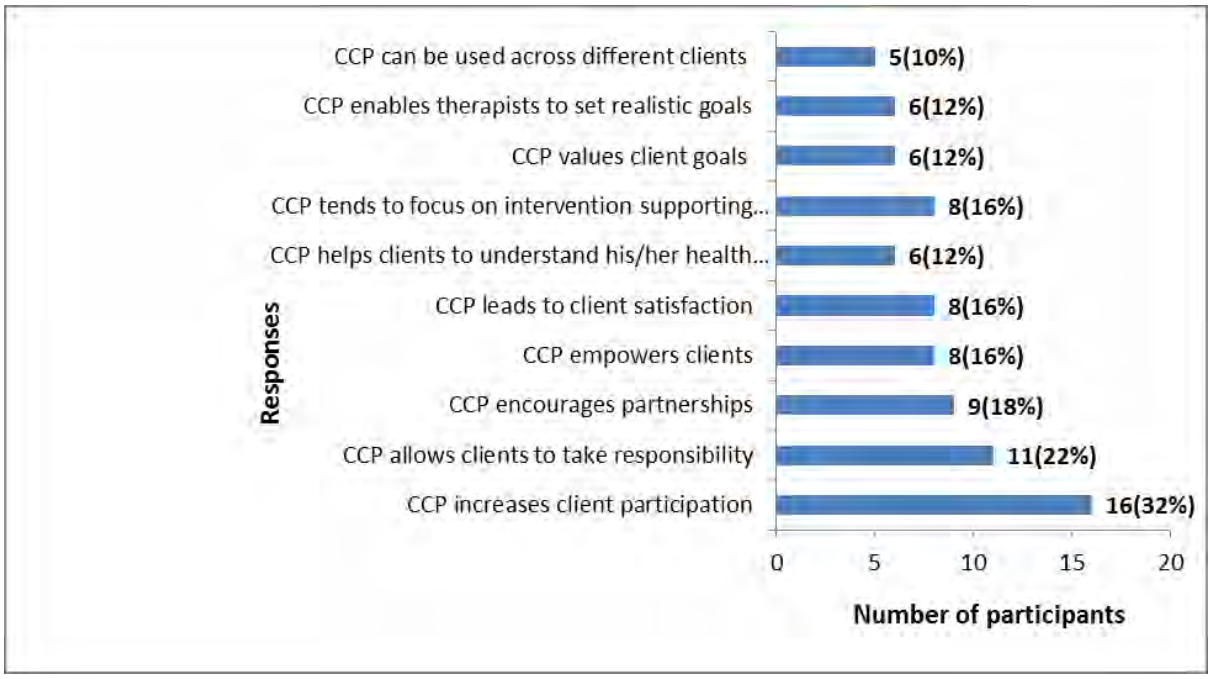

Figure 2 Categories for Theme 1 'CCP enriches the relationship'

Sixteen occupational therapists reported that involving clients in the decision making process while implementing CCP promotes the client's participation as shown in the following quotes.

> *'CCP in Tanzania is better in our practice because occupational therapy looks at a client as individual and in holistic way. It makes a client to be free on what s/he wants during therapy. Also it provides good stimulation to the client to continue participate in therapy during their appointment. CCP practices make a therapist see the client in a real life which the client uses to do at home environment' (participant no. 49).*

> *'CCP is very important for Tanzania as it gives satisfaction to both clients and therapist, if each one value the other and set goals together agree together on how to accomplish them and reach their goal together everyone will be happy and satisfied on what they planned and accomplish together. Client will feel valued and work hard to help the therapist to reach what they agreed' (participant no. 21).*

Eleven occupational therapists felt that CCP encourages clients to take responsibility for their treatment. The following quotes substantiate this category within the overall theme:

'I think CCP is of great importance – when using CCP the patients is given a chance to voice out their opinions. This makes treatment intervention easy. When using CCP the patient become aware that they are required to look after themselves and that their health depends on them. Furthermore CCP strengthen trust on the therapist intervention process becomes easier' (participant no. 7).

Nine occupational therapists reported the issue of partnership when describing the relationship they had developed with the client while using CCP. This is supported by the following quote:

'CCP in Tanzania is very important and helpful because it values the goals of the client treatment and fosters respect of client's opinions. It also places a therapist as an advisor and not as a controller of the client as in medical model approach' (participant no. 20)

Theme 2. CCP is difficult in Tanzania

Twelve categories were identified within this theme (see Figure 3).

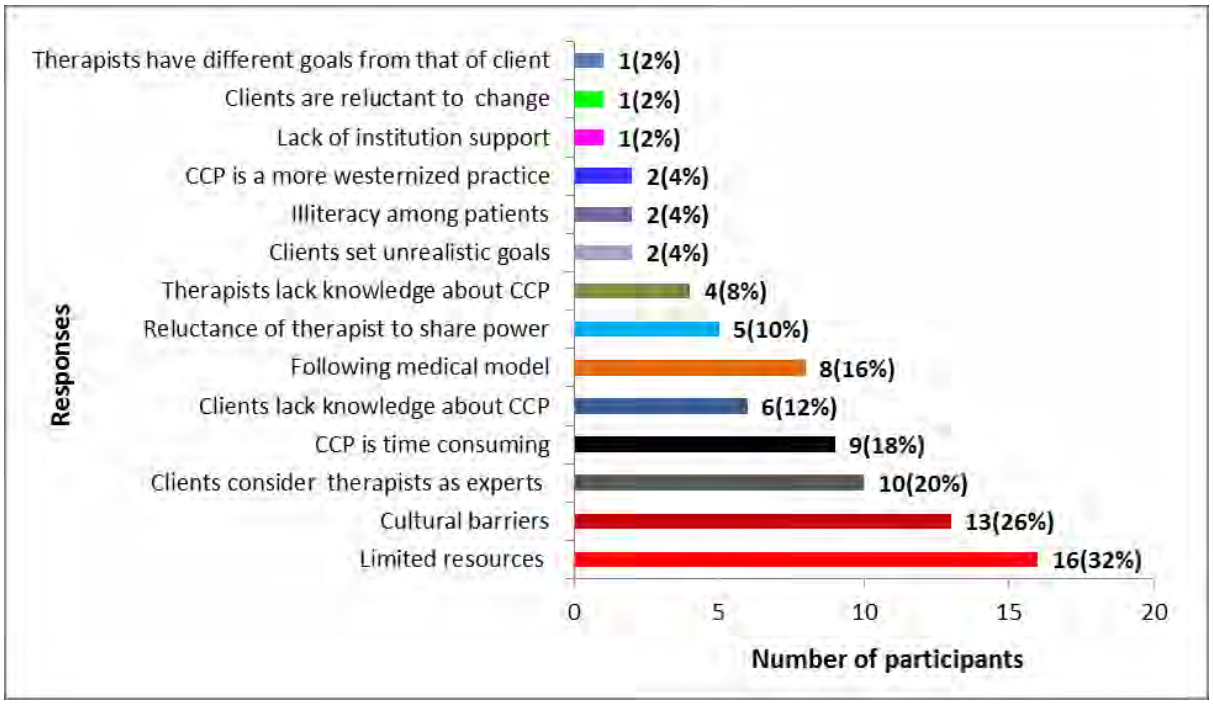

Figure 3 Categories for Theme 2 'CCP is difficult in Tanzania'

The three highest rated difficulties in implementing CCP in Tanzania were limited resources; cultural barriers and clients considering therapist as expert.

Sixteen occupational therapists felt that resource limitations hindered their capabilities in implementing the CCP as the following quote illustrates

> '*Few number of occupational therapists compared to big number of clients and lack of enough material is the challenges (sic)' (participant no. 56)*

Thirteen occupational therapists perceived the culture of Tanzanian people to be a hindrance to CCP. This is because serving the ill is a duty of the family to the extent that even when the client may be able to assist in the task, the family members and relatives do not allow their family member to be an active participant in the recovery process. This cultural belief leads to dependency. The following quotes provide further elaborations.

> *'Due to the nature/culture of the people CCP is not much practiced because people/client think that the therapist can do much rather than them to participate' (participant no. 60)*

> *'Myself, I implement CCP in my practice but I face some challenges like cultural barriers, so sometimes it becomes difficult to achieve my goals 100 %'. (participant no. 40)*

> *'CCP is a good practice but in our culture or context is challenged with interdependency practice of our community' (participant no. 35)*

The issue of clients considering the therapist as an expert of their health problems was perceived by therapists to be in conflict with the concept of CCP. The following quotations illustrate this:

> *'The relevance of CCP for Tanzania in my opinion is difficult to practice. This is because many people in Tanzania have little knowledge and understanding about disability. Therefore when they came for therapy, the disabled person expects the therapist to decide. As some say 'I will do as you say'. Also in Tanzania people know that the therapist knows everything and knows what to do concerning their problem. Though some can give their goals they may not correspond with the ability of the individual. For me in Tanzania therapists try to practice CCP with the person with a disability who can understand' (participant no. 25)*

'CCP for Tanzania becomes difficult practice as most of our clients depend on us to plan everything for them without them participating in decision making on what they want' (participant no. 52)

Theme 3. CCP in Tanzania needs to be supported

Ten categories were identified within this theme (see Figure 4).

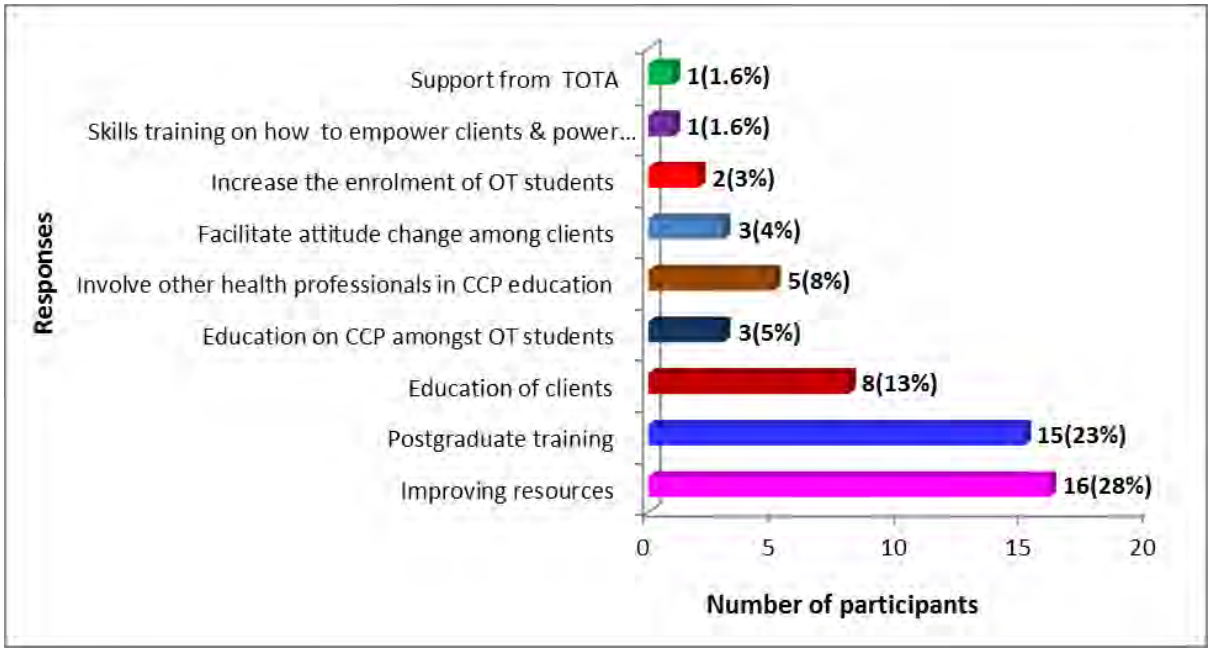

Figure 4 Categories for theme 3 CCP in Tanzania needs to be supported

The three highest rated categories recommending that CCP be supported in Tanzania are improving resources, postgraduate training and education of clients.

Sixteen occupational therapists who participated in this study felt that improving resources will enable the implementation of CCP. The main resources currently needed include human resources, materials, finances, time availability and a supportive environment. The following quotes from the participants provide further elaboration:

'Since CCP is important for service delivery and development of our profession, the Occupational Therapy School needs to have a strategy to enrol a large number of OT students and also provision education about CCP and workshops should be conducted among qualified practitioners' (participant no. 34)

Postgraduate training was expressed by fifteen participants as a way to support CCP implementation in Tanzania. The following quotes provide further explanations;

'Training during work is needed to facilitate occupational therapists to improve their knowledge about CCP' (participant no. 60)

'Involvement of professionals in seminars and CPD will enable therapists to share experiences and overcome challenges faced' (participant no. 53).

The education of clients was also expressed by eight participants as an important element in supporting the implementation of CCP in Tanzania. The participants indicated that client education should address the health condition in order to improve health literacy, understanding their rights as patients and also issues related to CCP, the decision-making process and collective goal-setting. The citations below from participants provide further elaboration;

'Education to the client to know that they are the ones to take responsibilities on their health and that they have the right to decide what is best for them' (participant no. 41)

'Education to our clients and other healthcare providers about the importance of involving the client in intervention process is importance because it makes client felt comfortable during occupational therapy process and participate fully' (participant no. 33).

4.8. Summary of Chapter 4

This chapter has described the characteristics of occupational therapists using CCP in Tanzania, their understanding of CCP and the various barriers to and enablers for implementing CCP. The top three barriers were: the therapist is short of time (n=51, 79.7%), the therapist thinks that CCP is too demanding for the client (n = 50, 78.1), and the therapist and client have different goals (n = 49, 76.6%). The highest three enablers were: education about CCP while still a student (n = 63, 98.8%), client involvement in planning of services (n = 62, 96.9%), and involvement of all staff and service providers in CCP training (n = 62, 96.9%). There were no statistically significant relationships between the understanding of CCP, barriers to CCP, enablers to CCP and demographic characteristics. Qualitatively, Tanzanian occupational therapists believe on the one hand that CCP enriches the occupational therapist-client relationship and needs to be supported in Tanzania, but on the other, they find CCP difficult to implement.

CHAPTER 5: DISCUSSION

This chapter discusses the results in answering the research question and meeting the study purpose. It points out that the perspectives of Tanzanian occupational therapists about the use of CCP are aligned with those documented in the literature.

5.1 Understanding of CCP

The study participants felt that they understand CCP**.** Their understanding complies with core elements of client-centred practice as identified in Maitra and Erway (2006), CAOT (2002), Sumsion (2000a) and Law and Baptise, (1995). Like the participants in Parker's study (2012) the therapists in this study also placed importance on working in partnership with their clients, respecting and listening to them in understanding their needs, valuing explanations and using discussion to identify goals and enable clients to make choices. Similar to Pettersen and Svilaas (2012), participants in this study felt that therapists focus on the client goals as a significant factor in CCP; they provide information for the patient to be able to make informed decisions and set goals and that the client participates actively in the decision making process.

Although participants in this study reported that they understand CCP, this finding contradicts the real situation of occupational therapy practice in Tanzania. Therapists may understand what CCP is but they are restricted in giving full expression to its principles because the health and insurance systems in Tanzania are dominated by the medical model (United Republic of Tanzania, Ministry of Health and Social Welfare, 2008). Townsend (1998) indicated that healthcare and insurance systems that are based on the medical model do not reflect the values of client-centred practice. Therapists who base their decisions on the medical model practice, are more likely to use a top down, expert driven approach to clinical decision-making than a collaborative, client centred one. Other factors making CCP difficult in Tanzania include a shortage of occupational therapists, illiteracy among clients and the newness of the profession in the country. Other health professionals working with clients are not familiar with the approach which might create confusion among team members. Duggan, (2005) also reported that clients, co-workers and community members do not truly understand the potential for occupational therapy and CCP. If CCP is truly valued by the profession, then the results suggest that the concepts

and principles of CCP deserve to be marketed more vigorously to change health service delivery.

5.2 Barriers to client-centred practice

The five leading barriers identified in this study are similar to those reported by Wressle & Samuelsson (2004) and Sumsion & Smyth, (2000) who found that therapists do not know enough about CCP, therapists have different goals from those identified by clients, therapists' values and beliefs prevent them from accepting their clients' goals, therapists feel uncomfortable letting clients choose their own goals and therapists believe that their intervention is dominated by the medical model. An interesting gender difference of opinion in the results about barriers to CCP was evident (but not statistically significant) and has not been reported in any other studies. In this study female occupational therapists rated the following three barriers higher than the male occupational therapists: the therapist is short of time, under financial pressure and has high levels of stress. The male occupational therapists rated the following three barriers high: CCP is too great a change from current practice, the therapist has difficulty assessing their clients' ability to choose their own goals and the therapist has difficulty in facilitating the clients' identification of their own goals. The roles and responsibilities of men and women could be taken into reflection during in-service training in CCP.

One study has reported on the influences of facility type on CCP (Maitra & Erway, 2006). Maitra and Erway noted that occupational therapists in hospital inpatient facilities tended to show the strongest trend of not using client-centred practice and having the most difficulty in their attempts to use CCP. They found that therapists' using CCP in hospital inpatient settings reported that their clients were not always able or ready to participate in the goal-setting process. The shortage of time reported by respondents in this study may also be linked to the rapid turnover of patients and short hospital stays in Tanzania.

Cole & McLean (2005) reported funding as a barrier in CCP in today's cost-conscious healthcare environment. They revealed differences in use of CCP among occupational therapists working with paediatric, adult and geriatric specialty subgroups, and attributed these to differences in the funding source. They found school-based therapists spent less time with a client because of the pressure of a high case load. Furthermore, it was noted

that since there were no longer payments for evaluation time in Medicare/PPS, that therapists talked little during evaluation and more during treatment. This funding-driven trend was also noted in geriatric specialist care. Although there were no statistically significant differences observed between the source of funding and barriers or enablers to CCP in Tanzania, it may be argued that differences may emerge over time as the profession begins to expand beyond the medical model of practice.

Sumsion and Smyth (2000) reported therapist time constraints as the ninth highest barrier while in Wressle & Samuelsson (2004) it was the seventh. In Tanzania it is likely that time constraint was rated first because of the shortage of occupational therapists. The recent WFOT human resource project (2014) shows Tanzania has 94 occupational therapists serving a population of 44.9 million (URT, 2012). The number of occupational therapists per 10,000 head of populations = median 0.9, mean 2 (WFOT, 2014). The high client-to-therapist ratio in Tanzania hinders occupational therapists from having the time to listen to their clients because they rush to complete the workload. The other countries using CCP in the developed world are reported to have higher numbers of occupational therapists. For example Sweden has 9400 occupational therapists, the USA 114,240, Canada 13,040, the United Kingdom 33,383 and South Africa 4,019. The countries considered to have few occupational therapists, apart from Tanzania, include Zambia 5, Nigeria 20, Namibia 50, Lesotho 5, Malawi 10 and Madagascar 1 (WFOT, 2014). The occupational therapist to client ratio differences between developed and developing countries raise questions about the assumed luxury of time and well-resourced service environments as pre-requisites of CCP. Hammell (2011) argued that theoretical imperialism must be resisted for occupational therapy to thrive in non-Westernised contexts. While the values of CCP are commendable, alternative occupational therapy practice models may need to be considered that allow different forms of contextually relevant CCP to emerge.

The second highest barrier to CCP was *the therapist thinks that CCP is too demanding for the client*. Studies by Sumsion & Smyth (2000) and Wressle & Samuelson, (2004) identified the same barrier. In the Tanzanian context the following reasons may account for this finding: illiteracy among clients, poverty, the severity of illness and increased number of clients demanding occupational therapy services. Once again, the context determines the

relevance of CCP and suggests the need for taking the client population into consideration before imposing CCP as the only or preferred way of working.

The third highest barrier to CCP was that *the therapist and client have different goals*. This barrier was also identified by Parker, (2012), Krizaj & Hurst, (2012), Maitra & Erway, (2006); Sumsion & Smyth (2000) and Wressle & Samuelson, (2004). Occupational therapy professionals have a tendency to assume that a client's goals and the therapist's goals are the same, when in reality they are not (Baptiste, 1994). Gateley & Borcherding, (2012 p. 49) reported that goals used in a treatment plan must be written in occupation-based, measureable, observable, action-oriented terms, must be realistic for the client, and be able to be achieved in a reasonable amount of time. Goals must be formulated from the problem identified in collaboration with the client. Rosa, (2009, p. 289) also indicated that occupational therapists have 'an ethical responsibility to take into account clients discussions regarding their own care and to provide them with the opportunity to share in the decisions that affect them'. It could be argued that this ideal is not feasible in Tanzania considering the low levels of literacy of clients and the time constraints faced by therapists. It also raises the question of how locally meaningful ways of problem-solving can be identified and woven into Afrocentric interpretations of CCP. The results point to the potential for African occupational therapists to theorise alternative ways of valuing clients during the occupational therapy process.

The domination of the medical model was also identified in this study as a barrier. This result has been supported by several authors (Pettersen & Svilaas 2012; Sumsion, 2006; Wressle & Samuelsson 2004; Wilkins, Pollock, Rochon & Law, 2001; Sumsion & Smyth, 2000) who found that a dominance of the medical model in occupational therapy intervention can be a barrier because it is completely opposed to the philosophy of CCP. The CCP philosophy emphasized autonomy/choice, partnership and responsibility, enablement, contextual congruence, accessibility and flexibility, respect for diversity (Law et al., 1990; Law, Baptiste and Mills, 1995). The medical model is a more mechanistic, diagnosis-led approach which can ignore the individual in the bed (Sumsion, 2006). If the referral for occupational therapy is restricted to the patient´s medical problems, this may conflict with the patient's functional problems (Duggan 2005; Sumsion, 2004). The need for

balancing the medical model[14] with other models which are not disease focused is important.

In Tanzania the biomedical model has been the dominant model in the delivery of healthcare because the emphasis is on the treatment of the illness to achieve cure. The introduction of the International Classification of Function (ICF) and Disability (ICF) (WHO, 2001) to guide rehabilitation services in Tanzania will promote a shift from the biomedical model to a humanistic or social model because it emphasizes social participation. The ICF is more clearly aligned with the roots of occupational therapy and in that sense the philosophy of CCP (Sumsion, 2006). Client-centred practice creates a natural balance between the medical and social models of care as it can be applied in both biomedical and social environments (Sumsion, 2006). The challenge then is for Tanzanian occupational therapists and occupational therapy educators to begin conversations about different models of occupational therapy practice that may be suited to the different domains of the ICF[18].

The therapist having difficulty with taking risks in order to support the client's goals was also reported to be a high barrier to implementing CCP in Tanzania. Clarke, (2000) reported that healthcare is a risky activity. She pointed out that in occupational therapy risk-taking is inherent in everyday practice; therefore part of the occupational therapists' clinical reasoning process is weighing up the benefits and potential outcomes of their decisions. The sampling of respondents in this study (see Table 1, p. 38) does not indicate the particular health and functional challenges of clients served by Tanzanian occupational therapists. It is therefore unclear exactly what the risks that they faced were. Sumsion, (2006) reported that therapists have a responsibility to ensure that the goals set for intervention are safe and that no harm will come to the client. Unsafe goals entail unnecessary risks (Law et al 1995). Therapists may also avoid taking risks especially when working with clients with cognitive impairments. Townsend and Polatajko (2007) indicated

[14] Note that in OT it does not mean that the medical model is not needed. From medical model point of view we see performance components whilst from a client-centred point of view they are focusing on performance areas (Petterson & Svilla, 2013)

that decision making processes can be affected by cognitive status; therefore occupational therapists may experience difficulties in engaging with clients with cognitive impairments.

5.3 Enablers to client-centred practice

An objective of this study was to identify enablers to CCP. Almost all the enablers listed in the study questionnaire were reported as useful in resolving the barriers to CCP by the study participants. This finding is supported by Wressle & Samuelsson, 2004 and Sumsion & Smyth 2000, the only differences being that management and peer support for using CCP came first in Wressle & Samuelsson's (2004) study while in Sumsion & Smyth's (2000) study, the leading enabler was the use of case examples, showing how to practice in a client-centred fashion. In this study, male and female therapists identified different enablers. The majority of studies on CCP which have been done involved only female occupational therapists because the profession - especially in developed world including South Africa - is dominated by females. All the participants in the study by Sumsion & Smyth (2000) were female. Wressle & Samuelson, (2004) and Krizaj & Hurst, (2012) do not explain or disclose the gender of their participants but it is assumed that the majority were female, because according to the WFOT, (2014) human resource project, 83% of occupational therapists worldwide are female. The critical issue here is the role of gender in determining what is valued by the profession in Tanzania. Clow and Ricciardelli (2014) reported that, based on social role theory, gendered division of labour leads to the development of gender stereotypes that are consistent with the social roles that men and women frequently occupy. The culturally-determined roles and responsibilities of men and women could be taken into consideration during in-service training in CCP. In so doing, Tanzanian occupational therapy can take the lead in developing insights into the intersectional features of CCP. Other intersectional perspectives such as ethnicity and disability may also play a role and warrant investigation (Duncan & Creek, 2014).

The highest enabler to CCP in Tanzania was education about CCP while still a student, although the participants reported that the knowledge and skills imparted to them as students was not adequate. It is unclear whether a difference in baseline education will affect understanding of CCP. In a Swedish study, the occupational therapy participants had a higher level of education (bachelors, masters and PhD) than those in the current study,

and they had also attended a course on how to use the Canadian Occupational Performance Measure (COPM) (which is based on CCP) in their different settings (Wressle and Samuelsson, 2004). Participants involved in a United Kingdom (UK) study were in the UK COPM Network (Parker, 1996). The Swedish and UK therapists involved in the two studies had more knowledge and skills in using CCP in their practice compared to the Tanzanian occupational therapists, most of which had a diploma level education and had not received further training in CCP since qualifying. It may be argued that the educational approach to teaching CCP needs revision. A study by Ripat et al (2014) on internalizing client-centredness in occupational therapy students reported the need for educators of health professionals to deliberately focus on client-centredness in uni- and inter-professional curricula. They advocate that by doing so students will be enabled and prepared to enact interprofessional collaboration for CCP.

The second highest enabler was involving staff and service providers in CCP training. This may be linked to therapists' views about the difficulty of using CCP and negative attitudes occupational therapists have observed in other service providers. It may also be due to occupational therapy services in Tanzania being dominated by the medical model. Sumsion & Smyth (2000) found that if all staff were trained to use CCP it would create a shared philosophy and understanding and strengthen practice.

5.4 Relevance of CCP in Tanzania

Analysis of the responses to the open question indicated overall that participants appreciated the relevance of CCP in Tanzania but also identified issues that prevented implementation. The relevance of CCP in Tanzania is supported by the theme 'CCP enriches relationships'. The majority of participants felt that CCP increases client participation, clients take more responsibility and CCP encourages partnerships. These findings are supported by Sumsion (2006) and Parker, (2012), both reported that CCP can lead to increased client participation, client self-efficacy and improved satisfaction with the service. The contradictions between the quantitative results and the qualitative comments warrant discussion. It may be argued that the respondents, schooled in CCP, were empowered to relate to their clients in collaborative and enriching ways even when the purist application of CCP was not possible. They reported qualitatively on the ideal relevance of CCP in

Tanzanian occupational therapy practice rather than the reality, which was reflected in the quantitative findings.

Based on the study findings, it is therefore difficult to conclude whether the CCP approach is relevant and realistic for Tanzania. Further investigation is required in order to draw clearer conclusions. For the time being, since the CCP approach is familiar to the majority of occupational therapists in Tanzania, it is a good starting point. However, the difficulties reported by occupational therapists on its implementation in Tanzania suggest that the time may be right to consider an alternative that is more practical for a resource-constrained country where occupational therapists are few and practice is dominated by the medical model and where the majority of occupational therapists work in paediatrics. Duggan, (2005) reported that the ideal of client-centred practice may not be realistic in today's healthcare climate. Hammel, (2013) urged the need to subject CCP into more critical reflection within the occupational therapy profession.

The potential shift, or additional perspective of occupational therapy practice in Tanzania, which could be considered in order to deal with the shortage of resources is *collaborative practice* which occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families carers and communities to deliver the highest quality of care across settings (WHO, 2010, p.13). Engagement in collaborative practice has received emphasis in recent healthcare delivery literature (WHO, 2010; WFOT, 2010). Interprofessional collaborative education is a necessary step in preparing a 'collaborative practice-ready' health workforce that is better prepared to respond to local healthcare needs (WHO, 2010). Interprofessional collaboration usually occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve healthcare (WHO, 2010). The WFOT position statement on consumer interface with occupational therapy (2010) indicated that occupational therapy services to need to be delivered in a collaborative partnership with the expressed needs of the clients being central to the process.

5.5 Strengths and limitations of the study

The strength of this study is that it is the first study on CCP that has been done in a low income country in Africa. It therefore contributes new knowledge about CCP. The study had an 80% response rate which is high for a survey. As the required sample size was 62, the study findings can be generalised to the population of occupational therapists working in Tanzania. The study has provided a clear picture on how occupational therapists in Tanzania have been implementing CCP in different work settings. The majority of participants reported their experiences on how they have transferred their theoretical knowledge on CCP into practice. This should be considered as positive feedback to the occupational therapy school and the TOTA that students are applying what has been taught despite existing challenges.

The study had several limitations. Although face-to-face distribution and collection of the questionnaire enabled participants to ask clarifying questions that could be answered while the researcher was still present, it may also have introduced a bias in the way that the respondents engaged with the questionnaire and the qualitative questions. Participants may have felt influenced by the researcher, a senior academic and clinician in Tanzania, to report favourably on CCP because it is the only theoretical frame taught at the training school. The research may also be subject to researcher bias, for example, in assuming that all participants were abiding by the occupational therapy Code of Ethics in Tanzania which states that they will practice in a client-centred manner. Ecological validity of this study might be low because of considering one barrier and enabler in isolation as they are inter-dependent on each other. An additional limitation was the unequal distribution of participants in terms of gender, and some facilities being over-represented while others were under-represented.

5.6 Summary of chapter 5

This chapter has discussed the major results of the study. It argued for increased attention to the development of locally relevant forms of CCP that are aligned with the needs and realities of the African context. The next chapter considers recommendations and conclusions of the study.

CHAPTER 6: RECOMMENDATIONS AND CONCLUSIONS

This chapter provides several recommendations and is followed by the conclusions arising from the study findings. The recommendations are grouped into those related to education, practice and further research.

6.1 Recommendations:

The following recommendations have been identified based on the findings of this study:

6.6.1 Education

- Continuous professional development workshops should be offered to occupational therapists to provide opportunities to learn more about different theoretical models that support CCP, including client-centred assessment tools and outcome measures. These events should be structured to enable participants to not only understand the theory of CCP in greater depth, but also to apply it in practice in ways that are helpful to recipients of occupational therapy services in Tanzania.

- The use of case examples that illustrate occupational therapists' application of CCP in practice should be included in the education of occupational therapy students. The use of assessment tools and outcome measures that are CCP-focused should be emphasized and practiced more during training and in clinical and community-based settings.

- Additional emphasis on the routine use of outcome measures in practice to evaluate intervention and ensure client satisfaction should be considered. The results should be shared with clients to reinforce their understanding of, and commitment to, client-centred practice.

- In order to shift to, or adopt, collaborative practice there is a need to restructure the occupational therapy training curriculum to meet the need for inter-professional collaborative education in future.

6.6.2 Occupational therapy practice

- *Client involvement* – the ambivalence that Tanzanian occupational therapists showed towards CCP suggests that they are aware of the limitations the medical model imposes on CCP. It also suggests that they are ready to start functioning

within the CRPWD and the ICF models because they consider the medical, functional and social aspects of people with health problems (WHO, 2001). Occupational therapists, while playing a role as supporters of consumer organizations, will collaborate with persons with disabilities (PWDs) in finding the best solutions for addressing those problems that hinder them to participate in occupations. Extending CCP to collaborative practice will ensure that occupational therapist's support PWDs as activists in improving their quality of life.

- Tanzania does not have a national rehabilitation policy and the national health policy does not adequately describe the practice of rehabilitation professionals in Tanzania. There is, therefore, a great need for rehabilitation professional associations including the TOTA to put more pressure on the Ministry of Health and Social Welfare to develop a detailed rehabilitation policy that endorses partnerships with people with disabilities.

- There is a great need for the occupational therapy school and the TOTA to form a CCP group that can be used to assist and motivate occupational therapists and even other health professionals on how to be client-centred. The CCP group can plan different activities including visiting occupational therapists in different working settings to see how CCP practice can be enhanced.

6.6.3 Further research:

- Research to unpack cultural issues that hinder CCP is indicated. The open-ended answers to the survey suggest that the majority of participants view culture as a barrier. However, they did not indicate what they mean by 'culture' and exactly how that hinders CCP. A qualitative study would be able to capture occupational therapists' perceptions on the role of culture in shaping the identity of Tanzanian occupational therapy including what CCP may mean from an indigenous perspective.

- Research focusing on client perceptions of CCP would enrich the profession in Tanzania because it will enable therapists to understand if there is any gap on how the clients perceive CCP. It will also help therapists to understand what their clients value in CCP.

- The PQACCP has not been sufficiently validated in middle, higher and low-income countries. Further validity and reliability studies should be done to establish its psychometric properties.

- The constructs of CCP might have a gender bias because its development and research involved mainly female occupational therapists. A study to compare the perception of male and female occupational therapists' understanding of CCP is important in Tanzania because barriers and enablers were rated by female occupational therapists quite differently from male occupational therapists' perspectives. This is an area that needs to be explored further.

6.6.4 Conclusion

The aim of this study was to determine the understanding and use of CCP by occupational therapists in Tanzania. The majority of participants 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. In order to address the above-mentioned hindrances they suggested education about CCP while still a student, involvement of all staff and service providers in CCP training, and client involvement in occupational therapy planning. 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. Tanzanian occupational therapy would benefit from reconsidering the dominance of the CCP model because the health service context is resource-constrained, hospi-centric and regulated by the medical model.

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Appendix A: Ethical approval letter UCT

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/research/humanethics/forms

25 April 2014

HREC REF: 242/2014

A/Prof E Duncan
Health & Rehab
Occupational Therapy
F45, OMB

Dear A/Prof Duncan

PROJECT TITLE: BARRIERS AND ENABLERS TO IMPLEMENTING CLIENT-CENTRED PRACTICE AMONG OCCUPATIONAL THERAPISTS IN TANZANIA

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th April 2015

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

We acknowledge that the student, Dominick Mshanga is also involved in this study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC reference no in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

HREC 242/2014

Appendix B: Ethical approval letter Tanzania

THE UNITED REPUBLIC OF TANZANIA

National Institute for Medical Research
P.O. Box 9653
Dar es Salaam
Tel: 255 22 2121400/390
Fax: 255 22 2121380/2121360
E-mail: headquarters@nimr.or.tz

NIMR/HQ/R.8a/Vol. IX/1829

Ministry of Health and Social Welfare
P.O. Box 9083
Dar es Salaam
Tel: 255 22 2120262-7
Fax: 255 22 2110986

25th September 2014

Mr Dominick M Mshanga
Tutor, School of Occupational Therapy
Moshi, KCMC,
P O Box 2240, MOSHI
Kilimanjaro, Tanzania

CLEARANCE CERTIFICATE FOR CONDUCTING MEDICAL RESEARCH IN TANZANIA

This is to certify that the research entitled: Barriers and Enablers to Implementing Client –Centered Practice among Occupational Therapists in Tanzania, (Mshanga D M et al) has been granted ethical clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is submitted to the Ministry of Health and the National Institute for Medical Research Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health & Social Welfare and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine. NIMR Act No. 23 of 1979, PART III Section 10(2).
5. Sites: All referral hospitals: Muhimbili National Hospital, Mbeya, Bugando, CCBRT Dar, CDP Kilimanjaro, Morogoro Regional Hospital, Sinyu Rehabilitation centre, YWCA Moshi,Gabriella Rehabilitation Centre, Selian Hospital, and Mtwara hospital.

Approval is for one year 25th September 2014 to 24th September 2015.

Name: Dr Mwelecele N Malecela

Signature
CHAIRPERSON
MEDICAL RESEARCH
COORDINATING COMMITTEE

Name: Dr Donan Mubamba

Signature
CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH, SOCIAL WELFARE

CC: RMO
DED
DMO

Appendix C: Participant information letter

Dear Participant

My name is *Dominick Michael Mshanga*; I am a student at the University of Cape Town, South Africa. I am doing a research study as part of my Masters of Science in Occupational Therapy degree. The title of this research study is ***'Perspectives of occupational therapists on the implementation client-centred practice (CCP) among occupational therapists in Tanzania'***. I am inviting you to participate in the research by filling in the attached questionnaire and returning it to me at the address provided at the end of this letter. Ethics approval has been obtained from the Human Research Ethics Committee (HREC) of the University of Cape Town (HREC REF 242/2014) and the National Institute for Medical Research Tanzania (NMR/HQ/R.8a/Vol.IX/1829).

This study is important because it will help occupational therapists in Tanzania to understand barriers and solutions they face in implementing client-centred practice. The information will guide the Tanzanian Occupational Therapy Association (TOTA) in planning possible continuous profession development (CPD/CPE) courses on CCP. It will also inform the staff at the occupational therapy school at Kilimanjaro Christian Medical University College about the inclusion of CCP in the curriculum.

Participation in this study is voluntary.

You have the right not to participate.

If you fill in and return the questionnaire it will be assumed that you have given consent for the data to be used. Your anonymity is guaranteed because your name will not appear on the questionnaire.

Beneficence is upheld by informing you of your rights and the procedures involved. The study findings will be presented at Tanzanian Occupational Therapy Association (TOTA) meetings and through the TOTA newsletter and/or Journal club. A copy of the research report will be available in the occupational therapy school library for future staff and students' reference.

It is possible that some minor distress may be evoked in some participants. If this is evident in the questionnaire responses an in-service training session in CCP will be offered. This will

be possible by negotiating with TOTA to include it as a topic during continuing profession education conducted every year.

I understand that I may ask questions at any time during the study. I realize that I am free to withdraw from the study without prejudice at any time, should I choose to do so. In addition, I know that the information derived from the survey remain anonymous and confidential.

I have read this form and I understand the nature, purpose and procedure of this study. I agree to participate in this research study

□ *By ticking this box, I accept the above statement and give my full permission to participate in this study.*

In case of any question or concern about your rights or welfare in participation in this study you can contact the following research ethics committee.

National Institute for Medical Research Tanzania
National Health Research Ethics Review Committee
2448 Ocean Road
P. O. BOX 9653
Dar es Salaam, Tanzania
Tel: +255 22 2121400
Fax: 255 22 2121360

Principal investigator

Mr. Dominick Mshanga
Kilimanjaro Christian Medical Centre
Occupational therapy Department
P.O.BOX 3010,
Moshi, Tanzania
Cell: +255754671846 (Tanzania)
Or 0810939781 (South Africa)
E mail:dominiquetz@yahoo.com

Supervisor 1

A/Professor Madeleine Duncan
MSc Occupational Therapy- Course convenor
Division of Occupational Therapy Department of Health & Rehabilitation Sciences
University of Cape Town
F45 Old Main Building
Groote Schuur Hospital
Observatory, 7925

Supervisor 2

Dr Helen Buchanan
Master Programme Course Convenor
Division of Occupational Therapy
Department of Health & Rehabilitation Sciences
University of Cape Town
F45 Old Main Building
Groote Schuur Hospital
Observatory, 7925
Tel: 021-4066383

Supervisor 3

Sarah Mkenda
MSc Occupational Therapy
Co-ordinator School of Occupational Therapy
Tumaini- Makumira
Kilimanjaro Christian Medical University College
P.O.BOX 2240 Moshi-Tanzania

Chairperson of the Human Research Ethics Committee

Professor Marc Blockman
Old Main Building of Groote Schuur Hospital,
Floor E52, Room 23,
Observatory, 7925
Telephone: 27 21 406 6338

Appendix D: Professional questionnaire for assessing CCP among occupational therapists

No:

PROFESSIONAL QUESTIONNAIRE FOR ASSESSING CLIENT-CENTRED PRACTICE (PQACCP) AMONG OCCUPATIONAL THERAPISTS

Thank you for taking the time to complete this questionnaire. Your participation is important because it will help to promote the advancement of CCP competencies of occupational therapists by guiding the Tanzanian Occupational Therapy Association (TOTA) on the development of continuous professional development (CPD/CPE) courses. It could also guide TOTA and the School of Occupational Therapy in critiquing the relevance of CCP for an African context. It will also contribute an alternative perspective (non-Western) on CCP and its applicability.

This questionnaire will take about 10 – 15 minutes to complete. The questionnaire consists of five sections. Please answer all five sections.

SECTION I. DEMOGRAPHIC AND PRACTICE INFORMATION

1. What is your age?.....
2. What is your gender?
    a. Male ☐
    b. Female ☐
3. How many years of work experience do you have as an occupational therapist? .....
4. What is your main area of occupational therapy practice?.....
5. What is the primary source of funding for your practice? You can tick (√) more than one box.
    a. Private ☐
    b. Public ☐
    c. Donor funding ☐
    d. Private companies ☐

6. What is your level of OT education? Tick (√) the appropriate box.

    a. Diploma in OT ☐

    b. Bachelor's degree in OT ☐

    c. Master's degree in OT ☐

SECTION II: CLIENT-CENTRED CHECK LIST (Adapted from Parker, 2006)

Client-centred practice (CCP) is defined as:

> Collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, government, corporations or others. Occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients in meeting clients' needs, and otherwise recognize clients' experience and knowledge (CAOT, 2002. p.49)

Please complete the following table by ticking (√) YES if you AGREE or NO if you DISAGREE with each question.

Do I?	**YES**	**NO**
a. Consider my clients as individuals?		
b. Listen to what they say?		
c. Inform them about what you are doing in a way they will understand?		
d. Educate them about occupational therapy?		
e. Naturally approach them in a genuine and honest manner?		
f. Treat them with respect and value their opinions?		
g. Cut down barriers to ensure they feel welcome in your OT service?		
h. Engage them actively in partnership throughout the occupational therapy process?		
i. Negotiate with them about goals and outcomes?		
j. Treat them politely and equally?		
k. Respect them when they change their minds and re-focus their goals?		

l. Ensure they understand about risks, safety issues and resource limitations?		
m. Demonstrate confidence in using CCP practice?		
n. Am I client centred?		

SECTION III: POTENTIAL BARRIERS TO CLIENT-CENTRED PRACTICE.

Below is a table with a list of barriers to CCP. Please indicate by marking an X on the 5-point scale how much each barrier prevents you personally from implementing client-centred practice. Please make an X on only one point on the scale for each statement. **Focus on your overall experience.**

Barriers	**5- point scale**				
	Completely prevents CCP	Prevents CCP a great deal	Prevents CCP moderately	Prevents CCP slightly	Does not prevent CCP
1. The therapist is short of time	5	4	3	2	1
2. The therapist is under financial pressure	5	4	3	2	1
3. The therapists level of stress is high	5	4	3	2	1
4. The intervention is dominated by the medical model[15]	5	4	3	2	1
5. The therapist does not know enough about CCP	5	4	3	2	1
6. The therapist does not have enough self-knowledge	5	4	3	2	1
7. The therapist has difficulty taking risks in order to support the client's goals	5	4	3	2	1
8. CCP is too great a change from current practice	5	4	3	2	1

[15]Medical model is an approach to pathology that aims to find medical treatments for diagnosed symptoms and syndromes and treats the human as a very complex mechanism.

9.	The therapist and client are of different culture	5	4	3	2	1
10.	The therapist and client are of different gender	5	4	3	2	1
11.	The therapist has difficulty assessing the client's ability to choose their own goals	5	4	3	2	1
12.	The therapist has difficulty facilitating the client's identification of their own goals	5	4	3	2	1
13.	The therapist thinks that CCP is too demanding for the client	5	4	3	2	1
14.	The therapist is uncomfortable letting the client choose their own goals	5	4	3	2	1
15.	The therapist and client have different goals	5	4	3	2	1
16.	The therapists' values and beliefs prevent them from accepting the clients' goals	5	4	3	2	1

SECTION IV: Enablers of CCP or ways to resolve barriers to CCP.

Below is a table with a list of possible enablers of CCP. Please indicate by marking with an X on the 5-point scale how much each enabler will help you personally in resolving barriers to CCP in your practice context. Please mark an X only on one point on the scale for each statement**. Focus on your overall experience.**

ENABLERS OF CCP OR WAYS TO RESOLVE BARRIERS TO CCP	**5- point scale**				
	Completely enables CCP	Enables CCP a great deal	Enables CCP moderately	Enables CCP slightly	Does not enable CCP
1. Education about CCP while still a student	5	4	3	2	1
2. Education about CCP while a practicing therapist	5	4	3	2	1
3. Education which is not disease centred	5	4	3	2	1
4. A clear definition of CCP	5	4	3	2	1
5. More explanation about and elaborations of CCP.	5	4	3	2	1
6. Case examples showing how to practice in a client-centred manner	5	4	3	2	1
7. Education about how to grade CCP for different capabilities	5	4	3	2	1
8. Education to increase knowledge of other cultures	5	4	3	2	1
9. Training to increase self-knowledge as an occupational therapist	5	4	3	2	1
10. Interpersonal skills training	5	4	3	2	1
11. Assertiveness training	5	4	3	2	1
12. Negotiation training	5	4	3	2	1
13. Involving people with disabilities in training to increase disability awareness	5	4	3	2	1
14. Client involvement in planning services	5	4	3	2	1
15. Client involvement in evaluating services	5	4	3	2	1
16. Management and peer support for use of CCP	5	4	3	2	1

17. Involvement of all staff & service providers in CCP training	5	4	3	2	1
18. Dedicated staff education time to learn how to practice in a client-centred fashion	5	4	3	2	1

Section V: Please comment (provide your opinion) on the relevance of CCP for Tanzania.

……

……

……

Please explain (provide a rationale for) your opinion.

……

……

……

Thank you for taking the time to complete this questionnaire. It is much appreciated.

Please put the sheet into the addressed envelope and post OR save the questionnaire as a word document and email to dominiquetz@yahoo.com

Appendix E: Table 7 Potential barriers to CCP (n=64)

		Does not prevent CCP	Prevents CCP slightly	Prevents CCP moderately	Prevents CCP a great deal	Completely prevents CCP	Total
Item	Barriers	No.%	No.%	No.%	No.%	No.%	No.%
1	The therapists short of time	6 (9.4)	7(10.9)	23(35.9)	17(26.6)	11(17.2)	64(100.0)
2	The therapist is under financial pressure	16(25.0)	13(20.3)	7(10.9)	17(26.6)	11(17.2)	64(100.0)
3	The therapists level of stress is high	10(15.6)	14(21.9)	14(21.9)	10(15.6)	16(25.0)	64(100.0)
4	The intervention is dominated by the medical model	9(14.1)	8(12.5)	14(21.9)	13(20.3)	20(31.3)	64(100.0)
5	The therapist does not know enough about CCP	11(17.2)	11(17.2)	6(9.4)	15(23.4)	21(32.8)	64(100.0)
6	The therapist does not have enough self-knowledge	12(18.8)	9(14.1)	8(12.5)	19(29.7)	16(25.0)	64(100.0)
7	The therapist had difficult taking risks in order to support the clients goals	5(7.8)	10(15.6)	19(29.7)	16(25.0)	13(20.3)	63(98.4)
8	CCP is too great a change from current practice	19(29.7)	13(20.3)	16(25.0)	9(14.1)	6(9.4)	63* (98.4)
9	The therapist and client are of different culture	19(29.7)	11(17.2)	18(28.1)	10(15.6)	4(6.3)	62* (96.9)
10	The therapist and client are of different gender	30(46.9)	17(26.6)	9(14.1)	5(7.8)	3(4.7)	64(100.0)
11	The therapist has difficult assessing the clients ability to choose their own goals	9(14.1)	10(15.6)	11(17.2)	21(32.8)	13(20.3)	64(100.0)
12	The therapist has difficulty facilitating the clients identification of their own goals	7(10.9)	12(18.8)	9(14.1)	18(28.1)	18(28.1)	64(100.0)
13	The therapist thinks that CCP is too demanding for the client	8(12.5)	6(9.4)	23(35.9)	9(14.1)	18(28.1)	64(100.0)
14	The therapist is uncomfortable letting the client choose their own goals	9(14.1)	10(15.6)	9(14.1)	19(29.7)	17(26.6)	64(100.0)
15	The therapist and client have different goals	3(4.7)	12(18.8)	12(18.8)	11(17.2)	26(40.6)	64(100.0)
16	The therapists values and beliefs prevent them accepting the clients goals	12(18.8)	12(18.8)	8(12.5)	11(17.2)	21(32.8)	64(100.0)

*Missing data for these items

Appendix F: Table 8 Enablers to CCP (n=64)

		Completely enable CCP	Enables CCP a great deal	Enables CCP moderately	Enables CCP slightly	Does not enable CCP	Total
Item	Enablers	No.%	No.%	No.%	No.%	No.%	No.%
1	Education about CCP while still a student	36(56.3)	22(34.4)	5(7.8)	1(1.6)	0(0.0)	64(100.0)
2	Education about CCP while a practicing therapist	33(51.6)	17(26.6)	5(7.8)	4(6.3)	3(4.7)	62* (96.9)
3	Education which is not disease centred	10(15.6)	14(21.9)	18(28.1)	4(6.3)	11(17.2)	57(89.1)
4	A clear definition of CCP	32(50.0)	17(26.6)	7(10.9)	5(7.8)	3(4.7)	64(100.0)
5	More explanation about and elaboration of CCP	34(53.1)	21(32.8)	5(7.8)	3(4.7)	0(0.0)	64(100.0)
6	Case examples showing how to practice in client-centred manner	44(68.8)	11(17.2)	6(9.4)	3(4.7)	0(0.0)	63* (98.4)
7	Education about how to grade CCP for different capabilities	39(60.9)	16(25.0)	5(7.8)	2(3.1)	0(0.0)	64(100.0)
8	Education to increase knowledge of other cultures	23(35.9)	22(34.4)	10(15.6)	5(7.8)	2(3.1)	62* (96.9)
9	Training to increase self-knowledge as an occupational therapist	38(59.4)	17(26.6)	4(6.3)	1(1.6)	2(3.1)	62* (96.9)
10	Interpersonal skills training	33(51.6)	23(35.9)	5(7.8)	2(3.1)	1(1.6)	64(100.0)
11	Assertiveness training	24(37.4)	25(39.1)	6(9.4)	6(9.4)	1(1.6)	62* (96.9)
12	Negotiation training	24(37.5)	18(28.1)	11(17.2)	6(9.4)	2(3.1)	61* (95.3)
13	Involving with disabilities in training to increase disability awareness	31(48.4)	22(34.4)	5(7.8)	3(4.7)	3(4.7)	64(100.0)
14	Client involvement in planning services	38(59.4)	16(25.0)	8(12.5)	0(0.0)	2(3.1)	64(100.0)
15	Client involvement in evaluating services	36(56.3)	17(26.3)	6(9.4)	1(1.6)	3(4.7)	63* (98.4)
16	Management and peer support for use of CCP	29(45.3)	18(28.1)	11(17.2)	6(9.4)	0(0.0)	64(100.0)
17	Involvement of all staff and service providers in CCP training	39(60.9)	19(29.7)	4(6.3)	1(1.6)	1(1.6)	64(100.0)
18	Dedicated staff education time to learn how to practice in client-centred fashion	34(53.1)	22(34.4)	5(7.8)	2(3.1)	1(1.6)	64(100.0)

*Missing data for these items

Appendix G. *Table 9 Relationship between gender and understanding of CCP (n=64)*[16]

Variable	Response	Gender					
		Male N=27	**Female N=37**	**Total**	X^2	**df**	***p***
1. Consider my clients as individuals?	Yes	27(100.0)	36(97.3)	64 (100.0)	0.741	1	0.389
	No	0(0.0)	1 (2.7)				
2. Listen to what they say?	Yes	26(96.3)	35 (97.2)	63* (98.4)	0.043	1	0.839
	No	1(3.7)	1 (2.8)				
3. Inform them about what you are doing in a way they will understand?	Yes	25(92.6)	36 (97.3)	64(100.0)	0.773	1	0.379
	No	2(7.4)	1 (2.7)				
4. Educate them about occupational therapy?	Yes	25(92.6)	35 (94.5)	64(100.0)	0.107	1	0.744
	No	2(7.4)	2 (5.4)				
5. Naturally approach them in a genuine and honest manner?	Yes	25(96.2)	37 (100.0)	63* (98.4)	1.446	1	0.229
	No	1(3.8)	0 (0.0)				
6. Treat them with respect and value their opinions?	Yes	24(88.9)	35 (97.2)	63* (98.4)	1.802	1	0.179
	No	3(11.1)	1 (2.8)				
7. Cut down barriers to ensure they feel welcome in your OT service?	Yes	24(88.9)	35 (94.6)	64(100.0)	0.706	1	0.401
	No	3(11.1)	2 (5.4)				
8. Engage them actively in partnership throughout the occupational therapy process?	Yes	23(85.2)	32 (86.5)	64(100.0)	0.022	1	0.882
	No	4(14.8)	5 (13.5)				
9. Negotiate with them about goals and outcomes?	Yes	20(74.1)	33 (94.3)	62* (96.9)	5.018	1	**0.025**
	No	7(25.9)	2 (5.7)				
10. Treat them politely and equally?	Yes	25(92.6)	33 (91.7)	63* (98.4)	0.018	1	0.893
	No	2(7.4)	3 (8.3)				
11. Respect them when they change their minds and re-focus their goals?	Yes	24(88.9)	32 (94.1)	61* (95.3)	0.547	1	0.460
	No	3(11.1)	2 (5.9)				
12. Ensure they understand about risks, safety issues and resource limitations?	Yes	26(96.3)	33 (91.7)	63* (98.4)	0.556	1	0.456
	No	1(3.7)	3 (8.3)				
13. Demonstrate confidence in using CCP practice?	Yes	21(77.8)	33 (89.2)	64(100.0)	1.542	1	0.214
	No	6(22.2)	4 (10.8)				
14. Am I client centred?	Yes	25(92.6)	34 (97.1)	62* (96.9)	0.685	1	0.408
	No	2(7.4)	1 (2.9)				

*Missing data for these items

[16] Bonferroni correction was applied

Appendix H. *Table 10 Relationship between years of experience and understanding to CCP (n=64)*

Variable	Responses	Years of experience			Total	X^2	df	*p*
		>5	5<10	10<				
1. Consider my clients as individuals?	Yes	38(100.0)	13(92.9)	12(100.0)	64(100.0)	3.628	2	0.163
	No	0(0.0)	1(7.1)	0(0.0)				
2. Listen to what they say?	Yes	37(97.4)	13(92.9)	11(100.0)	63* (98.4)	1.114	2	0.573
	No	1(2.6)	1(7.1)	0(0.0)				
3. Inform them about what you are doing in a way they will understand?	Yes	37(97.4)	12(85.7)	12(100.0)	64(100.0)	3.836	2	0.147
	No	1(2.6)	2(14.3)	0(0.0)				
4. Educate them about occupational therapy?	Yes	35(92.1)	13(92.9)	12(100.0)	64(100.0)	0.994	2	0.608
	No	3(7.9)	1(7.1)	0(0.0)				
5. Naturally approach them in a genuine and honest manner?	Yes	37(97.4)	14(100.0)	11(100.0)	63* (98.4)	0.669	2	0.716
	No	1(2.6)	0(0.0)	0(0.0)				
6. Treat them with respect and value their opinions?	Yes	34(89.5)	14(100.0)	11(100.0)	63* (98.4)	2.810	2	0.245
	No	4(10.5)	0(0.0)	0(0.0)				
7. Cut down barriers to ensure they feel welcome in your OT service?	Yes	33(86.8)	14(100.0)	12(100.0)	64(100.0)	3.711	2	0.156
	No	5(13.2)	0(0.0)	0(0.0)				
8. Engage them actively in partnership throughout the occupational therapy process?	Yes	32(84.2)	13(92.9)	10(83.3)	64(100.0)	0.716	2	0.699
	No	6(15.8)	1(7.1)	2(16.7)				
9. Negotiate with them about goals and outcomes?	Yes	32(86.5)	12(85.7)	9(81.3)	62* (96.9)	0.150	2	0.928
	No	5(13.5)	2(14.3)	2(18.2)				
10. Treat them politely and equally?	Yes	35(92.1)	13(92.9)	10(90.9)	63* (98.4)	0.032	2	0.984
	No	3(7.9)	1(7.1)	1(9.1)				
11. Respect them when they change their minds and re-focus their goals?	Yes	32(91.4)	12(85.7)	12(100.0)	61* (95.3)	1.768	2	0.413
	No	3(8.6)	2(14.3)	0(0.0)				
12. Ensure they understand about risks, safety issues and resource limitations?	Yes	35(94.6)	12(85.7)	12(100.0)	63* (98.4)	2.352	2	0.309
	No	2(5.4)	2(14.3)	0(0.0)				
13. Demonstrate confidence in using CCP practice?	Yes	30(78.9)	14(100.0)	10(83.3)	64(100.0)	3.452	2	0.178
	No	8(21.1)	0(0.0)	2(16.7)				
14. Am I client centred?	Yes	33(91.7)	14(100.0)	12(100.0)	62* (96.9)	2.277	2	0.320
	No	3(8.3)	0(0.0)	0(0.0)				

*Missing data these items

Appendix I. *Table 11 Relationship between main area of OT practice and understanding to CCP (n=64)*[17]

Items	**Responses**	Adult only No.%	Paediatrics No.%	CBR No.%	Mental health No.%	Pediatrics and adults with physical disabilities No.%	Teaching No.%	**Total** No.%	x^2	**df**	***p***
1. Consider my clients as individuals?	Yes	13(20.6)	29(46.0)	6(9.5)	8(12.7)	6(9.5)	1(1.6)	64(100.0)	1.151	5	0.949
	No	0(0.0)	1(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
2. Listen to what they say?	Yes	13(21.3)	30(49.2)	5(8.2)	7(11.5)	5(8.2)	1(1.6)	63*(98.4)	7.423	5	0.191
	No	0(0.0)	0(0.0)	1(50)	1(50.0)	0(0.0)	0(0.0)				
3. Inform them about what you are doing in a way they will understand?	Yes	13(21.3)	29(47.5)	6(9.8)	7(11.5)	5(8.2)	1(1.6)	64(100.0)	4.127	5	0.531
	No	0(0.0)	1(33.3)	0(0.0)	1(33.3)	1(33.3)	0(0.0)				
4. Educate them about occupational therapy?	Yes	13(21.7)	28(46.7)	5(8.3)	8(13.3)	5(8.3)	1(1.7)	64(100.0)	3.698	5	0.594
	No	0(0.0)	2(50.0)	1(25.0)	0(0.0)	1(25.0)	0(0.0)				
5. Naturally approach them in a genuine and honest manner?	Yes	13(21.0)	29(46.8)	6(9.7)	8(12.9)	5(8.1)	1(1.6)	64(100.0)	9.653	5	0.086
	No	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(10.0)	0(0.0)				
6. Treat them with respect and value their opinions?	Yes	12(20.3)	29(49.2)	6(10.2)	7(11.9)	4(6.8)	1(1.7)	63* (98.4)	3.049	5	0.692
	No	1(25.0)	1(25.0)	0(0.0)	1(25.0)	1(25.0)	0(0.0)				
7. Cut down barriers to ensure they feel welcome in your OT service?	Yes	10(16.9)	30(50.8)	5(8.5)	8(13.6)	5(8.5)	1(1.7)	64(100.0)	8.817	5	0.117
	No	3(60.0)	0(0.0)	1(20.0)	0(0.0)	1(20.0)	0(0.0)				
8. Engage them actively in partnership throughout the occupational therapy process?	Yes	12(21.8)	27(49.1)	6(10.9)	7(12.7)	3(5.5)	0(0.0)	64(100.0)	14.367	5	**0.013**
	No	1(11.1)	3(33.3)	0(0.0)	1(11.1)	3(33.3)	1(11.1)				
9. Negotiate with them about goals and outcomes?	Yes	9(17.0)	27(50.9)	5(9.4)	7(13.2)	5(9.4)	0(0.0)	62* (96.9)	4.158	4	0.385
	No	4(44.4)	3(33.3)	0(0.0)	1(11.1)	1(11.1)	0(0.0)				
10. Treat them politely and equally?	Yes	12(20.7)	28(48.3)	5(10.3)	6(10.3)	5(8.6)	1(1.7)	63* (98.4)	4.290	5	0.509
	No	1(20.0)	2(40.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
11. Respect them when they change their minds and re-focus their	Yes	12(21.4)	29(51.8)	5(8.9)	6(10.7)	3(5.4)	1(1.8)	61* (95.3)	5.986	5	0.308

[17] Bonferroni correction was applied

goals?	No	1(20.0)	1(20.0)	0(0.0)	2(40.0)	1(20.0)	0(0.0)				
12. Ensure they understand about risks, safety issues and resource limitations?	Yes	12(20.3)	28(47.5)	6(10.2)	7(11.9)	5(8.5)	1(1.7)	63* (98.4)	1.367	5	0.928
	No	1(25.0)	2(50.0)	0(0.0)	1(25.0)	0(0.0)	0(0.0)				
13. Demonstrate confidence in using CCP practice?	Yes	11(20.4)	25(46.3)	5(9.3)	8(14.8)	4(7.4)	1(1.9)	64(100.0)	3.124	5	0.681
	No	2(20.0)	5(50.0)	1(0.0)	0(0.0)	2(20.0)	0(0.0)				
14. Am I client centred?	Yes	12(20.3	30(50.8)	6(10.2)	7(11.9)	3(5.1)	1(1.7)	62* (96.9)	6.662	5	0.247
	No	1(33.3)	0(0.0)	0(0.0)	1(33.3)	1(33.3)	0(0.0)				

*Missing data these items

Appendix J. Table 12 Relationships between gender and barriers to CCP (n = 64)

Barriers		Male N=27 No.%	Female N=37 No.%	Total	X^2	df	*P*
1. The therapist is short of time	Substantial barrier	22 (81.5)	29 (78.4)	64(100.0)	0.93	1	0.761
	Minimal barrier	5 (18.5)	8 (21.6)				
2. The therapist is under financial pressure	Substantial barrier	15 (55.6)	20 (54.1)	64(100.0)	0.014	1	0.905
	Minimal barrier	12 (44.4)	17 (45.9)				
3. The therapists level of stress is high	Substantial barrier	16 (59.3)	24 (64.9)	64(100.0)	0.209	1	0.647
	Minimal barrier	11 (40.7)	13 (35.1)				
4. The intervention is dominated by the medical model	Substantial barrier	20 (74.1)	27 (73.0)	64(100.0)	0.10	1	0.922
	Minimal barriers	7 (25.9)	10 (27.0)				
5. The therapist does not know enough about CCP	Substantial barrier	16 (59.3)	26 (70.3)	64(100.0)	0.839	1	0.360
	Minimal barrier	11 (40.7)	11 (29.7)				
6. The therapist does not have enough self-knowledge	Substantial barrier	17 (63.0)	26 (70.3)	64(100.0)	0.378	1	0.539
	Minimal barrier	10 (37.0)	11 (29.7)				
7. The therapist had difficult taking risks in order to support the clients goals	Substantial barrier	20 (76.9)	28 (75.7)	63*(98.4)	0.13	1	0.909
	Minimal barrier	6 (23.1)	9 (24.3)				
8. CCP is too great a change from current practice	Substantial barrier	16 (59.3)	15 (41.7)	63*(98.4)	1.911	1	0.167
	Minimal barrier	11 (40.7)	21 (58.3)				
9. The therapist and client are of different culture	Substantial barrier	16 (64.0)	16 (43.2)	62*(96.9)	2.574	1	0.109
	Minimal barrier	9 (36.0)	21 (56.8)				
10. The therapist and client are of different gender	Substantial barrier	7 (41.2)	10 (58.8)	63*(98.4)	0.010	1	0.922
	Minimal barrier	20 (42.6)	27 (57.4)				
11. The therapist has difficult assessing the clients ability to choose their own goals	Substantial barrier	20 (44.4)	7 (36.8)	64(100.0)	0.317	1	0.574
	Minimal barrier	25 (55.6)	12 (63.2)				
12. The therapist has difficulty facilitating the clients identification of their own goals	Substantial barrier	19 (42.2)	8 (42.1)	64(100.0)	0.000	1	0.993
	Minimal barrier	26 (57.8)	11 (57.9)				
13. The therapist thinks that CCP is too demanding for the client	Substantial barrier	22 (44.0)	5 (35.7)	64(100.0)	0.308	1	0.579
	Minimal barrier	28 (56.0)	9 (64.3)				
14. The therapist is uncomfortable letting the client choose their own goals	Substantial barrier	19 (42.2)	26 (57.8)	64(100.0)	0.000	1	0.993
	Minimal barrier	8 (42.1)	11 (57.9)				
15. The therapist and client have different goals	Substantial barrier	22 (44.9)	27 (55.1)	64(100.0)	0.630	1	0.427
	Minimal barrier	5 (33.3)	10 (66.7)				
16. The therapists values and beliefs prevent them accepting the clients goals	Substantial barrier	16 (40.0)	11 (45.8)	64(100.0)	0.209	1	0.794
	Minimal barrier	24 (60)	13 (54.2)				

*Missing data these items

Appendix K. Table 13 Relationship between years of experience and barriers to CCP (n=64)

Barriers		Years of experience						
		<5	5<10	10<				
		No.%	No.%	No.%	Total	X^2	df	*P*
1. The therapists short of time	Substantial barriers	30(78.9)	11(78.6)	10(83.3)	64(100.0)	0.122	2	0.941
	Minimal barriers	8(21.1)	3(21.4)	2(16.7)				
2. The therapist is under financial pressure	Substantial barriers	16(42.1)	12(85.7)	7(58.3)	64(100.0)	7.931	2	0.019
	Minimal barriers	22(57.9)	2(14.3)	5(41.7)				
3. The therapists level of stress is high	Substantial barriers	21(55.3)	10(71.4)	9(75.0)	64(100.0)	2.125	2	0.346
	Minimal barriers	17(44.7)	4(28.6)	3(25.0)				
4. The intervention is dominated by the medical model	Substantial barriers	26(68.4)	12(85.7)	9(75.0)	64(100.0)	1.587	2	0.452
	Minimal barriers	12(31.6)	2(14.3)	3(25.0)				
5. The therapist does not know enough about CCP	Substantial barriers	25(65.8)	10(71.4)	7(58.3)	64(100.0)	0.492	2	0.782
	Minimal barriers	13(34.2)	4(28.6)	5(41.7)				
6. The therapist does not have enough self-knowledge	Substantial barriers	25(65.8)	11(78.6)	7(58.3)	64(100.0)	1.283	2	0.526
	Minimal barriers	13(34.2)	3(21.4)	5(41.7)				
7. The therapist had difficult taking risks in order to support the clients goals	Substantial barriers	26(70.3)	13(92.9)	9(75.0)	63*(98.4)	2.868	2	0.238
	Minimal barriers	11(29.7)	1(7.1)	3(25.0)				
8. CCP is too great a change from current practice	Substantial barriers	18(48.6)	8(57.1)	5(41.7)	63*(98.4)	0.630	2	0.730
	Minimal barriers	19(51.4)	6(42.9)	7(58.3)				
9. The therapist and client are of different culture	Substantial barriers	19(50.0)	4(33.3)	9(75.0)	62*(96.9)	4.273	2	0.118
	Minimal barriers	19(50.0)	8(66.7)	3(25.0)				
10. The therapist and client are of different gender	Substantial barriers	10(26.3)	2(14.3)	5(41.7)	64(100.0)	2.486	2	0.288
	Minimal barriers	28(73.7)	12(85.7)	7(58.3)				
11. The therapist has difficult assessing the clients ability to choose their own goals	Substantial barriers	25(65.8)	10(71.4)	10(83.3)	64(100.0)	1.355	2	0.508
	Minimal barriers	13(34.2)	4(28.6)	2(16.7)				
12. The therapist has difficulty facilitating the clients identification of their own goals	Substantial barriers	28(73.7)	9(64.3)	8(66.7)	64(100.0)	0.527	2	0.768
	Minimal barriers	10(26.3)	5(35.7)	4(33.3)				
13. The therapist thinks that CCP is too demanding for the client	Substantial barriers	29(76.3)	10(71.4)	11(91.7)	64(100.0)	1.728	2	0.422
	Minimal barriers	9(23.7)	4(28.6)	1(8.3)				
14. The therapist is uncomfortable letting the client choose their own goals	Substantial barriers	27(71.1)	12(85.7)	6(50.0)	64(100.0)	3.973	2	0.137
	Minimal barriers	11(28.9)	2(14.3)	6(50.0)				
15. The therapist and client have different goals	Substantial barriers	29(76.3)	10(71.4)	10(83.3)	64(100.0)	0.514	2	0.774
	Minimal barriers	9(23.7)	4(28.6)	2(16.7)				
16. The therapists values and beliefs prevent them accepting the clients goals	Substantial barriers	25(65.8)	10(71.4)	5(41.7)	64(100.0)	2.874	2	0.238
	Minimal barriers	13(34.2)	4(28.6)	7(58.3)				

*Missing data these items

Appendix L. Table 14 Relationships between the main area of OT practice and barriers to CCP

		Adult only	Pediatrics	CBR	Mental health	Children and Adult	Teaching				
		No.%	**No.%**	**No.%**	**No.%**	**No.%**	**No.%**	**Total**	**X^2**	**df**	***P***
Barriers	Categories										
The therapist is short of time	Substantial barriers	12 (23.5)	24 (47.1)	4 (7.8)	7 (13.7)	3 (5.9)	1 (2.0)	64(100.0)	5.733	5	0.333
	Minimal barriers	1 (7.7)	6 (46.2)	2 (15.4)	1 (7.7)	3 (23.1)	0 (0.0)				
The therapist is under financial pressure	Substantial barriers	8 (22.9)	16 (45.8)	2 (5.7)	5 (14.3)	3 (8.6)	1 (2.9)	64(100.0)	2.451	5	0.784
	Minimal barriers	5 (17.2)	14 (48.3)	4 (13.8)	3 (10.3)	3 (10.3)	0 (0.0)				
The therapist level of stress is high	Substantial barriers	8 (20.0)	17 (42.5)	4 (10.0)	7 (17.5)	3 (7.5)	1 (2.5)	64(100.0)	3.618	5	0.606
	Minimal barriers	5 (20.8)	13 (54.2)	2 (8.3)	1 (4.2)	3 (12.5)	0 (0.0)				
The intervention is dominated by the medical model	Substantial barriers	9 (19.1)	22 (46.8)	4 (8.5)	7 (14.9)	4 (8.5)	1 (2.1)	64(100.0)	1.573	5	0.905
	Minimal barriers	4 (23.5)	8 (47.1)	2 (11.8)	1 (5.9)	2 (11.8)	0 (0.0)				
The therapist does not know enough about CCP	Substantial barriers	9 (21.4)	18 (42.9)	4 (9.5)	5 (11.9)	5 (11.9)	1 (2.4)	64(100.0)	1.891	5	0.864
	Minimal barriers	4 (18.2)	12 (54.5)	2 (9.1)	3 (13.6)	1 (4.5)	0 (0.0)				
The therapist does not have enough self-knowledge	Substantial barriers	10 (23.3)	20 (46.5)	2 (4.7)	5 (11.6)	5 (11.6)	1 (2.3)	64(100.0)	4.959	5	0.421
	Minimal barriers	3 (14.3)	10 (47.7)	4 (19.0)	3 (14.3)	1 (4.8)	0 (0.0)				
The therapist had difficult taking risks in order to support the clients goals	Substantial barriers	11 (22.9)	21 (43.8)	3 (6.2)	7 (14.6)	5 (10.4)	1 (2.1)	63*(98.4)	5.532	5	0.354
	Minimal barriers	1 (6.7)	9 (60.0)	3 (20.0)	1 (6.7)	1 (6.7)	0 (0.0)				
CCP is too great a change from current practice	Substantial barriers	9 (29.0)	11 (35.5)	3 (9.7)	4 (12.9)	3 (9.7)	1 (3.2)	63*(98.4)	4.598	5	0.467
	Minimal barriers	4 (12.5)	18 (56.2)	3 (9.4)	4 (12.5)	3 (9.4)	0 (0.0)				
The therapist and client are of different culture	Substantial barriers	10 (31.2)	13 (40.6)	2 (6.2)	2 (6.2)	4 (12.5)	1 (3.1)	62*(96.9)	7.398	5	0.193
	Minimal barriers	3 (10.0)	17 (56.7)	3 (10.0)	5 (16.7)	2 (6.7)	0 (0.0)				
The therapist and client are of different gender	Substantial barriers	5 (29.4)	7 (41.2)	0 (0.0)	1 (5.9)	3 (17.6)	1 (5.9)	64(100.0)	8.539	5	0.129
	Minimal barriers	8 (17.0)	23 (48.9)	6 (12.8)	7 (14.9)	3 (6.4)	0 (0.0)				
The therapist had difficult assessing the clients ability to choose own goals	Substantial barriers	12 (26.7)	20 (44.4)	3 (6.7)	5 (11.1)	4 (8.9)	1 (2.2)	64(100.0)	5.084	5	0.406
	Minimal barriers	1 (5.3)	10 (52.7)	3 (15.8)	3 (15.8)	2 (10.5)	0 (0.0)				
The therapist has difficult facilitating the clients identification of their own goals	Substantial barriers	11 (24.4)	18 (40.0)	4 (8.9)	6 (13.3)	5 (11.1)	1 (2.2)	64(100.0)	3.834	5	0.573
	Minimal barriers	2 (10.5)	12 (63.2	2 (10.5)	2 (10.5)	1 (5.3)	0 (0.0)				
The therapist think that CCP is too demanding for client	Substantial barriers	13 (26.0)	20 (40.0)	4 (8.0)	7 (14.0)	5 (10.0)	1 (2.0)	64(100.0)	7.192	5	0.207
	Minimal barriers	0 (0.0)	10 (71.4	2 (14.3)	1 (7.1)	1 (7.1)	0 (0.0)				
The therapist is uncomfortable letting the clients choose their own goals	Substantial barriers	11 (24.4)	20 (44.4)	4 (8.9)	6 (13.3)	4 (8.9)	0 (0.0)	64(100.0)	3.994	5	0.550
	Minimal barriers	2 (10.5)	10 (52.7	2 (10.5)	2 (10.5)	2 (10.5)	1 (5.3)				
The therapist and client have different goals	Substantial barriers	10 (20.4)	25 (51.0)	5 (10.2)	4 (8.2)	5 (10.2)	0 (0.0)	64(100.0)	7.486	5	0.187
	Minimal barriers	3 (20.0)	5 (33.3)	1 (6.7)	4 (26.7)	1 (6.7)	1 (6.7)				

*Missing data for these items

Appendix M. Table 15 Relationship between source of funding and barriers to CCP n=64

		Source of funding												
		Private	Public	Donor funding	Private companies	Private and Public	Public and Donor	Private and donor	Private Public & Donor	All sources				
Barriers	**Categories**	**No.%**	**No.%**	**No.%**	**No.%**	**No.%**	**No.%**	**No.%**	**No.%**	**No.%**	**Total**	**X^2**	**df**	***P***
1. The therapist is short of time	Substantial barriers	13(25.5)	15(29.4)	9(17.6)	3(5.9)	4(7.8)	4(7.8)	1(2.0)	1(2.0)	1(2.0)	64(100.0)	13.996	8	0.083
	Minimal barriers	2(15.4)	2(15.4)	2(15.4)	0(0.0)	3(23.1)	0(0.0)	3(23.1)	0(0.0)	1(7.7)				
2. The therapist is under financial pressure	Substantial barriers	10(28.6)	10(28.6)	3(8.6)	2(5.7)	4(11.4)	1(2.9)	2(5.7)	1(2.9)	2(5.7)	64(100.0)	8.457	8	0.390
	Minimal barriers	5(17.2)	7(24.1)	8(27.6)	1(3.4)	3(10.3)	3(10.3)	2(6.9)	0(0.0)	0(0.0)				
3. The therapist level of stress is high	Substantial barriers	8(20.0)	12(30.0)	5(2.5)	2(5.0)	6(15.0)	2(5.0)	2(5.0)	1(2.5)	2(5.0)	64(100.0)	6.341	8	0.609
	Minimal barriers	7(29.2)	5(20.8)	6(25.0)	1(4.2)	1(4.2)	2(8.3)	2(8.3)	0(0.0)	0(0.0)				
4. The intervention is dominated by the medical model	Substantial barriers	11(23.4)	13(27.7)	13(27.7)	6(12.8)	2(4.3)	6(12.8)	4(8.5)	3(6.4)	1(2.1)	64(100.0)	5.081	8	0.749
	Minimal barriers	4(23.5)	4(23.5)	4(23.5)	5(29.4)	1(5.9)	1(5.9)	1(5.9)	0(0.0)	1(5.1)				
5. The therapist does not know enough about CCP	Substantial barriers	11(26.2)	10(23.8)	7(16.7)	1(2.4)	6(14.3)	2(4.8)	3(7.1)	1(2.4)	1(2.4)	64(100.0)	4.731	8	0.786
	Minimal barriers	4(18.2)	7(31.8)	4(18.2)	2(9.1)	1(4.5)	2(9.1)	1(4.5)	0(0.0)	1(4.5)				
6. The therapist does not have enough self-knowledge	Substantial barriers	12(27.9)	11(25.6)	5(11.6)	2(4.7)	7(16.3)	1(2.3)	3(7.0)	1(2.3)	1(2.3)	64(100.0)	11.036	8	0.200
	Minimal barriers	3(14.3)	6(28.6)	6(28.6)	1(4.8)	0(0.0)	3(14.3)	1(4.8)	0(0.0)	1(4.8)				
7. The therapist had difficult taking risks in order to support the clients goals	Substantial barriers	13(27.1)	13(27.1)	5(10.4)	2(4.2)	7(14.6)	3(6.3)	3(6.8)	1(2.1)	1(2.1)	63*(98.4)	9.605	8	0.294
	Minimal barriers	2(13.3)	4(26.7)	6(40.0)	1(6.7)	0(0.0)	1(6.7)	1(6.7)	0(0.0)	0(0.0)				
8. CCP is too great a change from current practice	Substantial barriers	7(22.6)	9(29.0)	6(19.4)	1(3.2)	3(9.7)	4(12.9)	0(0.0)	1(3.2)	0(0.0)	63*(98.4)	11.613	8	0.169
	Minimal barriers	7(21.9)	8(25.0)	5(15.6)	2(6.3)	4(12.5)	0(0.0)	4(12.5)	0(0.0)	2(6.3)				
9. The therapist and client are of different culture	Substantial barriers	8(25.0)	10(31.3)	5(15.6)	1(3.1)	3(9.4)	3(9.4)	2(6.3)	0(0.0)	0(0.0)	62*(96.9)	3.769	8	0.877
	Minimal barriers	7(23.3)	7(23.3)	6(20.0)	1(3.3)	4(13.3)	1(3.3)	2(6.7)	1(3.3)	1(3.3)				
10. The therapist and client are of different gender	Substantial barriers	5(29.4)	4(23.5)	3(17.6)	2(11.8)	1(5.9)	2(11.8)	0(0.0)	0(0.0)	0(0.0)	64(100.0)	7.108	8	0.525
	Minimal barriers	10(21.3)	13(27.7)	8(17.0)	1(2.1)	6(12.8)	2(4.3)	4(8.5)	1(2.1)	2(4.3)				
11. The therapist had difficult assessing the clients ability to choose own goals	Substantial barriers	11(24.4)	10(22.2)	8(17.8)	2(4.4)	7(15.6)	1(2.2)	4(8.9)	1(2.2)	1(2.2)	64(100.0)	10.587	8	0.226
	Minimal barriers	4(21.1)	7(36.8)	3(15.8)	1(5.3)	0(0.0)	3(15.8)	0(0.0)	0(0.0)	1(5.3)				
12. The therapist has difficult facilitating the clients identification of their own goals	Substantial barriers	11(24.4)	11(24.4)	6(13.3)	3(6.7)	6(13.3)	2(4.4)	3(6.7)	1(2.2)	2(4.4)	64(100.0)	5.793	8	0.670
	Minimal barriers	4(21.1)	6(31.6)	5(26.3)	0(0.0)	1(5.3)	2(10.5)	1(5.3)	0(0.0)	0(0.0)				
13. The therapist think that CCP is too demanding for client	Substantial barriers	12(24.0)	14(28.0)	9(18.0)	2(4.0)	6(12.0)	2(4.0)	3(6.0)	1(2.0)	1(2.0)	64(100.0)	3.843	8	0.871
	Minimal barriers	3(21.4)	3(21.4)	2(14.3)	1(7.1)	1(7.1)	2(14.3)	1(7.1)	0(0.0)	1(7.1)				
14. The therapist is uncomfortable letting the clients choose their own goals	Substantial barriers	12(26.7)	11(24.4)	6(13.3)	2(4.4)	5(11.1)	3(6.7)	3(6.7)	1(2.2)	2(4.4)	64(100.0)	3.615	8	0.890
	Minimal barriers	3(15.8)	6(31.6)	5(26.3)	1(5.3)	2(10.5)	1(5.3)	1(5.3)	0(0.0)	0(0.0)				
15. The therapist and client have different goals	Substantial barriers	15(30.6)	10(20.4)	7(14.3)	3(6.1)	6(12.2)	3(6.1)	3(6.1)	1(2.0)	1(2.0)	64(100.0)	10.946	8	0.205
	Minimal barriers	0(0.0)	7(46.7)	4(26.7)	0(0.0)	1(6.7)	1(6.7)	1(6.7)	0(0.0)	1(6.7)				
16. The therapists values and beliefs prevent accepting the clients goals	Substantial barriers	11(27.5)	9(22.5)	5(12.5)	2(5.0)	5(12.5)	3(7.5)	3(7.5)	1(2.5)	1(2.5)	64(100.0)	4.304	8	0.829
	Minimal barriers	4(16.7)	8(33.3)	6(25.0)	1(4.2)	2(8.3)	1(4.2)	1(4.2)	0(0.0)	1(4.2)				

*Missing data these items

Appendix N. Table 16 Relationship between gender and enablers to CCP

			Gender					
			Male N=27	Female N=37				
	Enablers	**Categories**	**No.%**	**No.%**	**Total**	**X^2**	**df**	***P***
1.	Education about CCP while still a student	Substantial enablers	27 (100.0)	36 (97.3)	64(100.0)	0.741	1	0.389
		Minimal enablers	0 (0.0)	1 (2.7)				
2.	Education about CCP while a practicing Therapist	Substantial enablers	24 (88.9)	33 (89.2)	64(100.0)	0.001	1	0.970
		Minimal enablers	3 (11.1)	4 (10.8)				
3.	Education which is not disease centred	Substantial enablers	20 (74.1)	29 (78.4)	64(100.0)	0.161	1	0.688
		Minimal enablers	7 (25.9)	8 (21.6)				
4.	A clear definition of CCP	Substantial enablers	22 (81.5)	34 (91.9)	64(100.0)	1.547	1	0.214
		Minimal enablers	5 (18.5)	3 (8.1)				
5.	More explanation about and elaboration of CCP	Substantial enablers	26 (96.3)	35 (94.6)	64(100.0)	0.101	1	0.750
		Minimal enablers	1 (3.7)	2 (5.4)				
6.	Case examples showing how to practice in a client-centred manner	Substantial enablers	27 (100.0)	34 (91.9)	64(100.0)	2.297	1	0.130
		Minimal enablers	0 (0.0)	3 (8.1)				
7.	Education about how to grade CCP for different capability	Substantial enablers	27 (100.0)	35 (94.6)	64(100.0)	1.507	1	0.220
		Minimal enablers	0 (0.0)	2 (5.4)				
8.	Education to increase knowledge of other cultures	Substantial enablers	27 (100.0)	30 (81.1)	64(100.0)	5.735	1	**0.017**
		Minimal enablers	0 (0.0)	7 (18.9)				
9.	Training to increase self- knowledge as an occupational therapist	Substantial enablers	27 (100.0)	35 (94.6)	64(100.0)	1.507	1	0.220
		Minimal enablers	0 (0.0)	2 (5.4)				
10.	Interpersonal skills Training	Substantial enablers	26 (96.3)	35 (94.6)	64(100.0)	0.101	1	0.750
		Minimal enablers	1 (3.7)	2 (5.4)				
11.	Assertiveness training	Substantial enablers	24 (88.9)	33 (89.2)	64(100.0)	0.001	1	0.970
		Minimal enablers	3 (11.1)	4 (10.8)				
12.	Negotiation training	Substantial enablers	24 (88.9)	32 (86.5)	64(100.0)	0.082	1	0.774
		Minimal enablers	3 (11.1)	5 (13.5)				
13.	Involving people with disabilities in training to increase disability awareness	Substantial enablers	24 (88.9)	34 (91.9)	64(100.0)	0.166	1	0.684
		Minimal enablers	3 (11.1)	3 (8.1)				
14.	Client involvement in planning services	Substantial enablers	26 (96.3)	36 (97.3)	64(100.0)	0.052	1	0.820
		Minimal enablers	1 (3.7)	1 (2.7				
15.	Client involvement in evaluating services	Substantial enablers	24 (88.9)	33 (89.2)	64(100.0)	0.001	1	0.970
		Minimal enablers	3 (11.1)	4 (10.8)				
16.	Management and peer support for use of CCP	Substantial enablers	27(100.0)	35(94.6)	64(100.0)	1.507	1	0.220
		Minimal enablers	0(0.0)	2(5.4)				
17.	Involvement of all staff & service providers in CCP training	Substantial enablers	27(100.0)	35(94.6)	64(100.0)	1.507	1	0.220
		Minimal enablers	0(0.0)	2(5.4)				
18.	Dedicated staff education time to learn how to practice in a client-centred fashion	Substantial enablers	27(100.0)	34(91.9)	64(100.0)	2.297	1	0.130
		Minimal enablers	0(0.0)	3(8.1)				

Appendix O. Table 17 Relationships between years of experience and enablers to CCP[18].

Enablers		Years of experience <5 No.%	5<10 No.%	10< No.%	Total	X^2	df	*P*
1. Education about CCP while still a student	Substantial enablers	37(97.4)	14(100.0)	12(100.0)	64(100.0)	0.695	2	0.706
	Minimal enablers	1(2.6)	0(0.0)	0(0.0)				
2. Education about CCP while a practicing Therapist	Substantial enablers	33(86.8)	13(92.9)	11(91.7)	64(100.0)	0.483	2	0.786
	Minimal enablers	5(13.2)	1(7.7)	1(8.3)				
3. Education which is not disease centred	Substantial enablers	33(86.8)	10(71.4)	16(50.0)	64(100.0)	7.162	2	**0.028**
	Minimal enablers	5(13.2)	4(28.6)	6(50.0)				
4. A clear definition of CCP	Substantial enablers	31(81.6)	14(100.0)	11(91.7)	64(100.0)	3.409	2	0.182
	Minimal enablers	7(18.4)	0(0.0)	1(8.3)				
5. More explanation about and elaboration of CCP	Substantial enablers	36(94.7)	13(92.9)	12(100.0)	64(100.0)	0.807	2	0.668
	Minimal enablers	2(5.3)	1(7.1)	0(0.0)				
6. Case examples showing how to practice in a client- centred manner	Substantial enablers	35(92.1)	14(100.0)	12(100.0)	64(100.0)	2.154	2	0.341
	Minimal enablers	3(7.9)	0(0.0)	0(0.0)				
7. Education about how to grade CCP for different capability	Substantial enablers	37(97.4)	13(92.9)	12(100.0)	64(100.0)	1.164	2	0.559
	Minimal enablers	1(2.6)	1(7.1)	0(0.0)				
8. Education to increase knowledge of other cultures	Substantial enablers	32(84.2)	13(92.9)	12(100.0)	64(100.0)	2.599	2	0.273
	Minimal enablers	6(15.8)	1(7.1)	0(0.0)				
9. Training to increase self- knowledge as an occupational therapist	Substantial enablers	37(97.4)	13(92.9)	12(100.0)	64(100.0)	1.164	2	0.559
	Minimal enablers	1(2.6)	1(7.1)	0(0.0)				
10. Interpersonal skills Training	Substantial enablers	36(94.9)	14(100.0)	11(91.7)	64(100.0)	1.074	2	0.585
	Minimal enablers	2(5.3)	0(0.0)	1(8.3)				
11. Assertiveness training	Substantial enablers	34(89.5)	11(78.6)	12(100.0)	64(100.0)	3.062	2	0.216
	Minimal enablers	4(10.5)	3(21.4)	0(0.0)				
12. Negotiation training	Substantial enablers	34(89.5)	11(78.6)	11(91.7)	64(100.0)	1.346	2	0.510
	Minimal enablers	4(10.5)	3(21.4)	1(8.3)				
13. Involving people with disabilities in training to increase disability awareness	Substantial enablers	34(89.5)	14(100.0)	10(83.3)	64(100.0)	2.259	2	0.323
	Minimal enablers	4(10.5)	0(0.0)	2(16.7)				
14. Client involvement in planning services	Substantial enablers	37(97.4)	13(92.9)	12(100.0)	64(100.0)	1.164	2	0.559
	Minimal enablers	1(2.6)	1(7.1)	0(0.0)				
15. Client involvement in evaluating services	Substantial enablers	33(86.8)	14(100.0)	10(83.3)	64(100.0)	2.316	2	0.314
	Minimal enablers	5(13.2)	0(0.0)	2(16.7)				
16. Management and peer support for use of CCP	Substantial enablers	36(94.7)	14(100.0)	12(100.0)	64(100.0)	1.413	2	0.493
	Minimal enablers	2(5.3)	0(0.0)	0(0.0)				
17. Involvement of all staff & service providers in CCP training	Substantial enablers	36(94.7)	14(100.0)	12(100.0)	64(100.0)	1.413	2	0.493
	Minimal enablers	2(5.3)	0(0.0)	0(0.0)				
18. Dedicated staff education time to learn how to practice in a client-centred fashion	Substantial enablers	36(94.7)	13(92.9)	12(100.0)	64(100.0)	0.807	2	0.668
	Minimal enablers	2(5.3)	1(7.1)	0(0.0)				

[18] Bonferroni correction was applied

Appendix P. Table 18 Relationship between main area of OT practice and enablers[19]

		Adult only	CBR	Pediatrics	Mental health	Children and Adult	Teaching				
		No.%	No.%	No.%	No.%	No.%	No.%	Total	X^2	df	*P*
1. Education about CCP while still a student	Substantial enabler	13(100.0)	6(100.0)	29(98.3)	8(100.0)	6(100.0)	1(100.0)	64(100.0)	1.151	5	0.949
	Minimal enabler	0(0.0)	0(0.0)	1(3.4)	0(0.0)	0(0.0)	0(0.0)				
2. Education about CCP while a practicing Therapist	Substantial enabler	12(92.3)	5(83.3)	25(91.4)	8(100.0)	6(100.0)	1(100.0)	64(100.0)	3.196	5	0.670
	Minimal enabler	1(7.7)	1(16.7)	5(17.2)	0(0.0)	0(0.0)	0(0.0)				
3. Education which is not disease centred	Substantial enabler	10(76.9)	4(66.7)	24(89.6)	7(87.5)	3(50.0)	1(100.0)	64(100.0)	3.725	5	0.590
	Minimal enabler	3(23.1)	2(33.3)	6(20.7)	1(12.5)	3(50.0)	0(0.0)				
4. A clear definition of CCP	Substantial enabler	10(76.9)	6(100.0)	27(98.8)	7(87.5)	5(83.3)	1(100.0)	64(100.0)	2.596	5	0.762
	Minimal enabler	3(23.1)	0(0.0)	3(10.3)	1(12.5)	1(16.7)	0(0.0)				
5. More explanation about and elaboration of CCP	Substantial enabler	12(92.3)	6(100.0)	29(98.3)	7(87.5)	6(100.0)	1(100.0)	64(100.0)	2.118	5	0.833
	Minimal enabler	1(7.7)	0(0.0)	1(3.4)	1(12.5)	0(0.0)	0(0.0)				
6. Case examples showing how to practice in a client- centred manner	Substantial enabler	13(100.0)	6(100.0)	30(100.0)	7(87.5)	4(66.7)	1(100.0)	64(100.0)	14.572	5	**0.012**
	Minimal enabler	0(0.0)	0(0.0)	0(0.0)	1(12.5)	2(33.3)	0(0.0)				
7. Education about how to grade CCP for different capability	Substantial enabler	13(100.0)	4(66.7)	30(100.0)	8(100.0)	6(100.0)	1(100.0)	64(100.0)	19.957	5	**0.001**
	Minimal enabler	0(0.0)	2(33.3)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	64(100.0)			
8. Education to increase knowledge of other cultures	Substantial enabler	12(92.3)	4(66.7)	26(89.7)	8(100.0)	6(100.0)	1(100.0)	64(100.0)	5.249	5	0.386
	Minimal enabler	1(7.7)	2(33.3)	4(55.1)	0(0.0)	0(0.0)	0(0.0)				
9. Training to increase self- knowledge as an occupational therapist	Substantial enabler	13(100.0)	5(83.3)	30(100.0)	8(100.0)	5(83.3)	1(100.0)	64(100.0)	8.946	5	0.111
	Minimal enabler	0(0.0)	1(16.7)	0(0.0)	0(0.0)	1(16.7)	0(0.0)				
10. Interpersonal skills Training	Substantial enabler	13(100.0)	6(100.0)	27(93.1)	8(100.0)	6(100.0)	1(100.0)	64(100.0)	3.567	5	0.613
	Minimal enabler	0(0.0)	0(0.0)	3(53.4)	0(0.0)	0(0.0)	0(0.0)				
11. Assertiveness training	Substantial enabler	12(92.3)	4(66.7)	26(93.1)	8(100.0)	6(100.0)	1(100.0)	64(100.0)	5.249	5	0.386
	Minimal enabler	1(7.7)	2(33.3)	4(13.8)	0(0.0)	0(0.0)	0(0.0)				
12. Negotiation training	Substantial enabler	11(84.6)	5(83.3)	26(93.1)	8(100.0)	5(83.3)	1(100.0)	64(100.0)	1.594	5	0.902
	Minimal enabler	2(15.4)	1(16.7)	4(13.8)	0(0.0)	1(16.7)	0(0.0)				
13. Involving people with disabilities in training to increase disability awareness	Substantial enabler	12(92.3)	6(100.0)	26(93.1)	8(100.0)	5(83.3)	1(100.0)	64(100.0)	2.524	5	0.773
	Minimal enabler	1(7.7)	0(0.0)	4(13.8)	0(0.0)	1(16.7)	0(0.0)				
14. Client involvement in planning services	Substantial enabler	13(100.0)	6(100.0)	29(98.3)	8(100.0)	5(85.3)	1(100.0)	64(100.0)	4.542	5	0.474
	Minimal enabler	0(0.0)	0(0.0)	1(3.4)	0(0.0)	1(16.7)	0(0.0)				
15. Client involvement in evaluating services	Substantial enabler	13(100.0)	4(66.7)	28(96.5)	7(87.5)	4(66.7)	1(100.0)	64(100.0)	8.480	5	0.132
	Minimal enabler	0(0.0)	2(33.3)	2(6.9)	1(12.5)	2(33.3)	0(0.0)				
16. Management and peer support for use of CCP	Substantial enabler	12(92.3)	6(100.0)	29(100.0)	8(100.0)	6(100.0)	1(100.0)	64(100.0)	1.578	5	0.904
	Minimal enabler	1(7.7)	0(0.0)	1(3.4)	0(0.0)	0(0.0)	0(0.0)	64(100.0)			
17. Involvement of all staff & service providers in CCP training	Substantial enabler	13(100.0)	5(83.3)	30(100.0)	7(87.5)	6(100.0)	1(100.0)	64(100.0)	7.570	5	0.182
	Minimal enabler	0(0.0)	1(16.7)	0(0.0)	1(12.5)	0(0.0)	0(0.0)				
18. Dedicated staff education time to learn how to practice in a client-centred fashion	Substantial enabler	13(100.0)	4(6.7)	30(100.0)	7(87.5)	6(100.0)	1(100.0)	64(100.0)	14.572	5	0.012
	Minimal enabler	0(0.0)	2(33.3)	0(0.0)	1(12.5)	0(0.0)	0(0.0)				

[19] Bonferroni correction was applied

*Missing data for these items

Appendix Q. Table 19 Relationship between source funding and enablers.[20]

Enablers		Source of funding: Private	Public	Donor funding	Private companies	Private& Public	Public & Donor funding	Private & Donor funding	Private, Public & Donor	All sources	Total	X^2	df	*P*
		No.%	No.%	No.%	No.%	No.%	No.%	No.%	No.%	No.%				
1. Education about CCP while still a student	Substantial enabler	14(93.3)	17(100.0)	11(100.0)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	3.319	8	0.913
	Minimal enabler	1(6.7)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
2. Education about CCP while a practicing Therapist	Substantial enabler	13(86.7)	16(94.1)	10(90.9)	2(66.7)	6(85.7)	3(75.0)	4(100.0)	1(100.0)	2(100.0)	64	3.870	8	0.869
	Minimal enabler	2(13.3)	1(5.9)	1(9.1)	1(33.3)	1(14.3)	1(25.0)	0(0.0)	0(0.0)	0(0.0)				
3. Education which is not disease centred	Substantial enabler	12(80.0)	13(76.5)	8(72.7)	3(100.0)	6(85.7)	4(100.0)	2(50.0)	1(100.0)	0(0.0)	64	11.071	8	0.198
	Minimal enabler	3(20.0)	4(23.5)	3(27.3)	0(0.0)	1(14.3)	0(0.0)	2(50.0)	0(0.0)	2(100.0)				
4. A clear definition of CCP	Substantial enabler	14(93.3)	15(88.2)	9(81.8)	2(66.7)	5(71.4)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	5.215	8	0.734
	Minimal enabler	1(6.7)	2(11.8)	2(18.2)	1(33.3)	2(28.6)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
5. More explanation about and elaboration of CCP	Substantial enabler	15(100.0)	14(82.4)	11(100.0)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	8.702	8	0.368
	Minimal enabler	0(0.0)	3(17.6)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
6. Case examples showing how to practice in a client- centred manner	Substantial enabler	14(93.3)	16(94.1)	11(100.0)	3(100.0)	6(85.7)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	2.859	8	0.943
	Minimal enabler	1(6.7)	1(5.9)	0(0.0)	0(0.0)	1(14.3)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
7. Education about how to grade CCP for different capability	Substantial enabler	15(100.0)	17(100.0)	9(81.8)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	9.947	8	0.269
	Minimal enabler	0(0.0)	0(0.0)	2(18.2)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
8. Education to increase knowledge of other cultures	Substantial enabler	14(93.3)	16(94.1)	7(63.6)	3(100.0)	7(100.0)	3(75.0)	4(100.0)	1(100.0)	2(100.0)	64	10.927	8	0.206
	Minimal enabler	1(6.7)	1(5.9)	4(36.4)	0(0.0)	0(0.0)	1(25.0)	0(0.0)	0(0.0)	0(0.0)				
9. Training to increase self- knowledge as an occupational therapist	Substantial enabler	14(93.3)	17(100.0)	10(90.9)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	3.141	8	0.925
	Minimal enabler	1(6.7)	0(0.0)	1(9.1)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
10. Interpersonal skills Training	Substantial enabler	14(93.3)	16(94.1)	10(90.9)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	1.696	8	0.989
	Minimal enabler	1(6.7)	1(5.9)	1(9.1)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
11. Assertiveness training	Substantial enabler	15(100.0)	16(94.1)	8(72.7)	2(66.7)	7(100.0)	4(100.0)	3(25.0)	0(0.0)	2(100.0)	64	17.397	8	**0.026**
	Minimal enabler	0(0.0)	1(5.9)	3(27.3)	1(33.3)	0(0.0)	0(0.0)	1(25.0)	1(100.0)	0(0.0)				
12. Negotiation training	Substantial enabler	14(93.3)	16(94.1)	9(81.8)	2(66.7)	5(71.4)	4(100.0)	4(100.0)	0(0.0)	2(100.0)	64	12.744	8	0.121
	Minimal enabler	1(6.7)	1(5.9)	2(18.2)	1(33.3)	2(28.6)	0(0.0)	0(0.0)	1(100.0)	0(0.0)				

[20] Bonferroni correction was applied.

13. Involving people with disabilities in training to increase disability awareness	Substantial enabler	13(86.7)	17(100.0)	10(90.9)	2(66.7)	6(85.7)	4(100.0)	3(75.0)	1(100.0)	2(100.0)	64	6.135	8	0.632
	Minimal enabler	2(13.3)	0(0.0)	1(9.1)	1(33.3)	1(14.3)	0(0.0)	1(25.0)	0(0.0)	0(0.0)				
14. Client involvement in planning services	Substantial enabler	13(86.7)	17(100.0)	11(100.0)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	6.744	8	0.564
	Minimal enabler	2(13.3)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
15. Client involvement in evaluating services	Substantial enabler	13(86.7)	15(88.2)	10(90.9)	3(100.0)	6(85.7)	3(75.0)	4(100.0)	1(100.0)	2(100.0)	64	2.259	8	0.972
	Minimal enabler	2(13.3)	2(11.8)	1(9.1)	0(0.0)	1(14.3)	1(25.0)	0(0.0)	0(0.0)	0(0.0)				
16. Management and peer support for use of CCP	Substantial enabler	15(100.0)	16(94.1)	11(100.0)	3(100.0)	6(85.7)	4(100.0	4(100.0)	1(100.0)	2(100.0)	64	4.597	8	0.800
	Minimal enabler	0(0.0)	1(5.9)	0(0.0)	0(0.0)	1(14.3)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
17. Involvement of all staff & service providers in CCP training	Substantial enabler	15(100.0)	16(94.1)	10(90.9)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0	64	2.881	8	0.942
	Minimal enabler	0(0.0)	1(5.9)	1(5.9)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				
18. Dedicated staff education time to learn how to practice in a client-centred fashion	Substantial enabler	15(100.0)	16(94.1)	9(81.8)	3(100.0)	7(100.0)	4(100.0)	4(100.0)	1(100.0)	2(100.0)	64	6.308	8	0.613
	Minimal enabler	0(0.0)	1(5.9)	2(18.2)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)				

*Missing data for these items

Appendix R. Table 20 Minor changes to questionnaire

Item no.	**Section**	**Original statement**	**Revised statement**
	Section I: Demographics	Items from the original questionnaire include: age, years of experience and main area of OT practice and type of practice.	Additional information on: gender, level of professional qualification and source of funding for the facility
a	Section II: Client-centred checklist (Adapted from Parker, 2006)	a) Do I demonstrate confidence in my practice?	Do I demonstrate confidence in ***using CCP***?
4	Section III: Barriers to CCP	4) The intervention is dominated by the medical model	No changes were done on the statement. A foot note was added to define 'medical model'. ***'Medical model is an approach to pathology that aims to find medical treatments for diagnosed symptoms and syndromes and treats the human as a very complex mechanism'.***
4	Section IV: Enablers of CCP or ways to resolve barriers to CCP	9. Training to increase self-knowledge	Training to increase self-knowledge ***as an occupational therapist***
		17. Involvement of all staff in CCP training	Involvement of all staff & ***service providers*** in CCP training
		18. Staff education time to learn how to practice in a client-centred fashion	***Dedicated*** staff education time to learn how to practice in a client-centred fashion

Appendix S. Table 21 Missing data

Item	Section	Focus	Missing data No	%
1	Section I Demographics	Age	2	3.1
2	Section II Understanding to CCP	Listen to what they say	1	1.5
		Naturally approach my clients in a genuine and honest manner?	1	1.5
		Treat my clients with respect and value their opinions?	1	1.5
		Negotiate with my clients about goals and outcomes?	1	1.5
		Treat my clients politely and equally?	1	1.5
		Respect my clients when they change their minds and re-focus their goals?	3	4.6
		Ensure my clients understand about risks, safety issues and resource limitations?	1	1.5
		Am I client centred?	1	1.5
3	Section III Barriers to CCP	The therapist had difficult taking risks in order to support the clients goals	1	1.5
		CCP is too great a change from current practice	1	1.5
		The therapist and client are of different culture	2	3.1
4	Section IV Enablers to CCP	Education about CCP while a practicing Therapist	2	3.1
		Education which is not disease centred	7	10.9
		More explanation about and elaboration of CCP	1	1.5
		Education about how to grade CCP for different capabilities	2	3.1
		Education to increase knowledge of other cultures	2	3.1
		Training to increase self- knowledge as an occupational therapist	2	3.1
		Assertiveness training	2	3.1
		Negotiation training	3	4.6
		Client involvement in evaluating services	1	1.5