The Advancement of Rwandan Rehabilitation Services Project

Presents

LEADERSHIP INSTITUTE

April – May 2015

Taught by

Maureen Romanow Pascal, PT, DPT, NCS
Ben S. Braxley, PT, DPT, NCS

And co-teachers

Nuhu Assuman, Msc PT &
Kirenga Bamurange Liliane, Msc PT

Presented in Partnership with

Acknowledgements

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Health Volunteers Overseas gratefully acknowledges the work of HVO Volunteers Maureen Romanow Pascal, PT, DPT, NCS and Ben S. Braxley, PT, DPT, NCS in developing, teaching, and modifying the course, “Leadership Institute.”

Dr. Pascal and Dr. Braxley were assisted in the teaching of the course by Rwandan co-teachers Nuhu Assuman, Msc PT and KIRENGA Bamurange Liliane, Msc PT.

Health Volunteers Overseas
Advancement of Rwandan Rehabilitation Services Project (ARRSP)

Leadership Institute

Course Instructors
Maureen Pascal, PT, DPT, NCS
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Co-teachers:
Nuhu Assuman, Msc PT
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April 13-May 23, 2015
3-weekend structure with two cohorts (A and B)

Weekend 1A – April 17-18
Weekend 1B – April 23-24 (Thursday – Friday)
Weekend 2A – May 1-2
Weekend 2B – May 8-9
Weekend 3A – May 15-16
Weekend 3B – May 22-23

Introduction

The primary goals of the ARRSP are:
1. Provide continuing professional development courses to Rwandan Rehabilitation Professionals in order to upgrade rehabilitation standards and improve services provided to those with disabilities.

2. Increase the awareness of the profession of physiotherapy among the general public and other health care professionals in order to increase utilization of rehabilitation services and reach under-served populations.

The Leadership Institute (LI) is the capstone course in the Project. It is designed to focus on Goal 2 of the Project in order to insure the continuity of the development and dissemination of the professional knowledge, values, skills, and physiotherapy practice that was initially experienced by participants in the project, and to share their professional growth with physical therapists, other colleagues, students, and appropriate Rwanda communities of interest. For this reason, the course will only be open to leaders in Rwandan physiotherapy.

All course participants must have fulfilled at least one of the following criteria:

- Be an elected leader in the Rwanda Physiotherapy Association (AKR)
- Be a member of the ARRSP Steering committee
- Be a physiotherapy faculty member at UR-CMHS
- Have successfully completed a previous ARRSP course and receive a recommendation from the course instructor.

The course will draw upon the participants' experiences in order to cultivate the professional identity, professional development and expanded utilization of physiotherapy with a focus on the growth of the physiotherapy profession after the ARRSP concludes in May 2015.

THEMES OF THE LEADERSHIP INSTITUTE

- Professionalism
- Leadership
- The Future of Physiotherapy in Rwanda

PROJECTS

GROUP PROJECTS

The class will work in groups of participants based upon similar work environments or responsibilities (department heads, administrators, educators/faculty, practice settings, or interest in a particular project), or areas of project interest.

Following instruction in planning and implementing projects (strategic plan development), groups will:

1. Identify a challenge or need related to professional development, leadership development, or continuity aims of the Project.
2. Plan and present a project to meet the objective, including a time frame for implementing the project.

Leadership in Physiotherapy

Ben S. Braxley, PT, DPT, NCS
Volunteer, Instructor
Advancement of Rwandan Rehabilitation Services Project
Health Volunteers Overseas

1

Learning Objectives

- Define Leadership in the context of Physiotherapy.
- Review and discuss leadership styles.
- Review and discuss follower styles.
- Reflect on your individual style of participation.

2

What is Leadership?

- A **trait**. Certain inherent qualities, part of the person's identity.
- An **ability**. A person is *able* to lead.
- A **skill**. People can learn to become leaders.
- A **behavior** - Observable qualities.
- A **relationship**
  - Relationship between **leaders** and '**followers**'.
  - A process of collaboration.

(Northouse, 2009, Green-Wilson 2013, Kouzes & Posner, 2007)

3

What is Leadership?

"**Leadership** is a *process* whereby an individual influences a group of individuals to achieve a common goal."
(Northouse, 2007)

4

What else is Leadership?

Leadership is influence.

People believe in a leader, even before they believe in the vision.

John C. Maxwell

What makes you a leader?

- You are personally, actively invested in goals.
- You always look for potential new opportunities.
- You seek new methods for long-standing problems.
- You inspire workers.
- You try to be creative and energetic.
- You learn how to get things done.

6

Five Practices of Great Leadership

1. Role Model
   - Set an example, clarify what needs to be done
2. Vision
   - Have a vision, inspire others
   - Enlists the help of others to make the vision a reality

7

Five Practices of Great Leadership

3. Challenge the *status quo*
   - Look for new opportunities
   - Be willing to experiment and take risks
4. Empower others
   - Collaborate with others
   - Help others improve their strengths

8

Five Practices of Great Leadership

5. Encourage others
   - Recognize the contributions of others
   - Recognize the value of others
   - Celebrate accomplishments of others

9

Leadership Styles

- There is more than one way to be a Great Leader

10

Six Leadership *Styles* (Goleman, 2000)

1. Coercive
2. Authoritative
3. Pacesetting
4. Affiliative
5. Democratic
6. Coaching

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Coercive Leader

- Often expects others to follow orders
- Expects, or even demands, immediate compliance
- This is a good style when a quick change is needed, if there is a crisis, or if an employee is not doing his job.

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Authoritative Leader

- May not expect others to follow orders, but does expect others to follow their example.
- Asks others to perform and work in the same manner they do.
- This is a good style when others need a clear direction, or at the beginning of a change in a group's vision.

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Pace-setting Leader

- In-between Coercive and Authoritative
- Sets high standards
- Expects otherå to comply and also maintain high standards
- This is a good style when the rest of the group is highly motivated, and willing to work hard for quick results.

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Affiliative Leader

- Works to create harmony in the workplace
- Takes into account the emotions of others, and works to build relationships.
- Believeå people come first.
- This is a good style to motivate people under stressful circumstances, or when members of the group do not get along.

15

Democratic Leader

- Works for group consensus and participation
- Asks others for their opinions
- This style helps a leader get input from others, especially valuable members of the department. Helps the group share ideas and visions. The style can help a group be more willing to change.

16

Coach / Leader

- Offers many suggestions
- Helps to develop individuals for the future.
- This is a good style to help people improve performance and develop long-term strengths.

17

Which type of leader are you?

- Are you more than one?
- Can you be more than one?

18

Yes, you can and should feel comfortable moving between and combining styles!

- Leaders need different styles for different situations.
- "Leaders who have mastered 4 or more styles – esp. authoritative, democratic, affiliative, & coaching styles – have the very best climate & business performance." (Goleman, 2000)

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What is the role of a leader?

A leader accepts a fundamental role to influence a group of individuals to achieve a shared vision.

This means leaders must have followers.
A leader cannot work alone!
– success depends on everyone

20

The *first* person you lead is YOU.

(Maxwell, 2002)

21

So, who comes *second*?

(Bradley, 2015)

22

What leaders want and need from followers:

- Willingness to collaborate
- Motivation to stay up-to-date
- A passion for learning and growing
- Positive attitude

23

What type of follower are you?

- Do you think for yourself?
- Do you analyze situations?
- Do you bring positive or negative energy to work?

24

Followers are as important as Leaders!

25

Different Types of Followers

- Passive – look to the leader to do everything. Passive followers want the leader to think for them and motivate them.
- Positive – Believe in the department's mission. Positive followers work to get the job done, and then move on to the next task.
- Alienated – Have negative energy. Alienated followers do not believe in the department's mission, and can come up with many reasons why something will not work.
- Content – Are not negative, but are happy with how things are. Will not work hard for change.
- Star - You think for yourself, and have positive energy. Star followers work actively, offer suggestions and ask questions.

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Other ways to be a leader – even if you are more of a follower.

- Be a star follower among your peers -- that really makes you a leader…
- Use ideas to influence a supervisor
- If **leadership** is a relationship, then **followers** perform a vital role in achieving goals.

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PERSONAL LEADERSHIP Development Plan

STYLE	Self-Assessment	Next Steps Action Plan
What is Your Leadership Style? Coercive, Authoritative, Coaching, Pacesetting. Affiliative, Democratic		
Do you follow good leadership practices? Role model, vision, challenge, enable, encourage		
What is Your Followership Style? Passive, Positive, Alienated, Content, Star		

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Personal Leadership Development Plan

Style	Self-Assessment	Plan for Improvement
What is Your Leadership Style? Coercive, Authoritative, Coaching, Pacesetting. Affiliative, Democratic		
Do you follow good leadership practices? Are you are a role model? Do you have a vision? Do you look for opportunities? Do you collaborate with and encourage others?		
What kind of follower are you? Passive, Positive, Alienated, Content, Star		

1

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Leadership Institute

SUCCESS!

SUCCESS

2

- What is it?
- Here's one definition:
- "Progressive realization of realistic goals."

Goals Book, Biago W. Sciacca, 2012

Success is Progressive

3

- Success happens in small steps
- Will not happen all at once or suddenly

Goals Book, Biago W. Sciacca, 2012

Success is Realization

4

- First part of realization: deciding what you want.
- Second part: Makes plans and goals for how to achieve it
- Success is not always the same thing as meeting your goals
- Success is making a goal, then modifying your behavior to help you meet that goal.

Goals Book, Biago W. Sciacca, 2012

Success cause change

5

- There will be a change in you, and others around you.
- When you change your behavior, others notice. They may start to change their behavior as well
- Even if you can't change the world, change what you can.

Goals Book, Biago W. Sciacca, 2012

Success is determined by you

6

- You determine your goals.
- If you set a goal, and you do not reach it..
  - Try again!
  - Evaluate what happened.
  - Do you need to make a new goal, or a different goal?

Goals Book, Biago W. Sciacca, 2012

Success is built on goals and plans

7

- Being able to formulate plans and goals is important if you want to accomplish those goals.
- Strategic planning

Goals Book, Biago W. Sciacca, 2012

8

SMART goals

A quick review

SMARTER goals

9

- Specific
- Measurable
- Attainable and Realistic
- Relevant
- Time-frame
- Evaluate
- Re-evaluate

Specific

10

- What exactly do you want to accomplish?
- Vague goals do not results in vague results.
  - They result in no results.

Goals Book, Biago W. Sciacca, 2012

Measurable

11

- How will you know if you have met your goal?
  - What will we monitor?

Attainable and Realistic

12

- Set a goal that will be possible to achieve.
- No one likes to make goals and not meet them.
  - Don't get used to failure
  - Get used to making SMART goals you can meet.

Goals Book, Biago W. Sciacca, 2012

Relevant

13

- Goals need to be relevant in terms of
  - Where you are in your career
  - Where you are in the rest of your life
  - Where the physiotherapy profession is in Rwanda
- Goals need to be relevant in terms of being
  - Something you really want to achieve
  - Something that is worthwhile and important to you

Timeframe

14

- We know it, but do we do it?
- A goal without a timeframe is a dream.
  - It is easy to put that goal to the side until tomorrow
  - And the next day….
- You will need to have timeframes and stick to them.

Goals Book, Biago W. Sciacca, 2012

Types of Goals

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- Short-term
- Long-term
- Intangible
- Tangible

Short-term goals

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- Will depend on what you want to accomplish
  - Could be one week
  - Can be longer

Long-term goals

17

- Might be something you never reach
- You may modify as you meet your short-term goals.

Intangible goals

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- These start the process.
- What do you want to become?
  - A better clinician?
  - More respected?
  - Better job satisfaction?

Tangible goals

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- We really need to work toward something we can see, instead of an intangible concept.
  - More physio jobs
  - More referrals from physicians
  - More patients requesting physiotherapy

THANK YOU!

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- Now it's your turn:
- Write down at least one SMART long-term goal for your practice setting.
  - Write down one or two ways you can be successful in working toward this goal.

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Leadership Institute

Recap from Day One

What we did yesterday

- Discussed physiotherapy: what we like, what's frustrating, barriers to use
  - We are the first ones who have to make improvements
- Discussed Leadership, styles of leaders and followers
- Discussed what we see as success, and where we want to be in 2 and 5 years.
- Discussed strategies for being successful and meeting goals.

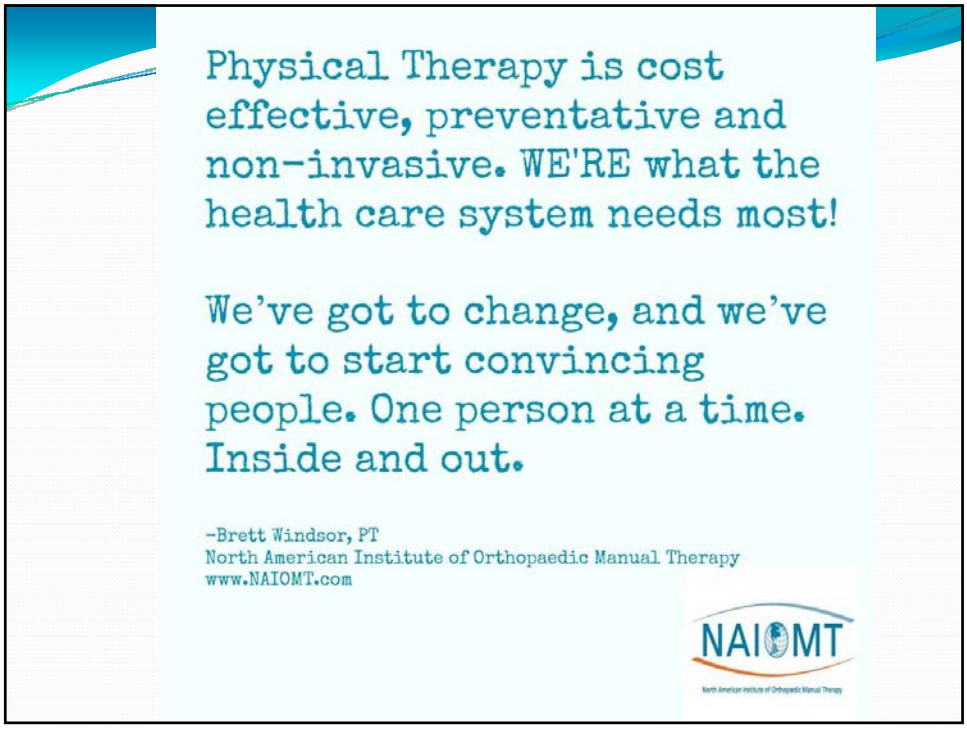
Our goals:
Where do you see physiotherapy in Rwanda in 2 years? 5 years?

- Recognized,
- Professional, more staff
- Excellent quality
- Respected, First contact
- Decision makers, Community centered, More income, Producing research, More materials, equipment

Possible Vision Statement

- Physiotherapists are recognized throughout Rwanda as health professionals who provide quality care to patients in multiple settings.

- How will we achieve this vision?
  - More income
  - More equipment and materials
  - Producing research, using EBP
  - Being independent decision makers
  - Being able to be the first contact for a patient
  - Respected for knowledge and services



Some other examples:

- Nike:
  - "To bring inspiration and innovation to every athlete* in the world"
- American Medical Association:
  - "To promote the art and science of medicine and the betterment of public health."

Vision:

Recognized throughout Rwanda as health professionals who provide quality care to patients in multiple settings.

Will achieve by: Having more staff

More income

More equipment and materials

Producing research, using EBP

Being independent decision makers

Being able to be the first contact for a patient

Respected for knowledge and services

Where do you ăŜŜ physiotherapy in Rwanda in 2 years? 5 years?

Recognized,

Professional, more staff

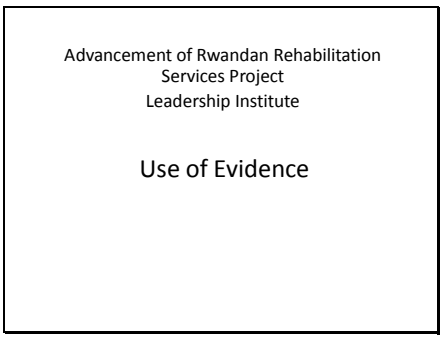
Excellent quality

Respected, First contact

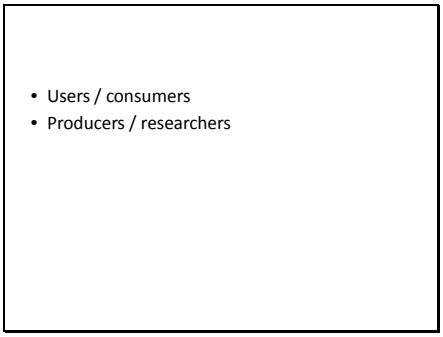
Decision makers, Community centered, more income, produce research,. More materials, equipment

Where shoud PT be in 2 ys? 5 yrs?	Total									
Decision makers	**3**	1	1	1						
Leaders	**1**	1								
Community centered care	**3**	1	1	1						
98% of health centers will have at least one physio	**2**	1	1							
look smart	**1**	1								
recognized	**8**	1	1	1	1	1	1	1	1	
appreciated	**1**	1								
more income	**3**	1	1	1						
more independent	**1**	1								
PT as consultant	**1**	1								
own a clinic	**2**	1	1							
first contact with patient	**4**	1	1	1	1					
payment with respect to education level	**1**	1								
produce research	**3**	1	1	1						
more materials for rehab of children	**1**	1								
more materials/ equipment	**3**	1	1	1						
more knowledge	**2**	1	1							
more staff	**6**	1	1	1	1	1	1			
more professional / professionalism	**6**	1	1	1	1	1	1			
use EBP	**2**	1	1							
role model	**1**	1								
research professionalism	**1**	1								
excellent in practice (quality)	**5**	1	1	1	1	1				
respected	**4**	1	1	1	1					
community will recognize	**2**	1	1							
health professionals will recognize	**3**	1	1	1						
improve rehab	**1**	1								
decrease costs	**1**	1								
new grads get jobs	**1**	1								
inspiring young people	**1**	1								
best in Africa	**1**	1								
more physical space	**1**	1								
recognition locally, regionally, internationally	**1**	1								
more patients	**1**	1								
leader in disability policy and practices, promotion of the disabled	**1**	1								
more staff in hospitals, health centers	**1**	1								
working fully according to WCPT rules of practice	**1**	1								

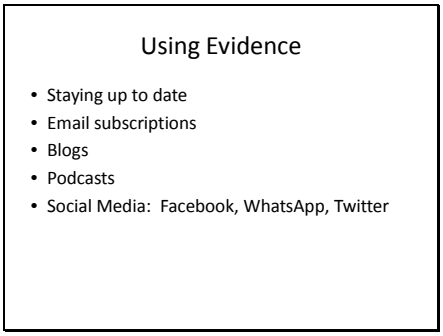
Slide 1



Slide 2

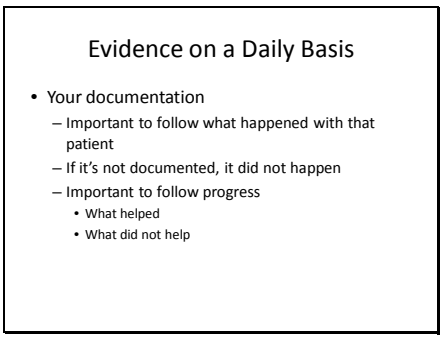


Slide 3



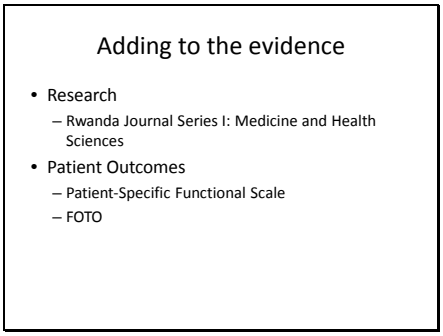
Email subscriptions: Dynamed, Evidence Update
Blogs: Evidence in Motion, The Manual Therapist, Body in Mind, Chris Johnson
Podcasts: Karen Litzy, a physiotherapist in New York City, has a weekly podcast. She also organized a virtual conference. I can get you access to the materials.

Slide 4



Slide 5

Slide 6

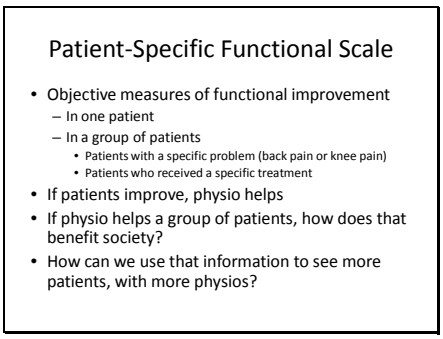


You can add to the research in several ways:

- case studies that you share with colleagues, present at a conference or even publish

-Systematic reviews of literature. This can take time, but can be accomplished by several individuals working together.

Slide 7



Use of outcome measures to demonstrate improvement and add to the evidence
-Outcome measures provide a standardized, objective way to assess a patient and how that patient responds to therapy

-Each patient is really a single-subject case study. By using an outcome measure, you have objective data about whether or not that patient improved. Since you completed your assessment, notes and discharge summary, you also have a record of what you did with that patient.
-If everyone collects data using the PSFS, you can begin to collect data by clinic, region and nationally.

- It will allow you to see whether or not patients improve, how much they changed,
-You can also track how long patients were in therapy, or even what interventions were used
-If the Minimal Detectable Change for the PSFS is 2, that means a patient's score on an individual item needs to improve by at least 2 in order for us to say there was real change. There is some new evidence (Haxby, Schmitt) that the Minimally Important Difference in the PSFS ranges from 1.3 to 2.7

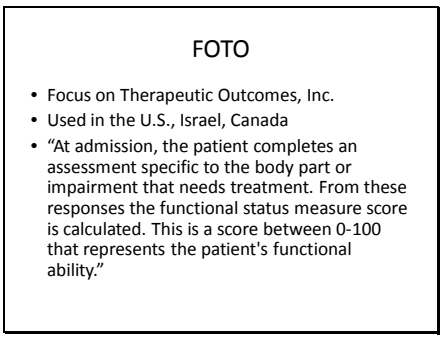
If everyone collects data using the PSFS, it helps us see the benefit of physiotherapy.
These benefits include: individual patients feel better and are more functional. Hopefully this means they can perform better in their work.
If we help people get better, they spend less time in the healthcare system, which helps reduce overall healthcare costs.
If we can show we can help more people, it is much easier to demonstrate the need for more physios.

What if our patients are not getting better, or only some are getting better? Or maybe patients at one clinic are getting better faster than at another clinic. This requires us to analyze the situation: are patients getting the best care? Are they getting enough care? Are they being properly referred to us? If we are seeing patients who have chronic pain, it may be harder to show improvement.

This gives us an opportunity: we can compare their outcomes to the outcomes of more acute patients. If patients with acute pain who get physio get better than those with chronic pain, this gives us evidence to talk to physicians and others about the importance of earlier referral to physio.

If we see more patients with acute pain, it may mean fewer people with long-term chronic pain. It may also mean more patients coming for physio, helping justify the need for more hires.

Slide 8



"FOTO uses 1O risk-adjustment factors to ensure that the predictions we make are reflective of the patient's characteristics. This is important both for accuracy and precision in national comparative and functional limitation reporting."

"Patients complete an assessment as needed during care and on the last visit to track the improvement of function. That amount of change is then compared to risk-adjusted national predictions from FOTO, providing a measure of treatment effectiveness."

http://www.fotoinc.com/what-is-foto

How to Stay Informed about Research

You can sign up with the following websites to get email updates about research:

- Evidence Update from McMaster University and BMJ: http://plus.mcmaster.ca/EvidenceUpdates/
- Dynamed EBM Focus https://dynamed.ebscohost.com/about/about-us

These websites have blogs you can follow. You can usually sign up to get an email when there is a new posting, so you do not have to remember to check it.

- Evidence in motion: http://www.evidenceinmotion.com/about/blog/
- The Manual Therapist http://www.themanualtherapist.com/
- Body in Mind http://www.bodyinmind.org/
- Chris Johnson, PT: https://chrisjohnsonpt.com/blog/

You can subscribe to a weekly podcast with this website. The site also has information about a virtual conference. Karen has said she would make the materials available to you if you are interested.

- Karen Litzy http://www.karenlitzy.com/

There is a Facebook Group called PHYSICAL THERAPY: PRACTICE, EDUCATION, AND NETWORKING. People seek advice on clinical problems, etc. The moderator enthusiastically embraces the idea of having our Rwandan colleagues join the group.

FOTO: Focus on Therapeutic Outcomes Inc.
http://www.fotoinc.com/

Patient-Specific Functional Scale:

https://www.tac.vic.gov.au/files-to-move/media/upload/patient-specific.pdf

Articles about the Patient-Specific Functional Scale:

Please see the abstract below.

If you would like the full text of either of these articles, email me at:

pascal.maureen@gmail.com

Maureen Pascal, PT, DPT, NCS
Leadership Institute
Health Volunteers Overseas, Advancement of Rwandan Rehabilitation Services Project

Scroll down for abstracts…

Record: 1

Title: The Patient-Specific Functional Scale was valid for group-level change comparisons and between-group discrimination.

Authors: Abbott JH; Centre for Musculoskeletal Outcomes Research, Orthopaedic Surgery Section, Department of Surgical Sciences, Dunedin School of Medicine, University of Otago, Great King Street, Dunedin 9054, New Zealand. Electronic address: haxby.abbott@mac.com.
Schmitt JS; Doctor of Physical Therapy Program, Henrietta Schmoll School of Health, St. Catherine University, 601 25th Avenue South, Minneapolis, MN 55454, USA.

Source: Journal Of Clinical Epidemiology [J Clin Epidemiol] 2014 Jun; Vol. 67 (6), pp. 681-8. *Date of Electronic Publication:* 2014 Feb 17.

Publication Type: Journal Article; Multicenter Study; Research Support, Non-U.S. Gov't

Language: English

Journal Info: *Publisher:* Elsevier *Country of Publication:* United States *NLM ID:* 8801383 *Publication Model:* Print-Electronic *Cited Medium:* Internet *ISSN:* 1878-5921 (Electronic) *Linking ISSN:* 08954356 *NLM ISO Abbreviation:* J Clin Epidemiol *Subsets:* MEDLINE

Imprint Name(s): *Publication*: New York : Elsevier
Original Publication: Oxford ; New York : Pergamon Press, c1988-

MeSH Terms: Disability Evaluation*
Group Processes*
Physical Therapy Modalities*
Musculoskeletal Diseases/*physiopathology
Musculoskeletal Diseases/*therapy
Activities of Daily Living ; Adolescent ; Adult ; Aged ; Aged, 80 and over ; Child ; Female ; Follow-Up Studies ; Humans ; Male ; Middle Aged ; Prospective Studies ; Reproducibility of Results ; Treatment Outcome ; Young Adult

Abstract: **Objectives:** To examine the validity of the Patient-Specific Functional Scale (PSFS) for the assessment of group-level change and between-group discrimination in group-level data. **Study Design and Setting:** We collected complete baseline and follow-up PSFS data in 1,181 consecutive patients reporting to physical therapy with a musculoskeletal disorder. Physical function was assessed at the baseline and final physical therapy visits using the PSFS and four region-specific patient-

reported outcome (PRO) measures: The Neck Disability Index, Oswestry Disability Index, Upper Extremity Functional Index, and Lower Extremity Functional Scale. Global Rating of Change (GROC) was assessed at discharge. We assessed data distribution and floor and ceiling effects. Correlation and linear regression analyses assessed concurrent, convergent, and discriminant validities of PSFS baseline, final, and change scores across the cohort. One-way ANOVA was used to test for differences in PSFS scores among strata defined by region-specific PRO score and GROC. Cohen's d was used to assess responsiveness.

Results: Results supported the concurrent, convergent, and discriminant validities (all $P < 0.001$), scale consistency ($P < 0.001$ omnibus, $P < 0.05$ post hoc tests), distribution, and responsiveness of the PSFS for both between-group discrimination and assessment of change over time in group-level data. The PSFS performed better than comparison PRO measures in most comparisons.

Conclusion: These results indicate that the PSFS is an appropriate measure for statistical comparisons in clinical research.

Contributed Indexing: *Keywords:* Instrumentation; Measurement properties; Musculoskeletal diseases; Outcome assessment; Patient-specific instruments; Physical function; Psychometrics; Questionnaires

Entry Date(s): *Date Created:* 20140428 *Date Completed:* 20140610

Update Code: 20141125

DOI: 10.1016/j.jclinepi.2013.11.002

PMID: 24556219

Database: MEDLINE

Record: 1

Title: Minimum important differences for the patient-specific functional scale, 4 region-specific outcome measures, and the numeric pain rating scale.

Authors: Abbott JH; Centre for Musculoskeletal Outcomes Research, Orthopaedic Surgery Section, Department of Surgical Sciences, Dunedin School of Medicine, University of Otago, Dunedin, New Zealand.
Schmitt J

Source: The Journal Of Orthopaedic And Sports Physical Therapy [J Orthop Sports Phys Ther] 2014 Aug; Vol. 44 (8), pp. 560-4. *Date of Electronic Publication:* 2014 May 14.

Publication Type: Journal Article; Multicenter Study

Language: English

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MeSH Terms: Disability Evaluation*
Musculoskeletal Diseases/*physiopathology
Musculoskeletal Diseases/*rehabilitation
Outcome Assessment (Health Care)/*methods
Pain Measurement/*standards
Adult ; Aged ; Female ; Humans ; Longitudinal Studies ; Male ; Mental Recall ; Middle Aged ; Pain Measurement/methods ; Physical Therapy Modalities ; Prospective Studies ; Time Factors

Abstract: **Study Design:** Multicenter, prospective, longitudinal cohort study.
Objectives: To investigate the minimum important difference (MID) of the Patient-Specific Functional Scale (PSFS), 4 region-specific outcome measures, and the numeric pain rating scale (NPRS) across 3 levels of patient-perceived global rating of change in a clinical setting.
Background: The MID varies depending on the external anchor defining patient-perceived "importance." The MID for the PSFS

has not been established across all body regions.
Methods: One thousand seven hundred eight consecutive patients with musculoskeletal disorders were recruited from 5 physical therapy clinics. The PSFS, NPRS, and 4 region-specific outcome measures-the Oswestry Disability Index, Neck Disability Index, Upper Extremity Functional Index, and Lower Extremity Functional Scale-were assessed at the initial and final physical therapy visits. Global rating of change was assessed at the final visit. MID was calculated for the PSFS and NPRS (overall and for each body region), and for each region-specific outcome measure, across 3 levels of change defined by the global rating of change (small, medium, large change) using receiver operating characteristic curve methodology.
Results: The MID for the PSFS (on a scale from 0 to 10) ranged from 1.3 (small change) to 2.3 (medium change) to 2.7 (large change), and was relatively stable across body regions. MIDs for the NPRS (-1.5 to -3.5), Oswestry Disability Index (-12), Neck Disability Index (-14), Upper Extremity Functional Index (6 to 11), and Lower Extremity Functional Scale (9 to 16) are also reported.
Conclusion: We reported the MID for small, medium, and large patient-perceived change on the PSFS, NPRS, Oswestry Disability Index, Neck Disability Index, Upper Extremity Functional Index, and Lower Extremity Functional Scale for use in clinical practice and research.

Contributed Indexing: *Keywords:* clinimetrics; functional outcome measure; outcome assessment

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LEADERSHIP INSTITUTE GROUP PROJECT Guidelines

Participants will work in groups and develop a project that addresses one of the following objectives:

- Increase the awareness of the profession of physiotherapy among the general public in order to increase utilization of rehabilitation services and reach under-served populations

- Increase the awareness of the profession of physiotherapy among other health care professionals in order to increase utilization of rehabilitation services and reach under-served populations.

- Continue the development and dissemination of professional knowledge, values, skills, and physiotherapy practice.

While no one project can completely meet one of the above objectives, your project should work *toward* these objectives with plans and goals. You should not expect your project will be ready to be implemented by the end of the Leadership Institute. You can expect that there will be ongoing feedback from volunteers to help you complete your project and get it ready for implementation.

Some examples:
In order to sensitize the general public about the profession of physiotherapy, a group may decide to organize a day in which the participants and colleagues perform postural assessments and offer suggestions for improvement.

To continue to develop physiotherapy practice, a group may decide to perform such a systematic review of literature, with the goal of presenting the information to others for CPDs, presenting at a conference and/or publishing in a journal.

YOUR GROUP'S FIRST STEP:
Choose which objective you would like to address.

NEXT STEP:
Think of some projects that will work toward this objective.
Completing this project will õŜ your group's Long Term Goal.

PROJECT WORKSHEET

Group Members :

Objective:

Your project:

What is your Long-Term Goal?

Group members:

Group Project / LTG:

Considerations for your long-term goal:

1) What will you gain by accomplishing this goal?

2) What obstacles do you see getting in the way as you start to work toward this goal?

List the obstacles and some potential strategies to overcome them.

Obstacles	Strategies

List the steps (short-term goals) you need to accomplish in order to complete your project and reach that long-term goal.

Some short term goals to consider:

Your group will need to talk to other people ('stakeholders') about this project.

- Come up with a list of who else will be involved in the project.
- Depending on the project, it may be other physiotherapists, community members, physicians, nurses, members of the RAHPC, etc.
- Come up with a plan of who will talk to the stakeholders.
  BE SPECIFIC – this is one set of short-term goals.

Consider if you need supplies for your project. Come up with a short-term goal for investigating that.

Are there statistics you need to obtain? For instance, if you want to do balance assessments, WHY do you want to do them? Is there a need? Is that need documented anywhere, or has someone told you about this need?

Assign group members to be responsible for each STG.

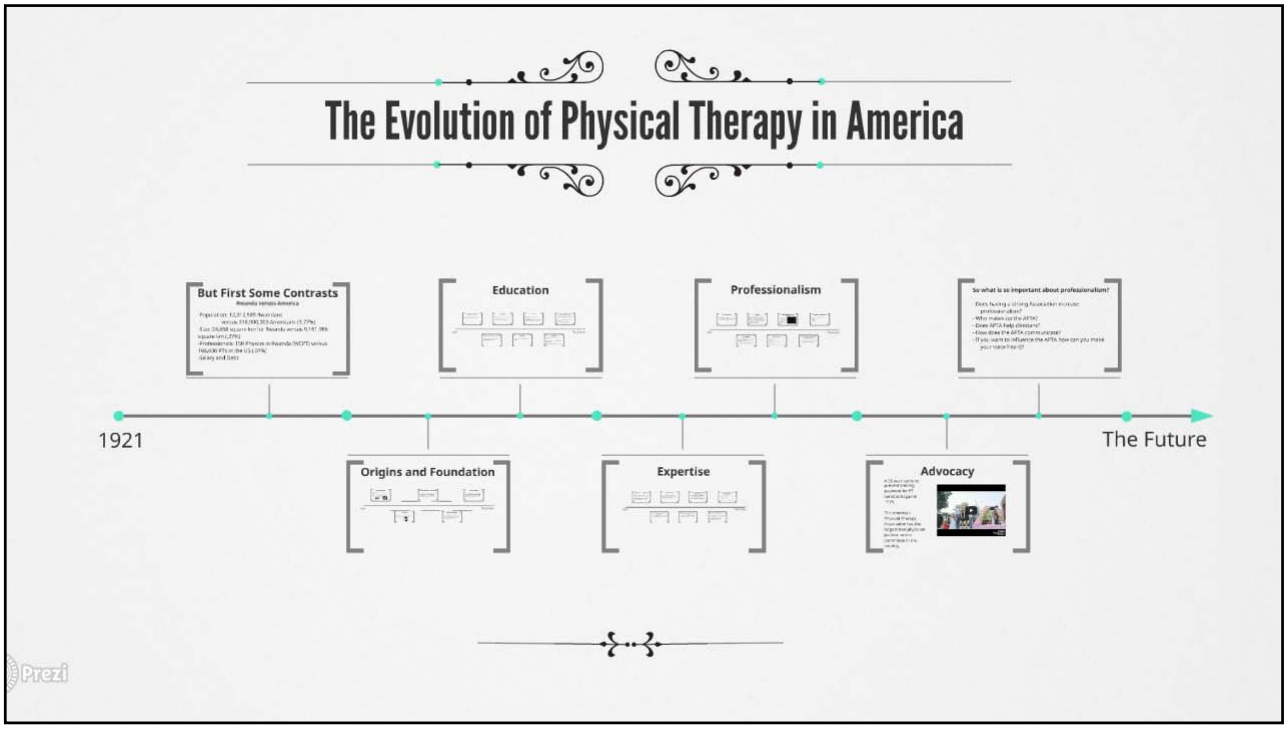
STG:	Who is responsible?

Example:
You live in an area with many elderly people who are at risk for falling.

You decide you can sensitize the community to physiotherapy and help identify people in the community who are at risk for falls.

Our Project: We plan to hold a balance clinic. We will assess balance using the Berg Balance Scale. We will provide participants with their balance score, and tell them if they are at risk for falls. We will provide a list of exercises that improve balance. The name of our clinic and the phone number will be on the sheet.

LTG: In 6 months, we plan to hold a balance clinic at the _____ to identify community members at risk for falls, and sensitize the community about physiotherapy.

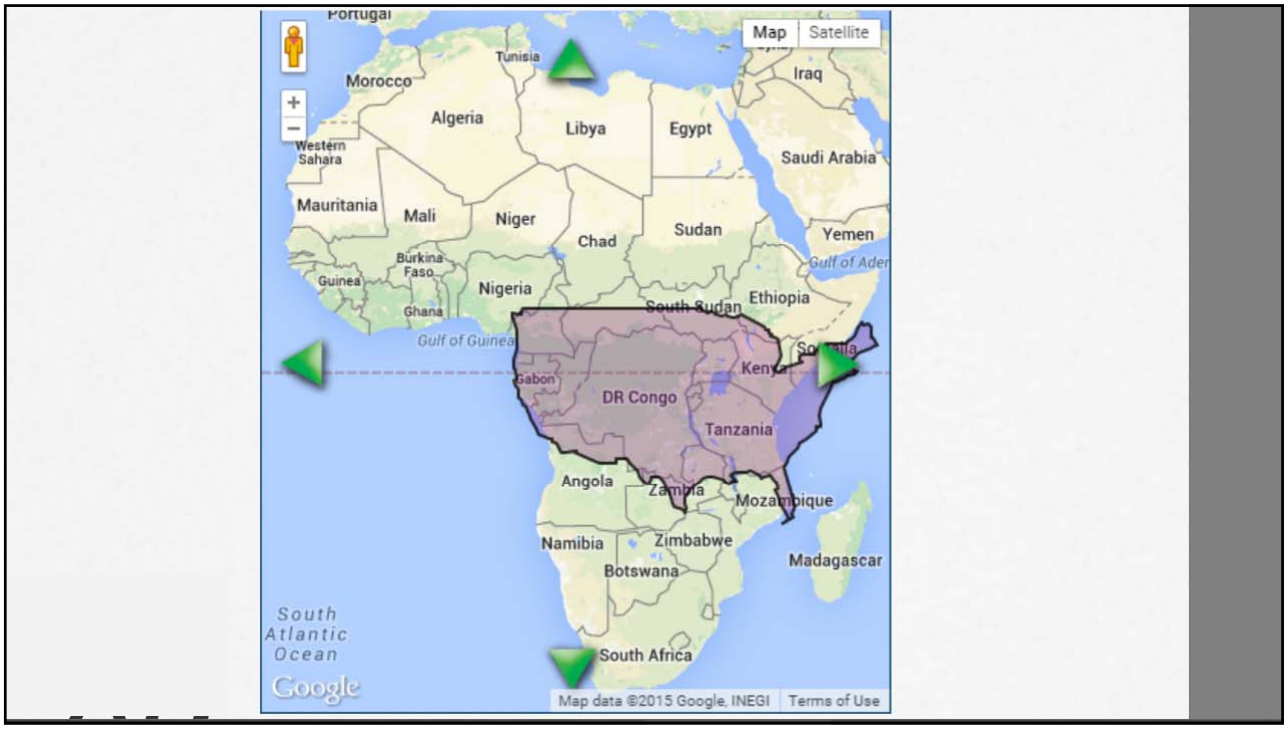


But First Some Contrasts

Rwanda versus America

-Population: 12,012,589 Rwandans
versus 318,900,000 Americans (3.77%)
-Size: 24,668 square km for Rwanda versus 9,161,966 square km (.27%)
-Professionals: 150 Physios in Rwanda (WCPT) versus 198,600 PTs in the US (.07%)
-Salary and Debt

Prezi


Map
Satellite
Portugal
Tunisia
Morocco
Algeria
Libya
Egypt
Iraq
Saudi Arabia
Western Sahara
Mauritania
Mali
Niger
Chad
Sudan
Yemen
Burkina Faso
Guinea
Nigeria
Ethiopia
Ghana
Gulf of Guinea
South Sudan
Kenya
Gabon
DR Congo
Tanzania
Angola
Zambia
Mozambique
Namibia
Zimbabwe
Botswana
Madagascar
South Atlantic Ocean
South Africa
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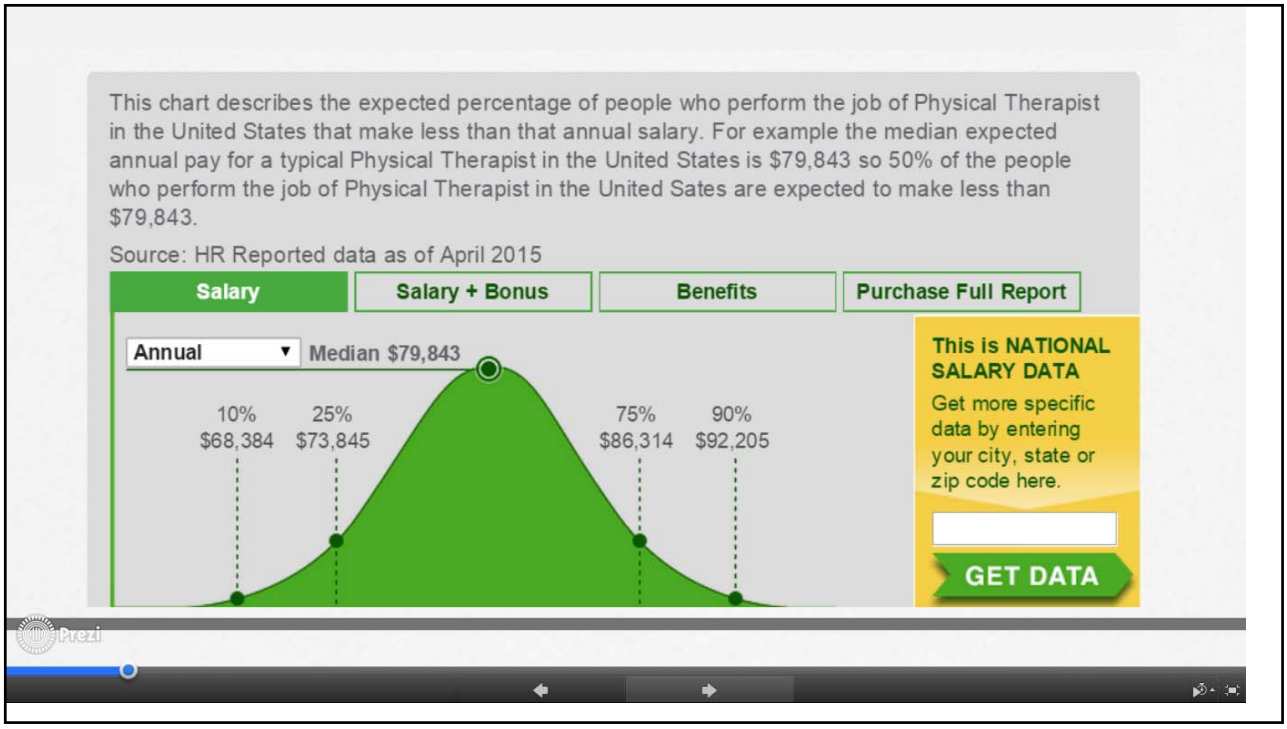
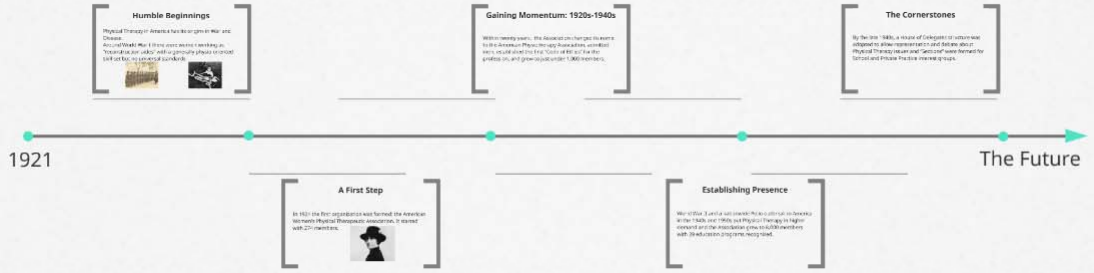

This chart describes the expected percentage of people who perform the job of Physical Therapist in the United States that make less than that annual salary. For example the median expected annual pay for a typical Physical Therapist in the United States is $79,843 so 50% of the people who perform the job of Physical Therapist in the United Sates are expected to make less than $79,843.
Source: HR Reported data as of April 2015
Salary
Salary + Bonus
Benefits
Purchase Full Report
Annual
Median $79,843
10%
$68,384
25%
$73,845
75%
$86,314
90%
$92,205
This is NATIONAL SALARY DATA
Get more specific data by entering your city, state or zip code here.
GET DATA
Prezi

Origins and Foundation



Humble Beginnings

Physical Therapy in America has its origins in War and Disease.
Around World War I there were women working as “reconstruction aides” with a generally physio-oriented skill set but no universal standards.

A First Step

In 1921 the first organization was formed: the American Women's Physical Therapeutic Association. It started with 274 members.

Gaining Momentum: 1920s-1940s

Within twenty years, the Association changed its name to the American Physiotherapy Association, admitted men, established the first "Code of Ethics" for the profession, and grew to just under 1,000 members.

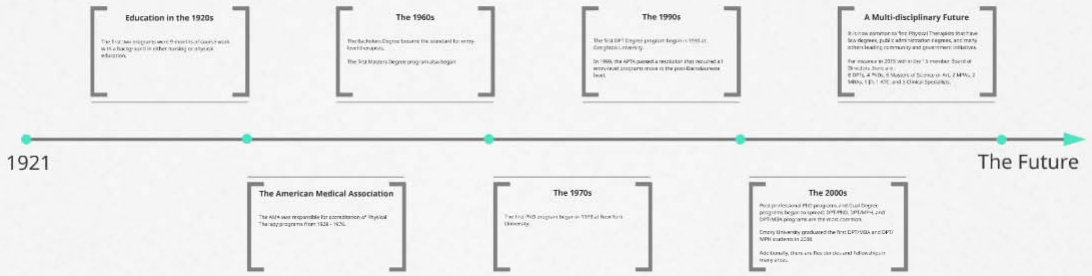
Establishing Presence

World War II and a nationwide Polio outbreak in America in the 1940s and 1950s put Physical Therapy in higher demand and the Association grew to 8,000 members with 39 education programs recognized.

The Cornerstones

By the late 1940s, a House of Delegates structure was adopted to allow representation and debate about Physical Therapy issues and “Sections” were formed for School and Private Practice interest groups.

Education



Education in the 1920s

The first two programs were 9-months of course work with a background in either nursing or physical education.

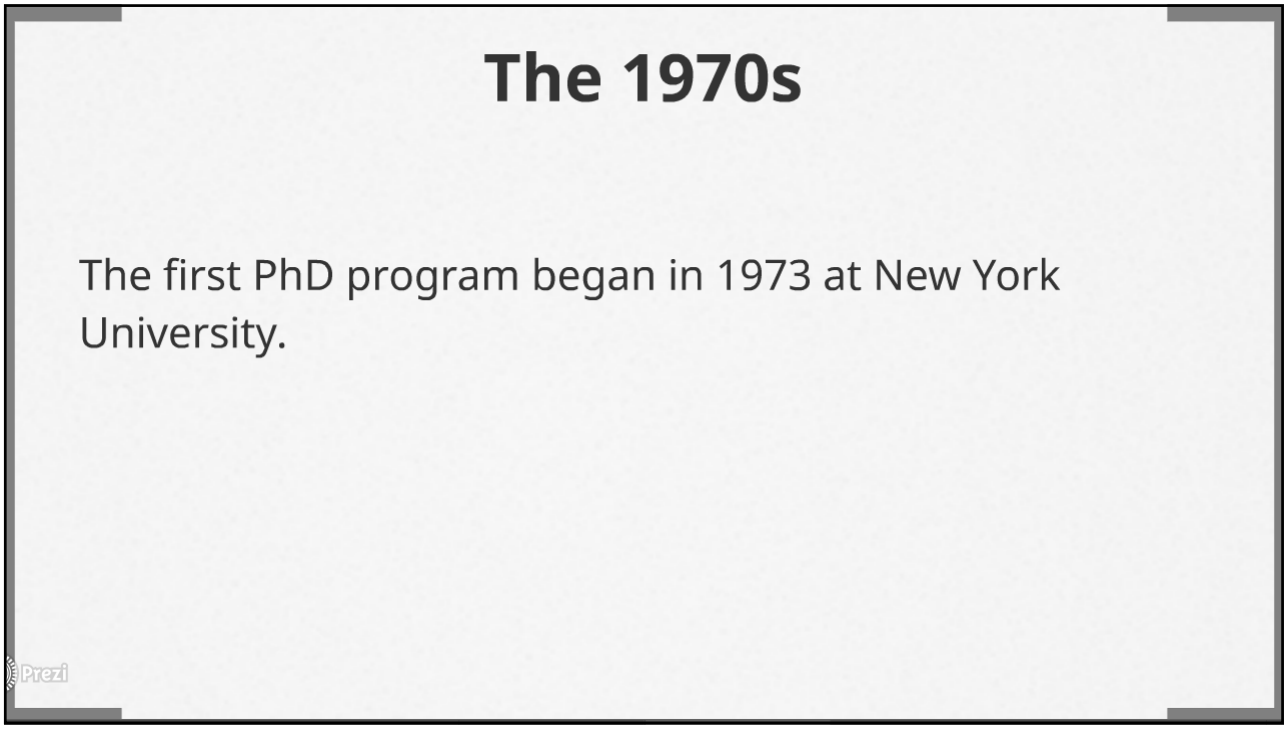
The American Medical Association

The AMA was responsible for accreditation of Physical Therapy programs from 1928 - 1976.

The 1960s

The Bachelors Degree became the standard for entry-level therapists.

The first Masters Degree program also began.


The 1970s
The first PhD program began in 1973 at New York University.
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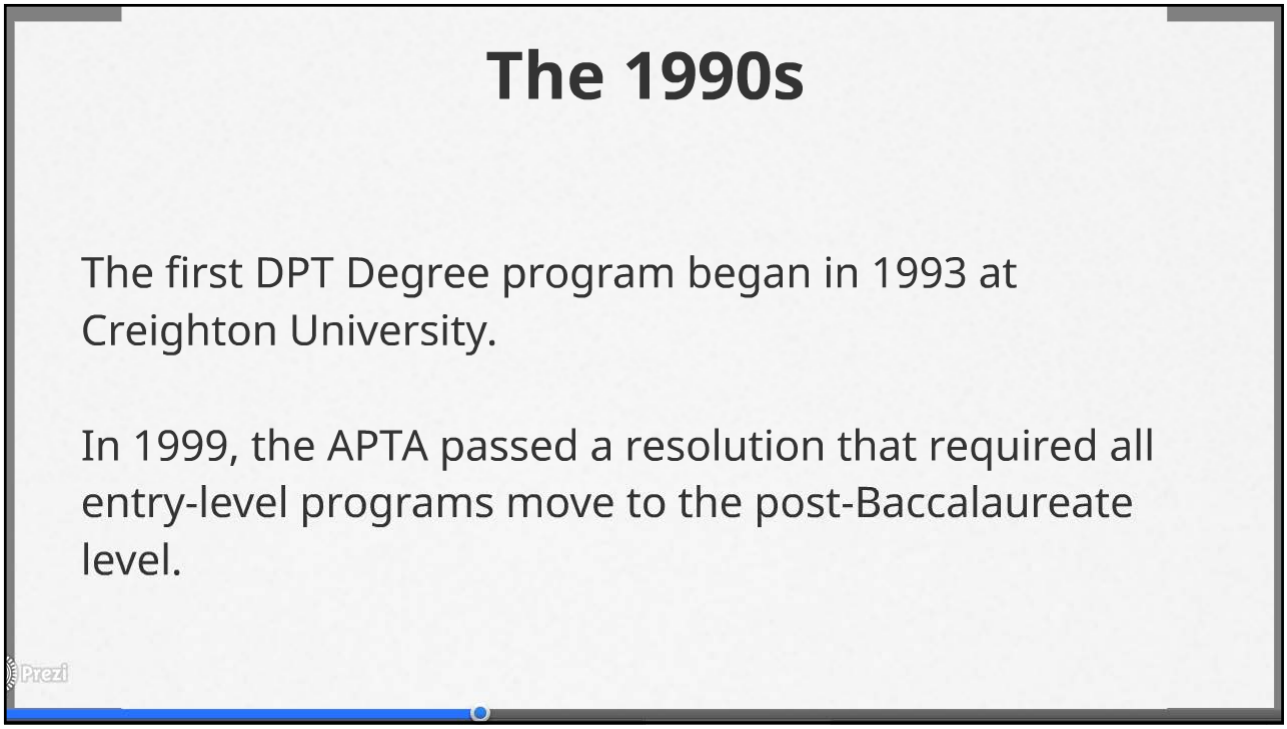

The 1990s
The first DPT Degree program began in 1993 at Creighton University.
In 1999, the APTA passed a resolution that required all entry-level programs move to the post-Baccalaureate level.
Prezi

The 2000s

Post-professional PhD programs and Dual Degree programs began to spread: DPT/PhD, DPT/MPH, and DPT/MBA programs are the most common.

Emory University graduated the first DPT/MBA and DPT/MPH students in 2008.

Additionally, there are Residencies and Fellowships in many areas.

A Multi-disciplinary Future

It is now common to find Physical Therapists that have law degrees, public administration degrees, and many others leading community and government initiatives.

For instance in 2015 within the 15 member Board of Directors there are :
8 DPTs, 4 PhDs, 6 Masters of Science or Art, 2 MPAs, 2 MBAs, 1 JD, 1 ATC, and 3 Clinical Specialists.

Expertise

Polio And Increased Demand

The effects of Polio found Physical Therapists working alongside physicians and researchers on the front lines of the disease.

During the 1940s two special interest groups formed within the Association: School and Private Practice

A Growing need for Content Expertise

In 1974 an Orthopedic Section was created for therapists focusing on Manual Therapy and Orthopedics.

Another Milestone

In 1976, the Association approved the concept of specialization. The precursor to advanced, specialty training was endorsed. (In fifty-five years, the profession grew from birth to splintering into specialties.)

The First Specialist Took A Little Longer

The first Specialization exam was given in Cardiovascular and Pulmonary Physical Therapy in 1985.

Practice Further Diverged From The Original Model

By the end of the 1980s, over 50% of active physical therapists were working outside hospital settings.

At the same time, disadvantages of Physician Owned Physical Therapy Services were being researched.

The 1990s: Defining What PT Does

APTA published the Guide to Physical Therapist Practice in 1995

Also by the mid 1990s, there were 18 Sections or nationwide special interest groups within the organization.

The 2000s: Guidelines and Consumer Focus

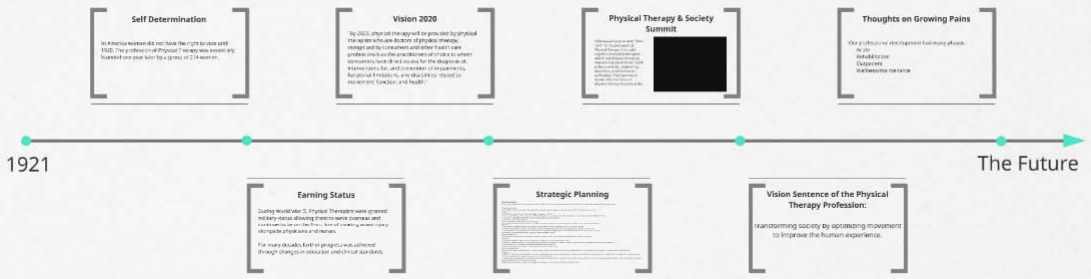
Clinical Practice Guidelines (109 of them) and Clinical Summaries are now available through the APTA website.

Guidelines for Documentation have been created.

The APTA maintains a "Consumer Portal" for potential clients looking for answers to their PT questions.

APTA also provides $2,000 worth of continuing education courses for free to members.

Professionalism



Self Determination

In America women did not have the right to vote until 1920. The profession of Physical Therapy was essentially founded one year later by a group of 274 women.

Earning Status

During World War II, Physical Therapists were granted military status allowing them to serve overseas and continue to be on the front line of treating acute injury alongside physicians and nurses.

For many decades further progress was achieved through changes in education and clinical standards.

Vision 2020

"By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health."

Strategic Planning

Association Purpose
The American Physical Therapy Association (association) exists to improve the health and quality of life of individuals in society by advancing physical therapist practice.

Effectiveness of Care
Goal 1: APTA will better enable physical therapists to consistently use best practice to improve the quality of life of their patients and clients.
Objectives:
a. Increase the number of peer-reviewed clinical practice guidelines (CPGs).
b. Increase practitioner use of and adherence to best practice guidelines to reduce unwarranted variation in care and enhance patient and client outcomes.
c. Develop and integrate available patient data registries, including quality measures.
d. Promote the use of valid measures.
Patient- and Client- Centered Care Across the Lifespan
Goal 2: APTA will be the recognized leader in supporting physical therapists in the delivery of patient- and client-centered care across the lifespan.
Objectives:
a. Increase the prevalence of physical therapists providing prevention (primary, secondary, tertiary) and wellness services.
b. Promote implementation of new or participation in existing innovative models of practice that target patient- and client-centered care.
c. Develop mechanisms to identify, prioritize, and address existing and emerging population-based health needs that will impact physical therapy.
d. Identify and address physical therapy supply and demand work force needs.
Professional Excellence
Goal 3: APTA will empower physical therapists to demonstrate and promote high standards of professional and intellectual excellence.
Objectives:
a. Promote modeling and demonstration of key values and behaviors that embrace professionalism.
b. Employ innovative active learning opportunities to enhance lifelong learning and collective abilities to provide optimal, collaborative patient- and client-centered care.
c. Promote excellence in entry-level education and lifelong learning for the PTA.
d. Demonstrate and promote interprofessional and intraprofessional collaboration.
Value and Accountability
Goal 4: APTA will be the recognized leader in setting standards for physical therapist service delivery and establishing and promoting the value of physical therapist practice to all stakeholders.
Objectives:
a. Advocate for appropriate administrative, legislative, and regulatory policies that demonstrate value, ensure safe and effective delivery, enhance access, and protect the integrity of the health care system.
b. Improve compliance with regulations, laws, and professional standards.
c. Advance payment systems that recognize the severity of patient condition and the intensity of interventions required; reflect the clinical reasoning, judgment, and decision-making of the physical therapist; and appropriately pay for the value of the services.
d. Define, advocate, and promote the role of the physical therapist in innovative and collaborative delivery models.

Physical Therapy & Society Summit

PASS was a first of its kind "Think Tank" for the profession of Physical Therapy. It brought together 90 physical therapists and 30 non-physical therapists representing government, health policy, academia, engineering, bioscience, and information technology. Their task was to decide what the future of physical therapy should look like.

https://www.youtube.com/watch?v=JqTz1Kuek1Q

Vision Sentence of the Physical Therapy Profession:

Transforming society by optimizing movement to improve the human experience.

Thoughts on Growing Pains

Our professional development had many phases:

- Acute
- Rehabilitation
- Outpatient
- Wellness/maintenance

APTA as it exists today:

- 90,000 members who elect 400 Delegates who elect 15 members of the Board of Directors and 5 members of the Nominating Committee
- 18 sections, 1 Assembly, and 1 Caucus.
- Annual budget of $43.5 Million with 180 full time employees.

Advocacy

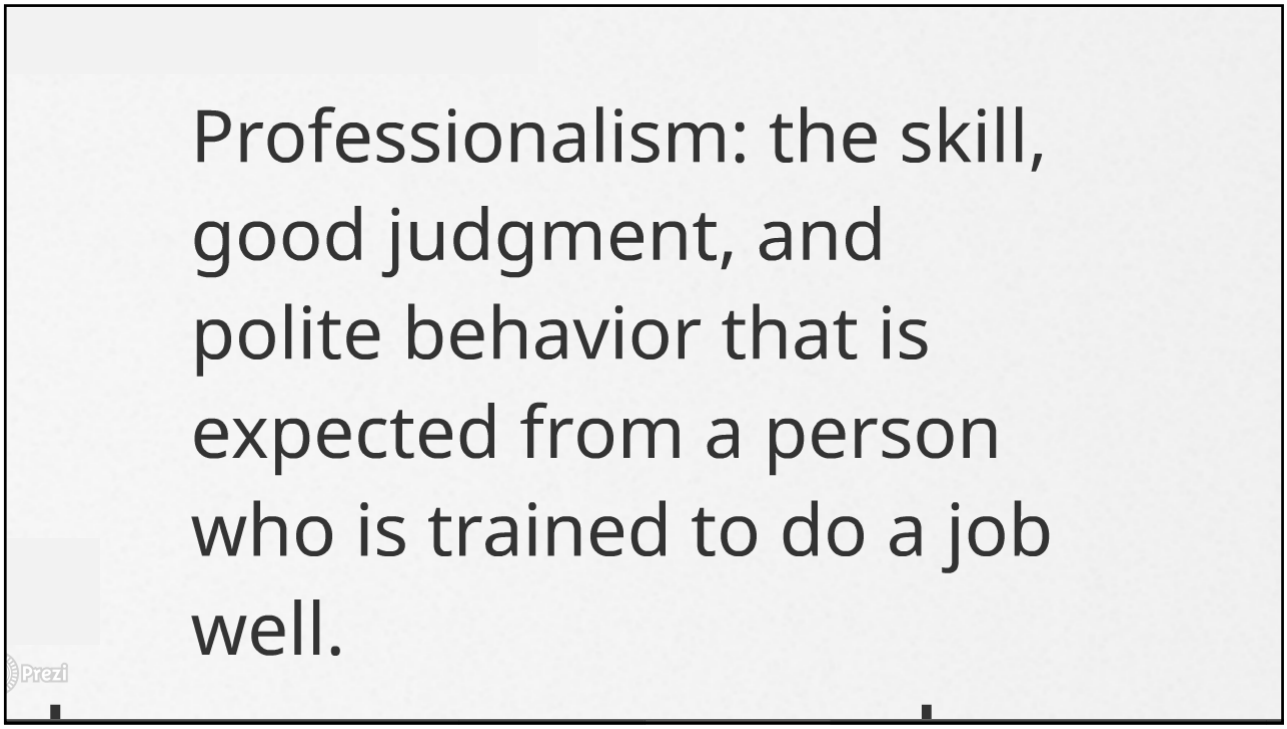
A 36 year battle to prevent limiting payment for PT services began in 1979.

The American Physical Therapy Association has the largest non-physician political action committee in the country.

PT Day on Capitol Hill 2011
https://www.youtube.com/watch?v=OCSetXGOgMc

So what is so important about professionalism?

- Does having a strong Association increase professionalism?
- Who makes up the APTA?
- Does APTA help clinicians?
- How does the APTA communicate?
- If you want to influence the APTA how can you make your voice heard?


Professionalism: the skill, good judgment, and polite behavior that is expected from a person who is trained to do a job well.
Prezi

What AKR can do for physiotherapists

Advocacy	23							
Advocate for increased employment			11					
Advocate for better salaries		6						
Advocate that PTs are paid based on their level of education				6				
Advocate to MOH for more PTs in District Hospitals / Hospitals			4					
Advocate to health ministry to increase PTs in all sectors of Health Centers			3					
Advocate for physio: what it is and their role; advocate to other health professions and leaders (MOH and Senate)							2	
Advocate to MOH that BSc is important in practice				3				
Advocacy for the recognition of our degrees							3	
Advocacy for more visibility and respect								
Advocate for PTs to be the first contact care providers								
Communication with members		**6**						
Increase communication - website and technology			2					
Consult members								
Recognize members								
Motivate other PTs to join by reaching out to them and getting their opinions								
Consider visits to departments to better understand condiitons and daily problems								
Do outreach to all physios; sensitize them to become members and pay membership								
Conduct a census about members' needs and suggestions								
We may try to join together to discuss our problems.								
Creat websites, journals			3					
Share information and experiences			2					
Plan meeting of members to share and discuss about PT vision				2				
Communcation through a leaflet about what we do								
Meetings at least twice per year						2		
Establish communication tools								

Reach PTs								
Reach all PTs, not just those in Kigali								
downwards communication								
Reach students before leaving school, sensitize them to join the association								
Make sure every PT student and PT is a member of the association				2				
Establish an office								
Give orders and recommendations to members								
Have a vision								
Make vision, mission and values available to members		6						
Establish a plan for the association and evaluation model								
Have a clear yearly strategic plan								
Set a good leadership / office and action plan								
Strengthen membership								
Market its role and working procedures to all Rwandans				2				
Sensitization about profession								
Explain the importance of the association								
Connect physio to MOH								
Search for PT sponsors								
Advertise the profession on the national level and regional								
Market Physiotherapy services								
Be more active								
Provide quarterly report								
Investigate an MSc program in Rwanda								
AKR would be regarded by daily development of careers								
Establish PT research center								
Scholarship for further education for at least one member per year								
Scholarship for further education for at least two members per year								
Advance education; evidence-based practice								

Work with government for scholarships for training to increase skills and knoweldge								
Organize / Provide CPDs		2						
Organize more training for members		2						
Create activities								
Find out about continuing education		2						
Should organize a conference to rebuild and renew all requesites for the future of the professsion								
Find out how PTs can work for schools, industries and communities								
Coordinate / establish professional policies, protocols and guidelines		3						
Develop guidelines for different conditions & disseminate them								
Avail job opportunities for non-working PTs								
Reduce physio unemployment / find jobs for PTs								
Find more ways to create new jobs for PTs								
Control PTs								
Help members be professional			2					
Protect members								
Protect from malpractice								
Leaders who work hard to improve the quality of the PT profession				1				
Leaders who are accountable	2							
Leaders who respect the law								
Leaders who respect the mandate								
Doesn't help	2							
Doesn't exist								

What you can do for the AKR

Contribute / pay membership	14		
Be active in association: participate in meetings and other activities	20		
Be a member	9		
Provide help for the advancement for the AKR's objectives, vision and mission	2		
Follow them in planned activties	2		
Advise AKR leaders	3		
Inform new members about the profession			
Be opinion producers in the association			
advocate for AKR	2		
Contribute ideas	3		
Encouragment of AKR Board of Directors			
Be star followers	2		
Form, start special interest groups			
Stead well in their position to make the association strong			
be professional at work			
Attend physiotherapy day			
Attend trainings			
Be ready to make change happen			
Encourage non-members to become members			

GUIDELINES: PHYSICAL THERAPY DOCUMENTATION OF PATIENT/CLIENT MANAGEMENT BOD G03-05-16-41
[Amended BOD 02-02-16-20; BOD 11-01-06-10; BOD 03-01-16-51; BOD 03-00-22-54; BOD 03-99-14-41; BOD 11-98-19-69; BOD 03-97-27-69; BOD 03-95-23-61; BOD 11-94-33-107; BOD 06-93-09-13; Initial BOD 03-93-21-55] [Guideline]

PREAMBLE

The American Physical Therapy Association (APTA) is committed to meeting the physical therapy needs of society, to meeting the needs and interests of its members, and to developing and improving the art and science of physical therapy, including practice, education and research. To help meet these responsibilities, APTA's Board of Directors has approved the following guidelines for physical therapy documentation. It is recognized that these guidelines do not reflect all of the unique documentation requirements associated with the many specialty areas within the physical therapy profession. Applicable for both hand written and electronic documentation systems, these guidelines are intended to be used as a foundation for the development of more specific documentation guidelines in clinical areas, while at the same time providing guidance for the physical therapy profession across all practice settings. Documentation may also need to address additional regulatory or payer requirements.

Finally, be aware that these guidelines are intended to address *documentation* of patient/client management, not to describe the provision of physical therapy services. Other APTA documents, including APTA Standards of Practice for Physical Therapy, Code of Ethics and Guide for Professional Conduct, and the Guide to Physical Therapist Practice, address provision of physical therapy services and patient/client management.

APTA POSITION ON DOCUMENTATION

Documentation Authority For Physical Therapy Services

Physical therapy examination, evaluation, diagnosis, prognosis, and plan of care (including interventions) shall be documented, dated, and authenticated by the physical therapist who performs the service. Interventions provided by the physical therapist or selected interventions provided by the physical therapist assistant under the direction and supervision of the physical therapist are documented, dated, and authenticated by the physical therapist or, when permissible by law, the physical therapist assistant.

Other notations or flow charts are considered a component of the documented record but do not meet the requirements of documentation in or of themselves.

Students in physical therapist or physical therapist assistant programs may document when the record is additionally authenticated by the physical therapist or, when permissible by law, documentation by physical therapist assistant students may be authenticated by a physical therapist assistant.

OPERATIONAL DEFINITIONS

Guidelines
APTA defines a "guideline" as a statement of advice.

Authentication
The process used to verify that an entry is complete, accurate and final. Indications of authentication can include original written signatures and computer "signatures" on secured electronic record systems only.
The following describes the main documentation elements of patient/client management: 1) initial examination/evaluation, 2) visit/encounter, 3) reexamination, and 4) discharge or discontinuation summary.

Initial Examination/Evaluation
Documentation of the initial encounter is typically called the "initial examination," "initial evaluation," or "initial examination/evaluation." Completion of the initial examination/ evaluation is typically completed in one visit, but may occur over more than one visit. Documentation elements for the initial examination/evaluation include the following:

Examination: Includes data obtained from the history, systems review, and tests and measures.

Evaluation: Evaluation is a thought process that may not include formal documentation. It may include documentation of the assessment of the data collected in the examination and identification of problems pertinent to patient/client management.

Diagnosis: Indicates level of impairment, activity limitation and participation restriction determined by the physical therapist. May be indicated by selecting one or more preferred practice patterns from the Guide to Physical Therapist Practice.

Prognosis: Provides documentation of the predicted level of improvement that might be attained through intervention and the amount of time required to reach that level. Prognosis is typically not a separate documentation elements, but the components are included as part of the plan of care.

Plan of care: Typically stated in general terms, includes goals, interventions planned, proposed frequency and duration, and discharge plans.

Visit/Encounter
Documentation of a visit or encounter, often called a progress note or daily note, documents sequential implementation of the plan of care established by the physical therapist, including changes in patient/client status and variations and progressions of specific interventions used. Also may include specific plans for the next visit or visits.

Reexamination
Documentation of reexamination includes data from repeated or new examination elements and is provided to evaluate progress and to modify or redirect intervention.

Discharge or Discontinuation Summary
Documentation is required following conclusion of the current episode in the physical therapy intervention sequence, to summarize progression toward goals and discharge plans.

GENERAL GUIDELINES

- Documentation is required for every visit/encounter.
- All documentation must comply with the applicable jurisdictional/regulatory requirements.
- All handwritten entries shall be made in ink and will include original signatures. Electronic entries are made with appropriate security and confidentiality provisions.
- Charting errors should be corrected by drawing a single line through the error and initialing and dating the chart or through the appropriate mechanism for electronic documentation that clearly indicates that a change was made without deletion of the original record.
- All documentation must include adequate identification of the patient/client and the physical therapist or physical therapist assistant:
    - The patient's/client's full name and identification number, if applicable, must be included on all official documents.
    - All entries must be dated and authenticated with the provider's full name and appropriate designation:
        - Documentation of examination, evaluation, diagnosis, prognosis, plan of care, and discharge summary must be authenticated by the physical therapist who provided the service.
        - Documentation of intervention in visit/encounter notes must be authenticated by the physical therapist or physical therapist assistant who provided the service.
        - Documentation by physical therapist or physical therapist assistant graduates or other physical therapists and physical therapist assistants pending receipt of an unrestricted license shall be authenticated by a licensed physical therapist, or, when permissible by law, documentation by physical therapist assistant graduates may be authenticated by a physical therapist assistant.
        - Documentation by students (SPT/SPTA) in physical therapist or physical therapist assistant programs must be additionally authenticated by the physical therapist or, when permissible by law, documentation by physical therapist assistant students may be authenticated by a physical therapist assistant.
- Documentation should include the referral mechanism by which physical therapy services are initiated. Examples include:

- Self-referral/direct access
- Request for consultation from another practitioner

- Documentation should include indication of no shows and cancellations.

INITIAL EXAMINATION/EVALUATION

Examination (History, Systems Review, and Tests and Measures)

History:

Documentation of history may include the following:

- General demographics
- Social history
- Employment/work (Job/School/Play)
- Growth and development
- Living environment
- General health status (self-report, family report, caregiver report)
- Social/health habits (past and current)
- Family history
- Medical/surgical history
- Current condition(s)/Chief complaint(s)
- Functional status and activity level
- Medications
- Other clinical tests

Systems Review:

Documentation of systems review may include gathering data for the following systems:

- Cardiovascular/pulmonary
  - Blood Pressure
  - Edema
  - Heart Rate
  - Respiratory Rate
- Integumentary
  - Pliability (texture)
  - Presence of scar formation
  - Skin color
  - Skin integrity
- Musculoskeletal
  - Gross range of motion
  - Gross strength
  - Gross symmetry
  - Height
  - Weight
- Neuromuscular
  - Gross coordinated movement (eg, balance, locomotion, transfers, and transitions)
  - Motor function (motor control, motor learning)

Documentation of systems review may also address communication ability, affect, cognition, language, and learning style:

- Ability to make needs known
- Consciousness
- Expected emotional/behavioral responses
- Learning preferences (eg, *education needs, learning barriers)*
- Orientation (person, place, time)

Tests and Measures:

Documentation of tests and measures may include findings for the following categories:

- Aerobic Capacity/Endurance

Examples of examination findings include:
- Aerobic capacity during functional activities
- Aerobic capacity during standardized exercise test protocols
- Cardiovascular signs and symptoms in response to increased oxygen demand with exercise or activity
- Pulmonary signs and symptoms in response to increased oxygen demand with exercise or activity

- Anthropometric Characteristics
  Examples of examination findings include:
  - Body composition
  - Body dimensions
  - Edema

- Arousal, attention, and cognition
  Examples of examination findings include:
  - Arousal and attention
  - Cognition
  - Communication
  - Consciousness
  - Motivation
  - Orientation to time, person, place, and situation
  - Recall

- Assistive and adaptive devices
  Examples of examination findings include:
  - Assistive or adaptive devices and equipment use during functional activities
  - Components, alignment, fit, and ability to care for the assistive or adaptive devices and equipment
  - Remediation of impairments, activity limitations and participation restrictions with use of assistive or adaptive devices and equipment
  - Safety during use of assistive or adaptive devices and equipment

- Circulation (Arterial, Venous, Lymphatic)
  Examples of examination findings include:
  - Cardiovascular signs
  - Cardiovascular symptoms
  - Physiological responses to position change

- Cranial and Peripheral Nerve Integrity
  Examples of examination findings include:
  - Electrophysiological integrity
  - Motor distribution of the cranial nerves
  - Motor distribution of the peripheral nerves
  - Response to neural provocation
  - Response to stimuli, including auditory, gustatory, olfactory, pharyngeal, vestibular, and visual
  - Sensory distribution of the cranial nerves
  - Sensory distribution of the peripheral nerves

- Environmental, Home, and Work (Job/School/Play) Barriers
  Examples of examination findings include:
  - Current and potential barriers
  - Physical space and environment

- Ergonomics and Body mechanics
  Examples of examination findings for *ergonomics* include:
  - Dexterity and coordination during work
  - Functional capacity and performance during work actions, tasks, or activities
  - Safety in work environments

- Specific work conditions or activities
- Tools, devices, equipment, and work-stations related to work actions, tasks, or activities

Examples of examination findings for *body mechanics* include:

- Body mechanics during self-care, home management, work, community, or leisure actions, tasks, or activities

- Gait, locomotion, and balance

  Examples of examination findings include:
  - Balance during functional activities with or without the use of assistive, adaptive, orthotic, protection, supportive, or prosthetic devices or equipment
  - Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
  - Gait and locomotion during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
  - Gait and locomotion with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
  - Safety during gait, locomotion, and balance

- Integumentary Integrity

  Examples of examination findings include:

  Associated skin:
  - Activities, positioning, and postures that produce or relieve trauma to the skin
  - Assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that may produce or relieve trauma to the skin
  - Skin characteristics

- Wound
  - Activities, positioning, and postures that aggravate the wound or scar or that produce or relieve trauma
  - Burn
  - Signs of infection
  - Wound characteristics
  - Wound scar tissue characteristics

- Joint Integrity and Mobility

  Examples of examination findings include:
  - Joint integrity and mobility
  - Joint play movements
  - Specific body parts

- Motor Function

  Examples of examination findings include:
  - Dexterity, coordination, and agility
  - Electrophysiological integrity
  - Hand function
  - Initiation, modification, and control of movement patterns and voluntary postures

- Muscle Performance

  Examples of examination findings include:
  - Electrophysiological integrity
  - Muscle strength, power, and endurance
  - Muscle strength, power, and endurance during functional activities
  - Muscle tension

- Neuromotor development and sensory integration

  Examples of examination findings include:
  - Acquisition and evolution of motor skills
  - Oral motor function, phonation, and speech production
  - Sensorimotor integration

- Orthotic, protective, and supportive devices
  Examples of examination findings include:
  - Components, alignment, fit, and ability to care for the orthotic, protective, and supportive devices and equipment
  - Orthotic, protective, and supportive devices and equipment use during functional activities
  - Remediation of impairments, activity limitations, and participation restrictions with use of orthotic, protective, and supportive devices and equipment
  - Safety during use of orthotic, protective, and supportive devices and equipment

- Pain
  Examples of examination findings include:
  - Pain, soreness, and nocioception
  - Pain in specific body parts

- Posture
  Examples of examination findings include:
  - Postural alignment and position (dynamic)
  - Postural alignment and position (static)
  - Specific body parts

- Prosthetic requirements
  Examples of examination findings include:
  - Components, alignment, fit, and ability to care for prosthetic device
  - Prosthetic device use during functional activities
  - Remediation of impairments, activity limitations, and participation restrictions with use of the prosthetic device
  - Residual limb or adjacent segment
  - Safety during use of the prosthetic device

- Range of motion (including muscle length)
  Examples of examination findings include:
  - Functional ROM
  - Joint active and passive movement
  - Muscle length, soft tissue extensibility, and flexibility

- Reflex integrity
  Examples of examination findings include:
  - Deep reflexes
  - Electrophysiological integrity
  - Postural reflexes and reactions, including righting, equilibrium, and protective reactions
  - Primitive reflexes and reactions
  - Resistance to passive stretch
  - Superficial reflexes and reactions

- Self-care and home management (including activities of daily living and instrumental activities of daily living)
  Examples of examination findings include:
  - Ability to gain access to home environments
  - Ability to perform self-care and home management activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment
  - Safety in self-care and home management activities and environments

- Sensory integrity
  Examples of examination findings include:
  - Combined/cortical sensations
  - Deep sensations
  - Electrophysiological integrity

- Ventilation and respiration
  Examples of examination findings include:
  - Pulmonary signs of respiration/gas exchange
  - Pulmonary signs of ventilatory function
  - Pulmonary symptoms

- Work (job/school/play), community, and leisure integration or reintegration (including instrumental activities of daily living)
  Examples of examination findings include:
  - Ability to assume or resume work (job/school/plan), community, and leisure activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment
  - Ability to gain access to work (job/school/play), community, and leisure environments
  - Safety in work (job/school/play), community, and leisure activities and environments

Evaluation

- Evaluation is a thought process that may not include formal documentation. However, the evaluation process may lead to documentation of impairments, activity limitations, and participation restrictions using formats such as:
  - A problem list
  - A statement of assessment of key factors (e.g., cognitive factors, co- morbidities, social support) influencing the patient/client status.

Diagnosis

- Documentation of a diagnosis determined by the physical therapist may include impairment, activity limitation, and participation restrictions. Examples include:
  - Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Localized Inflammation (4E)
  - Impaired Motor Function and Sensory Integrity Associated With Progressive Disorders of the Central Nervous System (5E)
  - Impaired Aerobic Capacity/Endurance Associated With Cardiovascular Pump Dysfunction or Failure (6D)
  - Impaired Integumentary Integrity Associated With Partial-Thickness Skin Involvement and Scar Formation (7C)

Prognosis

- Documentation of the prognosis is typically included in the plan of care. See below.

Plan of Care

- Documentation of the plan of care includes the following:
  - Overall goals stated in measurable terms that indicate the predicted level of improvement in functioning
  - A general statement of interventions to be used
  - Proposed duration and frequency of service required to reach the goals
  - Anticipated discharge plans
  -

VISIT/ENCOUNTER

- Documentation of each visit/encounter shall include the following elements:
  - Patient/client self-report (as appropriate).
  - Identification of specific interventions provided, including frequency, intensity, and duration as appropriate. Examples include:
    - Knee extension, three sets, ten repetitions, 10# weight
    - Transfer training bed to chair with sliding board
    - Equipment provided
  - Changes in patient/client impairment, activity limitation, and participation restriction status as they relate to the plan of care.
  - Response to interventions, including adverse reactions, if any.
  - Factors that modify frequency or intensity of intervention and progression goals, including patient/client adherence to patient/client-related instructions.
  - Communication/consultation with providers/patient/client/family/ significant other.

- Documentation to plan for ongoing provision of services for the next visit(s), which is suggested to include, but not be limited to:
  - The interventions with objectives
  - Progression parameters
  - Precautions, if indicated

REEXAMINATION

- Documentation of reexamination shall include the following elements:
  - Documentation of selected components of examination to update patient's/client's functioning, and/or disability status.
  - Interpretation of findings and, when indicated, revision of goals.
  - When indicated, revision of plan of care, as directly correlated with goals as documented.

DISCHARGE/DISCONTINUATION SUMMARY

- Documentation of discharge or discontinuation shall include the following elements:
  - Current physical/functional status.
  - Degree of goals achieved and reasons for goals not being achieved.
  - Discharge/discontinuation plan related to the patient/client's continuing care. Examples include:
    - Home program.
    - Referrals for additional services.
    - Recommendations for follow-up physical therapy care.
    - Family and caregiver training.
    - Equipment provided.

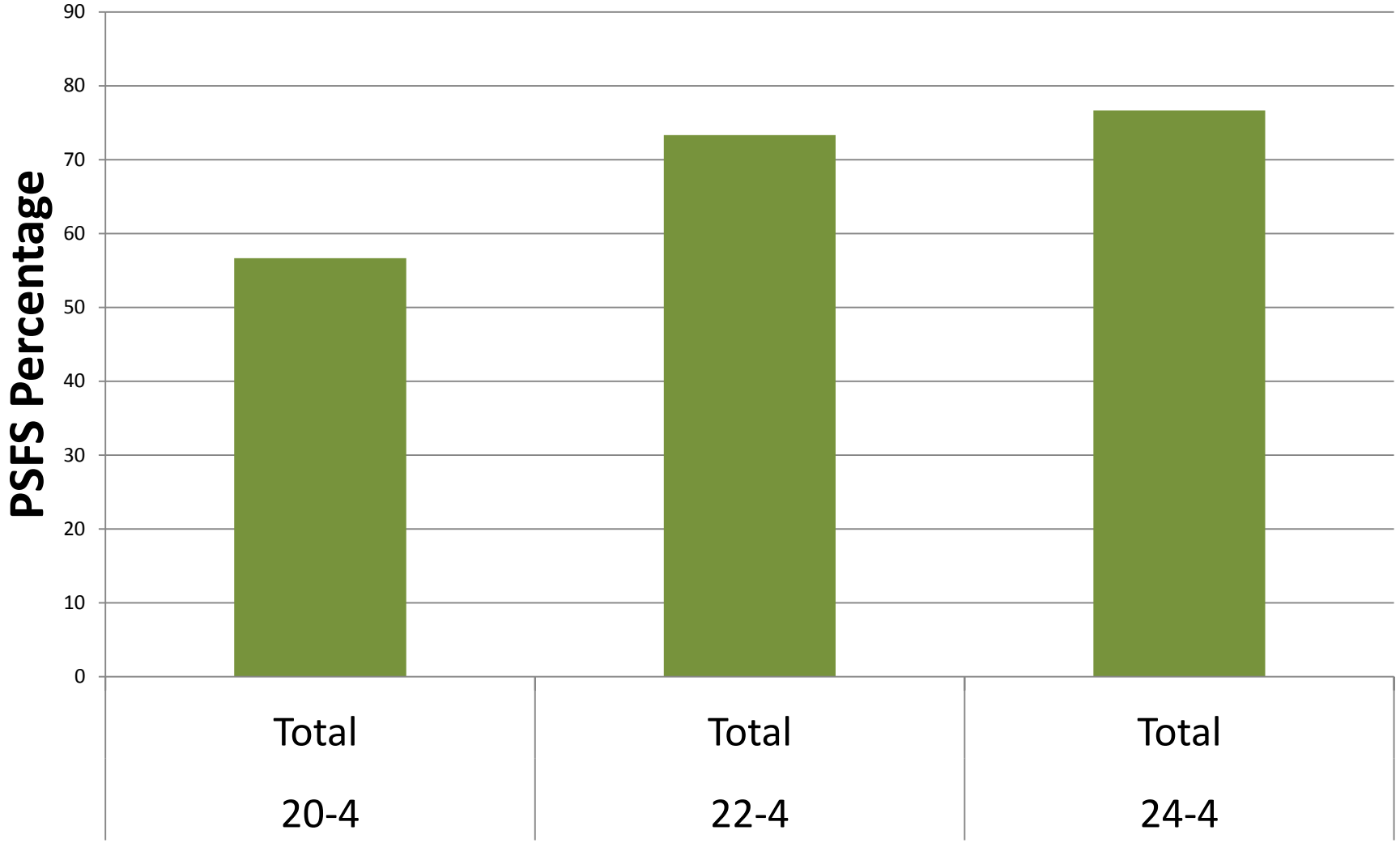
Relationship to Vision 2020: Professionalism; (Practice Department, ext 3176)

Explanation of Reference Numbers:
BOD P00-00-00-00 stands for Board of Directors/month/year/page/vote in the Board of Directors Minutes; the "P" indicates that it is a position (see below). For example, BOD P11-97-06-18 means that this position can be found in the November 1997 Board of Directors minutes on Page 6 and that it was Vote 18.

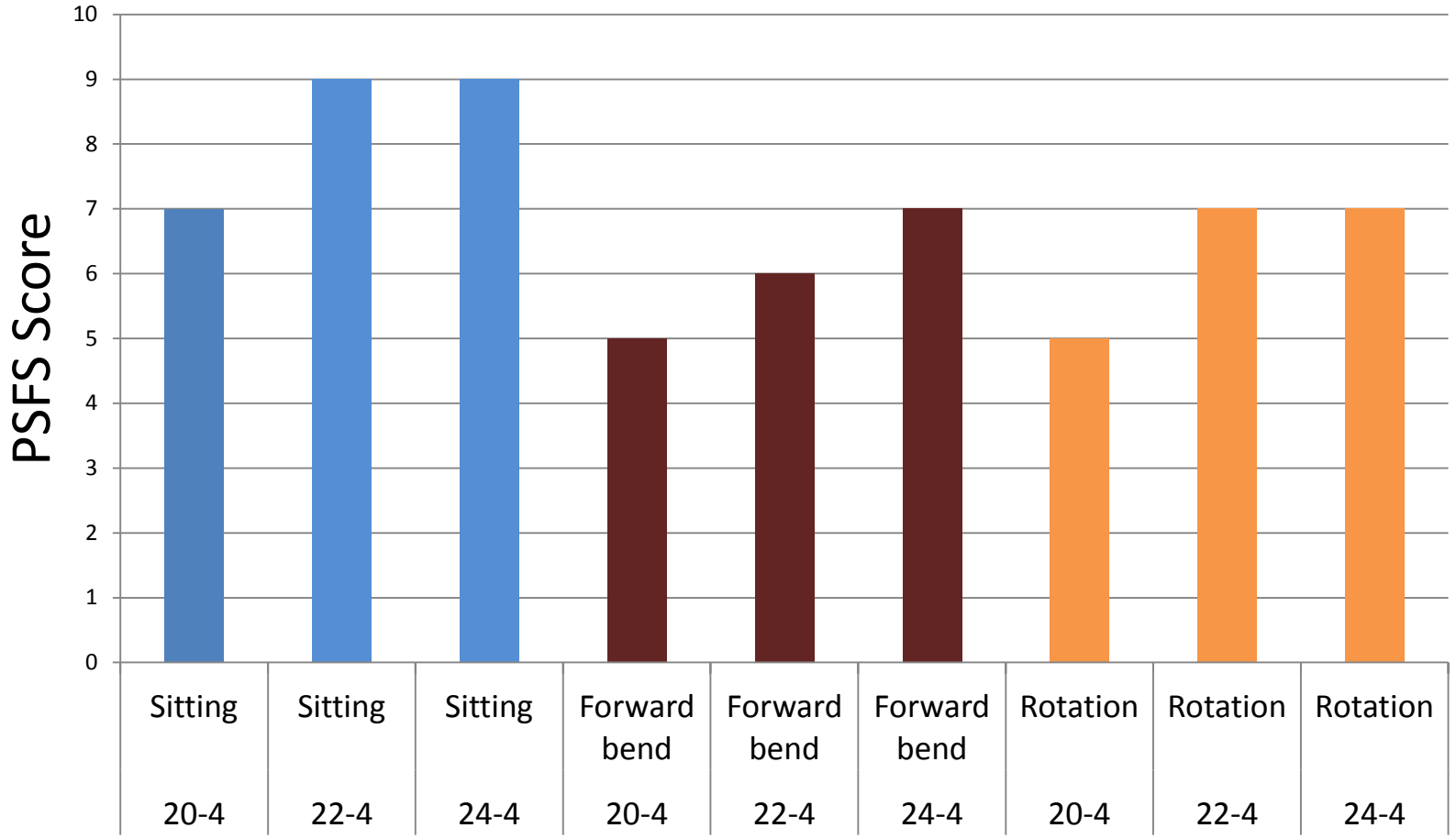
P: Position | S: Standard | G: Guideline | Y: Policy | R: Procedure


PSFS
REVIEW

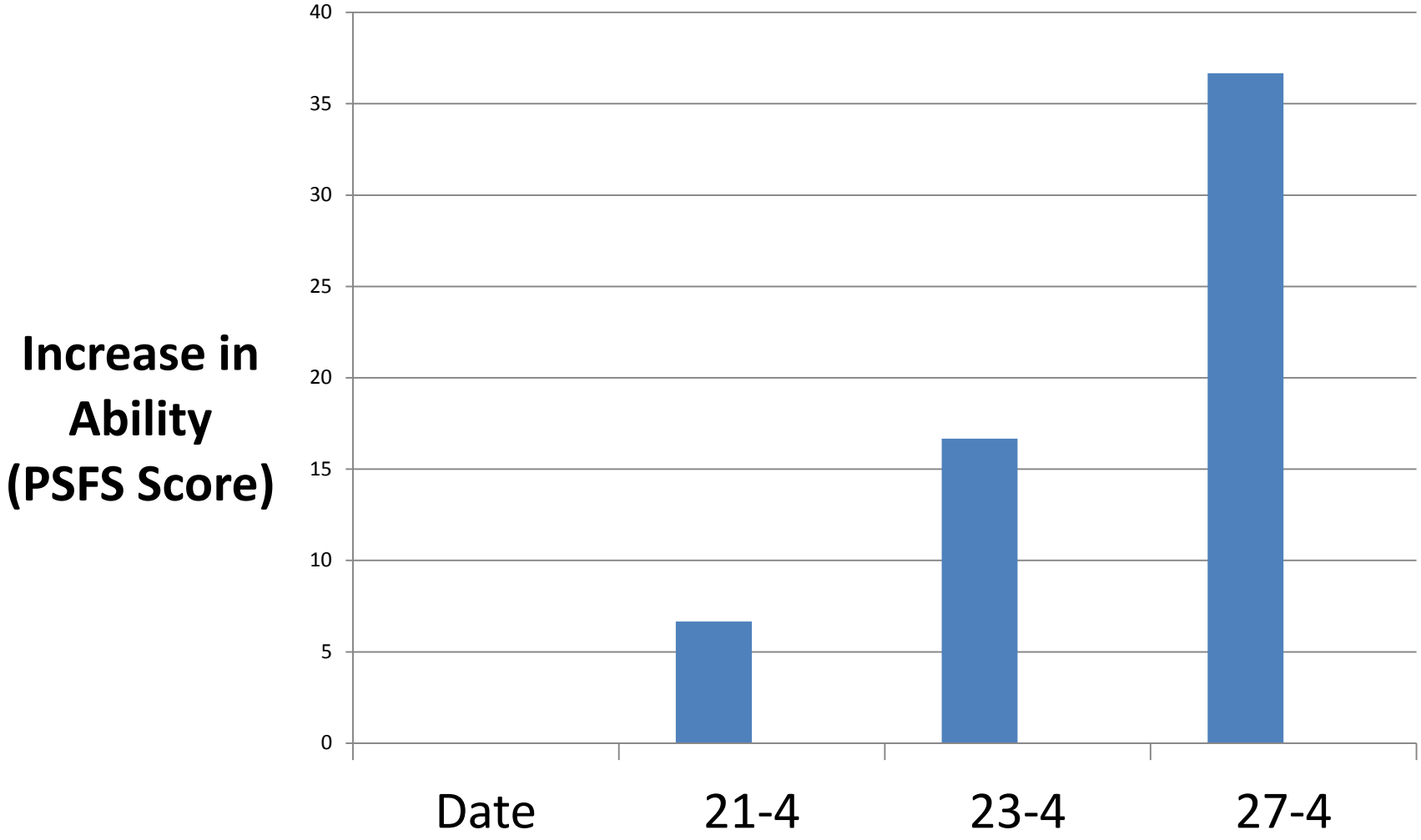
Improvement in Overall Disability - Low Back Pain



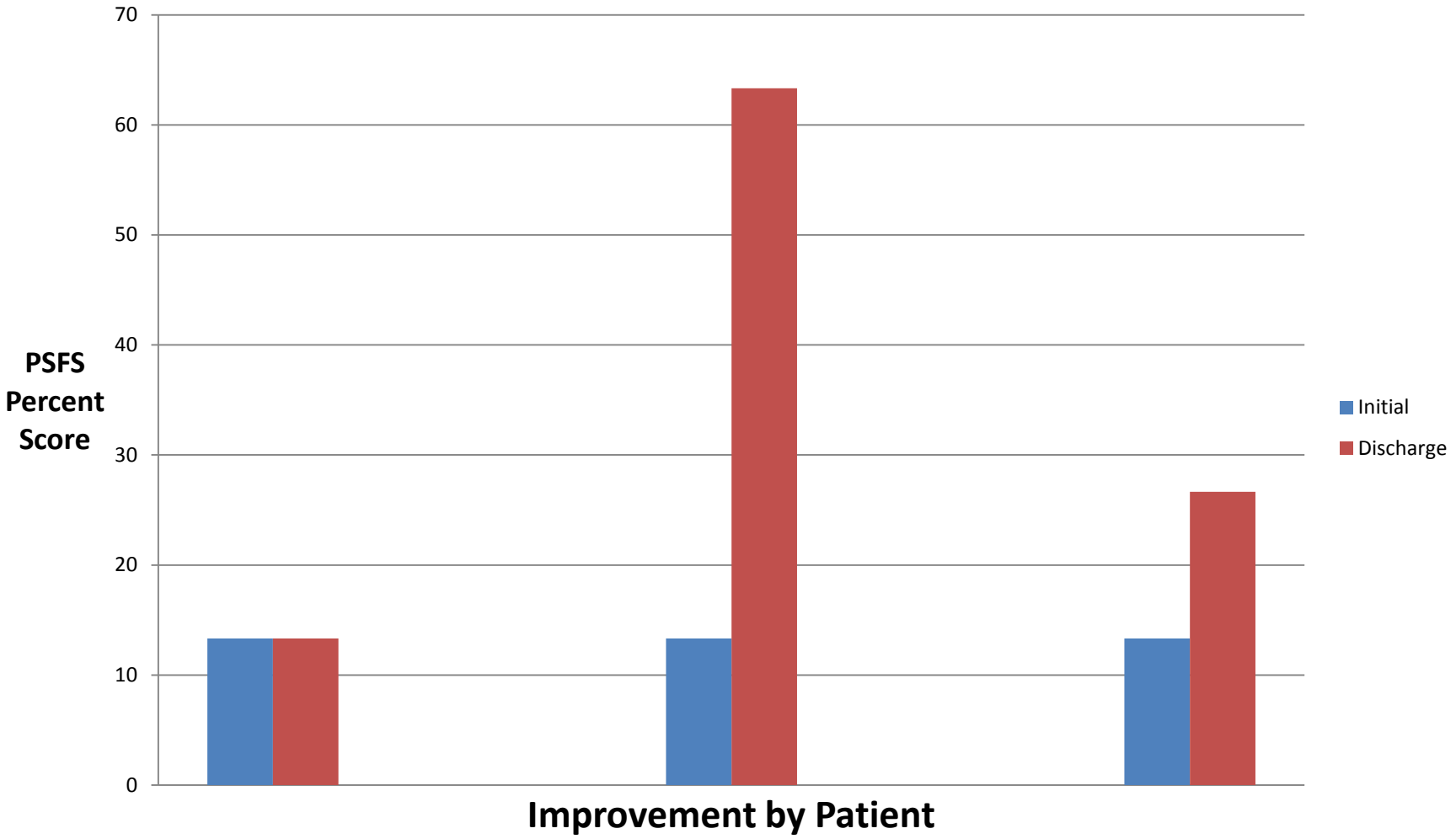
Improvement in Function: Low Back Pain



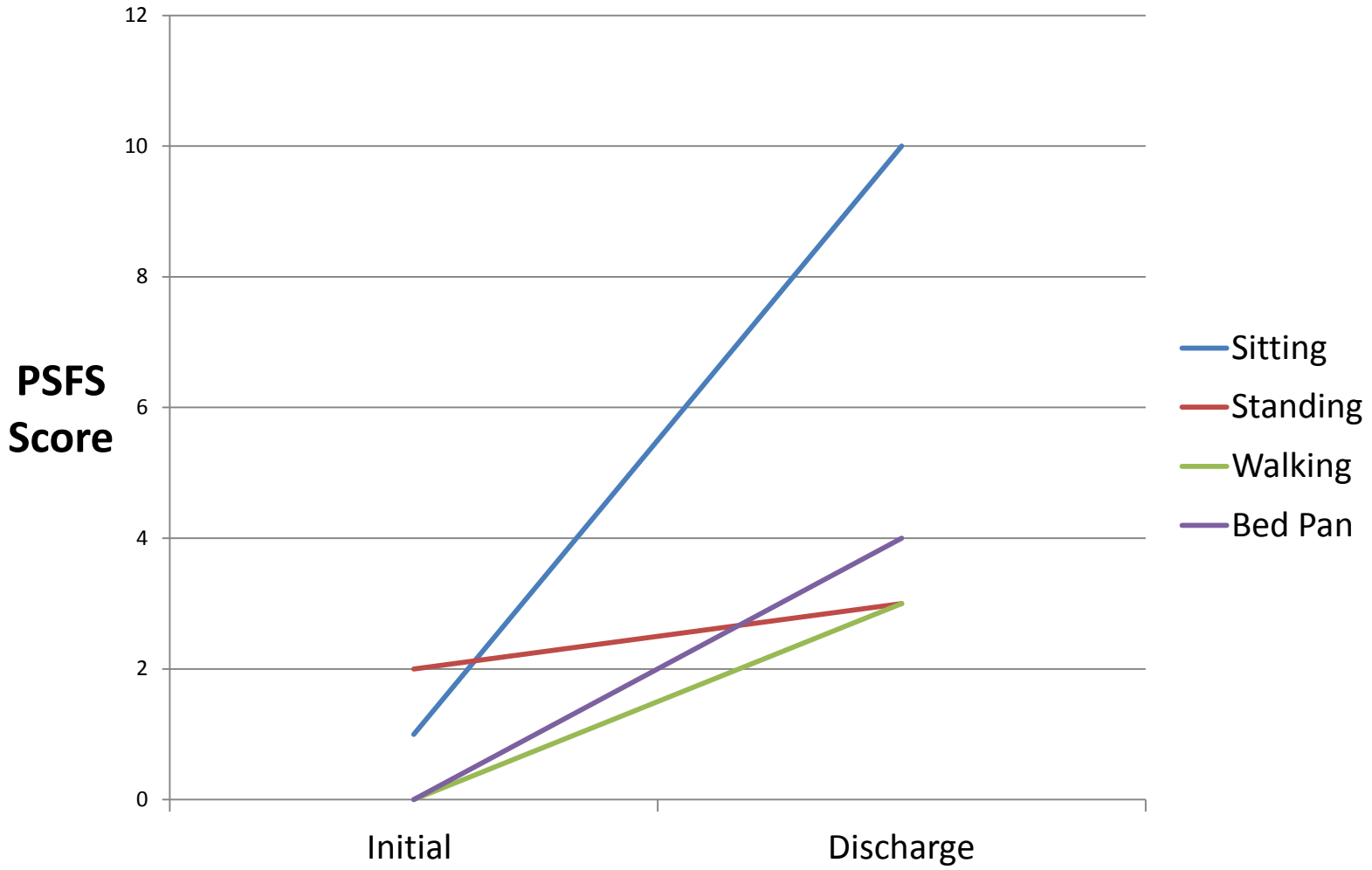
Improvement in Walking and Running: Ankle Sprain



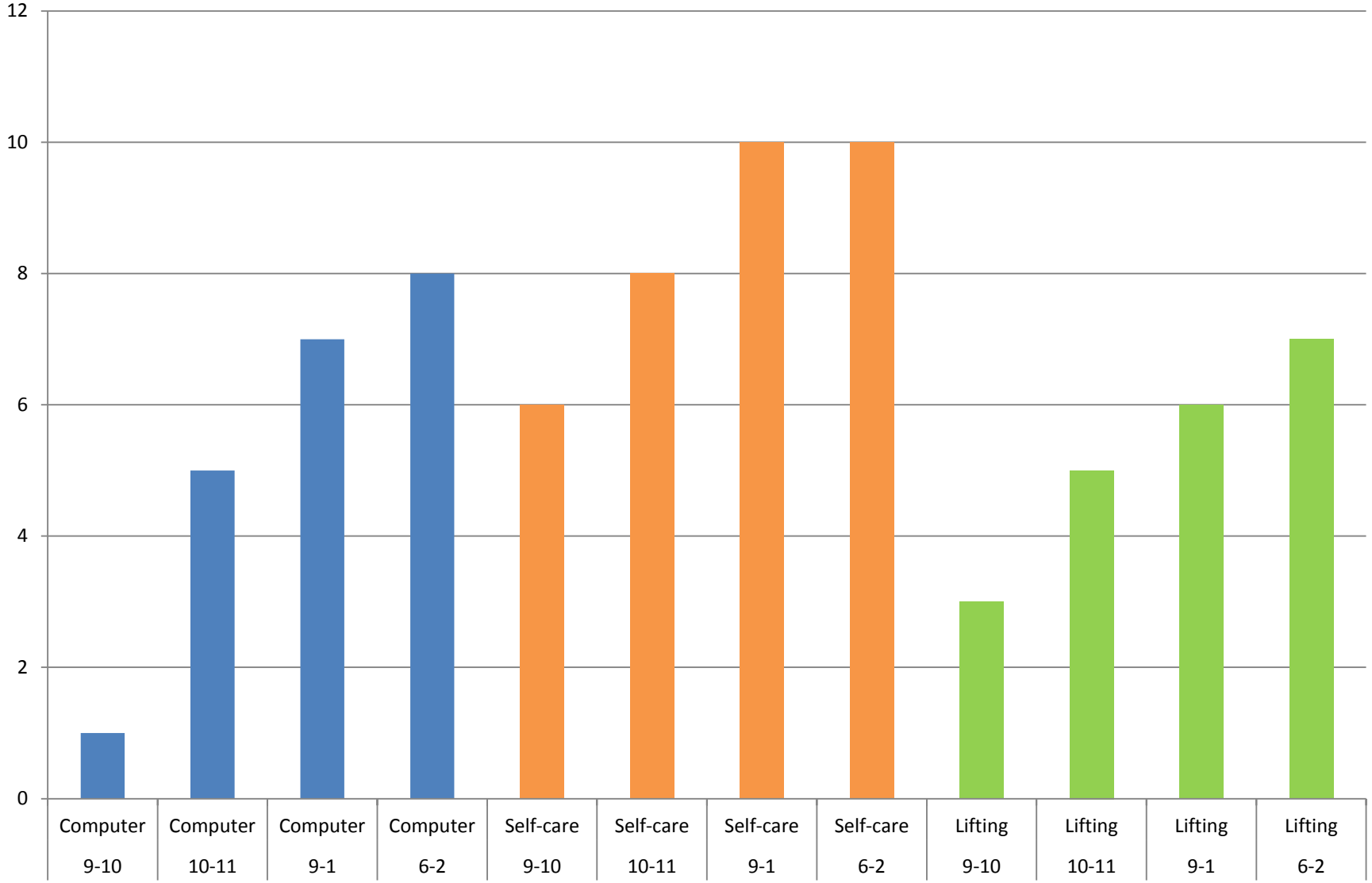
Improvement in Patients with Femur Fractures



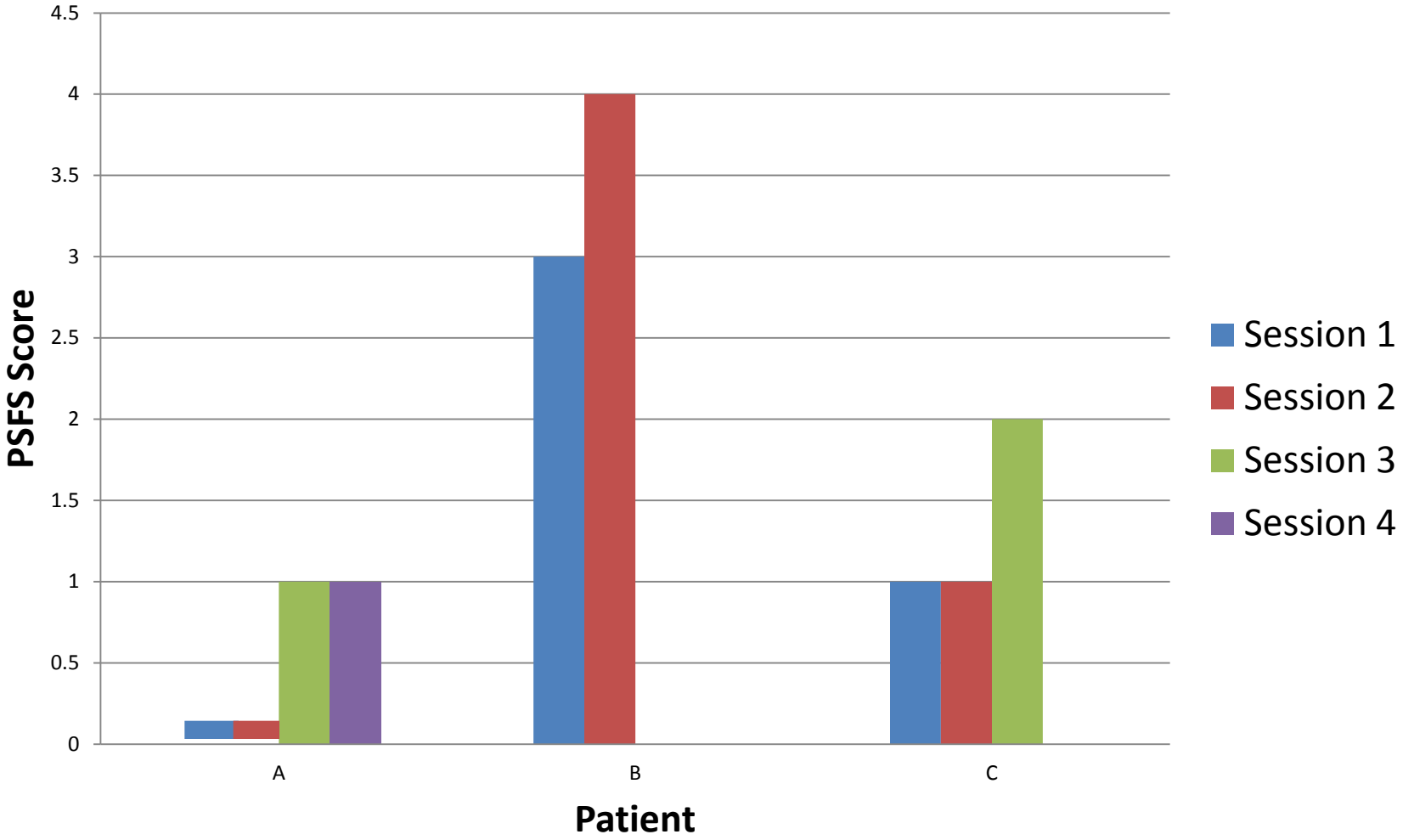
Improvement in Function with Physiotherapy after Femur Fracture



Improvement in Function from Physiotherapy for Thoracic Oulet Syndrome



Improvement in Squatting: 3 patients with Knee Stiffness



Other ways to use data / Other data

- Change over time
- Need for staff
- Patient volume per therapist
- Patient satisfaction
- Total income
- Diagnoses
- Number of sessions per patient
- Other outcomes

Peer review

- Treatment
- Documentation
  - Retrospective data

Name	Diagnosis	Date	Activity 1	Score	Activity 2	Score	Activity 3	Score	Total	Percent
1.1	Knee stiffness	26-4	Walking	6	Squatting	3	Kneeling	4	13	43.33
1.1	Knee stiffness	28-4	Walking	6	Squatting	4	Kneeling	4	14	46.67
1.2	LBP	20-4	Sitting	7	Forward bend	5	Rotation	5	17	56.67
1.2	LBP	22-4	Sitting	9	Forward bend	6	Rotation	7	22	73.33
1.2	LBP	24-4	Sitting	9	Forward bend	7	Rotation	7	23	76.67
1.3	Elbow ROM	20-4	Shaving	2	Eating	4	Lifting	2	8	26.67
1.3	Elbow ROM	24-4	Shaving	3	Eating	4	Lifting	3	10	33.33
1.4	Stroke	28-4	LUE use	0	LLE use	0	Turn	0	0	0.00
1.5	Tetraplegia	26-4	Turn	0	Lifting	0	Sitting	0	0	0.00
1.5	Tetraplegia	26-4	Turn	0	Lifting	0	Sitting	0	0	0.00
2.1	Knee stiffness	22-4	Walking	0	Squatting	0	Bending knee	2	2	6.67
2.2	paragplegia	20-4	Transfer	3	W/C propel	5	Sleep	6	14	46.67
2.3	Stroke	22-4	Sit to stand	4	Speak	2	Transfer	3	9	30.00
2.4	Ankle Stiffness	24-4	Squatting	3	Running	4	Don shoes	6	13	43.33
2.5	Shoulder dislocation	23-4	Don shirt	3	Grasp hands	1	Shake hands	1	5	16.67
3.1	Stroke	28-4	Sitting	1	Squatting	3	Walking	0	4	13.33
3.2	Colles fx	27-4	Comb hair	1	Lifting w hand	3	Shake hands	2	6	20.00
3.3	Arthritis	21-4	sleeping	2	Walking	3	Standing	2	7	23.33
3.4	Bronchitis	22-4	Breathing	3	Walking	4	Kneeling	2	9	30.00
4.1	DPN	11-4	Walking	3	Stairs	2	Bike	2	7	23.33
4.2	Shoulder pain	13-4	Washing	4	Combing	2	Brushing teeth	3	9	30.00
4.3	LBP	15-4	Tieing shoes	1	Independence	2	Sitting	3	6	20.00
4.4	RA	19-4	Bed mobility	3	Walking	3	Feeding	2	8	26.67
4.5	Knee stiffness	28-4	Toilet	1	Walking	2	Stairs	2	5	16.67
5.1	LBP	22-4	Sitting	4	Walking	2	Bathing	3	9	30.00
5.2	paragplegia	23-4	Stand	1	Sitting	2	Bed mobilty	3	6	20.00
5.3	Knee stiffness	27-4	Toilet	2	Stairs	2	Dressing	4	8	26.67
5.4	Stroke		Bed mobility	4	Walking	2	Bathing	4	10	33.33
6.1	Club foot	23-4	Squatting	1	Standing	4	Walking	4	9	30.00
6.2	Spastic diplegia	21-4	Walking	5	Squatting	2	Running	0	7	23.33
6.3	Down syndrome	27-4	Stand	6	Walking	3	Crawling	6	15	50.00
6.4	TBI	28-4	Squatting	0	Walking	3	Standing	0	3	10.00
6.5	SCI	27-4	Sitting	4	Supine to sit	1	Standing	1	6	20.00

7.1	tib-fib fx	21-4	Toilet	2	Bathing	3	Bed mobilty	1	6	20.00
7.1	tib-fib fx	27-4	Toilet	2	Bathing	2	Bed mobilty	2	6	20.00
7.1	tib-fib fx	30-4	Toilet	4	Bathing	4	Bed mobilty	4	12	40.00
7.2	tib-fib fx		Bed mobility	3	Jumping	4	Walking	4	11	36.67
7.2	tib-fib fx	21-4	Bed mobility	2	Jumping	1	Walking	1	4	13.33
7.2	tib-fib fx	28-4	Bed mobility	4	Jumping	2	Walking	3	9	30.00
7.2	tib-fib fx	30-4	Bed mobility	6	Jumping	5	Walking	6	17	56.67
7.3	femur fx	22-4	Stand	2	Supine to sit	2	Bed pan	0	4	13.33
7.3	femur fx	22-4	Stand	1	Supine to sit	2	Bed pan	1	4	13.33
7.3	femur fx	27-4	Stand	2	Supine to sit	3	Bed pan	2	7	23.33
7.3	femur fx	29-4	Stand	3	Supine to sit	1	Bed pan	4	8	26.67
7.4	femur fx	23-4	Bed mobility	2	Supine to sit	1	Dressing	1	4	13.33
7.4	femur fx	24-4	Bed mobility	1	Supine to sit	1	Dressing	0	2	6.67
7.4	femur fx	27-4	Bed mobility	1	Supine to sit	1	Dressing	1	3	10.00
7.4	femur fx	29-4	Bed mobility	1	Supine to sit	1	Dressing	2	4	13.33
7.5	femur fx	21-4	Sitting	2	Stairs	3	Walking	6	11	36.67
7.5	femur fx	21-4	Sitting	1	Stairs	1	Walking	2	4	13.33
7.5	femur fx	27-4	Sitting	2	Stairs	2	Walking	4	8	26.67
7.5	femur fx	29-4	Sitting	10	Stairs	3	Walking	6	19	63.33
8.1	plantar fascitis	17-1	Stand	6	Walking	6	Transfer	7	19	63.33
8.1	plantar fascitis	27-3	Stand	3	Walking	3	Transfer	3	9	30.00
8.1	plantar fascitis	16-4	Stand	1	Walking	1	Transfer	1	3	10.00
8.2	TOS	9-10	Computer	1	Self-care	6	Lifting	3	10	33.33
8.2	TOS	10-11	Computer	5	Self-care	8	Lifting	5	18	60.00
8.2	TOS	9-1	Computer	7	Self-care	10	Lifting	6	23	76.67
8.2	TOS	6-2	Computer	8	Self-care	10	Lifting	7	25	83.33
8.3	DDD	28-4	Sit to stand	3	Sitting	2	Standing	4	9	30.00
8.3	DDD	30-4	Sit to stand	4	Sitting	2	Standing	4	10	33.33
8.4	Ankle sprain	21-4	Walking	2	Running	0	Football	0	2	6.67
8.4	Ankle sprain	23-4	Walking	5	Running	0	Football	0	5	16.67
8.4	Ankle sprain	27-4	Walking	7	Running	4	Football	0	11	36.67
9.1	Malaria	24-4	Head control	5	Bed Mobility	7	Standing	7	19	63.33
9.2	Down syndrome	27-4	Head control	3	Bed Mobility	5	Standing	6	14	46.67
9.3	paragplegia	20-4	Toilet	3	Bed Mobility	5	Transfer	4	12	40.00

9.4	hemiplegia	28-4	Bed mobility	7	Toilet	7	Standing	5	19	63.33
9.4	paragplegia	28-4	Toilet	5	Bed Mobility	4	Transfer	4	13	43.33
10.1	BPI	13-4	Open door	2	Writing	1	Bathing	1	4	13.33
10.1	BPI	20-4	Open door	1	Writing	1	Bathing	1	3	10.00
10.1	BPI	27-4	Open door	1	Writing	1	Bathing	2	4	13.33
10.2	Tetraplegia	13-4	Sitting	2	Supine to side	2	Speaking	10	14	46.67
10.2	Tetraplegia	20-4	Sitting	2	Supine to side	2	Speaking	10	14	46.67
10.2	Tetraplegia	27-4	Sitting	3	Supine to side	3	Speaking	10	16	53.33
10.3	Elbow fx	13-4	Washing face	2	Eating	3	Dressing	6	11	36.67
10.3	Elbow fx	20-4	Washing face	4	Eating	4	Dressing	7	15	50.00
10.3	Elbow fx	27-4	Washing face	6	Eating	6	Dressing	8	20	66.67
10.4	hemiplegia	13-4	Toilet	4	Walking	5	Stairs	2	11	36.67
10.4	hemiplegia	20-4	Toilet	5	Walking	6	Stairs	3	14	46.67
10.4	hemiplegia	27-4	Toilet	5	Walking	7	Stairs	3	15	50.00
11.1	paragplegia	21-4	Walking	0	Squatting	0	Bed mobilty	3	3	10.00
11.2	LBP	27-4	Lifting	4	Carrying on head	2	Cultivating	0	6	20.00
11.3	facial palsy	28-4	Eat	8	Speak	7	Whistle	2	17	56.67
11.4	hemiplegia	21-4	Walking	3	Dressing	4	Bed mobilty	6	13	43.33
11.5	CP	23-4	Head control	0	Bed Mobility	0	Walking	0	0	0.00
KFH - DG			Drive	6	Computer	6	Wash	6	18	60.00
KFH - MJ			Stand	5	Sitting	6	Wash	5	16	53.33
KFH - PM	Neck pain		Neck pain	6	Neck stability	5	Sitting	6	17	56.67
KFH_RE			Bend back	7	Drive	6	Turn	5	18	60.00
12.1	LBP		Bend forward	4	Walking	6	Sitting	2	12	40.00
12.2	PN/ Sciatica		Bed mobility	3	Walking	4	Bike	2	9	30.00
12.2	PN/ Sciatica	30-4	Bed mobility	8	Walking	7	Bike	6	21	70.00
12.3	Knee stiffness		Walking	4	bike	2	knee flexion	2	8	26.67
12.4	wrist stiffness		Dressing	2	Bathing	3	Cooking	5	10	33.33
14.1	hemiplegia	23-4	Walking	4	Sex	5	supine to stand	5	14	46.67
14.2	hemiplegia	28-4	Standing	2	Walking	2	Speaking	1	5	16.67
14.3	paraplegia	28-4	Bed mobility	0	Knee flexion	0	Standing	0	0	0.00
14.4	hemiplegia	28-4	Dressing	2	Eating	1	Bathing	0	3	10.00
14.5	hemiplegia	29-4	Walking	2	Dressing	1	Bathing	1	4	13.33
16.1	paraplegia	24-4	standing	0	supine to sit	0	Walking	0	0	0.00

16.2	develop delay	21-4	Walking	5	feeding	2	Stairs	2	9	30.00
16.3	hemiplegia	20-4	Walking	7	Bathing	2	writing	2	11	36.67
16.4	Knee stiffness	20-4	Walking	8	Squatting	0	Stairs	3	11	36.67
16.4	Knee stiffness	22-4	Walking	8	Squatting	0	Stairs	4	12	40.00
16.4	Knee stiffness	24-4	Walking	8	Squatting	1	Stairs	4	13	43.33
16.4	Knee stiffness	294	Walking	8	Squatting	1	Stairs	4	13	43.33
16.5	elbow stiffness	22-4	knitting	5	combing	3	Bathing	2	10	33.33
15.1	wrist stiffness	20-4	washing face	2	lifting	2	cleaningtable	4	8	26.67
15.1		25-4		4		5		7	16	53.33
15.1		30-4		5		6		8	19	63.33
15.2	elbow stiffness	20-4	Washing face	4	brushing teeth	4	eating	5	13	43.33
15.2		24-4		5		5		6	16	53.33
15.2		27-4		6		6		7	19	63.33
15.3	Cp/ Down	21-4	lifting head	2	rolling	1	sitting	0	3	10.00
15.3		24-4		2		1		0	3	10.00
15.3		28-4		3		2		1	6	20.00
15.4	elbow stiffness	20-4	touchin face	3	feeding	3	washing	3	9	30.00
15.4		22-4		4		4		3	11	36.67
15.4		23-4		5		4		6	15	50.00
15.5	lnee stiffness	22-4	Walking	3	Sitting	6	squatting	1	10	33.33
		24-4		3		6		1	10	33.33
		30-4		4		7		2	13	43.33
15.6	Eerb's	21-4	lifting upper arm	3	feeding	1	toucing face	1	5	16.67
		2		3		1		1	5	16.67
		28-4		4		1		1	6	20.00
15.7	Club foot	20-4	eversion	1	Standing	0	dorsiflexion	3	4	13.33
		24-4		2		2		4	8	26.67
		25-4		4		5		6	15	50.00
15.8	hip stiffness	21-4	Walking	4	Sitting	6	squatting	1	11	36.67
		25-4		5		7		1	13	43.33
		30-4		6		7		2	15	50.00
17.1	CP	23-4	standing	4	Walking	2	Sitting	8	14	46.67
17.2	hemiplegia	20-4	Walking	0	sit to stand	2	Lifting arm	1	3	10.00
17.3	Knee stiffness	22-4	Squatting	0	Walking	4	Bike	1	5	16.67

17.4	CP	28-4	Walking	1	Sitting	5	head control	6	12	40.00
17.5	paraplegia	23-4	standing	0	crawling	4	Walking	0	4	13.33
17.6	hemiplegia	23-4	standing	0	Sitting	5	Walking	0	5	16.67
17.7	sciatica	27-4	sleeping	3	Walking	5	Standing	7	15	50.00
17.8	sciatica	28-4	Walking	6	Squatting	5	sleeping	3	14	46.67
18.1	hemiplegia	29-4	kneeling	6	Standing	4	Walking	2	12	40.00
18.2	elbow stiffness	24-4	Comb hair	3	feeding	4	Brushing teeth	4	11	36.67
18.3	CP	23-4	Head control	4	rolling	3	Sitting	2	9	30.00
18.4	develop delay	21-4	crawling	6	Standing	5	Walking	3	14	46.67
18.5	Ankle Stiffness	21-4	Squatting	5	Standing	8	Walking	6	19	63.33
19.1	CP	6-3	Standing	4	holding item	3	squatting	1	8	26.67
		8-4	s	6		5		7	18	60.00
		29-4		9		6		9	24	80.00
19.2	hemiplegia	23-1	standing	2	Squatting	0	Walking	0	2	6.67
		16-3		7		6		6	19	63.33
		24-4		10		9		9	28	93.33
19.3	k	6-3	turning head	2	supine to sit	0	looking up	2	4	13.33
		9-4		5		3		4	12	40.00
		24-4		7		4		5	16	53.33
19.4	Club foot	14-4	SLS	2	dorsiflexion	4	eversion	3	9	30.00
		21-4		8		6		7	21	70.00
		27-4		9		8		9	26	86.67
19.5	knee pain	27-4	Walking	3	Squatting	1	Running	0	4	13.33
		29-4		4		1		0	5	16.67
		30-4		4		2		1	7	23.33
20.1	TBI	21-4	talking	1	Walking	4	Feeding	6	11	36.67
20/2	Knee stiffness	23-4	Walking	6	Squatting	2	Dressing	7	15	50.00
20.3	hemiplegia	24-4	Walking	4	Dressing	6	Bathing	2	12	40.00
20.4	paraplegia	27-4	turning	6	washing	5	Walking	0	11	36.67
20.5	elbow stiffness	28-4	feeding	0	washing	6	writing	6	12	40.00
22.1	Knee stiffness	27-4	Toilet	2	motorcyle	0	Walking	5	7	23.33
22.2	hand stiffness	28-4	writing	0	feeding	5	Brushing teeth	7	12	40.00
22.3	weakness	28-4	Walking	5	Toilet	3	Dressing	3	11	36.67
22.4	hemiplegia	29-4	Sitting	6	Walking	4	Dressing	3	13	43.33

24.1	shoulder strain	20-4	shoulder flexion	0	Grasp hands	6	Dressing	2	8	26.67
24.2	torticollis	29-4	turn head	7	look down	7	posture	7	21	70.00
24.3	1st MTP stiffness	14-4	Squatting	4	Walking	6	jumping	8	18	60.00
24.4	radiculopathy	16-4	Sitting	4	Standing	6	cross legs	6	16	53.33
28.1	hemiplegia	21-4	Walking	5	Sitting	7	grasp	5	17	56.67
		23-4		5		7		5	17	56.67
28.2	facial palsy	20-4	drinking	3	Eating	5	eye mmt	6	14	46.67
		21-4		4		6		7	17	56.67
		23-4		5		6		8	19	63.33
		25-4		6		8		8	22	73.33
28.3	back pain	22-4	standing	5	Sitting	5	Walking	5	15	50.00
		23-4		5		6		7	18	60.00
		25-4		6		7		7	20	66.67
28.4	CP	21-4	Head control	3	Sitting	3	Crawling	3	9	30.00
28.5	Ankle sprain	22-4	4	7	Walking	6	squatting	7	20	66.67
		23-4		7		7		7	21	70.00
		25-4		8		8		8	24	80.00
29.1	CP	28-4	Head control	3	crawling	1	Sitting	0	4	13.33
29.2	Down syndrome	28-4	standing	7	Walking	3	Crawling	6	16	53.33
29.3	disc prolapse	27-4	standing	5	Walking	5	Bending	4	14	46.67
29.4	BKA	24-4	standing	2	Walking	0	squatting	1	3	10.00
29.5	CP	23-4	Head control	3	standing	0	Sitting	0	3	10.00
301	LBP post-partum	7-4	sitting	7	flexon	5	sweeping	6	18	60.00
		10-4		8		4		3	15	50.00
		13-4		4		4		2	10	33.33
30.2	pelvic pain	15-3	Toilet	7	stairs	6	sitting	5	18	60.00
		17-3		7		5		4	16	53.33
		19-3		6		3		3	12	40.00
30.3	LBP	16-3	kitchen	5	making bed	4	sweeping	5	14	46.67
		18-3		4		3		4	11	36.67
		20-3		3		3		2	8	26.67
30.4	Knee stiffness	12-4	Walking	7	stairs	6	RTW	8	21	70.00
30.5	plantar fascitis	18-4	Walking	6	Standing	6	driving	7	19	63.33
				5		4		7	16	53.33

				5		5		6	16	53.33
31.1	Erbs palsy	20-4	hands to midline	0	reaching	2	hand to mouth	0	2	6.67
		30-4		2		3		1	6	20.00
31.2	Down syndrome	20-4	supine ot side	0	Sitting	1	hands to midline	6	7	23.33
		30-4		0		7		10	17	56.67
31.5	CP	20-4	standing	3	Walking	0	stairs	0	3	10.00
		30-4		10		8		2	20	66.67
31.3	paraplegia	20-4	supine to prone	3	transfer	6	sitting	3	12	40.00
		30-4		5		8		3	16	53.33
32.1	CP	28-4	Sitting	2	turning	7	supine to sit	5	14	46.67
32.2	facial palsy	27-4	drinking	8	Speak	7	laughing	8	23	76.67
32.3	OA lumbar	29-4	Dressing	6	cleaning house	4	Bathing	6	16	53.33
	Down syndrome	28-4	standing	1	Squatting	3	kneeling	4	8	26.67
	elbow stiffness	29-4	lifting	6	washing	7	playing ball	6	19	63.33
	CP	28-4	lifting	4	turning	8	Sitting	7	19	63.33
	hemiplegia	28-4	eating	1	Walking	9	lifting	6	16	53.33
	torticollis	29-4	turning head	7	head midline	5	lfting head	7	19	63.33
33	LBP	27-4	bending	5	Sitting	7	Walking	8	20	66.67
	CP	22-4	crawling	3	Standing	3	Walking	0	6	20.00
	Down syndrome	27-4	rolling	6	Sitting	4	Crawling	2	12	40.00
	CP	28-4	crawling	8	Standing	8	Walking	5	21	70.00
	Down syndrome	23-4	crawling	9	Standing	6	Walking	4	19	63.33
34	thoracic pain	10-4	neck extension	5	typing	4	turn head	4	13	43.33
	LBP	15-4	Sitting	4	lifting	5		3	12	40.00
	wrist drop	16-4	writing	3	grasp	3	wrist extension	2	8	26.67
	sciatica	20-4	driving	3	Walking	6	sports	5	14	46.67
	hand paresthesia	25-4	typing	5	combing	5	driving	4	14	46.67
26.1	sciatica	20-4	Walking	8	bending	7	Standing	7	22	73.33
		22-4		7		6		9	22	73.33
		24-4		8		8		10	26	86.67
	piriformis	21-4	Walking	7	bending	8	Sitting	7	22	73.33
		23-4		9		9		8	26	86.67
	paraplegia	27-4	rolling	3	Knee flexion	4	knee flexion	2	9	30.00
		30-4		5		5		2	12	40.00

	LBP	27-4	bending	7	Sitting	6	prone	6	19	63.33
		29-4		8		7		8	23	76.67
KIGALI B									0	0.00
1.1	hemiplegia	25-4	walking	7	transfer c to b	4	transfer b to c	3	14	46.67
1.2	hemiplegia	28-4	walking	8	toileting	6	transfer	7	21	70.00
1.3	Knee stiffness	6-5	Squatting	6	toileting	4	walking	9	19	63.33
1.4	torticollis	28-4	turning head	2	reaching	0	don shoes	3	5	16.67
3.1	hemiplegia	4-4	Walking	4	hip and knee flexion	5	sensation	7	16	53.33
3.1		6-4		5		5		7	17	56.67
3.1		14-4		5		6		7	18	60.00
3.1	hemiplegia	20-4	Walking	6	hip and knee flexion	7	sensation	8	21	70.00
3.1		23-4		6		7.5		8	21.5	71.67
3.1		25-4		7		7.5		9	23.5	78.33
3.2	Down syndrome	1-5	sitting	9	rolling	7	standing	6	22	73.33
		4-5		9		7.5		6.5	23	76.67
		7-5		9		8		7	24	80.00
3.3	Down syndrome	3-5	sitting	9	walking	3	grasp	6	18	60.00
		5-5		9		4		6	19	63.33
		6-5		9		4		6	19	63.33
3.4	brachial plexus injury	10-4	sensation	8	elbow flexion	2	shoulder flexion	6	16	53.33
		13-4		8		4		6	18	60.00
		15-4		8.5		5		6	19.5	65.00
		18-4		9		6		6	21	70.00
		20-4		9		6		8	23	76.67
3.5	bell's palsy	7-4	closing left eye	6	holding air in cheek	3	whistling	2	11	36.67
		9-4		6		5		4	15	50.00
		12-4		6.5		6		5	17.5	58.33
		18-4		6		4		3	13	43.33
		20-4		6		5		4	15	50.00
		24-4		7		6		5	18	60.00
5.1									0	0.00
7.1	cp	15-4	sitting	3	holding toy	2	rolling	3	8	26.67
		5-5		3		2		3	8	26.67
7.2	hemiplegia	4-5	grasping	3	kneeling	9	holding baby	3	15	50.00

	cp	3-3	sitting	2	holding toy	2	rolling	1	5	16.67
		15-4		2		2		2	6	20.00
		7-5		1		3		3	7	23.33
	develop delay	28-4	sitting	3	crawling	1	head control	3	7	23.33
		7-5		1		1		n/a	#VALUE!	#VALUE!
7.5	develop delay	7-5	sitting	4	crawling	1	head control	4	9	30.00
7.6	Down syndrome	26-1	sitting	5	rolling	6	standing	8	19	63.33
		27-2		3		4		6	13	43.33
		4-5		8		6		4	18	60.00
9.1	radial nerve palsy	3-5	writing	2	lifting	3	washing clothes	1	6	20.00
	elbow stiffness	30-4	feeding	4	combing	5	lifting	3	12	40.00
	Knee stiffness	2-5	Squatting	3	ascending stairs	4	running	2	9	30.00
	rotator cuff	8-4	dressing	4	bathing	4	cleaning	5	13	43.33
10.1	cp	5-5	Head control	4	rolling	4	sitting	2	10	33.33
	elbow stiffness	7-5	combing hair	3	dressing	4	writing	7	14	46.67
	Knee stiffness	7-5	ascend stairs	4	Squatting	2	sitting	6	12	40.00
	Down syndrome	4-5	standing	3	walking	4	sitting	6	13	43.33
	cp	25-4	Head control	2	rolling	2	sitting	1	5	16.67
	elbow stiffness	30-4	combing hair	1	dressing	2	writing	5	8	26.67
	Knee stiffness	30-4	ascend stairs	2	Squatting	1	sitting	4	7	23.33
	Down syndrome	24-4	standing	1	walking	2	sitting	5	8	26.67
11.1	paraplegia	4-5	quadraped	7	kneeling	3	half-kneel	0	10	33.33
		6-5		7		4		0	11	36.67
	radial nerve injury	30-4	wrist extension	1	grip	0	holding spoon	0	1	3.33
		6-5		4		2		1	7	23.33
	elbow stiffness	27-4	feeding	3	lifting	2	dressing	5	10	33.33
		5-5		4		4		6	14	46.67
	Down syndrome	28-4	sitting	6	standing	3	quadraped	3	12	40.00
		6-5		8		4		4	16	53.33
12	burns	27-4	feeding	2	combing	2	Brushing teeth	1	5	16.67
		4-5		4		3		3	10	33.33
	Knee stiffness	27-4	walking	2	Squatting	0	football	1	3	10.00
		4-5		4		3		3	10	33.33
14	facial palsy	6-5	facial expressions	1	closing eye	1	drinking	1	3	10.00

	hemiplegia	14-4	bed mobility	4	sitting	3	moving right side	1	8	26.67
		21-4		6		5		4	15	50.00
		2-5		9		6		7	22	73.33
	shoulder stiffness	16-4	combing hair	3	brushing teeth	3	Bathing	2	8	26.67
		23-4		5		6		6	17	56.67
		30-4		8		8		9	25	83.33
	Knee stiffness	15-4	sitting	4	walking	6	driving	0	10	33.33
		24-4		7		7		5	19	63.33
		6-5		9		9		8	26	86.67
	wrist stiffness	23-4	writing	2	opening door	2	washing clothes	3	7	23.33
		30-4		6		5		5	16	53.33
		5-5		10		8		8	26	86.67
15	humeral fracture	5-4	brushing teeth	2	combing	1	dressing	2	5	16.67
	LBP	28-4	sitting	2	bending	2	wearing baby	2	6	20.00
	elbow stiffness	6-5	feeding	3	bathing	2	combing	1	6	20.00
	humeral fracture	24-4	brushing teeth	0	dressing	0	combing	0	0	0.00
17		28-4	standing	3	walking	3	sitting	1	7	23.33
		5-5		5		5		5	15	50.00
	tetraparesis	27-4	rolling	1	come to sit	1	sitting	2	4	13.33
		5-5		2		3		4	9	30.00
18	paraplegia	15-4	rolling	6	sitting	4	bridging	0	10	33.33
		17-4		6		5		1	12	40.00
		19-4		7		6		1	14	46.67
		21-4		7		7		1	15	50.00
	Knee stiffness	20-4	walking	5	squatting	0	knee flexion	2	7	23.33
		22-4		5		0		2	7	23.33
		24-2		6		1		3	10	33.33
		28-4		6		1		3	10	33.33
	hemiplegia	5-4	walking	7	Squatting	6	ascending stairs	5	18	60.00
		7-4		8		6		6	20	66.67
		10-4		8		6		6	20	66.67
		17-4		8		7		6	21	70.00
		18-4		8		7		8	23	76.67
		20-4		8		7		8	23	76.67

		22-4		8		7		8	23	76.67
		24-4		8		7		8	23	76.67
22	hand stiffness	7-4	eating	7	laying down	7	combing	9	23	76.67
	hemiplegia	2-4	driving	8	computer	7	bathing	5	20	66.67
	hemiplegia	5-4	walking	8	toil	9	turning	9	26	86.67
	paraplegia		sitting	6	walking	0	toileting	0	6	20.00
26	hemiplegia	27-4	grasping	2	walking	4	standing	7	13	43.33
	wrist drop	2-5	Washing	4	writing	6	combing	3	13	43.33
	GBS	4-5	rolling	3	sitting	1	grooming	3	7	23.33
29	Knee stiffness	27-4	Squatting	4	eat	10	bathing	7	21	70.00
	radiculopathy	25-4	eating	4	washing clothes	4	lifting	2	10	33.33
	hemiplegia	28-4	Squatting	3	lifting	4	Bathing	5	12	40.00
	elbow stiffness	30-4	rolling	1	eating	3	dressing	0	4	13.33
31	cp	29-4	sitting	0	crawling	0	walking	0	0	0.00
	lbp	4-5	sitting	0	walking	1	standing	2	3	10.00
	knee RA	4-5	Squatting	2	standing	3	walking	4	9	30.00
	lbp	1-5	sleeping	3	sitting	0	standing	1	4	13.33
		4-5		4		0		1	5	16.67
		6-5		6		1		3	10	33.33
33	cp	27-4	sitting	7	using hands	4	walking	0	11	36.67
		6-5		8		6		0	14	46.67
	cp	27-4	sitting	4	standing	0	walking	0	4	13.33
		5-5		8		2		0	10	33.33
	hemiplegia	28-4	hand use	2	walking	7	speaking	5	14	46.67
		7-5		3		7		6	16	53.33
	cp	4-5	standing	5	walking	0	hand use	5	10	33.33
	develop delay	27-4	standing	7	walking	2	go to school	0	9	30.00
		7-5		8		8		0	16	53.33
35	patellar tendonitis	27-4	walking	4	Squatting	5	stairs	4	13	43.33
		30-4	walking	6	Squatting	4	stairs	5	15	50.00
	cp	29-4	walking	3	standing	3	reaching	5	11	36.67
		6-5	walking	3	standing	3	reaching	5	11	36.67
36	ankle strain	4-4	Squatting	6	walking	8	toileting	4	18	60.00
		21-4		9		6		5	20	66.67

	ankle sprain	27-4	walking	6	toileting	5	squatting	5	16	53.33
	elbow stiffness	17-4	combing hair	7	lifting	6	Brushing teeth	5	18	60.00
	elbow stiffness	28-4	dressing	7	combing	6	Brushing teeth	2	15	50.00
	supraspinatus tendonitis	28-4	combing hair	5	brushing teeth	7	dressing	5	17	56.67
	Knee stiffness	22-3	sitting	5	Squatting	5	walking	7	17	56.67
24	hemiplegia	18-3	rolling	9	feeding	6	sitting	5	20	66.67
		25-3		7		6		4	17	56.67
		1-4		4		5		4	13	43.33
		8-4		1		4		2	7	23.33
24.2	elbow stiffness	27-4	dressing	6	combing	7	Feeding	4	17	56.67
		30-4		4		5		5	14	46.67
		4-5		2		4		1	7	23.33
		7-5		1		3		0	4	13.33
24.3	supraspinatus tendonitis	28-8	combing hair	7	washing clothes	4	secretarial activities	3	14	46.67
		29-11		1		0		0	1	3.33
24.4	ankle sprain	27-4	walking	10	toileting	6	biking	5	21	70.00

24 - second sheet
27 - one sheet
horaho - 1 sheet
21-one sheet
inkunziza - 2 sheets
6 - 2 sheets

16.4	Knee stiffn	20-4	Walking	8	Squatting	0	Stairs	3	11	36.66667				
16.4	Knee stiffn	22-4	Walking	8	Squatting	0	Stairs	4	12	40				
16.4	Knee stiffn	24-4	Walking	8	Squatting	1	Stairs	4	13	43.33333				
16.4	Knee stiffn	29-4	Walking	8	Squatting	1	Stairs	4	13	43.33333				
1.1	Knee stiffn	26-4	Walking	6	Squatting	3	Kneeling	4	13	43.33333				
1.1	Knee stiffn	28-4	Walking	6	Squatting	4	Kneeling	4	14	46.66667				
15.5	lnee stiffne	22-4	Walking	3	squatting	1	Sitting	6	10	33.33333				
		24-4		3		1		6	10	33.33333				
		30-4		4		2		7	13	43.33333				
16.4	Squatting	20-4	0											
16.4	Squatting	22-4	0											
16.4	Squatting	24-4	1											
16.4	Squatting	29-4	1											
1.1	Squatting	26-4	3											
1.1	Squatting	28-4	4											
15.5	squatting	22-4	1											
		24-4	1											
		30-4	2											
	Patient	A		B		C								
		Date	Score	Date	score	Date	Score							
16.4	Squatting	20-4	0	26-4	3	22-4	1							
16.4	Squatting	22-4	0	28-4	4	24-4	1							
16.4	Squatting	24-4	1			30-4	2							
16.4	Squatting	29-4	1											
1.1	Squatting													
1.1	Squatting													
15.5	squatting	22-4	1											
		24-4	1											
		30-4	2											

Session	A	B	C
1	0	3	1
2	0	4	1
3	1		2
4	1		

1.2	LBP	20-4	Sitting	7	Forward be	5	Rotation	5	17	56.66667			
1.2	LBP	22-4	Sitting	9	Forward be	6	Rotation	7	22	73.33333			
1.2	LBP	24-4	Sitting	9	Forward be	7	Rotation	7	23	76.66667			
		20-4	Forward be	5									
		22-4	Forward be	6									
		24-4	Forward be	7									
		20-4	Rotation	5									
		22-4	Rotation	7									
		24-4	Rotation	7									
		20-4	Total	56.66667									
		22-4	Total	73.33333									
		24-4	Total	76.66667									

		Date	Task	Score									
8.2	TOS	9-10	Computer	1	Self-care	6	Lifting	3					
8.2	TOS	10-11	Computer	5	Self-care	8	Lifting	5					
8.2	TOS	9-1	Computer	7	Self-care	10	Lifting	6					
8.2	TOS	6-2	Computer	8	Self-care	10	Lifting	7					
		9-10	Self-care	6									
		10-11	Self-care	8									
		9-1	Self-care	10									
		6-2	Self-care	10									
		9-10	Lifting	3									
		10-11	Lifting	5									
		9-1	Lifting	6									
		6-2	Lifting	7									
		9-10	Percent of	33.33333									
		10-11	Percent of	60									
		9-1	Percent of	76.66667									
		6-2	Percent of	83.33333									

Patient	diagnosis	date	activity		actvity		Activity					
7.4	femur fx	23-4	Bed mobili	2	Supine to s	1	Dressing	1	4	13.33333		
7.4	femur fx	24-4	Bed mobili	1	Supine to s	1	Dressing	0	2	6.666667		
7.4	femur fx	27-4	Bed mobili	1	Supine to s	1	Dressing	1	3	10		
7.4	femur fx	29-4	Bed mobili	1	Supine to s	1	Dressing	2	4	13.33333		
7.5	femur fx	21-4	Sitting	2	Stairs	3	Walking	6	11	36.66667		
7.5	femur fx	21-4	Sitting	1	Stairs	1	Walking	2	4	13.33333		
7.5	femur fx	27-4	Sitting	2	Stairs	2	Walking	4	8	26.66667		
7.5	femur fx	29-4	Sitting	10	Stairs	3	Walking	6	19	63.33333		
7.3	femur fx	22-4	Stand	2	Supine to s	2	Bed pan	0	4	13.33333		
7.3	femur fx	22-4	Stand	1	Supine to s	2	Bed pan	1	4	13.33333		
7.3	femur fx	27-4	Stand	2	Supine to s	3	Bed pan	2	7	23.33333		
7.3	femur fx	29-4	Stand	3	Supine to s	1	Bed pan	4	8	26.66667		
Patient	diagnosis	date	activity		actvity		Activity					
7.4	femur fx	23-4	Bed mobili	2	Supine to s	1	Dressing	1	4	13.33333		
7.4	femur fx	29-4	Bed mobili	1	Supine to s	1	Dressing	2	4	13.33333		
7.5	femur fx	21-4	Sitting	1	Stairs	1	Walking	2	4	13.33333		
7.5	femur fx	29-4	Sitting	10	Stairs	3	Walking	6	19	63.33333		
7.3	femur fx	22-4	Stand	2	Supine to s	2	Bed pan	0	4	13.33333		
7.3	femur fx	29-4	Stand	3	Supine to s	1	Bed pan	4	8	26.66667		
Patient	Initial	Discharge										
7.4	13.33333	13.33333										
7.5	13.33333	63.33333										
7.3	13.33333	26.66667										
	Initial	Discharge										
Sitting	1	10										
Standing	2	3										
Walking	0	3										
Bed Pan	0	4										

10.4	hemiplegia	13-4	Toilet	4	Walking	5	Stairs	2	11	36.66667		
10.4	hemiplegia	20-4	Toilet	5	Walking	6	Stairs	3	14	46.66667		
10.4	hemiplegia	27-4	Toilet	5	Walking	7	Stairs	3	15	50		
19.2	hemiplegia	23-1	standing	2	Squatting	0	Walking	0	2	6.666667		
		16-3		7		6		6	19	63.33333		
		24-4		10		9		9	28	93.33333		
28.1	hemiplegia	21-4	Walking	5	Sitting	7	grasp	5	17	56.66667		
		23-4		5		7		5	17	56.66667		

GRANT

3

THE AMBASSADOR'S SELF HELP PROGRAM
U.S. EMBASSY KIGALI

AMAZI WIVOMEYE ARARYOHA

(Self Help Instructions in Kinyarwanda)

The American Ambassador in Rwanda has a small grant fund to provide financial assistance to community-based projects. Every project requires strong community involvement, such as contributions of labor, materials or money. The community or cooperative must show that the project can be completed in one year or less and that the work of the project will continue in future years. For example, if the Embassy finances the purchase of equipment for a workshop, who will be responsible for repairs to the equipment in the future? All project profits should be deposited in a community account to benefit the members of the cooperative.

Project proposals will be accepted year round at KigaliSelfHelpProgram@state.gov or by paper copy sent to the U.S. Embassy. Grants are usually awarded in September.

Projects should be initiated by the community and should reflect a community need - not an individual or a family's need. Special consideration is given to projects that generate income or encourage community development. Examples of successful projects include modernization or expansion of agriculture or livestock-raising, such as bees or poultry, and the acquisition of equipment for technical schools or training programs. Project funding is limited to a maximum of RWF 5 million. However, smaller grants are encouraged and often have a better chance of funding. Submit requests in Rwandan Francs.

The Self-Help Fund cannot be used to fund certain items or activities. These include:

1. Sophisticated equipment such as trucks, projectors, stereo systems, computers, photocopiers, etc.
2. Religious, cultural, recreational, police or military projects;

3. Commercial private enterprises or assistance to individuals;
4. Salaries or unskilled labor;
5. Projects that are being financed by other donors such as embassies or foreign NGOs;
6. Revolving funds;
7. Chemical fertilizers or pesticides.
8. Construction or renovation of buildings or structures.
9. Rent

SELF HELP PROPOSAL SHOULD INCLUDE THE FOLLOWING:

PROJECT DESCRIPTION:

1. Name of Project
2. Location of Project (village or town, district and province.) Please include a map.
3. Project Leadership
    1. Cooperative or community group. Name and address or telephone number. If there is no a post-office box, please include telephone numbers of individuals who can pass a message to the group. Describe the cooperative, group, school, etc. How is it organized? When did the cooperative begin? How many members are there – males/females? How often does the group meet? What are the cooperative's current activities?
    2. Has the cooperative received or requested funding from the US Embassy or USAID in the past five years? Or from another donor? Is the cooperative receiving funding from another donor at the current time?
    3. Project Leader (name, telephone, address). Include a map or a description of the location and back-up contact information of someone who knows about the project. Inform the embassy if any project information changes.
4. Project Description: Describe the proposed activity and how it will solve an identified need or problem. Be specific about the purpose, size and location of the project.
5. Time required for completing the project.
6. Approximate number of people (males/females) who will directly and indirectly benefit from the project.
7. Community contribution to the project: Describe (money, materials, labor, etc.) and estimate the value of the

community contribution in Rwandan Francs. (An example is a pig project. The community contribution would be the construction of the pigsty and the Self Help request would be to purchase pigs and veterinary supplies.)

8. Will the project generate income? If yes, how much income? Who will control this revenue and how will it be used?
9. Describe the current status of the project? Who is doing the work? How much remains to be done?

DESCRIPTION OF PROJECT FINANCES

1. Provide a total project budget in Rwandan Francs. Indicate which budget items are requested from the Self-Help Fund and which items will be provided by the group or community. Please note: Funds are not given directly to the project; pro forma invoices from the suppliers of equipment and materials must be submitted first. Funds are usually disbursed in three or more payments during the project period and must be cleared promptly with receipts.
2. How much money has already been spent on the project?
3. Have other associations or government agencies provided funds to the project? If yes, provide details.

SIGNATURES OF PROJECT LEADER AND OF REPRESENTATIVE OF DISTRICT, CDC OR PROVINCE:

The Project Leader should sign the project proposal. Then, the proposal should be submitted to the office of a local administrative authority (the mayor, the vice-mayor or the prefet) for his/her signature. Keep a copy of the proposal for the group's records and send a copy to the U.S. Embassy, attention Ambassador's Self Help Fund.

Advancement of Rwandan Rehabilitation Services Project

Leadership Institute

Recap

https://www.powtoon.com/show/bC2ZLCg9zH5/leadership-institute/

Session One

- Discussed physiotherapy: what we like, what's frustrating, barriers to use
  - We are the first ones who have to make improvements
- Discussed Leadership, styles of leaders and followers
- Discussed what we see as success, and where we want to be in 2 and 5 years.
- Discussed strategies for being successful and meeting goals.

Evidence and Outcomes

- You are the ones who can use evidence to improve patient care
- You are the one who can show PT in Rwanda is effective and beneficial

Session Two

- Discussed professional associations
- What you want from AKR
  - Advocacy
  - (PT Capitol Day – Student Submission: https://www.youtube.com/watch?v=SwIJnSyTlhI&feature=youtu.be)
- What you need to do for AKR
  - Participation

Building a Rwandan Code of Ethics for the Practice of Physiotherapy

Sometimes an example is helpful. This is from the WCPT Policy Statement "Ethical responsibilities of physical therapists and WCPT members"

Ethical principle 1: "Physical therapists respect the rights and dignity of all individuals."

No one should be excluded based on who they are as an individual. Often this is where the declaration of non-discrimination is placed (e.g. regardless of age, gender, race, nationality, religion, ethnic origin, creed, color, sexual orientation, disability, health status or politics)

Ethical principle 2: "Physical therapists comply with the laws and regulations governing the practice of physical therapy in the country in which they practise."

You must understand and obey the laws that govern your practice. This principle includes advocating for the patient's right to treatment and also the therapist's right to refuse to treat if it is not in the best interests of the patient.

Ethical principle 3: "Physical therapists accept responsibility for the exercise of sound judgement."

The therapist is responsible for developing the plan of care based on the patient's potential and for determining if no further benefit is possible. They must also communicate this to their patient. This principle also incorporates referral to another care provider if diagnosis or treatment of the condition appears beyond the abilities of the treating therapist.

Ethical principle 4: "Physical therapists provide honest, competent and accountable professional services." Physical therapists shall: communicate, educate, document, and protect from harm.

Ethical principle 5: "Physical therapists are committed to providing quality services."

Physical therapists shall: be up to date with the best treatment techniques, research, evidence, and education strategies

Ethical principle 6: "Physical therapists are entitled to a just and fair level of remuneration for their services."

Physical therapists shall: charge reasonable fees and be moral in their business practices.

Ethical principle 7: "Physical therapists provide accurate information to patients/clients, other agencies and the community about physical therapy and about the services physical therapists provide."

Physical therapists: honestly promote knowledge, health, and best practices.

Ethical principle 8: "Physical therapists contribute to the planning and development of services that address the health needs of the community."

This principle incorporates the concept of physical therapy addressing societal issues and equal access to services.

The World Confederation for Physical Therapy (WCPT) expects its member organisations to:

- have a code of ethics or code of conduct

- publish, promote and circulate their code of ethics or code of conduct for the benefit of their members, the general public, employers, governments and government agencies

- have procedures for monitoring the practice of their members, disciplinary procedures and sanctions for members whose practice falls outside their code of ethics or code of conduct

WCPT offers advice and support to its member organisations wishing to develop codes of ethics or conduct.

World Confederation for Physical Therapy

Declarations of principle record the Confederation's agreed stance on issues affecting the practice of physical therapy internationally and have a two-thirds majority vote thereby becoming policy for all member organisations.

Declaration of Principle

Ethical Principles*

The World Confederation for Physical Therapy (WCPT) expects physical therapists to:

1. Respect the rights and dignity of all individuals
2. Comply with the laws and regulations governing the practice of physical therapy in the country in which they practice
3. Accept responsibility for the exercise of sound judgement
4. Provide honest, competent and accountable professional services
5. Provide quality services
6. Be entitled to a just and fair level of remuneration for their services
7. Provide accurate information to patients/clients[1], to other agencies and the community about physical therapy and the services physical therapists provide
8. Contribute to the planning and development of services which address the health needs of the community

Appendix follows on page 3

[1] The term patient/client is used in this document as a generic term to refer to individuals and groups of individuals who can benefit from physical therapy interventions/treatments.

WCPT Secretariat
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Date adopted:	Originally adopted at the 13th General Meeting of WCPT June 1995. Revised and re-approved at the 16th General Meeting of WCPT June 2007
Date for review:	2011
Related WCPT Policies:	Declaration of Principle: Patients'/clients' rights in physical therapy Endorsement: Rights of the child Endorsement: The United Nations Standard Rules on the equalisation of opportunities for persons with disabilities

Appendix to: WCPT Declaration of Principle on Ethical Principles

Responsibilities of WCPT and its Member Organisations

Member organisations have a duty to publish, promote and circulate their code of ethics or code of conduct for the benefit of their members, the general public, employers, governments and government agencies.

Member organisations have appropriate procedures for monitoring the practice of their members, disciplinary procedures and sanctions for members whose practice falls outside their code of ethics or code of conduct.

The WCPT will assist national physical therapy organisations with the development of their own code of ethics or code of conduct.

Interpreting WCPT's Ethical Principles

The following is intended to assist WCPT member organisations and individual physical therapists in interpreting WCPT's Ethical Principles. The information may be useful background for organisations developing their own codes of ethics or guides to ethical conduct which are consistent with WCPT's Ethical Principles and reflect national circumstances.

Ethical Principle 1: Physical therapists respect the rights and dignity of all individuals

All persons who seek the services of physical therapists have the right to service regardless of age, gender, race, nationality, religion, ethnic origin, creed, colour, sexual orientation, disability, health status or politics.

Patients/clients have the right to:

- services of good quality
- information
- informed consent
- confidentiality
- access to data
- health education
- choose who, if anyone, should be informed on his/her behalf

Physical therapists have the absolute responsibility to ensure that their behaviour is at all times professional, ensuring that the potential for misconduct can not arise.

Physical therapists have the right to expect co-operation from their colleagues.

Physical therapists shall apply sound business principles when dealing with suppliers, manufacturers and other agents.

Ethical Principle 2: Physical therapists comply with the laws and regulations governing the practice of physical therapy in the country in which they work

Physical therapists will have a full understanding of the laws and regulations governing the practice of physical therapy.

Physical therapists have the right to refuse to treat or otherwise intervene when in their opinion the service is not in the best interests of the patient/client.

Ethical Principle 3: Physical therapists accept responsibility for the exercise of sound judgement

Physical therapists are professionally independent and autonomous practitioners.

Physical therapists make independent judgements in the provision of services for which they have knowledge and skills and for which they can be held accountable.

For each individual accepted for service, physical therapists undertake appropriate examination/evaluation to allow the development of a diagnosis.

In light of the diagnosis and other relevant information about the patient/client, especially the patient's/client's goals, physical therapists plan and implement the intervention.

When the goals have been achieved or further benefits can no longer be obtained, the physical therapist shall inform and discharge the patient/client.

When the diagnosis is not clear or the required intervention/treatment is beyond the capacity of the physical therapist, the physical therapist shall inform the patient/client and provide assistance to facilitate a referral to other qualified persons.

Physical therapists shall not delegate any activity which requires the unique skill, knowledge and judgement of the physical therapist.

The physical therapist will consult with the referring medical practitioner if the treatment programme or a continuation of the programme are not in accord with the judgement of the physical therapist.

Ethical Principle 4: Physical therapists provide an honest, competent and accountable professional service

Physical therapists ensure patients/clients understand the nature of the service being provided, especially the anticipated costs, both time and financial.

Physical therapists undertake a continuous, planned, personal development programme designed to maintain and enhance professional knowledge and skills.

Physical therapists maintain adequate patient/client records to allow for the effective evaluation of the patient's/client's care, as well as the evaluation of the physical therapist's practice.

Physical therapists do not disclose any information about a patient/client to a third party without the patient's/client's permission or prior knowledge, unless such disclosure is required by law.

Physical therapists participate in peer review and other forms of practice evaluation, the results of which shall not be disclosed to another party without the permission of the physical therapist.

Physical therapists shall maintain adequate data to facilitate service performance measurement and shall make that data available to other agents as required by mutual agreement.

The ethical principles governing the practice of physical therapy shall take precedence over any business or employment practice, where such conflict arises the physical therapist shall attempt to rectify the matter, seeking the assistance of the national physical therapy association if required.

Physical therapists shall not allow their services to be misused.

Ethical Principle 5: Physical therapists are committed to providing quality services

Physical therapists shall be aware of the currently accepted standards of practice and undertake activities which measure their conformity.

Physical therapists shall participate in ongoing education to enhance their basic knowledge and to provide new knowledge.

Physical therapists shall support research that contributes to improved patient/client services.

Physical therapists shall support quality education in academic and clinical settings.

Physical therapists engaged in research shall abide by the current rules and policies applying to the conduct of research on human subjects shall ensure:

- the consent of subjects
- subject confidentiality
- safety and well-being of subjects
- absence of fraud and plagiarism
- full disclosure of support, and
- appropriate acknowledgement of assistance
- that any breaches of the rules are reported to appropriate authorities

Physical therapists shall share the results of their research freely, especially in journals and conference presentations.

Physical therapists in the role of employer shall:

- ensure all employees are properly and duly qualified, ensuring compliance with statutory requirements

- apply current management principles and practices to the conduct of the service, with particular attention to appropriate standards of personnel management
- ensure implementation and monitoring of appropriate policies and procedures
- ensures appropriate evaluation and audit of clinical practice
- provide adequate opportunities for staff education and personal development based on effective performance appraisal

Ethical Principle 6: Physical therapists are entitled to a just and fair level of remuneration for their services

Physical therapists should ensure that their own fee schedules are based on reasonable considerations.

Physical therapists should attempt to ensure that third-party fee schedules are based on reasonable considerations.

Physical therapists shall not use undue influence for personal gain.

Ethical Principle 7: Physical therapists provide accurate information to patients/clients, other agencies and the community about physical therapy and about the services physical therapists provide

Physical therapists shall participate in public education programmes, providing information about the profession.

Physical therapists have a duty to inform the public and referring professionals truthfully about the nature of their service so individuals are more able to make a decision about the use of the service.

Physical therapists may advertise their services;.

Physical therapists shall not use false, fraudulent, misleading, deceptive, unfair or sensational statements or claims.

Physical therapists shall claim only those titles which correctly describe their professional status.

Ethical Principle 8: Physical therapists contribute to the planning and development of services which address the health needs of the community

Physical therapists have a duty and an obligation to participate in planning services designed to provide optimum community health services.

Physical therapists are obliged to work toward achieving justice in the provision of health services for all people.

Virtual Conference

A gift from Karen Litzy, PT, DPT

klitzy@me.com

To obtain the link to access the conference, please contact Karen Litzy (see above) or Maureen Pascal, PT, DPT, NCS: pascal.maureen@gmail.com

Material available: video conferences, audio files, transcripts of conferences

Topics:

Creating and Building your Physical Therapy Practice

Module One: Creating

- Alan Siegel: Branding your Business
- Greta Rose: Managing your Website
- Gwen Simmons: Legal Issues
- Shaula Yemini: Starting a Successful Business

Module Two: Growing Your Business

- Denise Kovalevich: Public Relations
- Jeff Hathaway: Growing your Business
- Rick Gawenda: Growing your Business
- Rob Worth: Growing your Business
- Sarah Haag and Sandy Hilton: Growing your Business
- Growing your Practice worksheet
- Public Relations worksheet
- Seminars and Consulting worksheet

Module Three: Branching Out

- Chris Johnson: Performance Technology
- Jessica McKinney: Wellness programs for non-profits
- Tracy Sher: Finding your niche and becoming an expert
- Branching Out worksheet

Bonus Module A: Live and Learn

- Ann Wendel
- Erica Meloe
- Heidi Jannenga
- Jason Bellefleur
- Jerry Durham
- Marc Rubenstein
- Patrick Myers

Bonus Module B: Social Media

- Karen Yankovich: LinkedIn
- Stephanie Voong: Social Media

Women's Health

Sandy Hilton: Pelvic Pain

Marianne Ryan: Post-partum PT

Pain Management

Cervical Pain – 3 approaches

- Cervical Pain Case study
- Barrett Dorko: Simple Contact

Graded Motor Imagery

- David Sheridan and David Butler

Instrument Assisted Soft Tissue Massage

- Mike Reinold

Neurodynamics, Integrated Manual Therapy

- Joe Brence
- Joe Brence and Francois Prizinski

Therapeutic Neuroscience Education

- Adriaan Louw

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Developing Clinical Guidelines

Reference:

Shekelle P, Woolf S, Eccles M, Grimshaw J. Clinical guidelines: developing guidelines. *Bmj* [serial online]. February 27, 1999;318(7183):593-596.

Full text available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1115034/

PART VI

Improving Human Development Outcomes with Innovative Policies

CHAPTER 22

Innovative Financing for Health in Rwanda: A Report of Successful Reforms

C. Sekabaraga, A. Soucat, F. Diop, and G. Martin

Rwanda has been moving very rapidly to expand health service delivery. It has dramatically accelerated the trend of progress on health indicators, putting it back on track to reach the health Millennium Development Goals (MDGs). Three interrelated innovative reforms contributed to improvement: community-based health insurance, performance-based financing within a broader framework of reform of management of human resources for health, and fiscal decentralization. This chapter examines these reforms, showing how they worked together to improve health outcomes in Rwanda.

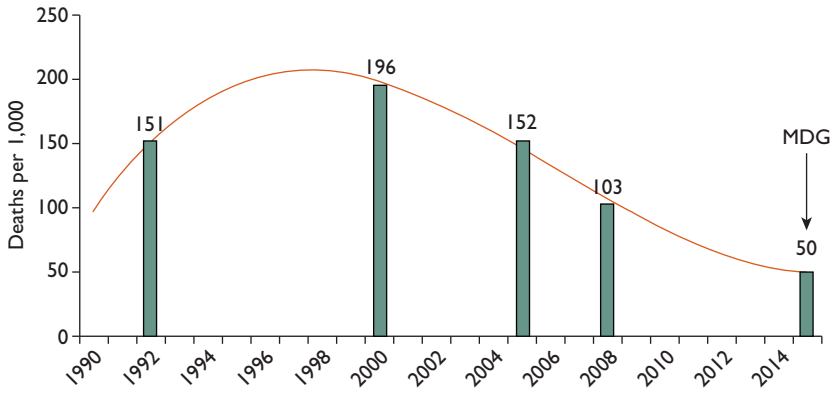
Health indicators in Rwanda improved dramatically in recent years, and projections for the coming years are positive. After an initial surge following the genocide, under-five mortality (the probability of death per 1,000 live births) significantly decreased, falling from 196 in 2000 to 152 in 2005 and 103 in 2007 (figure 22.1). The infant mortality rate decreased from 107 per 1,000 live births in 2000 to 86 in 2005 and 62 in 2007. Improvements were particularly significant among the poor, with the under-five mortality rate among the poorest quintile declining by 50 deaths per 1,000 between 2005 and 2008 compared with 38 deaths per 1,000 live births among the richest quintile. The annual rate of decrease achieved between 2005 and 2008 was 12.2 percent—far greater than the 9.7 percent needed to meet the MDG 4 target of 50 in 2015. Rwanda is thus back on track to reach the health MDGs.

Since 2000 the maternal mortality ratio has declined at an annual rate of 12.1 percent to reach 383 per 100,000 in 2008, ranking it among the best-performing countries in the world (figure 22.2). This rate of decline far exceeds the 5 percent rate needed to meet the MDG target of reducing the maternal mortality ratio by three-quarters between 1990 and 2015.

These achievements have been the result of innovative strategies to address some of the key challenges affecting maternal mortality. The share of women delivering their babies in health facilities has steadily increased, rising from 28 percent of pregnant women in 2000 to 45 percent in 2008. Many challenges remain, but preliminary data from the Ministry of Health for 2010 suggest that this figure has risen to two-thirds of all pregnant women; the finding should be validated by the 2010 Demographic and Health Survey.

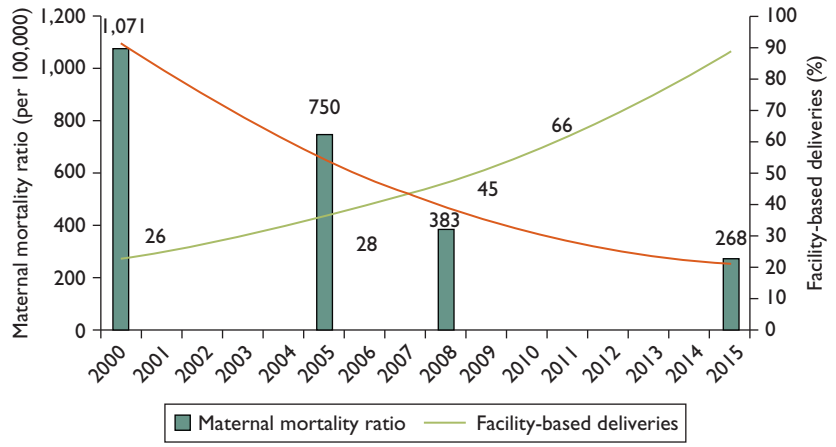
These successes can be attributed largely to an increase in the use of essential health interventions, particularly high-impact interventions that are critical in reducing disease burden in developing countries, including immunization, assisted deliveries, family planning, and the use of insecticide-treated bed nets to prevent malaria. Rwanda has maintained a very high and equitable coverage of vaccination against avoidable childhood diseases since 2000: immunization rates, at 95 percent in 2008, are among the highest in Sub-Saharan Africa. Major progress has also been made in extending the coverage of vitamin A supplementation among children and women, through a mass campaign and integration into routine health facility services. Treatment of acute respiratory infections of children has also increased, including among the poor.

Figure 22.1 Under-five Mortality Rate in Rwanda, 1990–2015



Sources: Measure DHS and ICF Macro 1995, 2000, 2005, 2008.

Figure 22.2 Maternal Mortality Ratio and Facility-based Deliveries in Rwanda, 2000–15



Sources: Measure DHS and ICF Macro 2005, 2008.

Improvements in the use of women's health services are also evident, with significant increases in the proportion of assisted birth deliveries and the number of emergency obstetrical cases referred. The use of modern contraceptives increased from 3 percent in 2000 to 27 percent in 2007, one of the fastest increases ever observed. The proportion of women having at least one antenatal consultation rose from 58 percent in 1995–2000 to 96 percent in 2000–07. The proportion of assisted deliveries increased from 39 percent in 2005 to 52 percent in 2007.

Major progress has also been made in controlling communicable diseases—including malaria, a prime cause of morbidity and mortality in Rwanda—and containing the HIV/AIDS epidemic. Malaria incidence and mortality have declined dramatically, largely as the result of increased use of insecticide-treated nets, which among children under five rose from 11 percent in 2005 to 56 percent in 2007. As a result, malaria-specific mortality was cut in half. Rwanda has thus moved from being a country where malaria was endemic to one focusing on eliminating malaria as a public health problem. The HIV/AIDS epidemic has been contained, with 3 percent of the population affected and more than 60 percent of patients needing treatment receiving highly active antiretroviral therapy. Knowledge of HIV/AIDS is better in Rwanda than in any other Sub-Saharan African country: nationwide 54 percent of women

and 58 percent of men had comprehensive knowledge of HIV/AIDS in 2005.[1]

This progress occurred in a context in which annual total per capita health expenditures doubled, from $17 to $34 between 2003 and 2006. In 2006 total health expenditures reached 10.7 percent of gross domestic product (GDP) (one of the highest levels of health expenditures observed in low-income countries), up from 3 percent in 2002.

The overall share of public expenditures allocated to health has remained stable, with most of the increase coming from donors. Private expenditures were about $9.40 per capita, and domestic public expenditure about $6.30 per capita, with donors contributing $17.70 per capita, one of the highest levels of donor dependency in Sub-Saharan Africa. Much of this donor funding is earmarked funding for HIV/AIDS.

Despite the increase in funding, resources are not sufficient to meet the country's health care needs. Rwanda has therefore pioneered profound reforms, including an innovative health system and a financing model grounded in grassroots initiatives and institutions. Three prominent reforms were adopted to boost both the demand for and the supply of health services: health microinsurance (*mutuelles*), performance-based financing, and fiscal decentralization. Those reforms have transformed the fiscal space landscape. Revenues generated by health facilities have increased significantly as a result of increased use of health services and health insurance coverage, and an increasing share of domestically generated revenues is captured by health centers, strengthening front-line providers.

In 2007 the Rwandan government adopted its second Poverty Reduction Strategy Paper (the Economic Development and Poverty Reduction Strategy). Its goals for the health sector are to maximize preventive health measures and build the capacity to provide high-quality and accessible health care services to the entire population in order to reduce malnutrition, infant and child mortality, and fertility and to control communicable diseases. The strategy also supports strengthening institutional capacity, increasing the quantity and quality of human resources, ensuring that health care is accessible to the entire population, increasing geographical accessibility, increasing the availability and affordability of drugs, improving the quality of services in the control of diseases, and encouraging the demand for such services. It also sets ambitious targets for slowing population growth, calling for innovative measures in the strengthening of reproductive health services and family planning and ensuring free access to information, education, and contraceptive services.

REFORM STRATEGIES: COMMUNITY-BASED HEALTH INSURANCE, PERFORMANCE-BASED FINANCING, AND FISCAL DECENTRALIZATION

Rwanda has pioneered major programmatic, organizational, and health financing reforms, which are increasing the accountability of major actors in the health sector. Rwanda has a long history of centralized management structures with a clear hierarchy and a relatively low level of corruption. It has progressively moved toward a modern health system design, including full autonomy of facilities, decentralization, third-party payment, and strategic purchasing through performance-based financing. It has transitioned from a faith-based service delivery model in the colonial era to a model guided by the Bamako Initiative, which sought to expand access to health services through the development of local models of primary health care that are managed and financed by communities. Both public and private not-for-profit health facilities charge fees that are locally retained and managed to cover the costs of health services and improve the quality of care.

To improve financial access, the government pioneered a microinsurance scheme and supported its expansion and subsidization. It then introduced a mechanism of performance-based financing to provide incentives to health facilities to deliver high-impact interventions and ensure quality of services. In 2006 it established a fiscal decentralization policy and a legal framework that delineated a clear role for central and local governments and service providers.

Together these three reforms constitute strategies to strengthen accountability for services to citizens as part of Rwanda's 2006 national decentralized service delivery policy (Government of Rwanda 2006). Fiscal decentralization has been accompanied by measures to strengthen citizen participation and accountability, including mechanisms for establishing accountability links between citizens and local government officials, contractual performance between health services providers and local governments or national policy makers, and contractual approaches between communities and health providers. This policy can be visualized by using the accountability framework laid out in the *World Development Report 2004* (World Bank 2004). Accountability of health providers to clients ("client's power") is strengthened through micro–health insurance funds that claim and fund health services on behalf of households. Accountability of providers to the government (the "compact") is

strengthened thanks to performance-based financing mechanisms. Accountability of government to citizens ("voice") is strengthened through decentralization, citizen report cards, and the possibility of recourse to the ombudsman (figure 22.3).

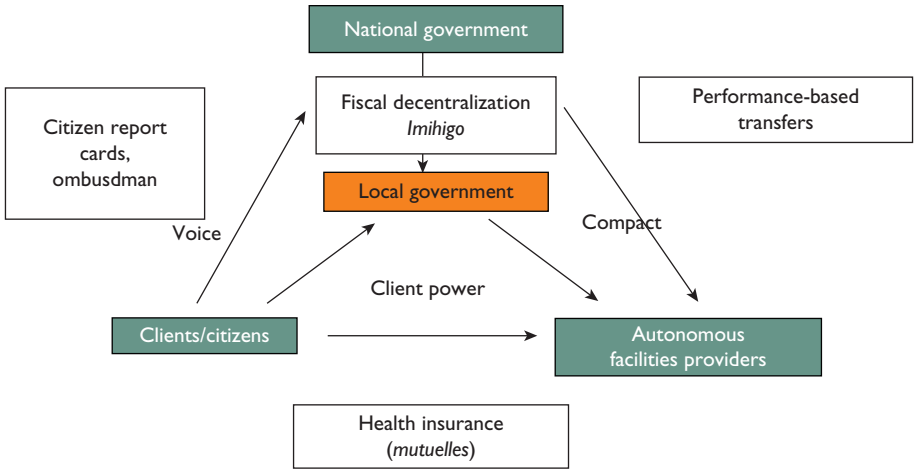
Rwanda has finally settled into its current decentralized model of care, in which health facilities are fully autonomous entities responsible for the management of financial resources, health service delivery, and human resources for health. Community-based health insurance schemes, which have been established and scaled up nationally, have evolved in response to low levels of utilization of health services. Partly to encourage community members to buy in to these health *mutuelle* schemes, the government developed performance-based financing as a complementary scheme to boost the performance and motivation of staff to deliver higher-quality services as well as to increase the delivery of preventive services.

Mutuelles and performance-based financing are two complementary schemes. Both aim to shift health financing mechanisms from inputs-based mechanisms toward output- or results-based contractual mechanisms. The interactions between the two strategies are therefore strong. Whereas *mutuelles* emphasize personal curative care services, performance-based financing emphasizes high-impact preventive services and the quality of services.

The nationwide expansion of both strategies has occurred rapidly since the pilot schemes were launched, thanks largely to government ownership and commitment, which have propelled these strategies forward. The nationwide implementation of *mutuelles* was closely followed by the implementation of performance-based financing. *Mutuelles* revealed the need for improvements in staff motivation and incentives to deliver high-quality health services, which in turn served as the driving force for performance-based financing. As the implementation of performance-based financing in the pilot districts proved successful in improving staff motivation and health outcomes, performance-based financing became a major pillar within the Ministry of Health Strategic Plan (2005–09). In 2006 the government, with the support of external partners, expanded performance-based financing to the entire health sector (table 22.1).

Rwanda has continuously learned from and adapted its health service delivery strategies. The ability of the government to adapt strategies—as evident in the scaling up of successful pilot schemes to the national level, in light of the changing macroeconomic and health sector environment—was also essential to strengthen health services. Independent controls and quality checks under contractual arrangements have been essential for the monitoring and evaluation of health facility performance. Performance-based financing is a prime example of a system in which independent controls on performance are in place to ensure proper monitoring and reporting of health centers and district hospitals on the quantity and quality of services delivered, which in turn drive facilities' reimbursement.

Figure 22.3 Decentralization of and Accountability for Health Services in Rwanda



Source: Government of Rwanda 2006.
Note: Imihigo are performance contracts in which the region and its districts promise the president of Rwanda that they will implement the measures outlined in the annual plans.

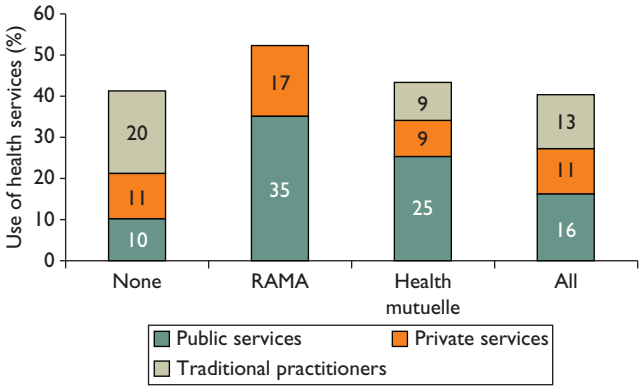
Table 22.1 Health Financing Reforms in Rwanda, 1999–2008

Reform	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Enrollment in *mutuelles* (percent)	0	1.6	2.6	4.7	7	27	44	73	75	85
Number of districts with performance-based financing	0	0	0	2	5	7	7	14	23	30
Assisted deliveries (percent)							39		52	
Key policy milestones		Rwandaise d'Assurance Maladie (RAMA) created; fiscal decentralization policy						Fiscal decentralization law passed; decentralized service delivery policy includes performance-based financing and *mutuelles*		Health insurance law passed
Key implementation milestones	Community-based health insurance pilots launched in three health districts since July 1999		RAMA established	Performance-based financing pilots launched in four districts			Integration of performance-based financing and subsidies to *mutuelles* in national budget		Fiscal decentralization	Full autonomy given to public health facilities, including over hiring and firing National guarantee fund established
Per capita health expenditures (National Health Account)				$15			$37			

Source: Authors.
Note: RAMA = Rwandaise Assurance Maladie.

Community mobilization and intersectoral collaboration have contributed significantly to the implementation of health reforms. Cultural and social factors, particularly solidarity within communities, have contributed to the success of several health service delivery innovations. The rapid proliferation of health *mutuelles* was made possible by the strong solidarity within Rwandan society, in which community members encouraged one another to join. This solidarity has been long-standing in Rwanda, evident even before the start of health *mutuelles*. In the case of health *mutuelles*, cultural barriers initially thwarted implementation, particularly because Rwandans were used to seeking care from traditional healers and because patients of traditional healers were able to pay in kind rather than making cash payments.

Figure 22.4 Use of Health Services in Rwanda in Event of Illness, by Health Insurance Coverage, 2005



Source: Government of Rwanda 2005.

Community-based health insurance

Health insurance has been scaled up at the national level on the basis of community-based health insurance schemes, with strong support from the government of Rwanda. Coverage of health *mutuelles* increased dramatically between 2003 and 2008, rising from less than 7 percent to 85 percent of the population in just five years.

Health *mutuelles* have had a significant positive impact on health service utilization, income protection, and household health behaviors (Sekabaraga, Diop, and Soucat 2010). Health insurance coverage increased the use of modern health services by children under five between 2000 and 2007. In the general population, use of modern services by the insured population is nearly twice as high as use by the uninsured (figure 22.4). In addition, health *mutuelles* seem to protect against expenditure caused by unexpected illness, because uninsured households spend directly twice as much as insured households for illness-related expenditure. Health insurance coverage has thus significantly reduced household out-of-pocket health expenditures (Ministry of Health of Rwanda and World Bank 2011). Among women who gave birth during the period 2000–05, 77 percent were affiliated with Rwandaise d'Assurance Maladie (RAMA). About 42 percent of women affiliated with a health *mutuelle* were assisted by a skilled health professional during delivery compared with 35 percent of women with no insurance (Sekabaraga, Diop, and Soucat 2010).

Before 1996 health services in Rwanda were free. Given problems associated with the quality of services and the financial sustainability of the health system, cost-recovery mechanisms were reintroduced in 1996, while policy debates continued over alternative financing mechanisms for reconciling internal resource mobilization and access to health services, including prepayment mechanisms through health insurance schemes. In view of the significant scope of poverty following the war of 1994, the reintroduction of user fees in the health sector in 1996 was accompanied by an exemption policy that allowed for free health care coverage in health facilities for people identified by the local administrative authorities as indigent. Coverage of the poor and vulnerable groups has been integrated in the development of health *mutuelles* since they were first piloted in 1999.

In 2000 Rwandaise d'Assurance Maladie, the first health insurance scheme for the formal sector, was established for civil servants. Membership in RAMA soon became compulsory in order to increase coverage. To complement insurance schemes such as RAMA and a few private insurance schemes that target the formal sector, health *mutuelles* covering rural communities and the informal sector were expanded to promote equitable access to quality health services. Health *mutuelles* were designed to pool or spread the financial risk of seeking care across their membership base. The goal was to respond to the low use of health services (caused in part by user fees) by improving financial access to health services, particularly for underserved populations. The package of services reimbursed by health *mutuelles* to health facilities has expanded over time and currently covers all services delivered within a health center as well as drugs from the national essential drug list. Health *mutuelles* also cover most costs for health services and drugs delivered at district and referral hospitals when *mutuelle* members receive referrals for these higher levels of care.

These schemes have been extended to empower citizens and communities in the health sector and to change their

interactions with health care providers. Through contractual relations between health *mutuelles* and health care providers, communities and citizens have a tool with which to hold health care providers accountable for services provided. In essence, health *mutuelles* in Rwanda reflected a bottom-up strategy, driven largely by local communities. The success of the initial pilot schemes motivated the central government to scale up this strategy. Currently, the central government sets national guidelines and policies, including benefit packages and contribution policies. In 2008 it instituted a national guarantee fund for providing general subsidies to support the extension of the benefit packages of health *mutuelles*. Since 2009 the government has also built on the national network of health *mutuelles* to elaborate and implement demand-based targeted subsidies, through which the government, donors, and nongovernmental organizations (NGOs) are providing health insurance coverage to poor people, vulnerable groups, and people living with HIV/AIDS. At the operational level, health *mutuelles* are run and organized by community representatives and local health care providers. They also serve as a forum for promoting dialogue between the community and providers on the quality and range of health services offered. In this way, community members are better able to hold providers accountable for services delivered.

For the majority of the population employed in the rural and informal sectors, an incremental approach was followed in developing mechanisms for pooling health risk. The process of cumulative building of national capacities is a hallmark of the incremental development of *mutuelles* in Rwanda. Capacity building for local actors involved in setting up, managing, and monitoring health *mutuelles* began in 1999, with the establishment of *mutuelles* in three pilot health districts.[2] The geographic extension of the *mutuelles* was accelerated in 2004, after the adoption of a national strategic framework for their development. The number of health *mutuelles* grew by a factor of 2.5 in a single year, climbing to 226 nationwide. In 2007 each of Rwanda's 403 health centers had a partner health *mutuelle* or "health *mutuelle* section," and all of the country's 30 districts had a district health *mutuelle,* which, on average, was linked to 13 health *mutuelle* sections.

The period of experimentation, which started in 2001, was followed by attempts to adapt the institutional arrangements for health *mutuelles* to the environment of administrative and political decentralization and by early efforts to expand the *mutuelles* to other districts of the country. In the absence of an explicit policy framework for coordinating the initial efforts of adaptation and expansion, a variety of local policies and incentives proliferated, initiated by local authorities of all categories (political groups, associations, and so forth) to motivate the population to join health *mutuelles* (by, for example, linking membership to civil status services, microcredit, and so forth). These initiatives helped develop the health *mutuelles* and contributed to the growth of social demand for their expansion nationwide.

Current levels of contributions to health *mutuelles* are affordable for all but the poorest 10 percent of Rwandans. Affordability of enrollment in health *mutuelles* is assessed based on the percentage of contributions in household total expenditures and household nonfood expenditures. The cost of membership rises with family size (for many reasons, including high disease burden in large families and the externalities of insurance benefits). Male-headed households have a higher proportion of enrollment than female-headed households, partly because of the income difference between the two groups. Family heads that completed primary school or received some vocational training tend to have the highest rate of enrollment among the least-educated and best-educated households. This trend is also reflected in the enrollment rate by income (expenditure) category, so that middle-income and middle-rich people tend to have the highest participation rates in health *mutuelles*. Out-of-pocket illness-related expenditures among households enrolled in health *mutuelles* are twice as high as those of members. Households that live very close to health centers spend more than those living far away. Households that are not covered by health *mutuelles* spent nearly twice as much for illness-related services as people who were insured.

Information has played an important role in the operational management and monitoring of the development of health *mutuelles* at the local level and in their strategic management at the central level. Indeed, Rwanda is one of the few African countries where an information system to support health *mutuelle* management has been developed to permit monthly monitoring of performance. It is also one of the few countries that has adapted training manuals on health *mutuelle* development, management, and monitoring in line with the local context, including availability in the local language. Numerous other activities to promote and raise awareness of health *mutuelles* are carried out around the country and at the national level. The Ministry of Health occasionally organizes an annual event on mutual organizations at which prizes are awarded to the best performing health *mutuelles*.

Performance-based financing and reforms of human resources management

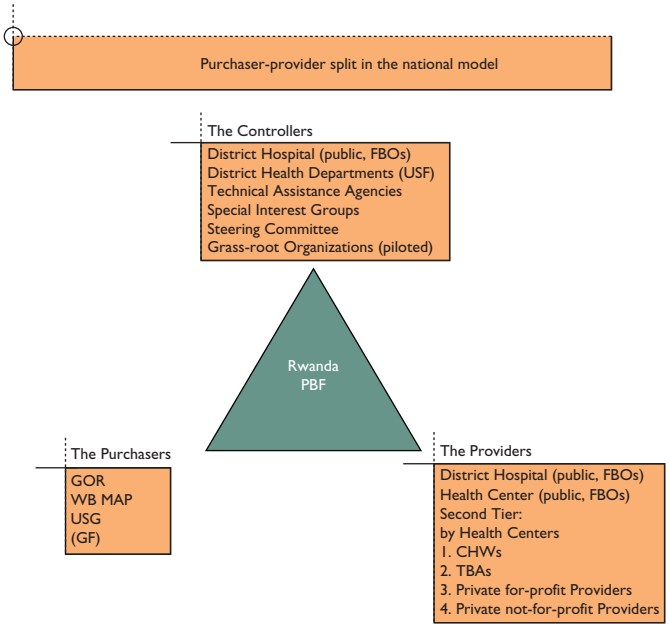
Based on a positive evaluation of a three-year pilot phase in two provinces, Rwanda has implemented a national program since 2005; it has scaled up performance-based financing since 2006 (Rusa et al. 2009).[3] Performance-based financing is currently implemented at three levels: health centers, hospitals, and community levels.

The performance-based financing model is based on the principle of separating purchaser and provider functions in health service delivery (figure 22.5). By distinguishing between and maintaining a split between bodies purchasing services and bodies providing services, this model promotes accountability and avoids conflicts of interest. The model consists of a family of methods and approaches that aim, through differing levels of intervention, to link incentives to performance. In the national model for health centers, payments for performance are based on the quantity of outputs achieved conditional on the quality of services delivered. Through performance-based financing, the central government purchases 13 quantitative indicators and 13 qualitative measurements from health facilities (tables 22.2 and 22.3).[4] At the hospital level, performance is assessed through a peer-evaluation mechanism.

Low intake of preventive services and poor quality of care in health centers served as the impetus for introducing performance-based financing strategies. Quality of care became a particularly salient issue as expansion of health *mutuelles* increased utilization rates dramatically at all health centers, adding to the workload of health personnel who, at the time, had little or no incentive to take on the additional work. The impetus for the performance-based financing strategy in Rwanda first came from external actors; additional resources and incentives were provided to health workers to improve efficiency and outcomes, under pilot schemes implemented in 2001–05. As a result of the pilots' success, performance-based financing became a major pillar within the Ministry of Health strategic plan and was implemented nationally.

Rwanda's institutional performance-based financing model can be classified as "output-based financing," because

Figure 22.5 Rwanda's Performance-Based Health Care Financing Model



Source: Rusa et al. 2009.

Note: Purchasers are those who pay for services. They include NGOs, which purchase services with their own funds and act as fundholders or pass-through mechanisms for other donors; the government of Rwanda (in the case of the national model); the U.S. government, through collaborative agencies such as Management Science for Health and Family Health International; World Bank MAP funding, NGOs in the Cyangugu and Butare pilots and purchasing performance through the new national model; and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which is expected to start purchasing through the new national model. Providers can include public and faith-based managed health facilities (health centers and hospitals) and private for-profit health facilities. Controllers are those who control the level of performance, such as district health teams in the Ville de Kigali pilot, who certify a mix of quantity and quality deliverables in health centers and hospitals. District health teams were used in Butare for random quantity control and in Cyangugu l for a quality measure in health centers. A peer-evaluation mechanism for district hospitals was piloted in Cyangugu and partially in Butare.

Table 22.2 Output Indicators and Unit Payments under Performance-Based Financing Formula

Output indicators	Amount paid per unit (US$)
Visit indicators (number of)	
Curative care visits	0.18
First prenatal care visits	0.09
Women who completed 4 prenatal care visits	0.37
First time family planning visits (new contraceptive users)	1.83
Contraceptive resupply visits	0.18
Deliveries in the facility	4.59
Child (0–59 months) preventive care visits	0.18
Content of care (number of)	
Women who received tetanus vaccine during prenatal care	0.46
Women who received malaria prophylaxis during prenatal care	0.46
At-risk pregnancies referred to hospital for delivery	1.83
Emergency transfers to hospital for obstetric care	4.59
Children who completed vaccinations (child preventive care)	0.92
Malnourished children referred for treatment	1.83
Other emergency referrals	1.83

Source: Basinga et al. 2009.

Table 22.3 Quality Indicators Services and Weights Used in the Performance-Based Financing Formula

Service	Weight	Share of weight allocated to structural components	Share of weight allocated to process components	Means of assessment
General administration	0.052	1.00	0.00	Direct observation
Cleanliness	0.028	1.00	0.00	Direct observation
Curative care	0.170	0.23	0.77	Medical record review
Delivery	0.130	0.40	0.60	Medical record review
Prenatal care	0.126	0.12	0.88	Direct observation
Family planning	0.114	0.22	0.78	Medical record review
Immunization	0.070	0.40	0.60	Direct observation
Growth monitoring	0.062	0.15	0.85	Direct observation
HIV services	0.090	1.00	0.00	Direct observation
Tuberculosis service	0.028	0.28	0.72	Direct observation
Laboratory	0.080	1.00	0.00	Direct observation
Pharmacy management	0.060	1.00	0.00	Direct observation
Financial management	0.050	1.00	0.00	Direct observation
Total	1.000			

Source: Basinga et al. 2009.

it pays on a fee-for-service or case reimbursement basis to improve outputs. Although performance-based financing incentives are generally meant to induce providers (the supply side), supply-side incentives in Rwanda work through supplier-induced demand, whereby suppliers actively seek to convince people to use more of certain kinds of services. Such incentives are necessary in Rwanda, where the goal is not to limit excessive supply and unnecessary demand (as is the case in richer health systems) but rather to induce providers to provide more services while also increasing financial revenues at the health facility level.

As of 2006 the government transferred about $1.80 per capita from the Treasury directly to health facilities at the basic health service level on the basis of a performance-based formula. The program channels funds directly from Treasury to the bank accounts of the more than 400 health clinics in Rwanda (40 percent of them faith based, 60 percent of them public) on the basis of performance agreements.

These funds are flexible and may be used for facility expenditures, including performance-linked salary bonuses, partially substituting for revenues from user fees. Rwanda implemented a three-tier performance-based financing model—including hospitals, health centers, and ultimately the community level—in order to make health services more community oriented.

One of the key objectives of performance-based financing was to introduce bonuses to health workers as incentives for good performance, based on a range of agreed indicators. This system was designed to allow for better monitoring of health personnel activities and hence to enable district and central levels to track staff performance over time. Although the central government determines the overall performance-based financing budget envelope that the health facility receives, based on a formula involving the quantity and quality of services provided, it is the committee within the health facility itself that determines how these funds should be used.

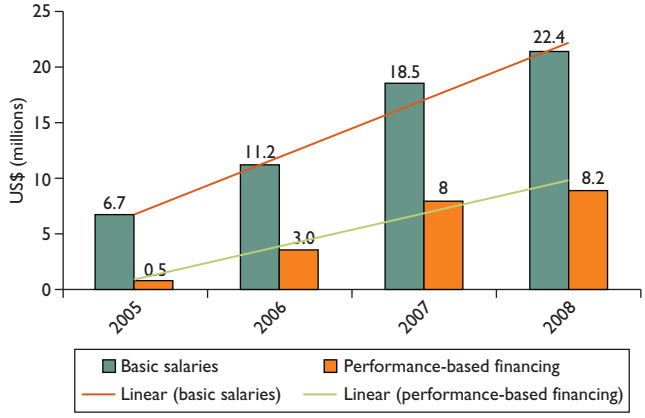
In 2008 Rwanda decentralized wages. As a result, financing and payments for health personnel are increasingly linked to performance in which block grants from the government and donors can be used as salary. Direct spending on wages and salaries by the central administration and transfers to public institutions for salaries of health workers have declined. In contrast, funds channeled to human resources for health through provinces and districts that come from both the government (including performance-based financing) and user fees collected directly by facilities have risen dramatically in recent years (figure 22.6).

It is the policy of the Ministry of Health, in collaboration with development partners, to harmonize the framework for compensation packages of health professionals. The objective is to avoid introducing distortions in the distribution of health workers, which occurs when health workers move from the public sector to donor projects where the pay is higher. In light of this concern, donors, such as the Global Fund, have begun to use national pay scales and to fully integrate staff within the health system at large.

Results-based block grants in Rwanda have contributed significantly to the increase in assisted birth deliveries as well as the intake of child health services; the grants have also increased the quality of services. Clinics that received performance-based financing (of about $1.80 per capita per year) performed more assisted deliveries and more post-natal visits than clinics receiving the same funding without a performance contract (figure 22.7). The quality of care of antenatal services was 15 percent higher in performance-based financing clinics than in control clinics (figure 22.8).

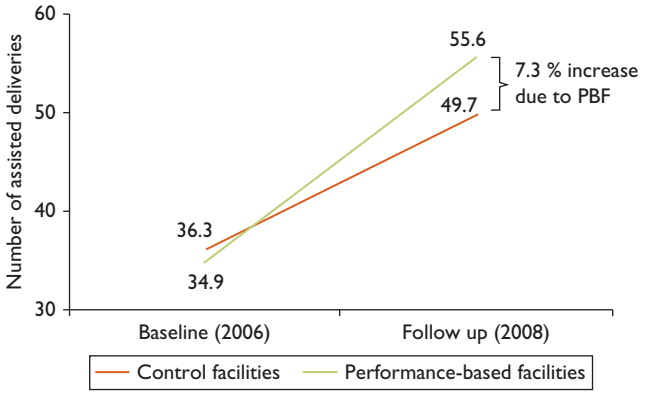
The results achieved—in service supply and the enthusiastic participation of all stakeholders—after a few years of experience point to a promising future. However, because it is a dynamic strategy, performance-based financing adjusts to innovative ideas that benefit the population and health care providers. The remaining challenges are related to the permanent oversight requirements, the accuracy of data, and the delicate balance of the pricing of the various indicators. The future of performance-based financing will depend on finding appropriate solutions to these issues.

Figure 22.6 Financing for Human Resources for Health in Rwanda, 2005–08



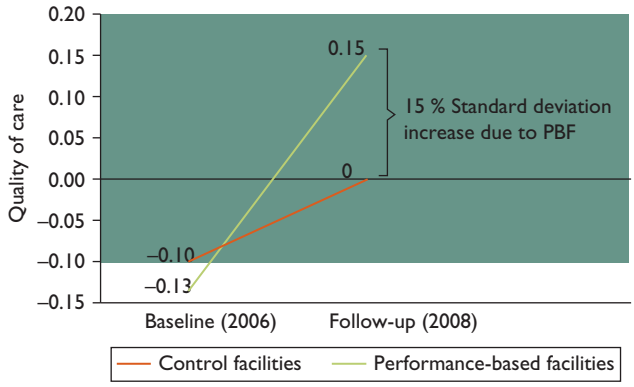
Source: Authors.

Figure 22.7 Number of Assisted Deliveries in Rwanda under Performance-Based and Nonperformance-Based Financing, 2006 and 2008



Source: Basinga et al. 2009.

Figure 22.8 Quality of Care in Rwanda under Performance-Based and Nonperformance-Based Financing, 2006 and 2008



Source: Basinga et al. 2009.

Fiscal decentralization

A strong commitment to bring services closer to the people resulted in rapid fiscal decentralization, increased citizen participation, and increased autonomy of health facilities. Fiscal decentralization (adopted as policy in 2001 and enacted into law in 2006) served as an essential component of Rwanda's decentralization agenda to devolve authority to the district level. As was to be expected, given the presence of such a strong state, a mindset change was needed to move forward on many of these reforms. As in the case of decentralization, some officials at the central level felt disempowered and were initially unwilling to relinquish their control at the outset. Officials at the local level had to adapt to accept their new responsibilities, and donors had to adjust to working with local governments.

The decentralization of authority across sectors was planned through an incremental, three-phased approach. The first phase (2001–05) focused on administrative and political decentralization; it aimed to institutionalize decentralized governance by establishing democratic and community development structures, delineating policies, establishing legal frameworks, and strengthening institutional capacity at local levels. Phase two, which began in 2006 and ran through 2008, focused on making local governments responsible for bringing health services closer to beneficiaries. The devolution of responsibilities in health services and the transfer of resources under fiscal decentralization are the backbone of relationships between the national government and districts in the health sector. It aimed to reorganize roles and responsibilities within local government under the decentralization framework and further strengthen district authority while allowing for greater community participation and facilitating resource allocation to local government. Central government responsibilities in this phase remained regulation and development of policy frameworks, capacity building of local government, and monitoring and evaluation.

Finally, phase three, which began in 2008, granted autonomy to health facilities and transferred fiscal responsibilities and financial resources from the central and local government to facilities. This reform has resulted in relative autonomy in budgeting and financial management within facilities, because health care providers are now contracted with and managed by health facilities.

Fiscal decentralization in Rwanda was government owned and driven, with strong support and collaboration of development partners. The objective was to bring services closer to the people, and to improve the financial viability of districts. The infrastructural changes needed may not have been in place (until June 2007 districts lacked accounting software to manage financial transactions, and local capacity in managing financial and human resources still remains limited), but overall success was striking. The strategy was organized by the central government, which from the outset determined the degree of authority delegated to local levels and delineated relevant policies and standards. In these efforts, the central government received significant technical assistance and guidance from development partners, which organized their support in the form of a sector-wide policy to ensure government ownership over decision making and policy setting; increase coherence between policy, spending, and actual results; reinforce the government's management systems; and harmonize donor support.

Decentralized units at local levels were given the authority to manage the flow of funds (once received) as well as the delivery of health services. Decentralization transformed health facilities into autonomous entities, with the ability to manage financial and human resources as they deem most appropriate, according to local needs. The process gave them complete control over the hiring and firing of health personnel.

The accountability links between local governments and national policymakers are strengthened through inspections, audits, and *Imihigo*—performance contracts in which the region and its districts promise the president of Rwanda that they will implement the measures outlined in the annual plans.[5] Decentralization reforms have resulted in increased responsibilities of local governments in many areas and are increasing space for community

participation and community-driven development initiatives. Satisfaction with service delivery is measured through citizen report cards.

CONCLUSION

Fiscal decentralization, performance-based financing, and the expansion of health insurance have led to a dramatic increase in resources for frontline providers. Between 2002 and 2007, public resources flowing to health facilities more than tripled (figure 22.9). The increase in resources took place at all levels, showing no higher priority given to the primary care level. An increasing number of donors are channeling their assistance through on-budget support, and major efforts are under way toward coordinating and harmonizing aid. Most of the increase in publicly managed resources flowed to human resources and to performance-based financing; resources directly managed by donors funded HIV/AIDS activities. On the domestic front, internally generated revenues of health facilities increased significantly as a result of increased utilization of health services and health insurance coverage; an increasing share of internally generated revenues is captured by health centers, strengthening frontline providers.

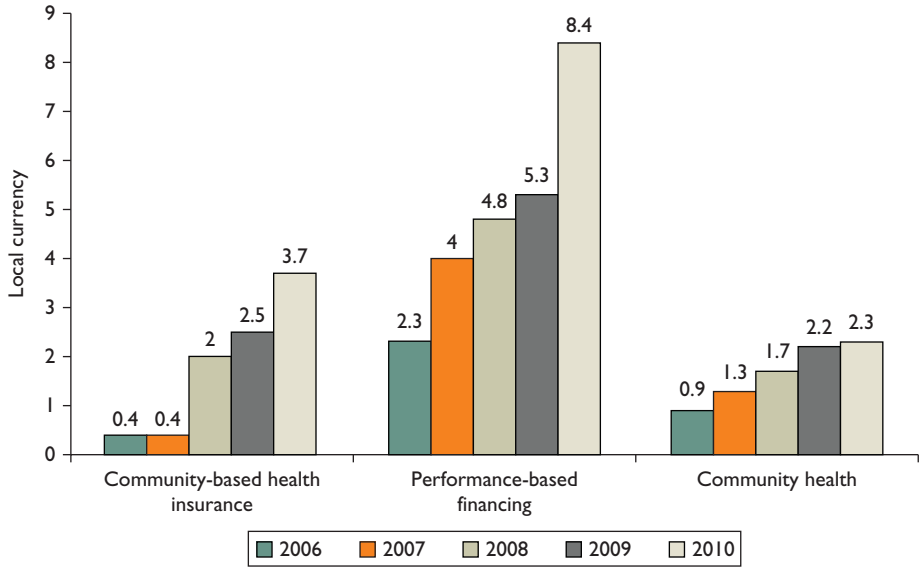
Rwanda chose to develop a mixed health care financing model, combining decentralization and performance-based financing with a strategy to pool private spending through the building of grassroots, community-based microinsurance. Key reforms included provisions for financial protection and other support for poor people.

Lessons learned from the Rwandan experience provide a strong base for future action. As financial barriers to access to health services are being reduced significantly through health care financing reforms, improving the quality and sustainability of health services will remain among the main challenges facing Rwanda in the coming years.

The success of Rwanda in improving health outcomes, particularly for women, children, and the poor, can be linked to both increased resources and implementation of reforms. Rwanda used the inflow of resources to strengthen its country system, including its public finance and health systems. It designed its own brand of reforms, staying away from donor fads and looking realistically and opportunistically at the balance between sustainability and equity. Reforms focused on results, and results attracted more funding, both domestic and external. Increased resources and reforms mutually reinforced each other as part of a virtuous cycle. Efficient and equitable use of resources required reform, and the success of reforms needed resources.

The success of the health financing innovations is critically linked to the institutional context. Decentralization reforms coupled with performance-based financing ensure that health facility managers have not only the incentives but also the power to ensure that these innovations translate

Figure 22.9 Financial Transfers to Districts for Priority Programs, 2006–10



Source: World Bank 2010.

into changes in the delivery of services. The performance-based financing system is now being extended to provide incentives to community health workers providing outreach services and demand-side incentives to women to continue the increased utilization of key maternal health services.

Strong government leadership, vision, and the step-by-step building of a policy and regulatory framework at all levels have fostered the short- and long-term sustainability of health sector reforms. The Rwandan government showed flexibility and was able to adapt strategies in light of the changing macroeconomic and international health environment. Government coordination of donor funding was critical to ensure that aid was used effectively and aligned with national priorities. Systems for improved accountability, including contractual arrangements, independent controls, and quality checks, were essential for monitoring and evaluating health facility performance. Cultural and social factors, particularly solidarity within communities, also contributed to the success of several health service delivery innovations.

A particularly important feature of the Rwanda experience is the integration of strong mechanisms to evaluate the impact of its policies. Rwanda's experience, as well as that of other low-income countries, in introducing pro-poor financing policies needs to be systematically evaluated using rigorous metrics and standardized benchmarks. It is possible for countries to nest impact evaluation designs when introducing new policies at scale. The donor community needs to support these evaluations if it wants to improve aid effectiveness.

A key issue for the future is sustainability and the necessary evolution of the institutional support for the health financing approach of Rwanda. Like many Sub-Saharan African countries, Rwanda is highly dependent on aid and will remain so for the next decade. Sustained support from the donor community is therefore needed to support the health system strengthening agenda. *Mutuelles* provide one way to ensure more sustained domestic funding. They represent an efficient way to pool private out-of-pocket spending, but there is a need for the government—with the help of donors—to subsidize the enrollment of the poorest Rwandans and to regulate the package of benefits as well as the provider payments mechanisms to ensure equitable access to quality services.

NOTES

1. Comprehensive knowledge of HIV/AIDS, which can be used as a tracer indicator of general health knowledge in the country, means knowing that use of condoms and having a single, uninfected, faithful partner can reduce the chances of contracting HIV, knowing that a healthy-looking person can have HIV/AIDS, and rejecting the two most common local misconceptions about HIV/AIDS transmission and prevention.
2. At the time, the districts were called Byumba, Kabgayi, and Kabutare. They are now called Gicumbi, Muhanga, and Save.
3. This program has been supported by a broad consortium of donors, including the World Bank, the U.K. Department for International Development, the European Union, Sweden, the African Development Bank, the Netherlands, and Germany.
4. A separate contract channels earmarked funds of global HIV/AID programs for another 16 indicators.
5. *Imihigo* are also monitoring instruments designed to help local authorities plan and act realistically.

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Original research articles include but are not limited to biomedical, clinical, behavioral research, health management research, educational research in medicine and health sciences. These full-length articles should describe new and carefully confirmed findings, and experimental procedures should be given in sufficient detail for others to verify the work. They should be double spaced, between 3000 and 6000 words, excluding tables, figures and references. The articles should have the following main sections: Introduction, Methods, Results, and Discussion..

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It should be in title case format in which all words except prepositions and conjunctions start with capital letter. Title should be short describing the contents of the article for comprehension and easy electronic retrieval. There should be no abbreviations in the title unless they are units of measurements. *The title page* should include the authors' full names. The authors' affiliation addresses (where the actual work was done) should be listed below the names. A superscript number just after the author's name and in front of the appropriate address should indicate the affiliation. Provide the full postal address of each affiliation, including the country name. Indicate the *Corresponding author* with asterisk after the author's name and before 'Corresponding author' in the footnote along with e-mail address and phone number.

Abstract

The abstract should be between 150-200 words and must include the following subtitles: Background, Objectives, Methods, Results, and Conclusions. No references should be cited and abbreviations must be avoided. Following the abstract, about 3 to 10 key words that will provide indexing references should be listed. It is recommended, to use keywords from the National Library of Medicine's (NLM) Medical

Subject List, whenever possible. The suitability of keywords can be checked on the NLM MeSH Browser at *http://www.nlm.nih.gov/mesh/* (e.g. MeSH on Demand: http://www.nlm.nih.gov/mesh/MeSHonDemand.html

Introduction

It should be short, providing the scientific background to the study to demonstrate the magnitude of the problem, its significance and what is not known (i.e. gaps in knowledge). It should contain a statement on the purpose of the present investigation with specific objectives presented preferably as questions. References cited should be few, relevant and as recent as possible The introduction should end with a very brief statement of what is being reported in the paper.

Methods

Detailed description of the investigation process and statistical methods should be provided such that verification by other researchers can be feasible. However, only truly new procedures should be described in detail, previously published procedures should be cited, and important modifications of published procedures should be mentioned accordingly. Research instruments such as questionnaires should be described adequately. A statement of the ethical issues including protection of human subjects and informed consent should be included (please see: http://www.wma.net/en/30publications/10policies/b3/index.html)

Results

Important findings should be described in logical sequence concisely and clearly without their interpretation or citation of references. Percentages should be accompanied by raw numbers. Measurements should be expressed in International System of Units (SI) but use of 'ml' and 'mmHg' is permitted. Numbers below 10 are written in words, unless they are followed by abbreviated measurements units e.g. 3 kg, 5 months. Tables and figures (i.e. graphs, drawings, and photographs) should be used to present different results which should not be repeated in the text. Tables without internal vertical lines and Figures should be numbered consecutively in Arabic numerals (e.g. Table 1, Figure 2), grouped together at the end of the manuscript, and their positions indicated in the text (e.g. "Table 1 insert here"). The tables should not exceed 3-4 maximum. A table should not exceed one page. Permission to reproduce images must be presented by the author. Statistical analyses done should be shown in the text and in all tables and figures where comparisons are indicated.

Discussion

It should emphasize new and important aspects of the study in relation to available standards and published evidence without repeating the results in detail. Explanation of the findings and their implications for future research and policy should be provided. Limitations of the study should be highlighted. Conclusions and recommendations should be related to the objectives and results of the study.

Acknowledgements and Funding

All persons other than the authors that contributed to the work should be acknowledged. In this section, the funding body should also be acknowledged as appropriate.

Conflict of interests

Any affiliation with organization(s) with financial interest, direct or indirect in the subject matter of materials discussed in the manuscript should be explicitly stated. If there is not, state that there are none.

Authors' contributions

These should have played a significant role in the conception, design, data analysis and interpretation, and writing of the manuscript. They should be indicated by the initials of their names and what they did.

References

In the reference list of the papers cited in the text, there should be included only papers published, in press or with Digital Object Identifier (DOI). Unpublished results and personal communications should not be in the reference list, but may be mentioned in the text. The American Psychological Association (APA) author–date in-text referencing format should be used. For more information from *APA Style* Guide (Sixth Edition) please visit this site: http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx. It is recommended that a reference management software be used to accurately cite the references used. In the list, the references should be arranged alphabetically from A to Z at the end of the article. It is the responsibility of the authors to ensure the accuracy of the references cited. The limit of the number of words excludes the references.

Abbreviations

Unless they are standard, when first used abbreviations should be written in full followed by their short form in brackets e.g. Institutional Review Board (IRB).

2. Review Articles

Review articles should include critical assessment of the works cited, explanations of conflicts in the literature, and analysis of highly significant topics in health sciences illustrating trends and discoveries, significant gaps in the research, current debates and ideas of where research might go next. The review can contain up to 6,000 words, six (6) figures, and three (3) tables, and it should be arranged in four sections: Abstract, Introduction, Topics (with headings and subheadings), Conclusions and Outlook. Systematic reviews shall be prepared in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and can be up to 6,000 words. Systematic reviews highly pertinent to public health policy and practice will be given priority. Examples of narrative review articles, and systematic review articles with and without meta-analysis:

- Church, J. A., Fitzgerald, F., Walker, A. S., Gibb, D. M., & Prendergast, A. J. (2015). The expanding role of co-trimoxazole in developing countries. *The Lancet. Infectious Diseases*, *15*(3), 327–339. doi:10.1016/S1473-3099(14)71011-4
- Khan, K. S., Wojdyla, D., Say, L., Gülmezoglu, a M., & Van Look, P. F. a. (2006). WHO analysis of causes of maternal death: a systematic review. *Lancet*, *367*(9516), 1066–74. doi:10.1016/S0140-6736(06)68397-9
- Sonuga-Barke, E. J. S., Brandeis, D., Cortese, S., Daley, D., Ferrin, M., Holtmann, M., … Sergeant, J. (2013). Nonpharmacological interventions for ADHD: systematic review and meta-analyses of randomized controlled trials of dietary and psychological treatments. *The American Journal of Psychiatry*, *170*(March), 275–89. doi:10.1176/appi.ajp.2012.12070991
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3. Short Communications

Short Communication of 1,000-1,500 words presents a completed study that is limited in scope about novel techniques, or special cases. It should contain an abstract (up to 150 words) and one other section combining introduction, methods, results, discussion and conclusion. It should contain a maximum of two figures and one table, and not more than 10 references. Example of short communication:

- Sereekhajornjaru, N., Somboon, C., Rattanajak, R., Denny, W. A., Wilairat, P., & Auparakkitanon, S. (2014). Comparison of hematin-targeting properties of pynacrine, an acridine analog of the benzonaphthyridine antimalarial pyronaridine. *Acta Tropica*, *140*, 181–3. doi:10.1016/j.actatropica.2014.09.002

4. Letters to the Editor

Letters, usually from authorities in the subject, should have a concise title, be short (up to 200 words, about a *Journal* article; and up to 400 words not about a *Journal* article), may have a single table or image, and up to 4 references . It should not include unpublished data or material published elsewhere. The submission of the letter to the journal gives the Editor authority for its publication and it is subject to editing. Example of letter to the Editor:

- Matthew P. Fox and Sydney B. Rosen **(**2010) Response to defaulting from antiretroviral treatment programmes in sub-Saharan Africa: a problem of definition**,** *Tropical Medicine & International Health* Vol 16 (3) DOI: 10.1111/j.1365-3156.2010.02707.x

5. Personal views

A Personal View is a thought stimulating opinion essay on a health related topic and must be prepared in a similar way to a Review article. It should contain about 1500-3000 words, and a maximum of 30 references. Example of personal view paper:

- Tully, C. M., Lambe, T., Gilbert, S. C., & Hill, A. V. S. (2015). Emergency Ebola response: a new approach to the rapid design and development of vaccines against emerging diseases. *The Lancet. Infectious Diseases*, *15*(3), 356–359. doi:10.1016/S1473-3099(14)71071-0

6. Clinical Practice

Clinical Practice articles are evidence-based reviews of topics relevant to practising physicians and other health professionals. Clinical Practice article contains: The description (i.e. Case vignette) of the Clinical Problem, Evidence supporting the various strategies, review of formal guidelines if available, and finally the authors' clinical conclusions and recommendations. Though usually single authored, a multidisplinary team can work on a Clinical Practice paper. The text should not exceed 3,000 words and not more than 30 references, with up to two figures and two tables. There is no abstract for this type of paper. Example of Clinical Practice paper:

- Iams, J. D. (2014). Prevention of Preterm Parturition. *The New England Journal Of Medicine*, *370*, 254–261. doi:10.1056/NEJMcp1103640

7. Lessons from the field

These are papers that capture experiences and practice gained in solving specific public health problems in the settings in which the practice takes place (e.g. leadership and management, cultural organization, and resources) in order to put the lessons gained in the right context. These papers present the process by including the following information: Background or motivation describing how the problem was perceived, context or settings, evidence and action, identification of solutions, how partners were engaged and lessons learned. The papers have an abstract of up to 250 words, and a total of up to 1500 words, with two figures and two tables. Example of Lessons from the Field article:

- Khan, M. I., Sahito, S. M., Khan, M. J., Wassan, S. M., Shaikh, A. W., Maheshwari, A. K., … Bhutta, Z. a. (2006). Enhanced disease surveillance through private health care sector cooperation in Karachi, Pakistan: Experience from a vaccine trial. *Bulletin of the World Health Organization*, *84*(05), 72–77. doi:10.2471/BLT.05.023630

8. Editorials

Editorials usually provide commentary and analysis concerning an article in the issue of the Journal in which they appear or to a theme. They have no abstract, may contain subheadings to guide the readers, and are limited to 1,000-1,500 words, excluding title and references, one figure or table and a maximum of 10 references. Examples of Editorial papers:

- Stein, J. H. (2007). Cardiovascular risks of antiretroviral therapy. *The New England Journal of Medicine*. doi:10.1056/NEJMe078037
- Schünemann, H. J., & Moja, L. (2015). Reviews : Rapid ! Rapid ! Rapid ! … and systematic. *Systematic Reviews*, *4*, 4–6. doi:10.1186/2046-4053-4-4
- Cram, P., & Rush, R. P. (2015). Length of hospital stay after hip fracture. *BMJ*, *350*(feb24 3), h823–h823. doi:10.1136/bmj.h823

9. Case Reports

Case reports describe an unusual disease presentation, a new treatment, an unexpected drug interaction, a new diagnostic method, or a difficult diagnosis. Case reports should include relevant positive and negative findings from history, examination, and investigation and can include clinical photographs. Additionally, the author should make it clear what the case adds to the field of health care. It should include an up-to-date review of all previous cases in the field. These articles should be no more than 2,500 words with up to 3 figures and 2 tables and a maximum of 15 references. Case Reports contain five sections: Abstract (100

words), Introduction, Case Presentation (clinical presentation, observations, test results, and accompanying figures), Discussion, and Conclusions. Examples of case report:

- Mitchell, H. K., Thomas, R., Hogan, M., & Bresges, C. (2014). Miracle baby: managing extremely preterm birth in rural Uganda. *BMJ Case Reports*, *2014*, bcr2013200949. doi:10.1136/bcr-2013-200949
- Shahani, L., & McKenna, M. (2014). Primary pulmonary lymphoma in a patient with advanced AIDS. BMJ Case Reports, 2014, bcr2013203265. doi:10.1136/bcr-2013-203265
- Henneman, D., Bosman, W.-M., Ritchie, E. D., & van den Bremer, J. (2015). Gastric perforation due to foreign body ingestion mimicking acute cholecystitis. *Case Reports*, *2015*(mar04 1), bcr2014207806–bcr2014207806. doi:10.1136/bcr-2014-207806

10. Perspectives

Perspectives provide a personal view on health care topics in a clear narrative voice. Articles can relate to personal experiences, historical perspective, or scientist. The articles should be no more than 1,500 words and may include one figure and a table and a maximum of five references. Perspectives contain four sections: Abstract, Introduction, Topics (with headings and subheadings), Conclusions and Outlook. Examples of Perspective article:

- Chertow, D. S., Kleine, C., Edwards, J. K., Scaini, R., Giuliani, R., & Sprecher, A. (2014). Ebola Virus Disease in West Africa — Clinical Manifestations and Management. *New England Journal of Medicine*, *371*, 2054–2057. doi:10.1056/NEJMp1413084
- Lipsitch, M., Riley, S., Cauchemez, S., Ghani, A. C., & Ferguson, N. M. (2009). Managing and reducing uncertainty in an emerging influenza pandemic. *The New England Journal of Medicine*, *361*, 112–115. doi:10.1056/NEJMp0904380

11. Analyses

Analyses provide an in-depth prospective and informed analysis of a policy, major advance, or historical description of a topic within the scope of this journal. These articles should be up to 3,500 words with no more than 3 figures and one table. Analyses contain four sections: Abstract (up to 150 words), Introduction, Topics (with headings and subheadings), Conclusions and Outlook. Example of Analysis article:

- Newton, P. N., Schellenberg, D., Ashley, E. A., Ravinetto, R., Green, M. D., Kuile, F. O. Ter, … Guerin, P. J. (2015). Quality assurance of drugs used in clinical trials: proposal for adapting guidelines. *BMJ (Clinical Research Ed.)*, *350*, h602. doi:10.1136/bmj.h602

12. Interviews

Report of interviews with prominent researcher or scholar may be published as questions and answers or as interviewer's personal reflection with an indication that it is based on an interview. These pieces should be no more than 5,000 words. The articles should include introduction, questions and answer or interviwer's reflection, lessons learned and conclusions. Examples of Interview article:

- Bashyam, H. (2008). Robert Menard: Tailing malaria parasites to the red blood cell. Interviewed by Hema Bashyam. *The Journal of Experimental Medicine*. Vol. 205(4), 744-745. Doi:10.1084/jem.2054pi
- Musgrave, E. (2009). Translate the promise into the practical: An interview with Peter Agre, MD, on Malaria, Translation, and Outreach. *Clinical and Translational Science*, Vol. *2* (2), 94–95. doi:10.1111/j.1752-8062.2009.00102

13. Health Management and Policy Briefs

Health Management and Policy Briefs provide timely clear, accessible evidence overview (from systematic reviews and local evidence) to important health management or policy debates for policymakers and practitioners to make informed decision. The health management and policy briefs begin with a description of a health management or policy problem, then summarise the best available evidence to clarify the size and nature of the problem, describe the likely impacts of key options for addressing the problem, potential barriers to implementing the options and strategies for addressing these barriers. Health management and

Policy briefs have up to 2,000 words including an abstract of no more than 100 words. Examples of Health Management and Policy Brief:

- http://www.who.int/evidence/sure/policybriefs/en/;
- Laura, M., George, M., & Paul, H.-C. (2014). The Relative Contribution of Multiple Determinants to Health Outcomes. *Health Affairs*, *34*(3), 1–9.
- www.who.int/hrh/documents/policy_brief/en/

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Manuscripts received will initially be scrutinized for the format and content by the Editors. If suitable for further consideration the article will be sent to experts to carry out peer review and their comments shall be communicated to the authors accordingly. It is the responsibility of the authors to respect the deadlines given in the whole editorial process.

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Articles of studies involving human subjects are published only if they fully conform to the ethical principles including those provided by the World Medical Association (WMA) Declaration of Helsinki (as amended in the 64th WMA General Assembly, Fortaleza, Brazil, October 2013, available at http://www.wma.net/en/30publications/10policies/b3/index.html). These articles shall include a concise description of how ethical considerations pertaining to the study were taken into account.

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