

Maisha Outreach Therapy Organisation

MOTO FIELD STUDY

2022



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1. Introduction.

This field study was carried out by volunteers of Maisha Outreach Therapy Organisation (MOTO), a small Tanzanian NGO which primarily focuses on supporting people with disabilities and long-term conditions, as well as improving access and quality to rehabilitation therapies within Tanzania. It was conducted in the Kilimanjaro region in November 2021.

The aim of this study was to help provide further insight into the factors that both support and challenge people with disabilities/long-term conditions, and their carer-givers; as well as the strengths and limitations effecting the work of rehabilitation therapists and service providers within Kilimanjaro – some of which are partnered with MOTO. This is all with the view of highlighting the needs of the groups involved in the study, and actions which will truly help to make positive change in these areas, as identified by the people affected by the challenges mentioned.

Understanding the needs of rehabilitation services and their potential service users is crucial to fulfilling a substantial global health need. The World Health Organisation (WHO) has specifically highlighted the importance of access to rehabilitation. In their 2017 study “Rehabilitation 2030: A Call to Action”, WHO identifies that there is a “substantial unmet need for rehabilitation worldwide” which has especially been evident during the COVID-19 epidemic, where rehabilitation therapists played a significant role in the recovery of those who experienced acute cases of the virus, and those who experienced “long-COVID”, and needed longer term rehabilitation in order to return to their previous levels of functioning. By facilitating this study, MOTO aims to contribute to a greater depth of understanding of rehabilitation provision in Tanzania, in line with the WHO initiative to address the need for rehabilitation – especially in low and middle-income countries.

MOTO intends to use the content of this research study to better inform its projects and programmes, as well as share the content to facilitate greater understanding within the local community, as well as fellow NGOs, authority bodies, and healthcare professionals.

For more information on MOTO, please visit www.maishaot.org

2. Method.

The method for information gathering in this study is face to face structured interviews, on a one to one basis. These were conducted by volunteers, with experience in field research, and were conducted in Kiswahili which is the main national language of Tanzania. Kiswahili was identified as the most appropriate language in which to conduct the interviews, as this is the language most commonly used across Tanzania, and utilised in education settings from primary school. And so, despite Kiswahili not being the regional language of Kilimanjaro, volunteers were able to identify that there would be enough people to engage in the study that would speak Kiswahili to a proficiency which would facilitate clear communication.

All volunteers who conducted the interviews were fluent in Kiswahili, with previous experience of conducting field research with a community development context, and with vulnerable people. All volunteers who facilitated the interviews took were required to sign and abide by MOTO's safeguarding policy, and were subject to the standard of conducted as per MOTO policy.

All participants consented to their interviews being used in the study, and signed a consent form to indicate this. There were no participants interviewed who were not able to consent verbally to the interview process and use of information. There were no participants interviewed in the study who may be deemed by a professional as lacking the mental capacity to consent, as guided by the concepts of the United Kingdom's Mental Capacity Act 2005, as suggested by MOTO volunteers who are qualified healthcare professionals in the UK, and can provide such guidance in lieu of clear clinical guidelines surrounding capacity assessment in Tanzania. Participants were found via partner organisations in the locality.

The interview questions were a range of open-ended and close-ended questions, which supported the collection of foundational data (demographics, satisfaction ratings, confirmation of service access etc.), whilst also providing space for interview participants to express their own opinions and experiences.

The interviews were recorded on protected audio devices and in writing. The data was then translated into English through re-reading/listening (as opposed to re-recorded or re-written directly into English) when the answers were inputted into fields for further analysis and grouping. The volunteers translating the content of the interviews have a highly proficient knowledge of the English language. The participants' answers for the open-ended questions were coded and grouped into themes to help highlight and identify key and recurring answers and topics, which could then be more effectively discussed by professionals wanting to use this report to inform action.

This study report has been written in English in order to be shared with volunteers, stakeholders and donors outside of Tanzania. A version in Kiswahili is planned in due course.

3. Limitations.

- Despite the best efforts of the interview facilitators, there is no possibility of completing eliminating any personal bias of interviewees.
- The report writer has not heard the original recordings of the interviews or read the original written interview questions due to language barrier.
- There is the potential for some information to be “lost in translation”, but it was felt that the volunteer producing the written report (in English, working from English translations of data) was best place to do this due to previous formal research experience and fluency in English.
- The report is limited by its size. The number of participants for each population is very small, and so no large-scale assumptions can be automatically made based on the key themes and recommendations highlighted as result of this work. A large-scale study is recommended for a more accurate overview across the region. However, this was the size of the study that was possible based on MOTO’s capacity at the time.
- This report has been produced to aid the work of professionals wishing to support the groups of people who were interviewed for this study. It is not of academic/scientific standard, but for information purposes. There has been no process of peer-reviewing or any specific academic checks on this report.

4. Results.

a) People with Disabilities.

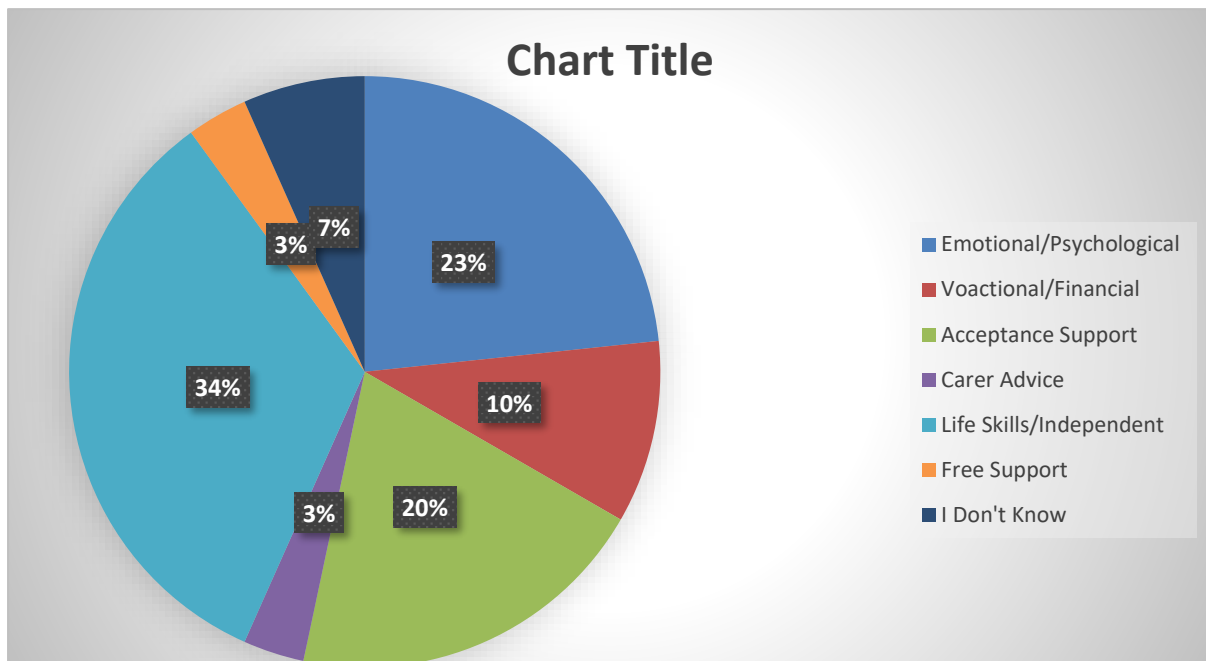
About the participants (30 in total)	
Age	17 youth participants (Between 17-35) 13 adult participants (Between 35-65)
Gender (self-identified)	23 males 7 females
Self-identifies as person with disability?	All participants self-identify as someone with a disability
Physical or mental disability?	100% of participants classified themselves as having a physical disability
Cause of disability (if known)	90% reported disability was caused following a motor vehicle accident. 3% reported disability was caused by a fall. 7% stated that "it just happened" 100% reported that their disability was acquired.
Impact of Disability	50% reported that their disability impacted their ability to engage in activities. 37% reported that their disability no longer had significant impact on daily activity, with 7 % stating that they never had any impact from their disability. (Please note 7% did not answer this)

Who provides daily support/care (if required)	<p>100 % of participants require daily care and support since acquiring their disability.</p> <p>100% of participants report that they are cared for by their relatives.</p>
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✓ **About Rehabilitation Services.**

All participants reported that they had received rehabilitation support following immediate acquisition of disability, and all of them had received this within the Kilimanjaro Christian Medical Centre (KCMC) located in Moshi town. All the participants were satisfied with the rehabilitation services that supported them, feeling that they were well-supported, and it did contribute to preparation for life in the community. However, only one of the participants received any continued therapy once discharged from the hospital.

The chart below reflects the participants’ opinion of what additional support they feel would have been beneficial as part of their rehabilitation support. Most prominently featured is the desire for emotional and psychological support, as well as further support with retaining independence and life skills, in accordance to how their disability would now impact their daily life.



Key themes:

- KCMC (acute care) appears to be the main provider for people with acquired disabilities.
- People with disabilities are unlikely to receive any rehabilitation therapy or support in the community, following discharge from hospital. (Please note that KCMC do not provide this service).
- 33% of participants identified that life skills to retain independence following acquiring a disability was a priority for them. Together with 10% citing that vocational support was an additional area they would like to be included in rehabilitation services, this indicates that participants generally had concerns about how they would function independently following acquisition of their disability.
- The need for emotional and psychological support is highlighted as a priority for people with a disability, and this is not currently provided by rehabilitation services available. If “acceptance support” is also classified as an emotional/psychological area, then this need is even greater than reflected on the chart above.

✓ Life as a Person with Disabilities.

Quality of Life	83% of participants reported that they were dissatisfied with their quality of life 10% stated that they were “somewhat dissatisfied” with their quality of life 7% stated that they were satisfied
Safety in the community	83% of participants say that they feel mostly safe in the community. 13% say that they feel safe 3% reported that they do not feel safe at all
Assistive Equipment	Mobility equipment was cited as the piece of equipment that would help the participants the most.

	<p>Wheelchairs were identified as the most useful piece of equipment, followed by “modern” crutches.</p>
Health Challenges	<p>30% of participants felt that their biggest health challenge was being able to pay for healthcare, especially in relation to continued health issues they experienced since acquiring the disability (such as management of pressure sores, urinary bag, on-going rehabilitation sessions).</p> <p>27% felt that on-going health issues (especially pain management and wound management) were their biggest issues, especially due to access to primary care services.</p> <p>13% felt that accessibility to community and health services was a challenge to them.</p> <p>13% also felt that they needed specialist equipment in order to retain their health, but did not have this.</p> <p>3% felt that lack of access to mental health care was a significant challenge.</p>
Social Challenges	<p>57% of participants felt that they were a burden to their family.</p> <p>23% felt that isolation was their biggest issue.</p> <p>20% reported that stigma and negative attitudes towards people with disability were the social challenges that affected them the most.</p>
Economic Challenges	<p>63% of participants reported that following their disability, they had experienced a reduction or complete loss of income.</p>

	<p>27% stated that they now had limited opportunity for work and education. This directly related both to stigma/negative attitude of others, and accessibility (as well as actual physical function limitations)</p> <p>10% felt that affording the continued healthcare that they needed was their biggest financial challenge.</p> <p>100% of participants felt that their best avenue for income was through a small business, with some support from others.</p>
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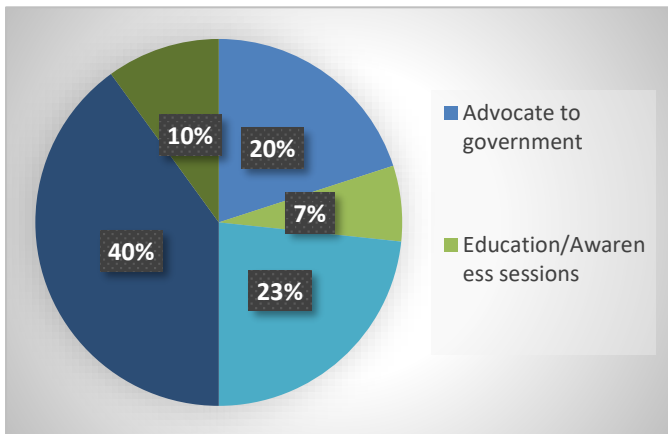
Key Themes.

- *The majority of the participants report that they are dissatisfied with their quality of life. Further exploration of this as a theme would prove useful to address solutions for this.*
- *Living with a disability has a significant negative impact on the financial/economic situation of a person with disabilities. A majority of this concern relates to meeting the cost of on-going health interventions required – including rehabilitation therapy.*
- *The participants felt that their best avenue for income was via a small business that they could run with support. This would help overcome the accessibility and stigma issues that they felt limited their opportunities for work and education.*
- *Continued community care (via primary or secondary services) to help maintain health and well-being does not appear to be easily available. The participants are limited in access to this due to cost and physical accessibility.*

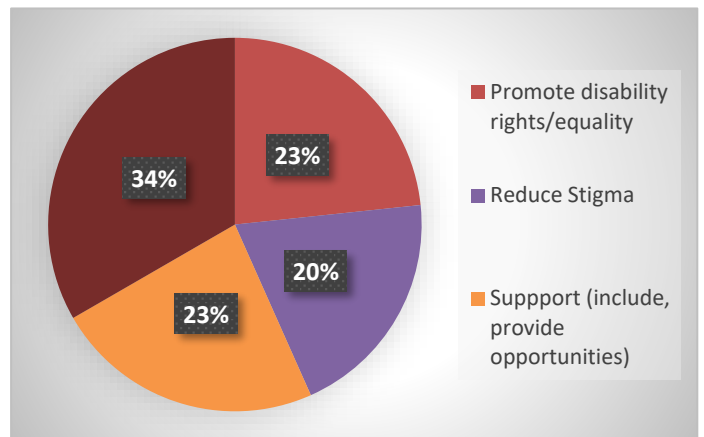
✓ **Calls To Action.**

We asked all participants what they felt the best course of action would be for MOTO, the community, and the government. We believe that lived experience is the greatest informer of effective change.

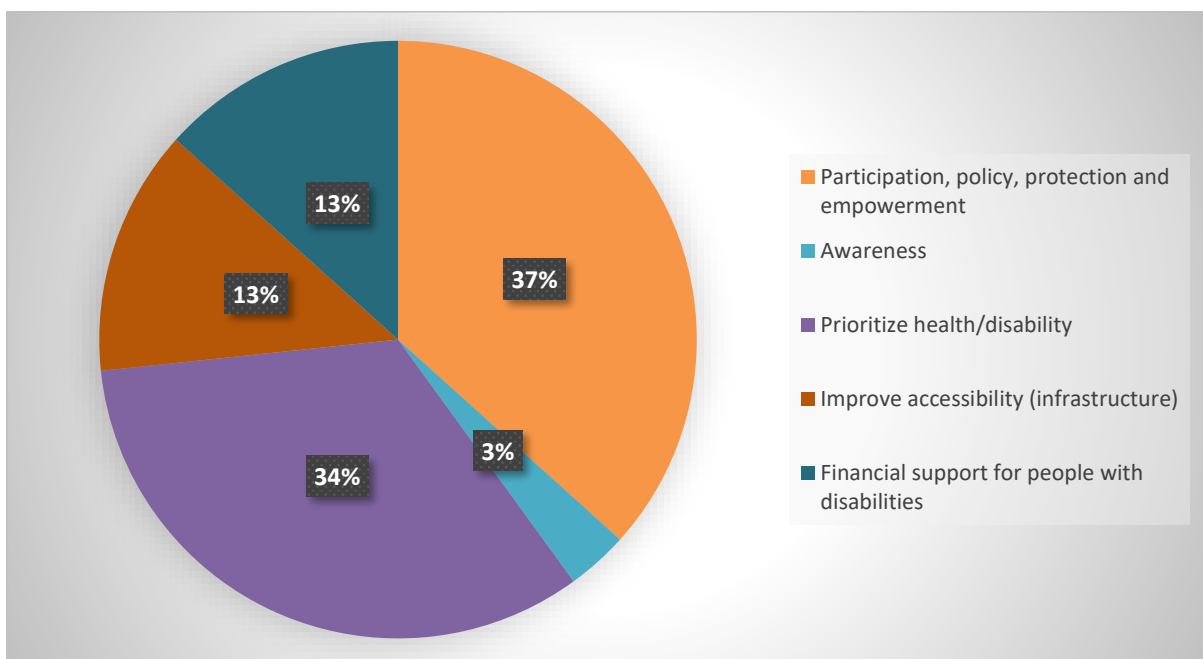
What can MOTO do to help?



What can the community do to help?



What can the Government do to help?



Key Themes:

- Promoting education and awareness about people with disabilities is identified as a key way which NGOs, communities and government can assist people with disabilities. This includes promotion of disability rights and understanding of equality.
- People with disabilities would like to the government prioritize their needs, and for NGOs to facilitate this by acting as advocates for people with disabilities.
- The participants feel that communities could help people with disabilities by providing more opportunities for them, such as in work and education.
- Support with health insurance to cover continuation of rehabilitation therapy and other healthcare costs was also highlight in the narrative about how NGOs could help.

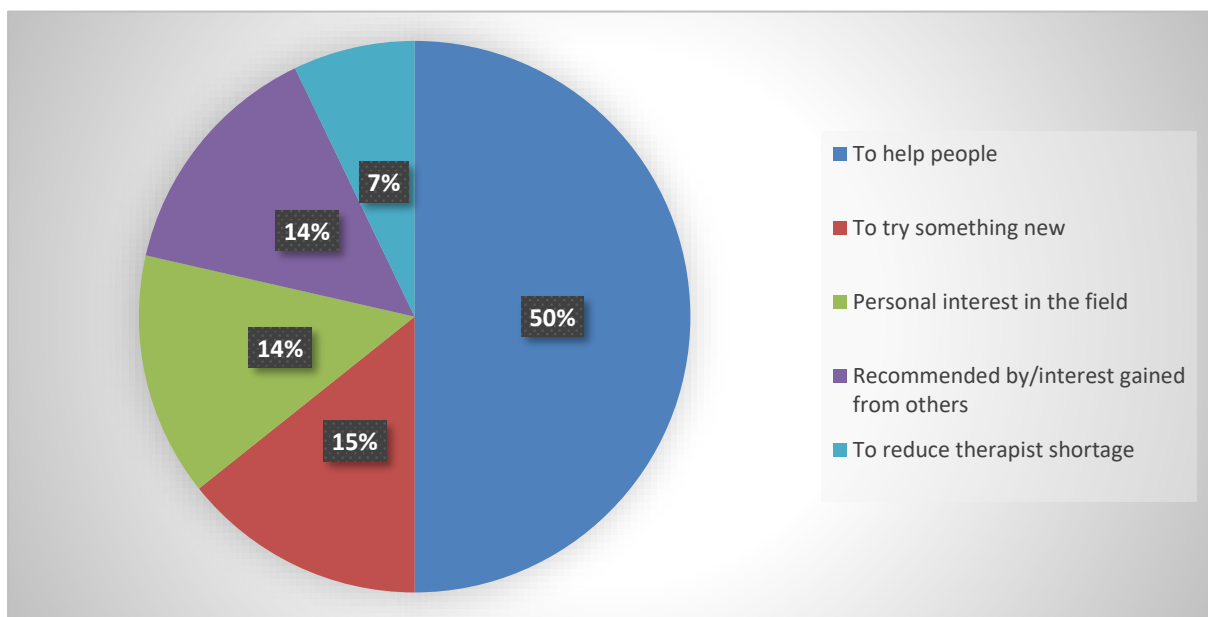
b) Rehabilitation Therapists.

About the Therapists (14 in total)	
What type of therapist?	<p>86% of participants were physiotherapists</p> <p>14% were occupational therapists</p> <p>All stated that they worked with other therapists types within their role (multi-disciplinary working),</p> <p>79% of the therapists worked in physical health, with 14% stating to work across both physical and mental health</p> <p>93% of therapists worked across both adult and paediatric services</p> <p>100% report that their profession is regulated.</p>

Level of training	<p>57% were educated to diploma level</p> <p>36% were educated to BSc level</p> <p>Only 1 participant was educated to MSc level</p> <p>79% were aware of scholarships to help with training, and 93% report that there are government incentives to train in this field</p>
Location of training	<p>93% of participants were trained at the Kilimanjaro Christian Medical University</p> <p>7% were educated overseas</p>
How many years since qualification?	<p>36% were in their first 2 years post-qualification</p> <p>7% had 3-5 years post-qualifying experience</p> <p>29% had 5-10 years of post-qualifying experience</p> <p>29% had over ten years of post-qualifying experience</p>
Location of employment	<p>86% of therapists interviewed worked in local government hospitals</p> <p>7% worked with an NGO or private hospital</p> <p>86% of therapists were able to find work immediately after graduation.</p>
Career Development	<p>100% of participating therapists feel they have the opportunity to progress in their role, but 0% felt they could specialize.</p>

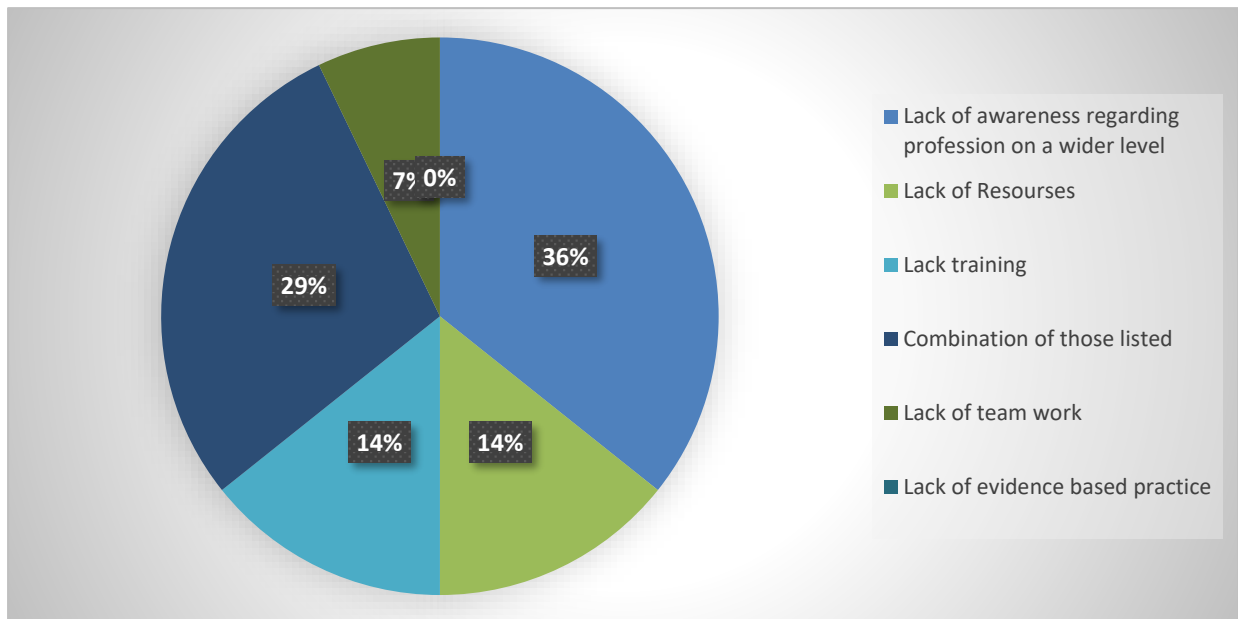
Skill Development	<p>71% of the participants felt that they needed more opportunity to develop and update their skills to retain a high level of skill and to learn about new clinical practices.</p> <p>Those that did access training online mostly, and via third-party organisations. 64% of the therapist had access to online training resources.</p> <p>100% felt that they had the opportunity for support and supervision regularly from a senior practitioner.</p>
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✓ Why did the therapists train to be therapists?



85% of the therapists came to the profession after learning about it from a family member or friend.

✓ Challenges for Therapists.



64% felt that they were not valued by the ministry of health. 100% felt that they were not valued by the wider community.

Key Themes:

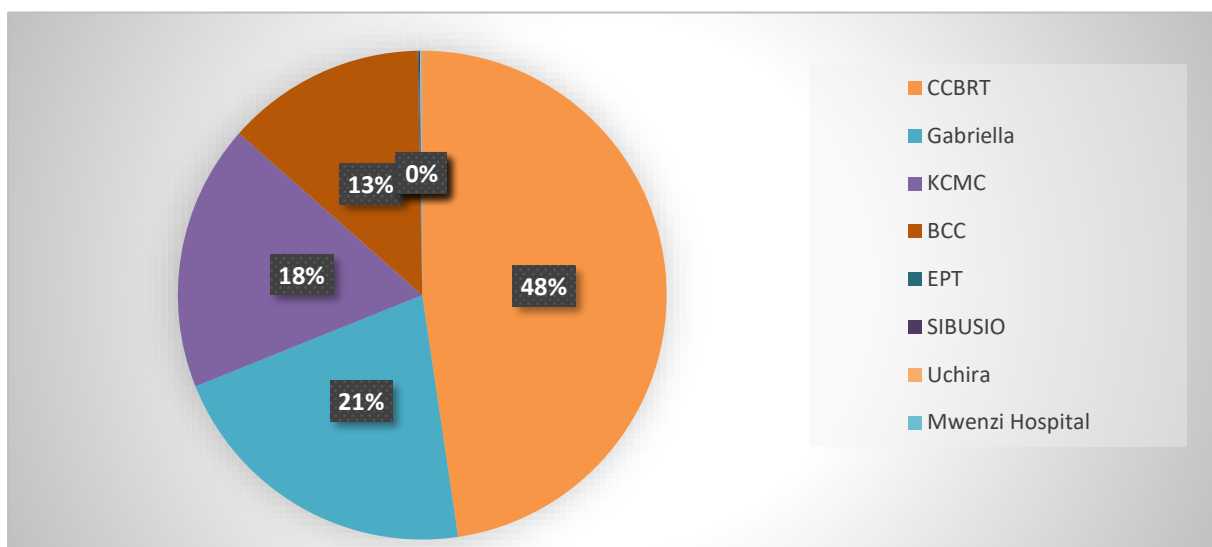
- *There is evidence that the therapist professions are regulated, and require training to at least diploma level in order to work professionally. The standards of regulation were not discussed in this study.*
- *The majority of therapists work in government hospitals, and across both adult and paediatric services, and work with other therapists to deliver rehabilitation support. There does not seem to be an issue with therapists finding employment within their field, and there appears to be good support (i.e. government incentive and scholarship) in order to support those undergoing training.*
- *Most therapists joined the profession as motivated by the desire to help others, and heard about the profession from people they knew.*
- *Kilimanjaro Christian Medical Centre (KCMC) has been identified as the only training facility within Tanzania (at least mentioned by the therapists participating).*

- *Opportunity to specialise and participate in additional skills development is significantly limited for most of the participants. However, they do feel they receive regular clinical supervision.*
- *Nearly all participants felt that their profession was not valued by others, including the ministry of health.*
- *Lack of understanding on a wider level was cited as a key challenge for the therapists.*
- *Lack of resources, training, team work and evidence-based practice were reported to be other challenges. 29% identified that their challenges were usually a combination of all these factors (including understanding of profession).*

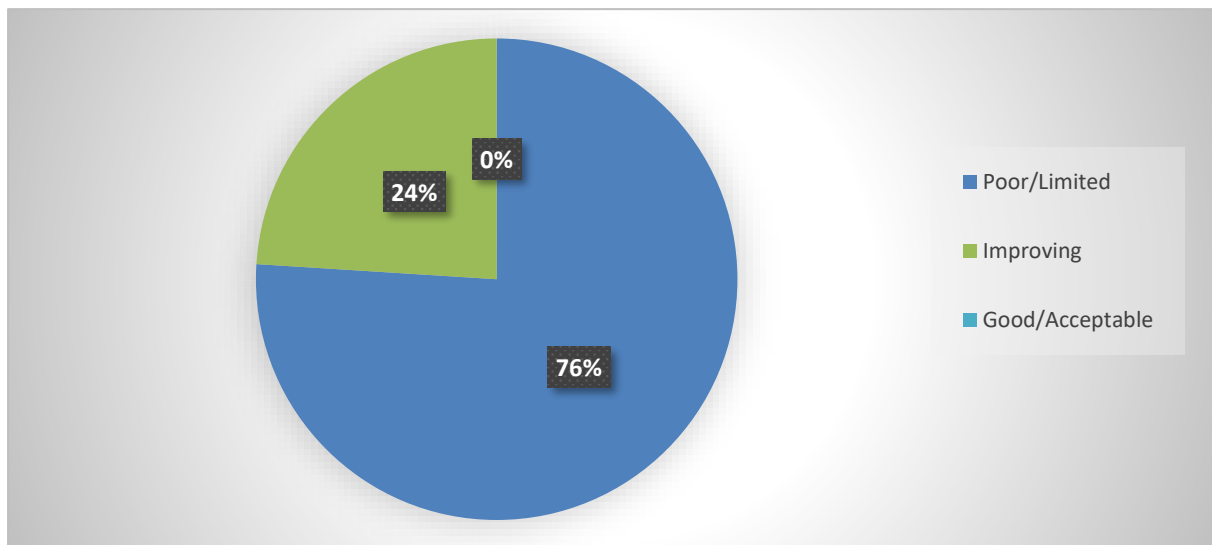
c) Partners & Service Providers.

For the comprehensive list of partners and service providers who participated in this study can be found in the acknowledgments section towards the end of the study.

✓ Know Rehabilitation Centres



✓ Partner/Provider Views on the current accessibility of therapy services.



About local therapy providers.

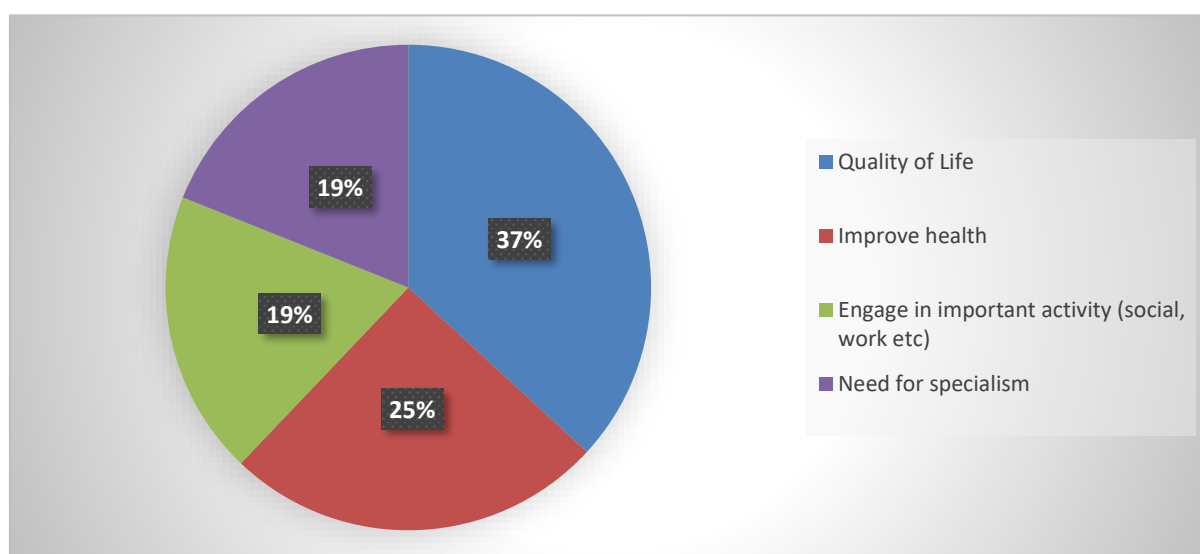
- All participants were able to identify at least one other provider of therapy (see chart above for those most identified).
- The cost for these services was generally quoted at approximately 5,000 TZS per day (\$2.14 USD or £2.00 per day).
- Partners felt that their services mentioned (in chart above) were chosen because of their specialist skills, holistic approach, and affordability.

Access to rehabilitation.

- 76% of the participants feel that accesses to rehabilitation services are “poor”.
- There were 4 key themes identified as challenges to access rehabilitation:

- a) *Education and Awareness (83% of participants identified that this was an issue)*
- b) *Affordability (78% of participants felt this was a barrier to access)*
- c) *Physical Access (39% identified this was a problem for access to services. This included issues with public transport, patient mobility, infrastructure and distance).*
- d) *Negative beliefs/stigma (28% reported that this may prevent people from reaching out to available services.)*

✓ **Why do providers feel that rehabilitation is so important?**



Key Themes:

- *Current providers of rehabilitation therapies are aware of other services in the area, but still feel that there is not enough provision or access to rehabilitation therapies. The majority of providers feel that current access to rehabilitation therapies is poor.*

- *Current providers recognize that their services have value to the level of specialism that they provide, as well as the cost. There is no government provision for community-based (primary or secondary level healthcare), which may also limit those who are under the government health insurance scheme from accessing rehabilitation once they have moved past acute-level/tertiary care. 18% identified that the need for specialist services is one of aspects which makes rehabilitation services so important.*

- *The majority of participants identified that rehabilitation is essential to quality of life and positive health outcomes. This could possibly infer a unified sense of value and professional identity among the service providers. It is very likely that most people who would clinically require rehabilitation are not receiving this, and as a result are not achieving the best health outcomes or quality of life that is possible, thus furthering both health and social inequality for people with injury, disability or long-term conditions.*

- *The key themes (Education/awareness; affordability; physical access and negative beliefs/stigma) highlighted in challenges to accessible services share themes with the challenges highlighted by the people with disabilities who were interviewed as part of this study. Education/awareness [of disability, of rehabilitation; of rehabilitation services] and affordable healthcare remain as important factors to consider in order to positively impact the lives of people with disabilities.*

- *The average Tanzanian wage stands at approximately 12,245 TZS per day (\$5.24 USD or £4.90 GBP) (Take-profit.com, 2022). The current approximate cost for rehabilitation services per day is often equivalent to half a day's wage for the average Tanzanian. Given that rehabilitation often requires multiple sessions, and in some-case long-term intervention over several months or years, this is not a realistic price that will support on-going engagement with rehabilitation services. Equally, rehabilitation services appear to be setting this price as there is limited income and support which could help facilitate lower priced or even free provision of services for those in need. This is especially important to consider with regards to the loss of livelihood and impact on finances that the participants with disabilities highlighted as a core issue for themselves and their families.*

e) Care Givers.

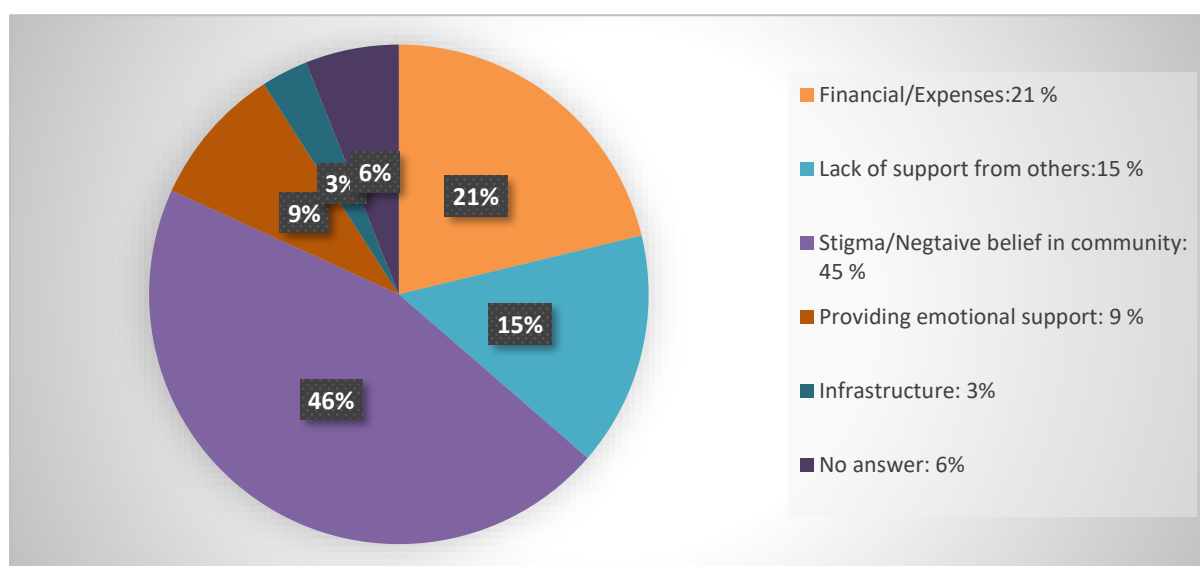
About the Care Givers (33 in total)	
Age	70% of participants were female 30% of participants were male
Gender	Elder (Above 66 years) – 9% Adult (36-65 years) – 56% Youth (17-35 years) – 33% Child (Under 17) – 6%
Relation to person they support	93% reported to be a relative (including spouse) of the person they cared for. 3% were not related, and were people in the local community like neighbours and teacher.
Employment Status	55% of the people providing care were unemployed. 24% reported that they were self-employed, and 21% said that they were employed.
Practicalities of care	45% felt that they were very dissatisfied with the support they received from family/friends with their role as a carer. 18% reported that they were dissatisfied. 30% reported that they were somewhat satisfied or satisfied, whilst only 6% felt very satisfied. 39% of the care givers reported that they were satisfied or very satisfied with the knowledge and skills that they had to support the person they cared for. Meanwhile 60% of

	<p>participants were on the scale of dissatisfaction, with 27% stating that they were very dissatisfied with their own knowledge and skills.</p> <p>Only 12% had received any kind of training to help with their role as a caregiver. They received this at the following locations:</p> <ul style="list-style-type: none"> - KCMC - Mtoni Centre - CCBRT - Tusonge - World Vision - Songambebe Initiative <p>The majority of the training the participants received was for 1-2 weeks.</p>
<p>Knowledge and Use of Rehabilitation Centres</p>	<p>27% of the participants had looked for rehabilitations for support and received this at the following organisations:</p> <ul style="list-style-type: none"> - Moshi EPT - CCBRT - KCMC <p>Of the participants who did not have support from a rehabilitation centre, 55% stated that it was because it was too expensive, while 3% reported that they didn't qualify for assistance, and 1% stated that they did not know why they hadn't. 6% felt that they did not need it.</p> <p>58% of the participants had heard of the local rehabilitation services, and could identify the following organisations:</p> <ul style="list-style-type: none"> - Moshi EPT - KCMC - CCBRT

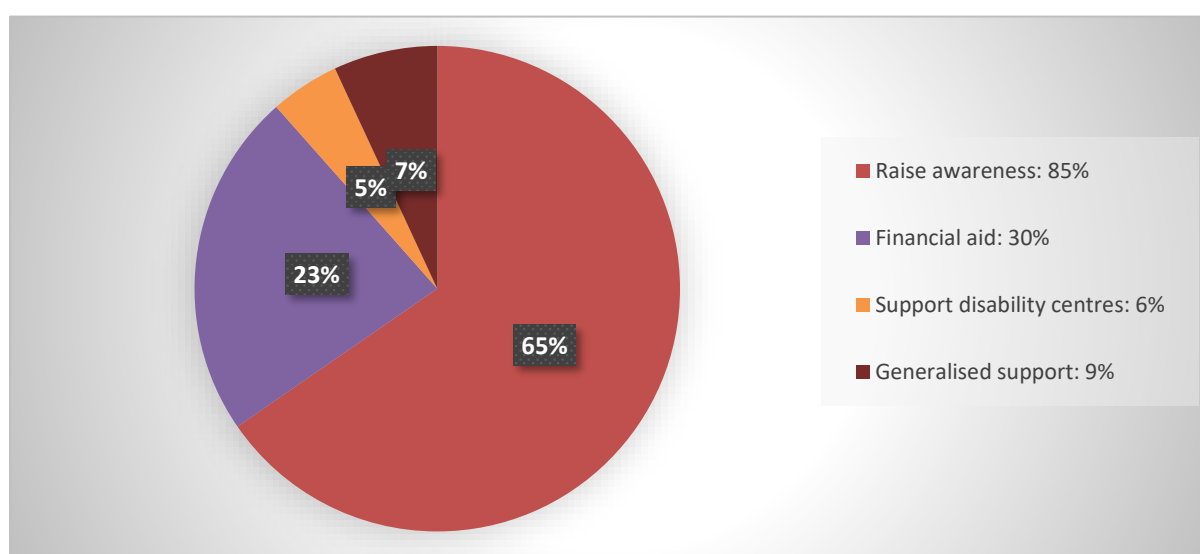
	<p>94% reported that they felt rehabilitation centres are/would be helpful.</p> <ul style="list-style-type: none"> - 58% felt this was because rehabilitation services would help to improve health and quality of life for people with disabilities/LTC. - 7% felt it was an opportunity for people with disabilities and their carers to meet others, learn about opportunities and receive general support. - 35% stated other reasons, like promoting independence for people with disabilities. <p>Only a minority of care givers were able to identify any assistive equipment that would be beneficial for the person they cared for. Only two participants named specific items: mattresses, wheelchairs, gloves were the items named.</p> <p>54% of participants reported that the people they cared for needed no medical care per month. 30% reported that medical care 1- 2 times per month, and 12% reported 3+ per month.</p>
<p>Accessing Rehabilitation Services</p>	<p>55% reported that cost was the biggest challenge to accessing rehabilitation services.</p> <p>28% reported that distance/physical access was an issue.</p> <p>18% reported other issues, which included finding the time, navigating the bureaucracy, and poor provision of service.</p>

✓ Challenges for Caregivers.

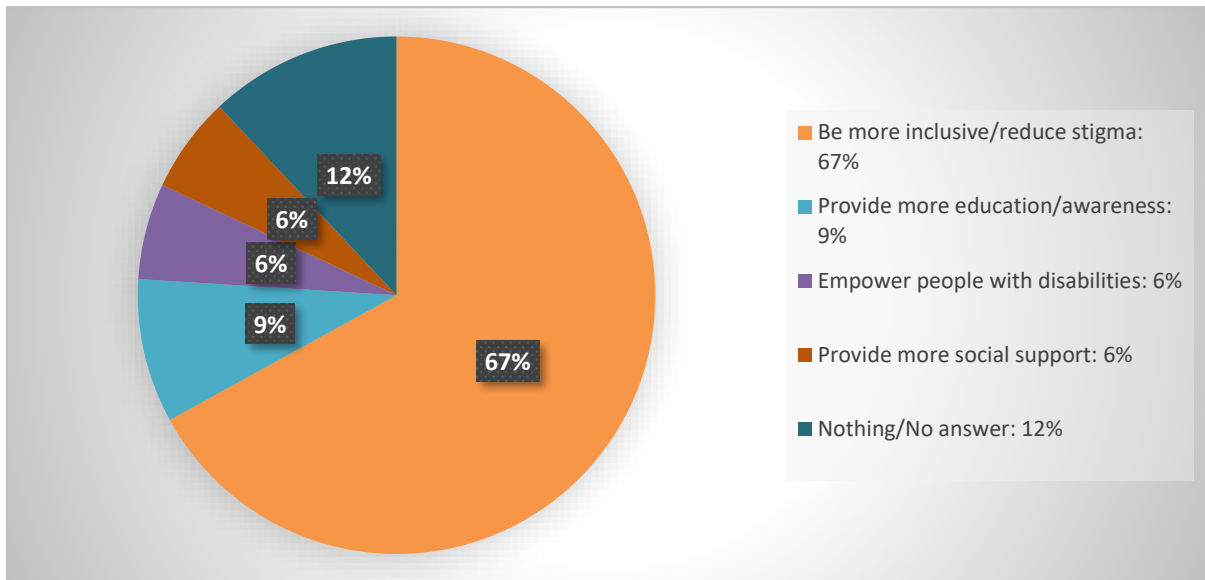
Challenges for caregivers share common themes with the challenges expressed by the people they support, and the challenges identified by therapists with relation to supporting people with disabilities. These overlapping themes are likely to indicate common areas that need to be addressed in order to provide impactful and positive change for people with disabilities (or LTC), and the people supporting them.



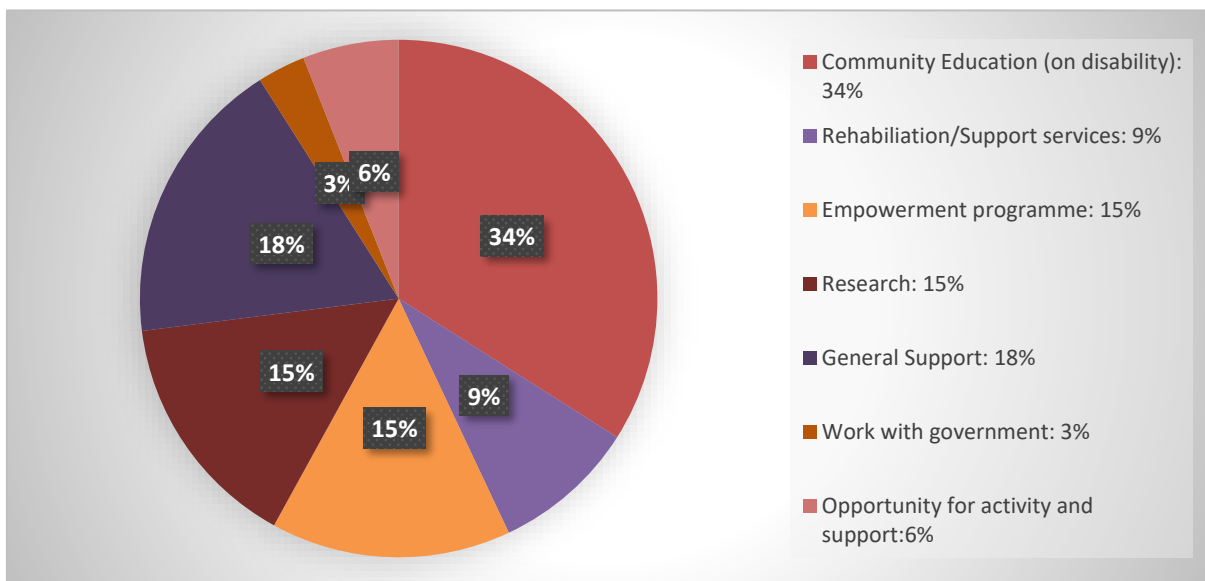
✓ What should the government do?



✓ What should the community do?



✓ What should MOTO do?



Key Themes:

- *The majority of the care givers interviewed were adult women (aged 35-65, who were relatives of the person that they cared for, and also stated that they were unemployed. This is a potential “snapshot” or profile of the average caregiver in the region. Further research would be beneficial to identify why exactly women of this age were more likely to be the caregivers, and to what extent this role has impacted on their employment and education opportunities – as well as the possible social implications for this. The relation between gender inequality and care-giving within this context requires more exploration for further insight.*
- *The majority of care givers were not satisfied with the level of support they received, which may imply a level of carer-strain and isolation.*
- *The majority of care givers have not received any formal training or support to undergo their role as carers.*
- *Although many caregivers had heard of the local rehabilitation centres, and the majority of them felt that access to these would improve the quality of life for the person (or people) they cared for, many had not accessed these services. For the majority, this was due to cost, although access and bureaucracy were also significant issues.*
- *The care-givers identified that their biggest challenge was living with the negative attitudes and stigma related to disability, which affected both them and the people they support. Following this, financial strain was cited as the next biggest issue.*
- *The majority of care givers identified that improving awareness and education of disability (and LTC) was the best thing that the government, community and MOTO could do presently to support them.*

5. Summary: Essential emerging themes of the field study & possible further avenues of study.

✓ **Rehabilitation therapies are inaccessible and unaffordable for the majority of Tanzanians.**

Although there are rehabilitation therapies available in some hospitals in the region, the therapists mainly work with those who are admitted to hospital, and support the immediate needs of those experiencing acute symptoms/injury such as in orthopaedics, and stroke. Further research is required to identify to what extent these interventions are supported by the government, and the most basic level of health insurance. It is also unclear if the hospital will provide any necessary equipment to support patients following discharge, and to what extent this is subsidised.

Following discharge, there is limited access to rehabilitation, and this is generally not provided by the hospital therapists. It is unclear that if any third sector therapy agencies would liaise with the hospital to support successful discharge with thorough understanding of previous interventions, and many patients and their families may not have heard of the available centres, and may not be able to afford the price of on-going therapy, which may be crucial to achieving rehabilitation potential, and adjusting to any long-term changes brought about by the illness or injury (as above, access to therapy per day can cost half a day's wage). In addition, many potential service users and their families may struggle to physically access the centres as there may not be safe or appropriate means of transport – the cost of transport may also be a significant barrier, especially for long-term interventions where weeks' worth of sessions may be required. Equally, any third sector agencies interested in providing outreach therapy may not be able to meet the costs associated with travelling out to service users, and in some cases, may not physically be able to due to road conditions.

✓ **People with disability and long-term conditions generally are not satisfied with their quality of life.**

The people with disability/long-term condition who participated in the study did not feel that their quality of life was satisfactory. Not only was there a theme of feeling isolated and at times resented (or as if they were a burden), it is often not possible for them to participate in social/leisure activities, education and generate their own income. This has immediate and negative impact on their self-worth, mental health and feelings of inclusion. They were also highly aware of the stigma and lack of understanding surrounding people with disabilities in their community, and whilst they generally felt safe, they tend not to feel valued, supported or included.

Further study surrounding potential methods of improving the quality of life for people with disabilities and long-term conditions is required, although as per other data within this study, providing community awareness, promoting inclusivity/support, and supporting independence and community access for people with disabilities and long-term conditions have all been identified as possible methods of addressing this issue. In addition, further exploration of the availability of emotional and psycho-social interventions for this population group.

✓ **The psychological needs of people living with disabilities/long-term conditions need further support and consideration.**

The people interviewed within this study were unable to identify any formal avenues for psychological support for people living with disabilities and long-term conditions. Given the dissatisfaction with quality of life, awareness of stigma and feelings of isolation identified within the studies, it is essential that further information is gained about how this population group can have their psychological needs met, and to what extent mental health support is available and can be naturally integrated into the rehabilitation services provided in acute, primary and secondary care settings. It would also be beneficial to gain further knowledge and understanding as to what extent psychological support is identified as a need alongside the elements of physical rehabilitation also present, and whether the practitioners delivering physical rehabilitation interventions have the necessary awareness and skill to recognise and deliver any form of mental health support (including vital mental health risk assessment), and whether there are the resources in place to do this should they wish to.

✓ **Rehabilitation therapists feel undervalued, under-supported and have limited access to the resources and training they need to perform their roles effectively.**

Therapists interviewed as part of this study did not feel that their profession was valued by the wider medical context, including by the government's health initiatives. As a result, they feel that their services are under resourced both in terms of clinical resources but also access to the training, equipment and time needed to continually develop practice, remain up to date and be as effective in their interventions as they would like to be. All participating therapists identified that they would like more training, and currently had any training that they did do online as opposed to face to face – which may have its own limitations in terms of successful implementation of new skills into clinical practice. Within the professions themselves (although please note it was mainly occupational therapists and physiotherapists interviewed), felt there was little progression for them. It is advised that further study is done on the morale of currently practising debilitation, rates of resignation, and to what degree the dissatisfaction felt by rehabilitation therapist contributes to

difficulties in recruitment and retention. In addition, it is necessary to understand how other professions within healthcare (including the ministry of health) view rehabilitation therapy, and what measures may be taken to boost the priority of this area of practice.

In order to achieve high standard and modern therapeutic intervention within the field of rehabilitation, it is essential that therapists have the opportunity for continued professional development (CPD) and supported to achieve this by having the time, resources and opportunities to do this. In countries where rehabilitation therapists are more stringently regulated to practice, therapists are required to evidence this in order to continue practice as it is considered to be a direct correlation to commitment, knowledge and safe/relevant practice. Further information is required as to what degree therapists are regulated within Tanzania and what the specific barriers to CPD are (be it cost, availability, time or priority of rehabilitation by management structures).

✓ **Carer-strain is significant, and may have be perpetuating other social issues such as gender inequality, poverty, social isolation and abuse.**

Caring for a person with a disability or a long-term condition is a significant responsibility which impacts both the carer and the person being cared for. Mostly, in the context of this study, care was provided by female relatives. The majority of the carers have no formal training to support their role and feel under supported to fulfil their caring role whether that is from professionals, family or the community at large. They also feel that they do not have the financial or practical means to deliver care effectively. Barriers identified include cost, lack of equipment, and lack of knowledge and access/knowledge of avenues of support.

From the information given, it is clear that the caring role has a notable impact on the lives of carers which is not always positive. As women and girls are largely delegated to be carers due to perception of gender roles, this also has subsequent effect on the opportunities for education/financial independence for women and girls in caring roles (although men and boys in caring roles would also be limited in this respect, they simply do not make up the majority of carers). Further exploration of this would be important in order to safeguard the needs of carers and to advocate and identify ways to support them in their caring role – and outside of it.

Finally - and as seen significantly during the time of COVID restrictions across the world – there is a general correlation between carer strain and the risk of abuse. This study has highlighted that the carers do feel the strain of their role (and that the people they care for are also aware of this), which raises questions regarding safeguarding people being cared for under difficult circumstances. Further study to understand understanding of carer-perpetrated abuse (i.e. is it recognised? Is it monitored?) and knowledge/use of

safeguarding practices and interventions is necessary to protect vulnerable people being cared for at home.

- ✓ **Further research is required on a larger scale to gain in-depth understanding of these issues.**

This small-scale study provides some basic information and themes surrounding the needs and challenges surrounding people with disability/long-term conditions; their carers; and the local provision of rehabilitation therapists. The limitations recorded at the start of the study must be taken into account, and it is not possible to make statements about larger populations at present. This cannot be considered to be a study which provides depth of knowledge at present.

MOTO will endeavour to explore funding opportunities for an expansion of this research study across a larger population, and additional studies to compliment the outcome of this study, which can then be used and shared to develop strategies and resources for meaningful and evidence-based interventions.

Secondary Research, Global Contexts, and Making Change.

If you are interested in understanding more about the summary notes above in the context of other available literature/guidelines and public health initiatives in Tanzania and globally, please contact Maisha Outreach Therapy Organisation (MOTO) to arrange a training and dissemination project, including support for project building using this study.

MOTO is a small organization committed to its work, including further studies like this one. Please consider that we may request donation to our work and support with training costs prior to contacting us.

6. Facilitators & Donors.

Facilitators: *Johnson Dickson; Mary Maika; Laudadeus Redomtory; Eric Johnson; Aika Wilfred; and Edward Ngala.*

Translation & Data Recording: *Johnson Dickson.*

Data analysis & report writing: *Judy Freeman.*

Donors: *Family & Friends of Theo Franklino; Private donors.*

7. About MOTO.

Maisha Outreach Therapy Organisation (or MOTO) was founded in 2016 and has the following aims:

- 1. Facilitate greater access to and function of rehabilitation services in Africa.**
- 2. Support those made vulnerable through health conditions or marginalization.**

Sub-Saharan Africa contains some of the world's lowest income (as per GDP) countries. For many people, living in poverty means that they are at greater risk of health inequality, without the means to effectively prevent, treat and access appropriate health interventions. Not only are there a lack of rehabilitation specialists (including OT), but the prevalence of conditions that may require rehabilitation therapies is increasing). Similarly, marginalised people (such as those who are homeless, or refugees) face health inequality, and can also face the same social stigma experienced by people with disabilities and long-term conditions. These challenges can lead to vulnerability. When illness, disability, or social exclusion becomes an obstacle to daily life, the prospects and equality of those people are compromised.

At MOTO, we believe that empowering and supporting individuals can reignite the "moto wa maisha" - the fire of life (in Kiswahili), and that access to support and rehabilitation therapies are key to reducing vulnerability and isolation, and increasing the chances of a happier, healthier life for individuals and their families.

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