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Developing a Global Strategy for strengthening the occupational therapy workforce: a two-phased mixed-methods consultation of country representatives shows the need for clarifying task-sharing strategies

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Abstract

Introduction Occupational therapy has been underdeveloped and often neglected in the global health workforce agenda, contrasting with the global rise of population needs for services. The World Federation of Occupational Therapists (WFOT) is utilizing a research-based, multi-step process for developing a Global Strategy for strengthening the occupational therapist workforce. A multi-pronged scoping review, situational analysis, and expert input process enabled the drafting of a provisional Global Strategy. Here, feedback on that draft from representatives of WFOT member organizations was obtained and analyzed as one key intermediate step toward shaping the in-developing Strategy's content and structure.

Methods Two-phased, mixed-methods consultation consisting of: (1) online survey with score ratings and comments on the utility of each strategy and (2) four in-person focus groups discussions on low-scoring items involving a total of 76 representatives of WFOT member organizations. The focus group discussions were analyzed using an inductive thematic analysis approach**.**

Results Strategies involving 'task shifting/task sharing' or the 'harmonization of workforce data-collection requirements' received the lowest scores in the initial survey and were thereby addressed in the focus groups discussions. The overarching theme of the focus groups was the need to: "*clarify, specify, and contextualize the strategies*", including: (1) "*clarify the terminology and specify the application*", for example, describe the meaning of task shifting, specify which tasks can (and cannot) be shifted and to whom, to address concerns regarding scope-of-practice, service demand, and safety; and (2) "*outline the context of need and the context for the implementation*" of the strategies, elucidating why the strategies are needed and how they can be feasibly implemented across the different jurisdictional contexts.

Conclusion Within a mixed-methods consultation, WFOT representatives identified challenging topics on the draft workforce strategies and suggested methods to improve the Global Strategy, its acceptability, and implementation.

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The terms 'task shifting/task sharing' raised the greatest discussion among the profession leaders, when the strategy was not sufficiently clarified, specified, or contextualized.

Keywords Health workforce, Occupational therapy, Consultation, Focus groups, Task-shifting

Introduction

Occupational therapists across the world aim to meet the health and occupational needs of the population [1]. Occupational therapists promote meaningful occupational engagement and functional performance for individuals and communities facing challenges with a wide range of physical, mental or cognitive health conditions or social determinants of health [2–5]. Occupational therapists work in many societal sectors, including health and rehabilitation. Global data for 2019 show that 2.4 billion individuals had health conditions or disabilities that would benefit from rehabilitation, reflecting an absolute increase of 63% since 1990 [6]. Adjusted for population growth, physical rehabilitation needs alone have increased from 1990 to 2017 by 17% worldwide, and nearly twice as much in upper-middle income countries [7–9]. The global aging population has been a key driver of the growing rehabilitation needs across countries, including for low- and middle-income countries (LMICs) [7, 10, 11]. Hence, there is a need to strengthen global availability and accessibility of occupational therapists to keep up with high and increasing population needs.

Although the rehabilitation needs of the population have increased, the development of the occupational therapy workforce continues to lag; a workforce shortfall is long standing and exists across countries of all income levels [12–14]. For many LMICs, the occupational therapy workforce is completely or almost completely absent. For example, recent data from the World Federation of Occupational Therapists (WFOT) show that 61% of member organizations (54 out of 89) had, on average, less than one occupational therapist per 10,000 population. This minimum supply of 0.001 occupational therapist per 10,000 population is 22,000 times less than Denmark with 22 occupational therapists per 10,000 population [12]. Furthermore, many LMICs have no entry level occupational therapy education programs, professional regulation, or continuing competency requirements, further complicating the scale up or strengthening of the occupational therapy workforce [15–17]. Inequitable distributions have also been found among LMICs. A study from South Africa found that most occupational therapists served densely populated and urbanized provinces, with 74.8% of the occupational therapists deployed in the private sector serving merely 16% of the country's population [18].

The supply and development of the occupational therapy workforce also has been inequitable in high income countries (HICs), with as much as a tenfold difference in supply of occupational therapists when adjusted for population size [14]. The differences are not explained by levels of population need. For example, an ecological study for HICs showed no statistically significant associations between an indicator of population need for physical rehabilitation and the supply of therapists, after adjusting for socio-economic indicators [15]. Within HICs, inequitable distribution of the occupational therapy workforce exists, across states or regions of nations [14, 19], and especially across urban and rural areas [19, 20]. For example, a study across the United States found that the absolute number of occupational therapists increased more in areas that were already better supplied when compared to regions experiencing shortages [21]. Inequities in the *skill mix* also exist; for example, the number of occupational therapists and physical therapists in Israel is equivalent, but in Italy there are 49 physical therapists for each occupational therapist [15].

At the global workforce level, monitoring data for occupational therapists are often absent or aggregated in the conjunct of allied or 'other' health professions. This is partly arising from the lack of specific code for occupational therapists in the International Standard Classification of Occupations, which is the global standard for classifying professions and other occupations and is often used for design census questions and workforce surveys [13].

Overall, the global occupational therapy workforce needs substantive and sustained strengthening for an improved supply and equitable distribution of a competent occupational therapy workforce, capable of meeting increasing population needs.

In this context, the World Federation of Occupational Therapists (WFOT) has followed a multi-step, research-based, stakeholder-engaged process for developing the first-ever Global Strategy for strengthening the occupational therapy workforce.

The process first involved a three-pronged scoping review of occupational therapy workforce research. The first of these reviews found minimal yearly growth in research volume, with over-reliance on cross-sectional studies, little use of advanced study methods, and few studies targeting LMICs [22]. The second of these reviews synthesized the findings of occupational therapy

workforce research to determine many important topics that were minimally addressed (e.g., racial/ethnic workforce representation) or not addressed at all (e.g., task shifting such as the delegation of simpler tasks to practitioners with shorter training or fewer credentials) [23]. Finally, the third review provided a synthesis of study limitations and recommendations which concluded that longitudinal studies were needed, in addition to strengthening of routine workforce data collection [16].

With knowledge of these results, a situational analysis of the worldwide occupational therapy workforce was conducted. For that, a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis was used and received, with input provided by workforce research experts with interdisciplinary expertise across LMICs and HICs [13]. Based on the scoping review and situational analysis, as well as with findings of an examination of recent global health and rehabilitation workforce developments [19, 24–29], the research team drafted the provisional items for the Global Strategy.

For this study, feedback was sought from WFOT member representatives on the drafted items using a two-phased, mixed-methods approach. The goal of the consultation was to inform the redraft of the first Global Strategy for strengthening the worldwide occupational therapy workforce in terms of its structure or contents. This study aims to analyze the feedback of that two-phased consultation process.

Methods

Figure 1 provides a flowchart of the entire, 10-step planned process for developing the first Global Strategy for the occupational therapy workforce. This research reports to a two-phased consultation process (steps number 5 and 6 in Fig. 1) on shaping the structure and contents of that strategy.

Study design

Here, we report to the two-phased, mixed-methods consultation focused on WFOT member organization representatives who regularly provide input to WFOT's varied development projects as part of their role. The consultation process first entailed an online survey to identify items of concern within the draft Global Strategy. The survey was followed by in-depth, in-person focus group discussions to gain understanding of lower ranked items from the survey and identify potential ways to address the concerns.

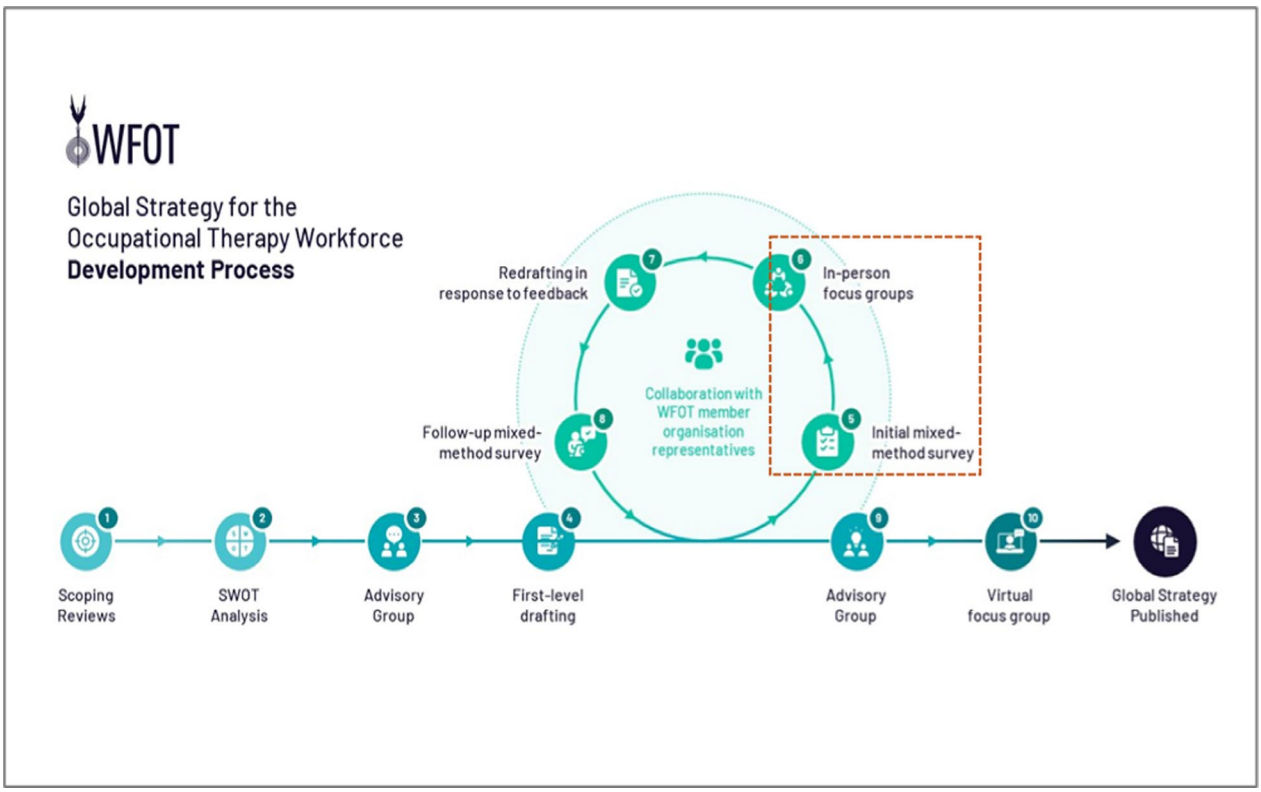

Fig. 1 The stages (5 and 6; dotted line) that this study reports to within the entire 10-stage plan for developing the first Global Strategy for the occupational therapy workforce

Phase 1—online survey

The purpose of this online survey was to gather feedback on the drafted strategy and identify topics for later in-depth focus group discussions with country delegates (i.e., national representatives). Each of the 98 WFOT member country organizations (i.e., entire population of WFOT national delegates, involving no sampling) received a link to an online survey from the WFOT through formal existing internal communications. Each member organization was requested to provide one response to the survey. The survey included Likert-type scales (0–10) for rating the perceived utility of a total of 62 drafted strategies, framed under eight strategic directions (see Supplementary Appendix 1). The survey also included space for qualitative comments, such as challenges or concerns raised by any given strategy. The survey was sent out on 21 September 2021 with a deadline of 15 November. A reminder email was sent on 1 November 2021.

The analysis of this phase included identifying topics with concerning qualitative comments or an average utility rating below 8 on a 10-point scale. Once the controversial or lowest-scoring items were identified, a focus group agenda and guiding questions were developed for Phase 2 (see Supplementary Appendix 2).

Phase 2—focus groups

The in-person focus group discussions were in August 2022 during the biennial WFOT Council Meeting held in Paris, France. Attending WFOT member organizations were represented by one delegate at the Council Meeting, with some with an additional one to two alternate delegates. The delegates attended a 90-min focus group discussion as one of the activities expected of WFOT member representatives. The representatives ($n=76$; 61.8% from HICs) were divided into four independent groups, respectively, with 18, 19, 19, and 20 participants per group. Albeit the number of participants per group was large, these participants were used to participating in focus groups together. Logistically, these were fixed groups of people rotating through this and other feedback activities at the Council Meeting. Each focus group discussion was led by the senior author (TJ), who was introduced by CvZ. Verbal consent was obtained from participants for audio recording the session and use of the de-identified discussion summary from the session for research purposes.

Each focus group included a 15-min introduction highlighting the goals for the focus group, a summary of findings from Phase I and the agenda. Each participant was given a copy of the draft Global Strategy content which was the same that was used in Phase 1. Participants were advised that the focus of the discussion was on the low rated or challenging topics identified during the survey used in Phase 1, although time was available to raise questions, concerns, or suggestions for improving any items included in the draft Global Strategy.

The discussion of each focus group was recorded. The recording was transformed into a de-identified transcript, generating a total of 44,303 words.

Focus group discussions thematic analysis The focus group discussions were analyzed using an inductive thematic analysis approach [30]. The primary analytical team was composed of three researchers with previous experience of qualitative methodologies and analyses (SC, SK, and SB). The transcripts were read by all three researchers for familiarization. The analysis was initiated using an open coding process by SC, which allowed for initial common themes to be generated [31]. Axial coding was next used to organize the data into related groups [32]. This combined approach was applied to all transcripts. To ensure reliability, a second coder (SK) reviewed and coded all transcripts [31] and any disagreements were resolved through discussion and review by SB. After completing the coding process, SC and SB collaboratively discussed and identified the main categories that were observed through the focus group discussions [33]. Overarching themes were then identified in collaboration with the senior author (TJ), and refined by the full set of authors.

Results

Our mixed-methods results are reported below, for each phase.

Phase 1—online survey

A total of 32 WFOT delegates responded to the survey, representing an overall 33% response rate. This rate level was deemed sufficient for this initial phase; we focused on identifying challenging items for in-depth and exhaustive participation in Phase 2. Responses were received from all of the five WFOT world regions (Fig. 2). Nineteen responses came from HICs, three from upper middle-income countries, and finally 10 from either low or lower middle-income countries.

The lowest rated item (average score = 7.28/10) was for a strategy related to task shifting/sharing; while the strategy was directed towards optimizing the use of skilled occupational therapy workforce resources, it raised concerns for the scope of practice of occupational therapy among some respondents. Three additional items had similar low scores (average < 8). Table 1 details the items with low score that were selected for focus group discussions.

Fig. 2 Participating country-level delegates of WFOT member organizations in the Phase 1 online survey

Table 1 Items of the draft strategy that raised concerns and were selected for focus group discussion

Strategy items	Rating summary	Comments showing elements of concern
4.9) Study and deploy task-shifting and task-sharing approaches (e.g., delegating simpler tasks, acquiring advanced roles) for an optimized use of skilled occupational therapy workforce resources	Average Score (7.28). Minimum score (1)	"*Task shifting is good if it is within the Occupational Therapy profession, but not across multidisciplinary teams as Occupational Therapists are suddenly becoming nurse assistants or similar. We need a strong profession to engage is this development*". Participant #11 "*Why is task shifting included? I agree with other strategies but that does not seem to be in the same level*". Participant #11 "*The intention of this statement is not clear. Is this suggesting better utilizing OTAs or training interprofessional team members*?" Participant #28
1.3) Develop minimum requirements for data sets for workforce across comparable jurisdictions	Average score (7.75). Minimum score (1)	"*A global approach to monitoring occupation which is very difficult to do given the uniqueness of occupation. (…) Monitoring the workforce is beneficial but set classification systems could be quite challenging.*" Participant #28
1.2) Develop minimum requirements for standardized workforce data collection and auditing across comparable jurisdictions	Average score (7.81). Minimum score (2)	"*Is there an indication that agencies want this?*" Participant #4 "*Who is proposed to undertake these strategies*?" Participant #11
5.6) Harmonize competency and licensing requirements across comparable jurisdictions toward improved comparisons, mobility, or remote service delivery	Average score (7.81). Minimum score (2)	No specific comments on concerns were provided for this draft strategy

Phase 2—focus groups

The overarching theme of discussion during the focus groups was: "*clarify, specify, and contextualize the strategies*" to be more commonly understood, acceptable, relatable, and implementable across varied national contexts. From this overarching theme, two sub-themes were derived: (1) "*clarify the terminology and specify the application*", such as describing the meaning of task shifting and specifying which tasks can (and cannot) be shifted and to whom; and (2) "*outline the context of need and the context for implementation*" for a

tailored and context-sensitive local implementation of the global-level strategies.

Sub-theme 1: clarify the terminology and specify the application

Within this sub-theme, the task shifting/sharing strategy raised the greatest discussion among some participants and was subject to several refinement suggestions. Regarding task shifting as a term, one participant stated: "*that language didn't really make sense.*" Alternative terms were suggested, such as to use "*delegate*" or "*exchange*" in lieu of "task shifting." Another participant that supported the strategy rephrased task shifting as "*encouraging occupational therapists to practice at the top level of their expertise or credentials.*"

Some participants raised concerns regarding reduced service demand if transferring tasks to a profession with an equivalent level of training. For example, one participant stated that *"we have to be very careful; if you show [another health profession] how to do our job every time, and then suddenly they may not come to you because they do it on their own."*

Concerns about scope-of-practice infringements and losing professional ground were voiced by some participants when non-credentialed professionals were considered. For example, one participant stated that "*we don't want to emphasize that even non-professional people can do our job.*" Safety concerns were emphasized by another participant: "*It certainly opens a huge debate on what's actually safe to do and not do*."

To address their comments, participants recommended that the strategy "*should be very specific by what is meant.*" Participants emphasized the need to identify which tasks can be delegated or shared with lower-level providers or informal caregivers and, by the same token, specify those which are core professional tasks and skills that cannot be transferable.

For overcoming safety concerns, participants stressed the importance of occupational therapists maintaining responsibility and supervisory roles when delegating tasks; for example, one participant stated: "*It is about delegating the task, not delegating the responsibility.*"

Although generating less controversy, improved clarity and specificity were also recommended regarding terminology for the three strategies that focused on standardized, harmonized, or minimum requirements (e.g., for workforce data collection) across comparable jurisdictions (Table 1, second row). For example, participants wondered, *"What does it mean to harmonize?"* or whether the term 'comparable jurisdictions' meant "*within a country, if that country has different states, or is it meant in a more global way?*" Comments were also made regarding terminology used in 'non-hot-topic' strategies, such as replacing 'stakeholder' with 'interested parties' or 'interested partners.' To improve understanding of the overall strategy, participants emphasized the need to further describe each strategic direction.

Sub-theme 2: contextualize the need for the strategies and for a tailored implementation

Providing a rationale for the strategies included in the Global Strategy emerged as an issue in the focus group discussions. For the task shifting strategy, one participant noted, "*I feel I need background in terms of why are we doing this*". With more explanation, participants recognized the potential for the strategy to facilitate increased access to occupational therapy services by delegating lower-level tasks to allow occupational therapists to focus on more specialized functions. One participant explained: "*Because occupational therapy is a limited resource in some places and to improve access we need to get occupational therapists to do value driven tasks.*"

The same pattern was noted with participants questioning the need for a greater standardization of workforce data collection. One participant asked: "*[We] need to understand why is this, why is that collecting data regarding the workforce important? Why is this an important issue for the WFOT and for our countries?*" Participants noted that significant challenges exist for data collection regarding the occupational therapy workforce, for example, as result of variable licensing requirements. One participant indicated, *"If you live in the [capital city] you're licensed by the Ministry of Health, if you live in [another region or province of the same country], you are licensed by the College of [that region or province] […] every [region or province] has its own way."* Another participant stated that "*there is also a cultural difference in how you collect data, and what kind of data, and how are you able to compare them*," while several participants had logistic concerns: "*There may be some manpower needed to get you that data and in certain areas they don't have that infrastructure in place*." A participant questioned, "*Who should be responsible to collect this data?*".

Participants stressed the contextual variation of the profession and the need for the implementation of the strategies to be tailored to each context, above and beyond a set of minimum requirements. One participant stated, "*The most important thing is that we as the Federation agree on the core competencies that we have as a profession and not actually the way it should be actually done, because that is bound to the context, and that will be different between our countries*." Another also noted that "*too much explanation […] may not be adaptable to the local context.*" So, a reasonable balance is necessary between global strategic guidance and latitude for

adapting the operationalization of the strategy and context-sensitive local implementation.

Discussion

In this paper, we present the results of a two-phased, mixed-methods consultation with WFOT member organization representatives as an intermediate step within a comprehensive process for developing the first-ever, Global Strategy for strengthening the occupational therapy workforce. From the online survey (phase 1), the strategies involving task shifting and broadly on the harmonization of workforce data collection requirements raised the greatest concerns, and were thereby selected for in-depth review in the focus groups discussions. These discussions identified the need to clarify, specify, and contextualize the strategies for its improved understanding, acceptance, context-sensitive adoption and use.

Task shifting or task sharing generated the greatest discussion among some participants for a variety of reasons. The lack of a clear description affected how participants appraised the utility of this strategy, which sometimes was associated with apprehensions for the development of the profession (for example, as a result of a loss of demand for occupational therapy), as well as with safety or service quality concerns. To increase the acceptability of the strategy, participants recommended specifying which 'simpler' tasks can be delegated, to whom, and under which circumstances. In the health workforce field, the recent COATS framework (Concepts and Opportunities to Advance Task Shifting and Task Sharing) provides a refined definition of task shifting and task sharing and a purpose statement to guide such initiatives [34]. This framework, along with suggestions offered by the focus group participants (e.g., for refining the language, providing further context, emphasizing the need and benefit of working at the top of professional credentials) can provide greater acceptability of task shifting/sharing strategies in occupational therapy.

Hesitancy towards task shifting or sharing is not new within the health workforce [35, 36]. As an example, nurses with advanced training to perform tasks traditionally performed by physicians have reported challenges with acceptance of the nurse practitioner role by physicians and other colleagues [37]. While quality and safety concerns are often raised, these issues can be addressed by research findings and structured protocols. For example, a systematic review found that in primary care contexts, task shifting to nurses following structured protocols and validated instruments may achieve similar outcomes to physicians for managing the course of disease [35]. Another recent study involving health professions determined consensual role-boundary shifts were facilitated with the simultaneous upward expansion of roles for all professions and the delegating profession in charge of role delegation [36]. Our focus group participants recounted task shifting experiences more positively or more likely acceptable when the delegation of tasks allowed time for occupational therapists to work at the top of their credentials and acquire more advanced skills.

Our previous scoping review of the occupational therapy workforce research found no study explicitly addressing task shifting or task-sharing strategies [23]; this is an important background finding to understand the accounts of some participants with their initial hesitancy toward the strategy. On the one hand, this may imply a lower familiarity with the scope and purpose of the strategy among the study participants (i.e., representatives of WFOT member organizations); this reinforces the need for added clarity, specificity, and contextualization of any related documentation. On the other hand, the lack of studies on the subject for occupational therapists affects the available evidence regarding the effectiveness of the strategy. An improved level of study is required to provide the needed profession-specific evidence base on effectiveness, utility, and needed adaptations for the use of task shifting or task-sharing strategies in occupational therapy.

The other subjects raising major concerns were the need for greater standardization and use of minimum uniform requirements in occupational workforce data collection across similar jurisdictions. Participants were mostly concerned with the pragmatic difficulties of implementation of the strategy, while some had difficulty envisioning how improving data collection would strengthen the profession. The SWOT analysis of workforce literature that informed development of the strategy [13] identified weaknesses that included a lack of occupational therapy workforce data in major global repository, for example the National Workforce Accounts; the omission of a profession-specific definition of occupational therapists in the International Standard for Classification of Occupations; and the variability of workforce data collection procedures that compromised cross-national or cross-jurisdictional comparisons of the occupational therapy workforce. Hence, the lack of available, rigorous, and comparable occupational therapy workforce data can be a structural barrier for the identification of the sub-developments within this workforce, thereby affecting any major policy toward its strengthening. In addition to these factors, the development of the occupational therapy workforce is disadvantaged by its relatively small size compared to other health professions (e.g., nurses, medical doctors). The focus of occupational therapy on function and quality of life also receives less policy attention and interest when compared with medical outcomes [13].

The pragmatic barriers for implementation of more uniform workforce data requirements across jurisdictions, based on contextual differences, are substantive and need consideration. Developing a hybrid solution such as an international framework with minimum uniform requirements for occupational therapy workforce data collection, but with a level of flexibility toward context-sensitive operationalization and local adoption [38, 39], can potentially address the common need for standardization/comparability and the complex operationalization in varying local contexts.

Overall, participants' feedback and insights are instrumental for the subsequent redrafting the structure and content of a Global Strategy. For instance, the final Global Strategy will benefit from further details on the rationale and context for each major strategic direction as well as specific guidance toward operationalization. While selected strategies were addressed, the need for further clarity, specificity, and contextualization (i.e., the overarching theme of our results) is applicable to the whole scope of the initially drafted strategies. The redrafting of the Global Strategy and the execution of the subsequent consultation, assessment and refinement steps will provide the final shape to the first Global Strategy for developing the occupational therapy workforce.

Limitations

This two-phased consultation process only involved feedback from WFOT member representatives; further refinement steps and more interested parties, as well as external experts, may help to further refine the envisioned Global Strategy. The consultation process, at this stage, did not aim to evolve toward consensus or using a consensus-seeking methodology (e.g., Delphi process); such type of methods may be followed with a closer-to-final version. Phase 1 was conducted online and, as an intermediate step, was not planned to be exhaustive of the member organizations, yet this is partly overcome by the more exhaustive participation in the subsequent, in-person focus group discussions. The delegates participating in focus groups were involved in this activity as part of their regular roles in representing their member organization within WFOT. Although participants were not typical volunteer research participants or arising from a random sample, this was intentionally planned to assure the best possible national representativeness and a pool of participants that were used to provide input to strategic, global-level WFOT developments. While two of the authors directly involved in the drafting of the Strategy conducted the focus groups (TJ and CvZ), which can be a potential source of bias, the qualitative data analyses were primarily performed by a separate group set of authors (SB, SC, and SK) who were blinded using the de-identified transcripts as a partial counter measure. The fact that each focus group involved around 20 participants (and with a duration capped at 90 min) may have refrained some participants to provide dissonant perspectives, even though this group of participants are used to and likely skilled in the role of providing program development feedback for WFOT's activities. Also, most participants in the focus groups (61.8%) were from HICs which skews the representation. Furthermore, not all countries have the same type or level of practitioners with less training or lower credentials such as OT assistants or community health workers which may have interfered with the specifics of the task-shifting discussions. Finally, the focus groups addressed mainly the subjects that raised most concerns, either quantitative ratings or qualitative comments, in the Phase 1 survey; however, time in the focus groups was explicitly provided for discussion of any other components of the draft strategy.

Conclusion

The occupational therapy workforce has been underdeveloped relative to the global population needs. A mixed-methods, two-phased consultation with WFOT member organization representatives was used in the process of developing the first-ever Global Strategy for strengthening the occupational therapy workforce. WFOT member representatives identified areas of lower priority on a draft set of workforce strategies and recommended possible ways to address the concerns. Task shifting and task-sharing strategies raised the most discussion among the country representatives of the profession and may be a possible deterrent to acceptability and implementation of the strategies if not reworded, clarified, specified, or contextualized. Increased standardization on data collection requirements also raised implementation concerns, more so than the scope of the strategy itself. These insights provided and analyzed here for specific strategies might also be applicable for the overall structure and content of a redrafted strategy. For instance, each strategy in a final version may benefit from added clarification. Specificity and contextualization, including the exact scope and need for a given strategy as well as the possible ways to operationalize them in varied contexts. Overall, the participants' feedback analyzed here is instrumental for the WFOT to initiate the ongoing process of refining the drafted strategies, and for transforming the drafted items into a fully fledged Global Strategy for strengthening the occupational therapy profession. The subsequent revised version of the Global Strategy remains subject to further refinement from experts and interested parties before its final launch.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Author contributions
SB: study's conception; initial data analysis; scientific reporting. SC: initial data analysis. SK: data analysis, critical edits. CvZ: study's conception; data collection; data management, critical edits. GR: critical edits, scientific reporting. KM: study's conception; critical edits. SK: study's conception; critical edits. RL: study's conception; critical edits TJ: study's conception; data analysis; scientific reporting; study's coordination. WFOT: data collection; data management.

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Availability of data and materials
The datasets during and/or analyzed during the current study are available from the corresponding author on reasonable requests.

Declarations

Ethics approval and consent to participate
This work is part of a program development/quality improvement activity of the World Federation of Occupational Therapists (WFOT) whose input was obtained from country representatives that are delegates to the WFOT and whose periodic input to the WFOT's development activities is part of their country representative role. Data were internally collected through the WFOT (e.g., using internal communication channels), whose de-identified data were then shared with the research coauthors for analysis, i.e., treated as secondary data.

Consent for publication
No personal or identifiable data are provided.

Competing interests
CvZ and RL are affiliated with the WFOT.

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