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Experiences of Occupational Therapists Practicing in Rural Kenya

By

Cherotich Leitich

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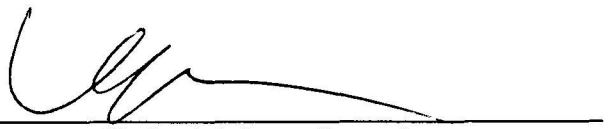

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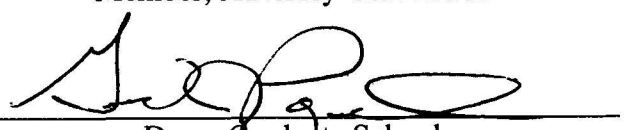

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Experience of Occupational Therapists Practicing in Rural Kenya

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DEDICATION

This thesis is dedicated to my fiancée

Josphat Melly, my family and my occupational therapists friends from Kenya

for their unwavering support.

ACKNOWLEDGMENTS

I would like to thank my thesis Advisor, Dr. MaryEllen Thompson, for her continuous support, guidance and patience all through the research. I would also like to thank the other committee members, Dr. Christine Privott and Dr. Anne Shordike, for their time and assistance. I would like to express my thanks to my fiancée, Melly, for his support and encouragement during those times when everything was falling apart and all I needed was a shoulder to lean on. He always offered his emotional support and provided a nutritional meal which sustained me when there was no more energy left to cook. I would like to thank all the Kenyan occupational therapists both in Kenya and in the USA for each role they played, without which this research would have been impossible. Finally, I would also like to thank my friends and family in Kenya for all their prayers and support.

ABSTRACT

In Kenya, occupational therapy, which is slowly gaining attention, is still concentrated in the cities with a very small number working in rural areas. Occupational therapy practice in rural areas is impacted by various factors that are naturally occurring in rural settings such as poor infrastructure, cultural beliefs and values, language barriers, economic statuses, lack of resources, geographical barriers, lack of transportation and limited number of occupational therapists. In this study, three occupational therapists were interviewed as well as photographs of the resources used in these rural settings were collected in order to understand the nature of their work in that context. The data collected shows the challenges they face which include weather, lack of transportation, poverty, geographical barriers, language barriers and cultural beliefs. Some of the skills that they have developed over the years include creativity, perseverance, ability to empower and cultural literacy. These are self-coping skills and strategies that they have found to be very helpful to them and to other future occupational therapist looking to work in the rural areas.

CHAPTER 1

INTRODUCTION

Healthcare, which is defined by the medical dictionary as the maintenance of physical and mental health, is made up of medical providers and allied health professionals. Healthcare providers comprise of various health professionals such as doctors, surgeons, nurses, pharmacists, physical therapists, and occupational therapists among others. Occupational therapists (OT) are health care providers who ensure individual's participation, performance, and function in roles in various contexts such as home, school, workplace, community, and other settings.

The American Occupational Therapy Association (AOTA) states that, "occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction" (1998). Occupational therapy is a health care profession that has been growing at a very high rate recently in first world countries such as the United States, European countries, Australia, and China. We often hear in the news about how occupational therapists are changing lives by making a difference in children with developmental delays, Autism, Down syndrome and many other disabilities. They play a very important role in ensuring that individuals are able to participate in their daily routines and engage in their favorite occupations despite their disabilities. Therefore, occupational therapy plays a very important role in the health care profession thus the need of occupational therapy all over the world. Since occupational therapy is not well known in developing countries, it is still concentrated in the urban areas.

In Kenya, most occupational therapy students graduate from colleges that are situated in cities and remain in the cities to seek job opportunities. Very few of them go back to work in the rural areas due to various reasons. That being said, this study will go the distance to explore what it takes to be an occupational therapist in the rural areas of Kenya and why there are only a few number working in that setting.

BACKGROUND AND NEED

Kenya is a multi-ethnic country in the East of Africa, bordered by Tanzania, Uganda, Sudan, Ethiopia and Somalia. The population is estimated to be approximately 42 million people. The majority of Kenyan citizens reside in rural areas with a small percentage of the population residing in urban areas; approximately four million inhabitants live in Nairobi, the largest city in East Africa. An estimated 31.5 million people, or approximately 78% of the Kenyan population, reside in rural areas while the remainder of the population (approximately 10 million people) live in urban areas (Unicef, 2010).

Africa, a third world continent, is heavily dependent on revenue obtained from farming and tourism. These industries provide the majority of income (75%) for Kenyan residents. Since the majority of people inhabit rural areas in Kenya, the need for healthcare providers in these areas is critical. Since most rural residents are of a lower socioeconomic status (SES) and engage in farming occupation to provide the necessary monetary support, it is essential for these individuals to be fully functional and capable of performing the manual laborious tasks and activities required of farmers. For example, in a nuclear family, which has an average of six people, a father is expected to provide monetary support in order to purchase goods and services that cannot be acquired from

farming practices. The mother is expected to work in the gardens and farm to produce enough food for three meals in the family. On the other hand, the children are expected to do their part in helping with household chores like fetching firewood after school and during weekends so that the mother can do the complex tasks such as milking cows.

Generally, everyday life circumstances in rural areas is very demanding and taxing with little room for errors, disabilities, or injuries. It is then very critical that people are able to access health care facilities and get services to manage and improve their health so that they can get back to their routines and roles. Health care provision is said to be affected by various factors such as accessibility of healthcare, socioeconomic status, economy of the country, and culture of the nation (Guidetti, 2001). Occupational therapy services are an essential part of health care which assists individuals to return to participating in activities of daily living and other important occupation. Guidetti (2001) also reports that there are 600 occupational therapists (OTs) working in Kenya to improve function and occupational participation. Occupational therapy in Kenya dates back all the way to 1948 where they worked with orthopedic patients with Tuberculosis (TB) of the bones (Keer & Kirkaldy-Willis, 1948).

Shimali gives a breakdown of clinical training of occupational therapists in Kenya. It includes 1736 hours of hands-on training, 1442 hours of which is from their third year in school (1987). The hours above are spent equally on psychiatric, physical dysfunction and pediatric settings with each placement getting two months. It talks very little about balancing those hours with community experience. However, after their six months of training, the graduates are send to provincial/district hospitals that are close to rural areas. The World Federation of Occupational Therapy (WFOT) Kenya delegate,

Shimali also noted that the resources in these rural areas are very different from urban areas due to lack of equipment and materials (1987).

According to Kielhofner (2008), it is required that an individual is able to engage in their meaningful occupations in order to live an occupationally balanced life. Occupational therapists work to ensure that clients are capable of returning home to their families and community to help make a living and to improve, not only their own, but also the family's quality of life. The goal of occupational therapy is to, "support people's health and participation in life through engagement in occupations" (AOTA 2008, p. 626).

To be able to help all the clients seeking services, these occupational therapists are expected to work with what they have, what the context provides and the knowledge that they have to provide the best treatment that provides the best outcomes. They sometimes have to go out of their way to the community to treat those who cannot get to clinics due to various reasons such as poverty, lack of transportation, lack of education, impassible roads, etc. Rural health care is reported to face very different challenges as compared to the urban areas.

Very little is known about current occupational therapy practices in Kenya. That being said, as a future occupational therapist interested in working in Kenya there is an increased need for research to learn more about rural context and how it impacts service provision. Until recently, occupational therapy in rural settings of Kenya was not famous. It would also be interesting to know what occupational therapy practice entails, how the context (villages/community) influences their practice and how these occupational therapists go about the challenges in order to provide the best services to their clients.

Due to the need of research on occupational therapy services in Kenya, this research topic will be important in helping not only those occupational therapists practicing in Kenya but also throughout the world. It will also enhance their understanding on the experience of fellow occupational therapists who are doing their best with the little that the context offers to help those people living in villages. This will also encourage them to find solutions and suggestions to the problems being encountered in the rural areas. Hopefully, it will shed a light to the government and the residents of Kenya, to know the importance of occupational therapy services, thus the need to help in reducing the problems and providing services.

PROBLEM STATEMENT

Several developed countries have given rural health notable attention when it comes to research. The majority of research that has been done on rural health has been conducted on developed nations. For example Australia has done a lot of research on rural health to an extent that they have Australian Journal of rural occupational therapy. Canada and the USA also have a journal of rural health. On the opposite end, in developing countries such as Kenya, very little information can be found about rural health in general. Two published articles are available online that talk about occupational therapy in Kenya. However, the two articles were published in 1948 and 1987. These articles are more than 15 years old and it's about a health profession that is growing at an alarming rate as of 2014 and is still very important. Even though finding these two articles on Kenyan occupational therapy was a privilege they were not research-based articles. One of them discussed about occupational therapy programs in Kenya and the other was about the origin of occupational therapy in Kenya. The statistics above showed

that approximately 78% of Kenya's population resides in rural areas, thus the need of more health care providers. Also, the occupational therapy students graduating in Kenyan colleges are required to complete 1736 hours in three settings, which doesn't include community programs.

There is a Facebook page called Kenya Occupational Therapy Association (KOTA) created to connect the occupational therapists throughout Kenya and those practicing outside the country. It is also a means of communicating important ideas that affect the career, and sharing important knowledge with each other. The members on their page show that some of these occupational therapists had reported that they work in rural hospitals or community programs. On seeing this, curiosity to explore more about rural occupational therapy in Kenya developed especially since very little is known about their experiences. For a person who grew up in the rural areas without encountering occupational therapists, it is difficult to imagine nor understand what they do in the village to improve the lives of the village residents. In conclusion, the lack of enough research, large population living in the rural areas, and presence of rural occupational therapist are amongst the biggest factors behind this study.

RESEARCH GOAL/QUESTION

The goal of this research is to provide a qualitative examination of the lived experience of rural occupational therapists in Kenya. Its objective is to capture and describe the phenomena, so as to develop an understanding and description of what it takes to be a rural occupational therapist in Kenya.

STATEMENT OF PURPOSE

The purpose of this cross case study was to:

1. To understand the lived experience of occupational therapists working in rural areas of Kenya.
2. To understand how context influences the type of occupational therapy services provided in the rural areas of Kenya and what the occupational therapists do to adapt to these influences.

Research Questions:

This study aims to answer the following questions:

1) What makes up the occupational therapy clientele in rural Kenya?
2) How does the rural context impact occupational therapy in Kenya? What strengths and challenges exist in this context?
3) What skills and self-coping strategies are important in rural practice?
4) Are there any differences between rural and urban occupational therapy practice in Kenya?

DEFINITION OF TERMS

- Rural - Pertaining to the countryside, upcountry (www.dictionary.com)
- Village - A group of built homes in a rural area where people live and own pieces of land for farming
- Tribe - A group of people, who speak the same dialect, originated from one place and share a common ancestry. (In Kenya there are 42 tribes who all speak different dialects)

- Community - A group of people living in the same place, usually from the same tribe and practicing the same cultural values and beliefs
- Context – Internal or external conditions within and surrounding the client that influences performance (OTPF Framework)
- Cultural context - Customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the individual is a member of (OTPF Framework)

METHODOLOGICAL ASSUMPTIONS

The study was conducted based on the following assumptions:

- That a qualitative study is preferred over a quantitative study when doing a research to explore and understand the lived experience of a group of people.
- That rural occupational therapists in Kenya experience more challenges compared to those who work in the urban areas.
- That the use of interviews and photographs is the best way to collect data for this study.
- That the inclusion and exclusion criteria will facilitate the richness of data to be collected

CHAPTER 2

LITERATURE REVIEW

In order to better understand the experience of occupational therapists working in rural areas of Kenya, it is beneficial to look at what type of information already exists on rural health and rural health care providers in Kenya and in other countries. There has been research done on why most health professionals chose to work in urban areas and not rural settings. Most of the research that existed on rural health care practices was mostly done in South Africa but not the rest of Africa. However, there are many other research studies that have been done in other rural areas all over the world such as Canada, United States, Australia and New Zealand. It is hard to find specific information on occupational therapy in developing countries especially in the rural areas. This limits the amount of research that has been done in those places.

Rural health, as defined above, studies health and health care provision in the rural environment. The rural environment is an environment outside the metropolitan area. The research that has been done on healthcare in the rural areas explored how it differs from health care in the urban areas. The people living in the rural areas face challenges such as cultural, economic, social, educational, political and legal factors. All these factors affect their health directly and indirectly thus impacting health care providers. For example, the people living in rural areas travel a longer distance to find a medical facility. Due to the distance to be travelled, most residents chose to stay at home and use the available complimentary medications.

Thomas & Clark (2007) in their study strived to understand what skills would benefit health professionals who take up jobs in remote areas. Through narratives from

these health professionals they found that the following skills are required: being systematized, cooperative, and culturally aware, being knowledgeable about the community, flexible, creative, reflective and communicative. They also found out that problems may also arise from the skills that are required for these contexts. They then concluded that, there are specific skills that are very important and necessary when working in these rural settings which may not be as useful when working in urban areas (Thomas, & Clark, 2007).

Mills & Millsteed (2002) conducted an ethnographic study in order to understand why occupational therapists who had worked in rural areas chose to leave to work in urban areas. The research, which was done in Australia, found out that it was a challenging working environment and that practicing in the rural is different from what they had learned in school as it was usually based on metropolitan areas thus making it difficult to continue working there (Mills, & Millsteed, 2002). A big reason why most research has been done on rural health in Australia is because it is home for the indigenous Aborigines. Another article added that other challenges include high therapist-client ratios, diverse client populations and lack of enough human resources (Boshoff, & Hartshorne, 2008). The various dilemmas require unique problem solving skills, multiskilling of staffs and using labor intensive service delivery in order to overcome these challenges. In Canada, school health programs are being designed to prepare their graduates to work in rural areas of Canada. Deciding to participate in training on rural healthcare provision was an already made decision that they already wanted to work in rural areas and most of them had prior experiences in that environment (Manahan, Hardy, & MacLeod, 2009).

Two things that kept recurring in rural health care from most articles on rural health, that is; difficulty recruiting and retaining health care providers and the type of challenges that these rural health providers face in this working environment. It also showed that those challenges are common in most rural areas as per research. However, one cannot conclude that the challenges that have been reported in the rural areas of developed countries are the same as those in developing countries. An obvious difference in these two settings would be availability of high tech equipment and resources. Since there is very little research on rural health care in developing third world countries, this research will enhance our understanding of the nature of rural occupational therapy experience in Kenya.

Some of the questions that arose from the literature review included:

1. How do occupational therapy services provided in rural Kenya compare to that provided in other rural areas of the world?
2. Is occupational therapy practice in rural Kenya different from that of the rest of the world?
3. What are the similarities between occupational therapy practice in rural and urban settings?
4. How does the practice and principles of occupational therapy vary between rural and urban settings?

CHAPTER 3

METHODOLOGY

The study adopted a qualitative method in order to provide an in-depth understand of rural OT practice in Kenya. It used a phenomenological study, which is a type of qualitative research, was favored over other types because the purpose of the study was to understand the lived experience of occupational therapist practicing in the rural areas of Kenya. The phenomenon here which is being shared by the participants is rural occupational therapy practice. The researcher thus seeks to understand this phenomenon.

Procedure

Research began immediately following the approval by the institutional review board in June, 2013. Due to several factors such as time, distance and financial costs the researcher was not able to travel to the meet the participants. Therefore the researcher was based in the United States and the participants were based in Kenya. Therefore the study was conducted through phone calls, emails and Facebook inbox messages.

PARTICIPANTS

The participants of the study were chosen based on the following inclusion criteria:

- Have been practicing in the rural areas of Kenya for at least one year.
- At least one participant will have practiced in both the rural areas and the urban settings of Kenya for at least one year in each area.
- At least 25 years of age.
- Must speak either English or Swahili.

Recruitment of these participants was a response following a Facebook post that the researcher posted on KOTA's (Kenya Occupational Therapy Association) Facebook page. Several Kenyan occupational therapists responded to the post but through inclusion/exclusion criteria the researcher picked three participants who best fit the study. Participant A and B were still practicing in the rural areas of Kenya while participant C was taking an educational break from work to take a continuing education course. The participants were all born in Kenya and raised in rural areas but studied in the city. The three participants are all licensed occupational therapists who are members of Kenya Occupational Therapy Association (KOTA). Participants B and C worked at a local district hospital where they focused on community program and participant D worked with a sponsored community rehabilitation program. They all spoke English and Swahili. They were all male whose ages ranged from 25-35 years. The participants did not have any relationship with the researcher.

DATA COLLECTION METHODS

The two methods that were used to collect data included interviews and participant generated photographs. Interviews were conducted between the researcher and each participant. The interviews consisted of ten questions on each interview for each of the three participants. That gave a total of approximately six interview sessions which lasted 45-60 minutes each. The interview questions were standard open ended questions but throughout the interviews informal conversations would arise from the participants responses to enhance richer understanding. Each interview was recorded using a tape recorder and notes were taken during the interview. The three interviews were then trancribed. Secondly, question and answer method was also used as follow-up questions through emails was sent to the participants following the interview

transcription so as to clarify their first responses and to explain more of a response that needed more description. All the responses were printed and added onto their first interview responses.

Photographs were requested so as to enhance richness of data. The participants were asked to take pictures of some of the resources and equipment that they utilize during their interventions especially in the village settings. The pictures were sent as an attachment through the official email provided.

DATA ANALYSIS

The three interview transcriptions from each participant were printed out and reviewed four times so as to have a clear picture of each of the participant. After review a table was created which compared the responses of those important parts of the interview. For example there was a column that showed each participant's response on reason for choosing OT, for choosing to work in rural setting, their client population, their worst experiences, and their self-coping strategies among others parts of the interview. Then this would give a holistic picture of each participant compared to the other. This step will be represented on table T1 below.

Following the multiple readings, the researcher went through each of the three transcripts again highlighting the important sentences from the responses and writing them on index cards. After further data analysis, the marked sentences were put into categories and some of them formed subcategories to create major themes. The line numbers were noted on index cards if the sentences emerged more than once from each participant. Data coding was then used to create concepts and categories through which the important responses would fit best. A specific type of coding called open coding

was used to break down, compare, and categorize the results. Following data coding, a cross-case analysis was used also to analyze and/or compare the themes that were common across the three participants to further understand the common themes.

Table 1 Cross-case Analysis

	Participant A	**Participant B**	**Participant C**
Basics	KMTC 2004	KMTC 1998	KMTC 2009
Work Experience:	Previous: Autism Society of Kenya Now - Kimilili District Hospital	Previous: Eldoret Community based rehab Now: Eldoret Special school for mentally ill and physically challenged	Previous : ADRA Kenya CBR as a field officer and therapist Now : ADRA Finland CBR as a field coordinator and therapist Volunteered at district Hospital
Reason for choosing OT	Did not know what OT was Qualified for the course Advertisement	Did not know what OT was Qualifications and then developed interest to change the mentality and perception of PWDs in the rural.	Did not know about it and developed interest
Reason for choosing rural:	Job opportunity	Job opportunity To change the perception of people on PWDs Born and raised in rural areas	Job opportunity Uniqueness of rural setting
Preference	Community based setting	Home based therapy (Prevent them from losing hope and save them the cost)	Community Based Rehabilitation
Client Population	Autism, Cerebral palsy, Birth defects, Hydrocephalus , Burns, Malnourished children, accidents Age – Children 2-15 yrs old	Cerebral Palsy, Burns, Developmental delays, Epilepsy Age – Below 10 years	Mostly children under 18 but majority are 0-12 years Cerebral Palsy

Table 1 (continued)

	Participant A	Participant B	Participant C
Negative Impact of rural context on OT practice	Cultural beliefs (bewitched, cursed, demon possessed) People not educated, Poverty No resources so you have to create your own Lack of transportation and longer distance Weather (rain) Poor infrastructure- Language barrier Work load is high	Cultural practices i.e. curses or witchcraft, herbal medicine, Low economic status Weather (rain) Seasons (Planting) Illiteracy	Change of weather Economic status Coverage area Seasons (planting and harvesting) The cultural beliefs (Disability viewed as a curse or a result of unfaithfulness) Financial constraint- Language barrier Illiteracy Poor infrastructure Limited information circulation
Positive Impact of context on OT practice	People are cooperative and they are one community and ready to learn	Availability of local resources and local materials Amount of Space Readiness of the community to work together Availability of children to play with	A lot of clients in rural areas with disabilities hence experience and creativity.
Tactics		Individualize therapy (Work with individual)	Alternating bookings and making appointments
Worst Experience	A child who was brought from another district due to lack of occupational therapist there passed away and …"I was very much demoralized. I don't know what happened if they killed the child or if they became tired or what".	The parents of a child he'd seen for 4 months gave up therapy and started local medicines/herbs and child died.	Identified the child with disability but the parents came up saying that, that is the work of the hands of God
Intervention strategies	Family approach	Biomechanics approach	Client centered approach techniques Biomechanical approach

		Patient centered therapy Compensatory technique	

Table 1 (continued)

	Participant A	**Participant B**	**Participant C**
Self-coping skills	Creativity and innovative Ready to learn new things Ready to go an extra mile Caring and being supportive	Creativity Ability to convince Perseverance Cultural literacy	Modification and Creativity Use of local resources and personnel. Persevering and ready to face many challenges Ready to learn the cultures Be flexible Temperament
Urban areas	Differences: People are enlightened, have money and they already know your work so there are many clients. More equipment. More OTS. Similarities: Our aim is to try to rehabilitate this person to normal or near normal so that these people can be independent and get to work again.	Differences: Pay well, More institutions, More information, Highly developed machines, civilization. Similarities: End goal is make patient independent.	Differences: The therapist is the key role play in therapy Similarities: Both are aiming at improving the lives of PWDs by adding value to life through therapy

CHAPTER 4

RESULTS

This chapter includes both the data results and the interpretation of the results. The results aims at using the data collected from the three participants to understand the lived experience of occupational therapists in the rural areas of Kenya. The three participants each individually gave their own responses and also generated photographs of equipment used during therapy. Following data analysis the researcher used two methods to represent the data collected so as to ensure that the study achieved its purpose. The first method included doing comparisons to find out the similarities and differences across the three participants. A comparison table was used for this section. The second method was categorizing the in vivo codes generated from data analysis into general themes. Each theme will include those concepts that fit best each theme.

The five themes are:

- Attraction to rural setting
- Impact of rural context on OT services
- Impact of culture on occupational therapy
- Nature of rural OT practice
- Becoming an OT in rural Kenya

Attraction to rural setting

Under this theme the researcher classified all the things that the participants reported that make rural areas a better working place. First, in rural areas there is less stigmatization of people with disabilities because once the community is empowered about the disability they will be accepting and will not judge the disabled children. As

compared to urban areas where people are educated but they still stigmatize people with disabilities and do not want to identify with them.

Secondly in the rural areas, there are locally available materials which are used to make equipment for therapy. The advantage of this is that the clients will use very familiar equipment during therapy and makes transitions to their occupational lives easier. By using the local material also the clients get to see the importance of occupational therapy in enabling them to function and improve independence.

Thirdly, the availability of space and children to play with were also reported to be very important resourceful. In the villages children are very free to play outdoors under no supervision as opposed to urban areas where the children come for therapy individually and therapy sessions are usually individualized. Participant B responded, "The space in the rural areas is a lot. Especially for small children where we use games as a therapeutic material so there is a lot of space compared to urban areas". That makes rural setting favorable especially for social participation, play, and leisure activities.

The fourth advantage of working in a rural area as reported was the diversity of the clients. This was reported by one participant. From the interviews the common cases reported are cerebral palsy, Down syndrome, Autism, burns, malnutrition cases, epilepsy and delayed development. However the diversity of the clients was mostly the diagnoses and not the ages since most of them were children below 17 years. Due to the increased number of diagnoses there is increased number of clients needing occupational therapy services in the villages. The participants sometimes are the one to do the diagnoses because most caregivers/parents do not know what they are. The fifth rural attraction is stimulated from the challenges that the residents including the clients face. This includes

the cost of travelling to hospitals, distance of hospital which increases disability rates (home deliveries) & the distance makes the clients loose hope easily. Due the need for services and the challenges that the clients face, the occupational therapist feel needed in the rural area.

The participants also reported that providing therapy services in the rural areas is rewarding. This is because seeing the change after going through all the challenges is satisfactory especially when the parents/caregivers had given up on what to do in improving their child's life. The participants also noted that people are very appreciative when you have helped them and sometimes they come looking for you at the hospital months later. The occupational therapist also appreciated that they are able to identify the kids who need occupational therapy because they believed that they can make a difference in their lives. On the opposite side they preferred working in these areas because of the existing challenges in urban occupational therapy such as lack of community connection, lack of local resources, and limited space for children to play during therapy.

Impact of rural context on occupational therapy

This theme comprises those factors that the rural context generates that impact occupational therapy which are either controlled and /or controlled naturally or by the people living in that context. For instance the challenges that the occupational therapists face such as increased distance to the clients. The therapists have to travel a longer distance to get to the client and this impact the number of clients to be seen in a day. The participants reported that they have to travel for approximately 45 kilometers from one village to another. At times due to bad weather the roads become impassible, washed

away and thus they do not have transportation. The participants also reported that the salary they get paid is low compared to the salary of those working in urban areas but due to the attractions to the rural setting discussed above they would rather provide services in rural areas.

The third factor that was reported to be impacting occupational therapists in rural areas is the heavy work load. The occupational therapist takes up the health care provider role both in the community and at the local hospital and also has the administrative role. One participant said, "The other thing is that the government is not employing many occupational therapists. I think since 2009 they have not employed any occupational therapist and so we are underserved because in the whole district there are only 2 occupational therapists and when one is on leave the other one cannot manage the work load." Another participant said that they may be attending to a client in the villages and are called in for an urgent meeting at the provincial headquarters. The amount of work that they have to do together with lack of transportation makes rural settings a challenging workplace.

Challenges that people living in these rural places, is another major issue that impacts the work of occupational therapists. This includes low economic status. Most of the people residing in these places, as discussed above in the introduction, are poor and rely on farming as their source of income. The little income that they get is divided into the demanding basic needs and they can barely have any left to pay for therapy services. The lack of income was also a major reason why they can't afford to visit the hospital for health care services. Another issue that is common in the rural areas is that most of the caregivers are not educated thus occupational therapy illiteracy. Lack of education

impacts both their children and the health care providers. One participant explained how hard it is to educate these residents about the diagnoses and the need for occupational therapy. The need to educate them about occupational therapy and how it can help their children therefore becomes a priority in most client cases.

Language barrier was also reported to be a challenge for the occupational therapists. Kenya being a multi-ethnic nation means that there are many dialects. Due to lack of education in most rural areas the caregivers and the clients may not have learned how to speak any other language other than their dialect. Swahili and English are usually taught once a child has started school. All three participants worked in a different geographic place other than their own and did not speak the dialect being spoken at their place of work. This led to language barrier between the two parties. As a self-coping strategy that will be discussed later in the chapter, they are forced to look for an interpreter which makes their work even more challenging.

Impact of culture on OT

The third theme comprises of how culture both ethnic and rural impacts occupational therapy services. Kluckhohn & Kelly (1945) defined culture as, "Those historically created designs for living, explicit and implicit, rational, irrational, and non-rational, which exist at any given time as potential guides for the behavior of men." Therefore ethnic culture includes those beliefs, values and traditions followed by people belonging to a certain ethnic society. Whilst rural culture refers to the shared traditions, patterns or practices that the people residing in the rural areas have. These practices done in a rural environment distinguishes those done in an urbanized society and ethnic culture distinguishes one ethnic group from another.

Kenya being a multiethnic nation means that the various tribes occupy specific geographical regions. The districts where these occupational therapists work are mostly inhabited by one or two tribes who each have their own ethnic culture. The participants in the study reported that the culture followed by these tribes impacts their work in a major way. The most commonly reported belief is superstition. This is the accepted belief that the effects or a result of an act is due to bad luck usually religion based or custom based. In the rural areas disability is seen as an outcast and the people believe that the situation is externally controlled. For example all the participants reported that most families believe that reason why the children are disabled is because they have been bewitched by another tribe. The second cultural belief that was reported is that the presence of the disability in the family is a curse. For example the family has been cursed either because the parents disrespected the ancestors resulting in a disabled child. In some scenarios the family claims that the mother was unfaithful to her husband hence the disabled child.

Another cultural belief that impacts provision of occupational therapy services in the villages is the belief that the disabled child is demon possessed. According to these communities such a child or person should be locked inside the house and homebound thus should not be seen by the public. The participants reported that these children do not engage in important occupations such as attending school or playing with other children.

The social workers then refer the children for occupational therapy. The occupational therapists are then left with the challenge of educating the family about their child's condition and also educating them on how they can help improve their child's occupational being. The goal is to build trust between the occupational therapists and family that by allowing them to provide services to their 'demon-possessed child' is to

help improve their lives and not judge them. Participant A said, "….any child born with a defect or any malfunction they are believed to have demons. That is their cultural belief. They are not supposed to mingle with people and they are supposed to be locked in houses. With the help of community health workers they tell us that there is a child who needs OT. So you go talk to the parents and tell them you have come to offer services and that is the only time they can open up. Otherwise you cannot see them in the community and they are seen as outcasts."

People who live in the rural areas have a culture different from the urban culture. This rural culture may impact provision of occupational therapy services. One common tradition in the rural community is the shift in priorities during planting seasons which is often during the rainy season. This is the time when the family members are all very busy working in their farms. Occupational therapy services are then either cancelled or postponed to a less busy day. This usually occurs with no communication from the family. Participant A reported that sometimes he has travelled to the client only to get there and be told he can't see the child because they are busy. Since the planting season is the rainy seasons the roads are usually impassible, with no transportations and become a challenge for the therapists to get to the clients. The child ends up missing therapy more in the rainy seasons and it impacts the progress in therapy.

Due to challenges that hinder the child from receiving occupational therapy services such as priority shifts, poor infrastructure, and occupational therapy illiteracy the families end up opting for witchcrafts or herbal medications. Sometimes this happens when the family are not seeing change quickly enough and thus they lose hope with therapy. The participants all reported this as one of the most demoralizing thing because

sometimes herbal treatment can result in the child's death. Participant C reported that he lost one of his clients who had come a long way in therapy when the parents stopped therapy and opted for witch doctor.

Nature of rural OT

This theme comprises of the nature of occupational therapy in the rural areas. These are the important statements that the participants reported as how typical therapy sessions are. The three participants all said that the first thing that they do when they first meet a client is to educate on what occupational therapy and its benefits. They also have to educate the family and client what the diagnosis is and convince them that it is not their superstitious beliefs. Participant B emphasized so much on why it is very important to empower the community about disability. He believed once the community is empowered they can then work towards the same goals, which is to improve occupational performance of those living with a disability.

Secondly, occupational therapists first aim to create a trust between the therapist, family and client. This is because, living in a society where culture is strictly followed; it is hard to trust an outsider who comes to you and claims to provide therapy to their disabled child so as to improve their performance. This is also even harder because most of them haven't heard about occupational therapy. So the occupational therapists have to gain that trust first before even discussing anything about the client.

The third one is the use of family approach theory and caregiver training. These are both among the top most important things to do in these rural areas. The main reason as to why this is a much needed thing to do during therapy is because there are so many factors that may affect and/or delay occupational therapists from getting to the clients.

Thus during the time when the therapists is away, the caregivers can perform the various therapeutic strategies that they had been trained on. This is important in ensuring that the clients' progress is continuous and not slowed or stopped. This will ensure that changes are seen on the client soon enough before the family gives up and opts for other alternative medications. Once the caregiver has been trained, the occupational therapist who is already facing many challenges due to rural environment, will be assured that the client still be engaging in therapeutic activities in his/her absence.

The fourth significant nature of occupational therapy in the rural areas is the use of very locally inspired modifications which are not pre-fabricated equipment. This was reported to be common because most clients need some type of equipment in order to engage in an activity. Given their economic status and also the existing challenges the required equipment has to be modified from what can be found locally. For example,

Becoming an OT in rural Kenya

Under this theme are those skills or strategies that the participants reported to be very beneficial to them during their practice. It also includes the skills that any new occupational therapy looking forward to working in the rural context need to develop so as to adapt easily and thrive more smoothly. The theme also comprises of the self-coping strategies that these occupational therapists have developed to help them cope with the challenges imposed by the context they are working in. This theme will be divided into two sub-themes which are the skills required by rural occupational therapists and then the self-coping strategies.

The first reported skill that was emphasized by all the participants is creativity. In the rural areas there is no readily available equipment to use for therapy. The therapists have

to come up with equipment needed using what the environment offers. This will be seen in the provided photographs below. One participant said that one is expected to come up with equipment from scratch comparing it to the urban areas where all you need is a catalog to order the resources. Creativity is also a necessity because most of the times the client cannot afford to even pay for services so buying therapy equipment no matter how expensive they are. For example in the case of a child with cerebral palsy who needs a wheelchair for mobility. The therapists have to come up with ideas to make a wheelchair from the simple materials available with little or no cost at all to the clients.

The second skill is that the therapist should be ready to have a big heart to help. The participant all explained how much these clients need services and with the challenges that are encountered it is easy for one to lose hope with the client. So they should persevere through the challenges and sacrifice to help improve these clients. Also considering how little the occupational therapists working for the government get paid it makes it even harder to continue working. Participant A & C both said that they would rather paid little and see their clients improve. That means that they have a big heart to help.

Flexibility was also reported as an important skill. This is because in the rural areas you never know what to expect during each planned therapy session. For example during the planting season, therapy becomes optional due to family priorities. The therapists can't force their client to attend therapy if the family chose to go work in the farm. So the therapists need to be flexible enough to re-schedule therapy.

Fourthly, cultural literacy is also important. This is because when one is familiar with ones' culture it is easier to adapt and plan for therapy sessions. It also makes planning

interventions easier because you are more knowledgeable if what is important to the client and the family. With cultural literacy the therapists will be able to come up with ways of explaining to the family about the diagnoses without offending their traditions.

The therapists are also supportive and ready to go an extra mile when providing therapy. By being supportive, they are providing services to a family who are already having the challenge of raising a child with a disability through which they are not sure what they can do to help improve their lives. The therapists provide support to the family of the client such as emotionally, socially, financially and even spiritually. The therapist also go an extra mile such as using their own money for transport because the government doesn't compensate for transport costs neither do they provide transportation.

Lastly the therapists found that having the convincing power is very helpful. The main reason why this is an important skill to have is because of all the factors that were discussed above that hinder occupational therapy services in the rural areas such as occupational therapy illiteracy and cultural beliefs. The therapists have the tough job of convincing the family beyond the cultural beliefs that they are going to be helping their child to be able to participate in those occupations that they are having difficulty with. They also have to proof to them that therapy sessions can be long but it is worth the long wait.

The second sub-theme includes the self-coping strategies that the clients reported to be very beneficial in overcoming the challenges. These include temperament, perseverance, creativity, empowerment and flexibility. The therapists should be ready to cancel therapy sessions because the client misses therapy without notice even when they

have travelled to their home. Perseverance is needed to be able to stand the challenges and still have the same therapy spirit to help. Sometimes they have to withstand the news of losing a client to alternative treatment such as witch-crafts or herbal medicine after working so hard to help the child improve. Participant C reported that as the most demoralizing thing he had encountered. The therapists have also realized that by individualizing therapy it helps because it enhances the results since the intervention is specific to each client separately. Flexibility is also seen when they use of motorbikes instead of cars due to lack of roads to get to the clients. Those are some self-coping strategies that the participants reported that are helpful to them and to those occupational therapists who may be interested in working in that context.

CHAPTER 5

DISCUSSION

The main objective of this study was to understand the experience of occupational therapists practicing in the rural areas of Kenya. The study thus concentrated on gathering very rich data through various ways including comparing both rural verses urban practice and gathering photographs generated by the participants. After the research study there is improved knowledge about occupational therapy in the rural areas of Kenya. The readers now have a general idea what it is and how a typical therapy day goes unlike before.

The Problem

Occupational therapy an internationally known career, which was not very widely known a few years back, is growing at an alarming speed. It is becoming a very significant part of health care in ensuring that an individual's independence is maintained as much as possible during diagnosis or injuries. Occupational therapists work in most settings including but not limited to home health, hospitals, schools, institutions, and community programs among many others. However, occupational therapy in some countries such as the United States, Europe or Australia is more developed as compared to other developing countries. This makes it so hard during research studies to find any literature about such countries. This study seeks to understand the nature of occupational therapy in the rural areas of Kenya. There were very few old studies that had been done in Kenya about occupational therapy thus expanding the literature review boundaries to rural occupational therapy in Africa. There was little success on this as well leading to an even broader search which was rural occupational therapy all over the world. Understanding what research had already been done on the area of study would have

facilitated the study. There was no research at all on the same topic, 'Occupational therapists in rural Kenya'. This then inspired the researcher to continue with the study because very little is known about their experiences and how they cope with the challenges imposed.

The Purpose of the Study

The purpose of the study was to understand occupational therapy in rural Kenya and to understand how context influences the type of occupational therapy services provided in the rural areas of Kenya and what the occupational therapists do to adapt to these influences. Data collected from each participant was compared across the cases of the three participants. The difference and similarities between each participant's experiences is what will help the researcher, readers, occupational therapists and other researchers to better understand how context impacts health care provision. The participants were all located in different geographical locations thus representing three completely different areas/ tribes of Kenya.

RELATIONSHIP TO LITERATURE

A meta-analysis of qualitative studies by Roots & Li retrieved 650 articles published between 1980 and 2009. It chose to focus on 12 studies on rural health care providers, gave a broader general understanding of this topic. Its goal was to broaden understanding of factors related to recruiting and retaining of occupational therapists and physical therapists in rural areas. The reported challenges on their study included limited resources, large varied caseload, limited support, less professional support, culture shock, lack of social and emotional support, large geographic area, isolation, varied conditions and ages. It was also reported that working in a rural setting is different from working in

the urban areas and there are more challenges that are only unique to this context than there are strengths (Mills & Millsteed, 2002). The existing challenges according to the literature review were the main reason why it was hard to retain these health professionals. On the other side, this study of rural health care in Kenya also generated very closely related challenges which included cultural beliefs, heavy workload, lack of resources, illiteracy, poverty, poor infrastructure, and limited professional support from fellow occupational therapists. In this study, the challenges were reported by the participants as making their work harder but they did not mention anywhere in the study on many of them leaving the rural areas. However, it did mention that it is the reason why most occupational therapists in these rural areas are male.

The skills that were reported as important for these healthcare providers to succeed in that setting were creativity, being organized, flexibility, cooperation, collaboration, networking, problem solving, educative role, cultural awareness and multi-skilling (Roots &Li, 2013). On another ethnographic study by Thomas & Clarke (2007), found that being knowledgeable about the community, having time management skills, personal resourcefulness and adventure were some of the things were said to be helpful. Similarly, the skills that were reported as need to succeed in rural Kenya included perseverance, readiness to learn, having a heart to help, flexibility, creativity, cultural awareness, and having the power to convince and empower.

SIGNIFICANCE OF THE STUDY

This study will be very helpful to occupational therapists who are interested in working in rural settings of Kenya or even any other African country. It educates the new occupational therapists on what they should expect when taking the job and it will impact

their efficiency because they will be expecting the reported findings from the study. Sharing the study and providing the actual findings from the study will enhance the country's healthcare system because they will have read about the challenges that exist. Occupational therapy when viewed from a rural perspective is different from the urban occupational therapy. This was one of the sub-goals of the study as well.

Knowledge gained from this study will also have a big impact on rural health care in Kenya. This is because the study focused on understanding the experiences of a significant health profession and it gathered data from the actual participants' word of mouth. As mentioned before there is very limited research on this topic and having this small study will shed a light. Statistics showed that 78% of the population reside in the rural thus a greater need for more health care providers. The reported challenges that the occupational therapists encounter will also enlighten the government and hope that they would step in to support these health care providers i.e. by proving transportation or improving infrastructure. Colleges who teach occupational therapy will also benefit from the study in that they will teach their students on the, often forgotten topic, 'Rural health care', and the graduates will be informed of what to expect if they ever have to work in this settings.

Limitations

Just like any other type of research there are limitations to this study as well. Even though using a phenomenological study is a great approach in understanding a lived experience of a population and to gather rich data, it has its limitations as well. First some of the interview questions and responses had to be translated from Swahili to English. The translation likely impacted the results because it is hard to get the exact words in the

other language and loses meaning when a closer word is used. Also some words cannot be translated from Swahili to English.

Secondly, the distance between the researcher and participants affected both the research and the responses. Lack of face-to face connections also missed out important parts of interviews such as facial expressions, and body language. This would have helped the researcher to capture that true meaning and feelings of their experience in the rural areas. The interviews had to be recorded over the phone which had technical and network problems such as poor connections, poor network services in the rural areas, delayed interviews due to the rainy seasons affecting phone connections and time differences in the two countries. The participants may have lost their patience during the several attempts to connect and the many times the researcher had to repeat the questions due to clarity. Also the participants may have been uncomfortable and intimidated by the fact that the interviews had to be recorded.

Additionally encouraging informal conversations during the open ended questions affected the responses because it created its own sub-questions. Therefore each participant may have responded to a main question different because they all received different sub-questions. This method was disorganized and so made analyzing of data difficult. All participants were male making the research biased by gender.

RECOMMENDATIONS FOR FUTURE RESEARCH

There is a huge need for more research studies on this topic. Rural health care is more demanding and at the rate at which the world is developing, it would be important that it gets everyone going on the same direction. Developed countries have already established plenty of research on this topic and are now working on improving their

services in the rural areas. Rural residents of third world nations are still tied down by issues that can be easily eliminated if everyone was enlightened about them. For example at the time of this study, November 2013, the participants who are still actively working in the rural areas, reported that children being locked indoors due to disabilities and not being able to attend school due to cultural beliefs that they are either bewitched or cursed. The disabled children who are seen as cursed or bewitched are actually have diagnoses such as Autism, Down syndrome or Cerebral palsy. It is just that they are illiterate and do not understand their child's disabilities. Such barriers can only be eliminated with more research to give attention to the rural health care and what the professionals working in those rural regions suggests to be done.

Therefore, future studies to further explore the factors needed to reduce those challenges and whether or not those implemented factors make a difference on rural health care provision. Studies should also be done to understand the lived experience of urban occupational therapists in Kenya. This will help future researchers to better understand both contextual sides, and enhance creativity on strategies that are needed on both of these settings. It would also be very beneficial if this study was done on a larger diverse population. That will ensure that every district or tribal geographical region is represented, so as to avoid generalizing findings from two tribes to 42 different tribes. The larger participant population may also generate results that are more sensitive to gender equality as compared to this study where all the participants were male. According to the data from this study, the participants reported very close findings however they may not be true for all tribes since they all have different cultures. It would also be interesting to hear about experiences of female occupational therapists working in

rural Kenya and how would culture impact them. A quantitative study could also be done so as to generate the general statistics about occupational therapy in Kenya.

An additional area of interest, would be researching on whether education makes an impact on cultural beliefs about disability. In this study , superstition was a very strong belief in the villages, but, would this be the same if the caregivers, parents or villagers were educated? How does a family with a disabled child, living in the rural areas differ from a disable child living in the urban areas? Would they see the disability as a curse/witchcraft or as a diagnoses reported medically? Those are some recommendations that arose from this study that could make an impact in future studies.

List of References

American Occupational Therapy Association. (1998). Standards of practice. *American Journal of Occupational Therapy,* 52, 866–869.

American Occupational Therapy Association. (2008). Occupational therapy practice framework: Domain and process (2nd ed.). *American Journal of Occupational Therapy,* 62, 625–683.

Bent, A. (1999). Allied health in Central Australia: Challenges and rewards in remote area practice. *The Australian Journal of Physiotherapy*, *45*(3), 203-212.

Boshoff, K., & Hartshorne, S. (2008). Profile of occupational therapy practice in rural and remote South Australia. *Australian Journal of Rural Health, 16*(5), 255-261.

Denham, L., & Shaddock, A. (2004). Recruitment and retention of rural allied health professionals in developmental disability services in New South Wales. *The Australian Journal Of Rural Health*, *12*(1), *28-29.*

Guidetti, S. (2001). Description of self-care training in occupational therapy: Case studies of five Kenyan children with cerebral palsy. *Occupational Therapy International*, *8*(1), 34.

Keer, F., & Kirkaldy- Willis, W. (1948). Occupational therapy in Kenya. *Occupational Therapy and Rehabilitation, 27*(6), 473-478.

Kielhofner, G. (2008). *Model of Human Occupation Theory and Application*. 4th Ed. Baltimore: Lippincott Williams & Wilkins.

Kluckhohn, C., & Kelly, W.H. (1945). The concept of culture. In R. Linton (Ed.). *The Science of Man in the World Culture.* New York. (pp. 78-105).

Lee, S., & Mackenzie, L. (2003). Starting out in rural New South Wales: The experiences of new graduate occupational therapists. *Australian Journal Of Rural Health*, *11*(1), 36-43. doi:10.1046/j.1440-1584.2003.00476.

Manahan, C., Hardy, C., & MacLeod, M. (2009). Personal characteristics and experiences of long-term allied health professionals in rural and northern British Columbia. *Rural and Remote Health*, *9*(4), 1238.

Mills, A., & Millsteed, J. (2002). Retention: An unresolved workforce issue affecting rural occupational therapy services. *Australian Occupational Therapy Journal*, *49*(4), 170-181.

Roots, R. K., & Li, L. C. (2013). Recruitment and retention of occupational therapists and physiotherapists in rural regions: a meta-synthesis. *BMC Health Services Research*, *13*(1), 1-13.

Shimali, I. (1987). Clinical training of OT students in Kenya. WFOT Bulletin, 1613-14.

Thomas, Y., & Clark, M. (2007). The aptitudes of allied health professionals working in remote communities. *International Journal of Therapy & Rehabilitation*, *14*(5), 216-220