

CHILDREN AND YOUNG PEOPLE WITH DISABILITIES

IN MAINLAND TANZANIA AND ZANZIBAR



SITUATION ANALYSIS OF

CHILDREN AND YOUNG PEOPLE WITH DISABILITIES

IN MAINLAND TANZANIA AND ZANZIBAR

September 2021

Table of Contents

Boxes, Figures, and Tables	vi
Acknowledgements	ix
List of Acronyms	xi
1. Executive Summary	1
1. Introduction	1
2. Legislative and Policy Context	2
3. Conceptualisation, Definitions and Measurement of Disability	3
4. Disability Prevalence	3
5. Realising Rights: Interventions and Barriers	4
6. Enabling Environment	6
7. Conclusions and Recommendations	7
2. Introduction	10
2.1 Conceptual background	10
2.2 Purpose	11
2.3 Objectives	11
2.4 Target audience	12
2.5 Conceptual and theoretical framework	12
2.6. Methodology	15
3. National Legislative and Policy Context	
3.1 Introduction	20
3.2 International Legislative Framework Relating to Children with Disabilities in the United Republic of Tanzania	22
3.3 Regional Legislative Framework Relating to Children with Disabilities in the United Republic of Tanzania	25
3.4 Sub-Regional Legislative Framework Relating to Children with Disabilities in the United Republic of Tanzania	28
3.5 National Legislative Frameworks Relating to Children and Young People with Disabilities in the United Republic of Tanzania	28
3.6 National Policies Relating to Children with Disabilities in the United Republic of Tanzania	32
3.7 Key findings from the URT Legislative Framework review	37
3.8. Conclusion	38
4. Conceptualisation, Definitions and Measurement of Disability in the United Republic of Tanzania	39
4.1 Conceptualisations of Disability in URT	39
4.2 Measurement of Disability in URT	44
4.3 Conclusion	46



5. Disability Prevalence in the United Republic of Tanzania	47
5.1 Introduction	47
5.2 Disability Prevalence in Tanzania Mainland	49
5.3 Prevalence of Disability in Zanzibar	53
5.4 Rural and Urban Disability Prevalence Rates for URT	57
5.5 Change in Prevalence since 2013	57
5.6 Prevalence Rates for Tanzania and Zanzibar in International Context	59
5.7 Key Findings	60
5.8 Conclusion	61
6. Realising Rights: Interventions and Barriers in the United Republic of Tanzania	63
6.1 Introduction	63
6.2 The Right to Health	63
6.3 The Right to Adequate Nutrition	78
6.4 The Right to Employment	82
6.5 The Right to Quality and Inclusive Education	86
6.6 Rights to be Free from Exploitation, Violence and Abuse	92
6.7 The Right to Social Protection	96
6.8 Key findings and conclusions	100
7. Enabling Environment	103
7.1 Introduction	103
7.2 Factors Supporting or Hindering the Rights of Children and Young People with Disabilities	103
7.3 Institutional and Political Factors	105
7.4 Capacity to Address Inclusion of Children and Young People with Disabilities	108
7.5 Reliable Data for Planning	109
7.6 Regional Best Practices Programme Approaches	109
7.7 Conclusion	110
8. Conclusion	112
8.1 Recommendations	114
Annex 1: Reference List	119
Annex 2: Data Collection Matrix	130
Annex 3: Terms of Reference	134
Annex 4: Literature Search Inclusion/Exclusion Criteria	143
Annex 5: Literature Review Coding Guide	144
Annex 6: Data Collection Tools	147
Annex 7: Approval Letter from Includovate's Internal Review Board	155
Annex 8: Data Tables from Analysis of 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS	156
Annex 9: Stakeholder Mapping	165
Annex 10: Preliminary Action Plan	185

Boxes, Figures, and Tables

List of Boxes

Box 1: Definition of Disability	11
Box 2: Principles of a Human Rights-Based Approach	12
Box 3: Mr X v. Tanzania	23
Box 4: The Cost of Excluding People with Disabilities from Education	117

List of Figures

Chapter 1:

Figure 1: Conceptual Framework	13
Figure 2: UNICEF's Theory of Change for Social Inclusion	15

Chapter 4:

Figure 4.1: Overall Prevalence of Disability in Mainland Tanzania for Respondents Aged 5 and Older	49
Figure 4.2: Disability Prevalence Rates by Age and Sex for Mainland Tanzania	50
Figure 4.3: Overall Prevalence of Disability in Zanzibar for Respondents Aged 5 and Older	53
Figure 4.4: Disability Prevalence Rates by Age and Sex for Zanzibar	55
Figure 4.5: Overall Disability Prevalence Rates in Mainland Tanzania and Zanzibar, 2008, 2012, 2018-20	58

List of Tables

Chapter 1:

Table 1.1: Survey Data Sources	16
Table 1.2: Key Informant Interviews	18
Table 1.3: Focus Group Discussions	18

Chapter 2:

Table 2.1: URT's Reporting Record under International and Regional Human Rights Treaties	21
Table 2.2 Continental Plan of Action Priority Actions Concerning Children and Youth ⁶ with Disabilities	25
Table 2.3: Summary of EAC Policies and Mechanisms	28
Table 2.4: International Laws on Rights of Persons with Disabilities	29
Table 2.5: Summary of Mainland Tanzania's Disability-Related Policies	33
Table 2.6: Summary of Zanzibar's Disability-Related Policies	34
Table 2.7: Summary of Inclusive Education Laws and Policies in URT	36
Table 2.8: Summary of Health-Related Policies and Plans in URT ⁹	34

Chapter 3:

Table 3.1: Disability Measurement in Key National Surveys and Censuses in URT	44
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Chapter 4:

Table 4.1: Mainland Tanzania Disability Prevalence Rates and Population Estimates by Type of Disability	51
Table 4.2: Mean Differences in Disability Prevalence across Sex and Age Groups among Children and Young People, Mainland Tanzania	52
Table 4.3: Zanzibar Disability Prevalence Rates and Population Estimates by Type of Disability	56
Table 4.4: Mean Differences in Disability Prevalence across Gender among Children and Young People, Zanzibar	56
Table 4.5: Disability Prevalence Rates for Mainland Tanzania and Zanzibar, 2008-2020	58
Table 4.6: Prevalence Rates of Different Types of Impairments among Children Aged 5-17 Based on MICS Data from Four Countries	60

Chapter 5:

Table 5.1: Features of Selected Rehabilitation Facilities in URT	67
Table 5.2: Summary Table on the Right to Health	75
Table 5.3: Summary Table on the Right to Adequate Nutrition	81
Table 5.4: Percentage Distribution of Employment among Young Persons with Disabilities 15-24 Years Old	83
Table 5.5: Distribution of Regular Employees with Disability by Sector and Sex, Tanzania Mainland, 2016	84
Table 5.6: Summary Table on the Right to Employment	85
Table 5.7: Children with Disabilities in Primary and Secondary School, 2018-2019	75
Table 5.8: Summary Table on the Right to Quality and Inclusive Education	91
Table 5.9: Summary Table on the Right to be Free from Exploitation, Violence and Abuse	96
Table 5.10: Summary Table on the Right to Social Protection	100

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List of Acronyms

Acronym	In full
ACRWC	African Charter on the Rights and Welfare of the Child
ADD	Action on Disability and Development International
ADPD	African Decade of Persons with Disabilities
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CBR	Community Based Rehabilitation
CFM	Child Functioning Module
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
EAC	East African Community
ECD	Early Childhood Development
FGD	Focus Group Discussion
GPE	Global Partnership for Education
HBS	Household Budget Survey
HRBA	Human Rights Based Approach
HSSP	Health Sector Strategic Plan
ICT	Information Communication Technology
KII	Key Informant Interview
LGAs	Local Government Authorities
MoEST	Ministry of Education Science and Technology
MoHSW	Ministry of Health Social Welfare
MVC	Most Vulnerable Children
NBS	National Bureau of Statistics
NHIF	National Health Insurance Fund
NMNAP	National Multi-Sectoral Nutrition Action Plan
NSSF	National Social Security Fund
NGO	Non-Governmental Organisation
OCS	Office of the Chief Government Statistician
OPD	Organisation of Persons with Disabilities
PSSN	Productive Social Safety Nets
PHC	Population and Housing Census
REC	Reaching Every Child
TDHS	Tanzania Demographic and Health Survey
TDS	Tanzania Disability Survey
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Program
URT	United Republic of Tanzania
WG-SS	Washington Group of Short Set
WASH	Water Sanitation and Hygiene
ZMNSAP	Zanzibar Multi-Sectoral Nutrition Strategy Action Plan



Executive Summary

1.1 Introduction

This Situation Analysis provides updated information on the current situation of children (0-17 years) and young people (aged 10-24 years)¹ with disabilities in the United Republic of Tanzania (URT). The report discusses current laws, policies, and programmes. It then identifies critical issues and existing gaps and barriers facing children and young people with disabilities and uses this evidence to provide recommendations.

This study has three main objectives:

1. To update UNICEF's 2013 Situation Analysis of Children with Disabilities in Tanzania, covering changes and critical data gaps related to:
 - a. National policy context
 - b. Definitions and measurements of disabilities currently used in Tanzania (Mainland and Zanzibar)
 - c. Programmes and services
 - d. Barriers faced by children and young people with disabilities
 - e. Stakeholders and enabling environment

f. Data and evidence

2. Update data on the prevalence of disabilities among children and young people
3. Provide recommendations to UNICEF for:
 - a. Priority advocacy issues
 - b. Strategic programming opportunities
 - c. Key partnerships

1.1.1. Methodology

Drawing inspiration from the UNICEF's Guidelines for Disability Situation Analyses (2013b) and UNICEF's Core Guidance: New Generation Situation Analysis (2019), this study is grounded in a human rights-based approach and social model of disability, with attention to gender analysis, intersectionality, equity and equal opportunity, inclusive development, and a lifecycle approach.

The methodology adopted a mixed-methods approach to identifying new patterns and trends in the situation and barriers experienced by children and young people with disabilities.

¹ UNICEF, other UN agencies, the URT government and the African Union employ a variety of definitions of "young people" and "youth". UNICEF defines "children" as aged under 18 years and "young people" as aged 10-24 years. The category of "young people" is further divided into early adolescence (10-14 years), late adolescence (15-19 years) and young adults (20-24 years). Some UN agencies define "youth" as 15-24 years (UNDESA, n.d.). The African Union and URT define "youth" as 15-35 years. This report predominantly uses the categories and language of "children and young people" per UNICEF definitions. However, the term "youth" is used when referencing specific legislation, policies, or reports that use this terminology.

- » **Literature and document review:** A structured literature and document review explored new published and grey literature released since 2013. Documents were screened according to inclusion and exclusion criteria, then coded and analysed based on pre-identified themes.
- » **Survey data analysis:** Statistics on the prevalence of disability among children and young people (male and female) were updated through quantitative analysis of data from the 2017/18 Tanzania Household Budget Survey (HBS) and the 2019/20 Zanzibar HBS which included the international standard Washington Group - Short Set questions for assessing disability. The analysis of the HBS datasets covered disability prevalence disaggregated by age, sex, and type of functional limitation.
- » **Key informant interviews (KIIs):** Semi-structured interviews were conducted with 19 key informants to triangulate and augment findings from the literature and document review and the secondary data analysis. The KIIs targeted respondents from strategic partner organisations in URT including: government officials, organisations of persons with disabilities (OPDs), non-governmental organisations (NGOs), and other stakeholders with relevant expertise.
- » **Focus group discussions (FGDs):** 11 FGDs were conducted to capture the insights of children and young people with disabilities, their families, and their teachers. A twelfth FGD engaged key stakeholders from UN sister agencies. Children and young people with disabilities are the primary stakeholders in this study, yet their voices are often missing from the research that concerns them (Groce, 2013). Including children with disabilities in research with appropriate provisions and adaptations, upheld participation as a fundamental element of the rights-based approach underpinning this study, and contributed to challenging assumptions about them and reducing their marginalisation in society (Wickenden & Kembhavi-Tam, 2014).
- » **Validation workshop:** Finally, a validation workshop with key stakeholders will inform the interpretation of the findings and the generation of recommendations and priorities for future advocacy and programming.

The study faced limitations based on the availability of published literature and data, relatively small sample size tailored to the study's budget and timeline, and periodic challenges with remote data collection. The research team mitigated limitations associated with sample size and availability of recent URT-specific research through careful triangulation of findings across available literature, primary data collection, and survey data analysis. A

locally-based enumerator was engaged to conduct FGDs and KIIs to address the challenges of remote data collection.

In line with Includovate's ethics policy and the UNICEF Procedure for Ethical Standards in Research, Evaluation and Data Collection (2015), ethical considerations and protection of human rights have been factored into all Situation Analysis components. The study methodology was reviewed and approved by Includovate's Internal Ethical Review Board.

1.2 Legislative and Policy Context

1.2.1. International and Regional Frameworks

Several international, regional and national instruments set standards on the enjoyment of rights of every child, including the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). The global principle that underpins this right is that children with disabilities are children first. At the regional level, the African Charter on the Rights and Welfare of the Child (ACRWC) and the African Charter on Human and Peoples Rights (African Charter) and its additional Protocols also prioritise every African child.

1.2.2. National Legislation, Policies and Strategies

At a national level, Mainland Tanzania's 1977 Constitution and Zanzibar's 1984 Constitution both provide fundamental rights and freedoms to "all persons" but do not explicitly mention persons with disabilities. Other national laws do explicitly protect the fundamental rights of children and young people with disabilities, including the 2010 Persons with Disabilities Act and the 2019 Law of the Child Act (Mainland Tanzania), and the 2006 Persons with Disabilities (Rights and Privileges) Act and the 2011 Children's Act (Zanzibar). Both Mainland Tanzania and Zanzibar have also developed national policies and strategies that guide the implementation of the rights of children and young people with disabilities. These include the overarching 2004 URT National Policy on Disability and the 2014 Zanzibar Social Protection Policy, as well as sector-specific policies and strategies on inclusive education, health, violence against women and children, nutrition, and development and poverty reduction, which include provisions relevant to children and young people with disabilities.

1.2.3. Alignment of National Laws with International Commitments

Despite URT's ratification of international and regional human rights instruments, there is a poor alignment of key national legislation with regional and international obligations relating to children and young people with disabilities. The Bill of Rights in both the Mainland and Zanzibar do not mention the rights of persons with disabilities as fundamental rights. Rather the rights are mentioned under directive principles of state policy rendering them non-justiciable and non-enforceable in the court of law. URT has a poor reporting record, particularly with regards to regional human rights obligations dealing with children and young people with disabilities. While the CRPD has been domesticated in the Persons with Disabilities Acts in Mainland Tanzania and Zanzibar, there remains a gap in the domestication of specific rights for children with disabilities under the children's Acts in both states. The domestication is especially weak of CEDAW where none of the national legislations recognises the specific rights to girls and women with disabilities.

1.3 Conceptualisation, Definitions and Measurement of Disability

Conceptualisations of disability are expressed through formal definitions enshrined in laws and policies, through the way disability is defined and measured in official data collection efforts, and informally through social norms, attitudes, and behaviours. The ways in which disability is understood, defined, and measured - both formally and informally - are important in informing policies, programs, and services to promote disability inclusion, as well as in shaping the lived experiences of persons with disabilities.

Examination of legislation, published literature, and input from key informants revealed that different conceptualisations of disability co-exist in the URT. While a human rights-based understanding of disability is enshrined in key international rights instruments and domestic legislation, medical and charity-focused understandings of disability also persist through religious, cultural, and social norms.

Different models of disability not only influence norms and expectations regarding inclusion and exclusion of children and young people with disabilities, but also how disability is defined, measured, and reported on. URT has made substantial progress over the last two decades in integrating more consistent measurement of disability into national data collection and reporting. Since 2008, a number of key national surveys have utilised the Washington Group - Sort Set questions to identify prevalence of different forms of functional limitation, in line with international standards. However, URT has yet to utilise the Washington Group/UNICEF Child Functioning Module, which would facilitate more detailed and accurate data collection regarding children experiencing functional limitations and at risk of exclusion from full participation in society.

1.4 Disability Prevalence

Includovate analysed raw datasets from the 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS to update disability prevalence data for both jurisdictions. The HBS data sets were analysed to yield disability prevalence rates disaggregated by age, sex, and type of functional limitation. Data disaggregated by sex, age, disability, and other key variables are an essential foundation for capturing the intersections of different forms of

Compliance with International Laws on Rights of Persons with Disabilities

State	National Law	Compliance with International Instruments		
		CRPD	CRC	CEDAW
Mainland Tanzania	1977 Constitution	Somewhat compliant	Not compliant	Not compliant
	Persons with disabilities Act, 2010	Compliant	Compliant	Not compliant
	The Law of the Child Act, 2009	Somewhat compliant	Compliant	Not compliant
Zanzibar	1984 constitution	Somewhat compliant	Not compliant	Not compliant
	Persons with Disability Act, 2006	Compliant	Compliant	Not compliant
	The Children's Act, 2011	Somewhat compliant	Compliant	Not compliant

marginalisation and the diversity of experiences within broad population groups.

The HBSs both use the WG-SS as the core questions to assess disability. The WG-SS is a set of six questions that ask respondents about the level of difficulty they experience with vision, hearing, mobility, communication, cognition, and self-care. The WG-SS questions focus exclusively on functional difficulties, rather than diagnoses or specific causes of such impairments. For consistency and to allow comparison across time, for the purposes of this analysis, disability prevalence was defined and calculated in the same manner as in the 2008 TDS Report, which was aligned with international guidance: respondents who reported “a lot of difficulty” or “cannot perform” to at least one WG-SS question, and those who reported “some difficulty” in two or more WG-SS domains were defined as living with a disability (National Bureau of Statistics, 2008).

Key findings include:

- » **Overall disability prevalence rates:** The overall disability prevalence rates for those aged 5+ based on HBS data are 6.8% in Mainland Tanzania and 3.2% in Zanzibar. This means that across URT, over 3.3 million people are living with a disability. Further investigation is required to assess the potential reasons behind the lower rate found in Zanzibar compared to Mainland, including exploring demographic and socio-economic differences between the two jurisdictions that are correlated with disability rates, as well as methodological differences in the design and execution of the source surveys. The 2017/18 Tanzania HBS also found an albinism prevalence rate of 0.6% across age groups. The 2019/20 Zanzibar HBS did not include a question on albinism.
- » **Prevalence rates among children and young people:** For children and young people aged 5-24, the analysis revealed a disability prevalence rate of 2.3% for Mainland Tanzania, and 1.8% in Zanzibar. These rates indicate over 600,000 children and young people are living with disabilities in URT.
- » **Sex differences:** In both Mainland Tanzania and Zanzibar, women have higher prevalence rates of disability than men. In Mainland, 7.8% of women live with a disability compared to 5.7% of men. In Zanzibar, 4% of women live with a disability compared to 3% of men. Prevalence rates among children, however, do not show significant differences between boys and girls in either Mainland or Zanzibar, with sex differences only appearing in early-to-mid-adulthood.
- » **Age trends:** In both Mainland Tanzania and Zanzibar, disability prevalence increases in adulthood and rises steeply among older adults. While Mainland data shows the increase starting among the 20-24 age group, the Zanzibar prevalence rates stay consistently low until the 35-54 year age group, particularly women face an increase in prevalence rates.
- » **Types of disabilities:** The most common type of disability reported for children in Mainland Tanzania was difficulty remembering, while in Zanzibar it was difficulty with self-care. For children, overall prevalence rates for each individual type of disability are low (0.5%-1.8% prevalence for each). These findings are not out of line with varied findings from other sub-Saharan African countries.
- » **Data reliability:** Data from censuses and surveys (within and across countries) should be used with caution because of differences in the phrasing of questions about disability and the definition of a person with disability. Use of the Washington Group/ UNICEF Child Functioning Module would also provide an additional source of internationally comparable data which could help triangulate findings from other national URT surveys and censuses.
- » **Definition of disability:** The prevalence rates reported in this chapter are based on a definition of disability consistent with international guidance and previous prevalence calculations in URT. However, Washington Group guidance for interpreting WG-SS data leaves room for countries to determine how to interpret responses of “some difficulty” (Washington Group, 2020). Compared to the 6.8% disability prevalence rate on Mainland based on the internationally-aligned definition, 15.5% of Mainland Tanzania respondents and 7.1% of Zanzibar respondents live with at least “some difficulty” in one or more of the WG-SS domains. Further exploration of the associations between moderate functional difficulties and indicators of participation could inform a more nuanced interpretation of the ways in which impairments interact with societal and environmental barriers to shape experiences of inclusion and exclusion in URT.

1.5 Realising Rights: Interventions and Barriers

Chapter 5 discusses interventions that the URT Government has undertaken in selected areas of human rights for children and young people with disabilities since the drafting of the last situational analysis in 2013. Focus is given to the following specific rights clusters: health; nutrition; employment; education; freedom from

exploitation, violence and abuse; and social protection. Each rights cluster begins with a brief discussion of the normative framework provided to establish the expected standard and obligations. This includes an outline of the key programmes and services that the URT has undertaken in efforts to implement the specific right clusters and barriers / challenges to fulfilling these rights.

1.5.1 The Right to Health

This chapter covers access to health care services, assistive devices, habilitation and rehabilitation services, sexual reproductive health services, health insurance services, immunisation, mortality, HIV/AIDS, early detection and diagnosis and found that while some progress has been made in advancing the rights to health of children and young people with disabilities in URT since 2013, considerable challenges and gaps remain. Key findings demonstrate a need for health services to be more accessible, affordable and adaptable for children and young people with disabilities. This includes improving access to assistive devices. Inadequate access to, and unaffordability of, assistive devices has an adverse impact on children and young people with disabilities.

There is a need for improved access to and quality of rehabilitation centres and services in URT. Gaps are also evident in provision of habilitation and rehabilitation services where these services are oftentimes unaffordable for families. The lack of local services means that families have to travel to neighbouring jurisdictions to access services, contributing to higher costs, longer wait times and overcrowding.

Misconceptions about disability and sexuality, as well as stigma and discrimination, inaccessible health facilities and information is underscored in the chapter. This means that young people with disabilities are missing out on crucial sexual and reproductive health services. A proactive approach is required to address this gap, for example by the government partnering with OPDs to provide better services that meet the needs of persons with disabilities.

Additionally, children and young people and their families face challenges accessing health insurance. Only about 10% of disability reported households are reported to have some form of health insurance. To encourage early detection and diagnosis of disability, disability screening and early intervention programs must be prioritised. Training of healthcare professionals, and raising awareness in communities more broadly, will be fundamental to achieving rights to health for children and young people with disabilities.

The Right to Adequate Nutrition

Realising the right to adequate nutrition is critical to addressing common causes of disability. High rates of stunting and widespread anaemia associated with poor nutrition are documented in children across Tanzania, and may contribute to elevated rates of disability. Some nutrition-based programmes and objectives are primarily aimed at preventing disabilities that could result from malnutrition. There is a need for accurate and reliable disability disaggregated nutrition-based data. This disability disaggregated data would help to better understand the prevalence of malnutrition among children and young people with disabilities in both Mainland and Zanzibar. An evaluation of nutrition-based efforts and programmes in both Mainland and Zanzibar is necessary to provide critical lessons learned and evidence of the success of nutrition-based programmes. Further research is required to better understand the linkages between poor nutrition and disability, and the gaps in programmes and service for children and young people with disabilities relating to nutrition.

1.5.2 The Right to Employment

Young people with disabilities in URT face limited employment opportunities due to discrimination, limited education opportunities, non-inclusive working conditions and non-enforcement of existing employment laws. Difficulty in accessing assistive devices and the absence of reasonable workplace accommodations for young people with disabilities further exacerbates barriers to available employment opportunities. To address this, targeted employment services for young persons with disabilities are required as well as more in-depth research on how young people with disabilities are affected by employment services by impairment type and severity. The impact of caring for a person with disabilities on employment and income outcomes also needs further investigation.

1.5.3 The Right to Quality and Inclusive Education

Inclusive education is not yet widely available in URT. All efforts to make education inclusive remain at the primary level. Many schools/classrooms are inaccessible to persons with disabilities due to the distance and inaccessible transportation and school infrastructure. Insufficient learning materials particularly for learners with visual impairments remains a challenge. Social stigma and misconceptions about persons with disabilities ability to learn/thrive in a classroom environment also contribute to poor educational outcomes for children and young people with disabilities. Lack of disability specific training amongst educational professionals and inadequate

access to assistive devices are critical issues that need to be addressed if equity for persons with disabilities is to be realised.

1.5.4 Right to Freedom from Violence, Exploitation and Abuse

Discrimination against children and young people with disabilities remain widespread in the country. While there are general policies and laws prohibiting disability-based discrimination in place, this chapter exposes the gendered dimensions of discrimination and violence. This includes a lack of specific laws that explicitly criminalise multiple and intersecting forms of disability and gender-based discrimination that women and girls with disabilities face daily in the country. The chapter draws attention to empirical research that supports the idea that killings of children and young people with albinism have considerably reduced. Yet, evidence of hidden fears and anxiety about possible resurgence of violence in the URT remains.

1.5.5 Right to Social Protection

Social protection schemes are available in both Mainland and Zanzibar to ensure that children and young people with disabilities enjoy the right to adequate standard of living and social protection. Nonetheless, it is clear that despite existing social schemes, there are gaps in coverage, barriers to access, and limitations to benefits. There is a need for improved social protection schemes and cash transfers that would be beneficial for children and young people.

1.6 Enabling Environment

Chapter 6 examines the existing social, institutional and political factors (e.g., social norms, institutional capacities at all levels of government, accountability and coordination mechanisms, policy, and legal frameworks) that can support or hinder the creation of an enabling environment for the realisation of the rights of children and young people with disabilities.

1.6.1 Social Norms

Although attitudes towards persons with disabilities have changed significantly in the last two decades, perceptions of disability still have an important role in forming attitudes and the treatment of children and young people with disabilities.

- » **Discriminatory social norms persist**, but are diverse and changing: whereas some cultural and religious beliefs reinforce negative assumptions about children and people with disabilities, some groups

hold religious beliefs that affirm the value of children with disabilities.

- » **Negative attitudes** may be reinforced by economic and material barriers to participation (for example lack of inclusive and accessible education facilities can increase cost to parents of educating children with disabilities, reinforcing negative attitudes about investing in education for these children).
- » **Social norms can change** with concerned awareness raising, as evidenced by the success of OPD-led campaigns to end violence against persons with albinism.

1.6.2 Institutional and Political Factors

Since 2013, the URT has shown important progress in political and institutional determination to improve the welfare of persons with disabilities in general, and that of children and young people in particular. Key institutional and political factors shaping the environment for realising rights of children and young people with disabilities in Mainland Tanzania and Zanzibar include:

- » **Relationships with NGOs and OPDs:** The URT government has shown increased openness to NGO activity both in providing services directly to persons with disabilities and in influencing government policy outcomes. The government has also been engaging more with OPDs in various policy processes. OPDs, however, often lack the technical expertise and resources to effectively hold the government accountable.
- » **Disability inclusion in leadership and politics:** the URT and Zanzibar governments are progressively increasing visibility of persons with disabilities in leadership positions. However, significant political and institutional hurdles remain in advancing meaningful implementation of policy positions and legislation meant to support rights of children and young people with disabilities.
- » **Financial support for disability inclusion:** despite URT commitment to address disability inclusion and poverty, the government remains heavily dependent on donor aid and support for its disability policy implementation.
- » **Coordination mechanism:** Gaps exist in local coordination mechanisms for aligning the work of government and civil society actors across sectors.
- » **Accountability mechanism:** the URT government has made reforms on good governance but challenges persist related to corruption, lack of

infrastructure, poor access to information, technocratic procedures, power imbalances, low capacity and a lack of citizen participation. Weak accountability mechanisms undermine successful implementation of disability policies.

1.6.3 Capacity to Address Inclusion

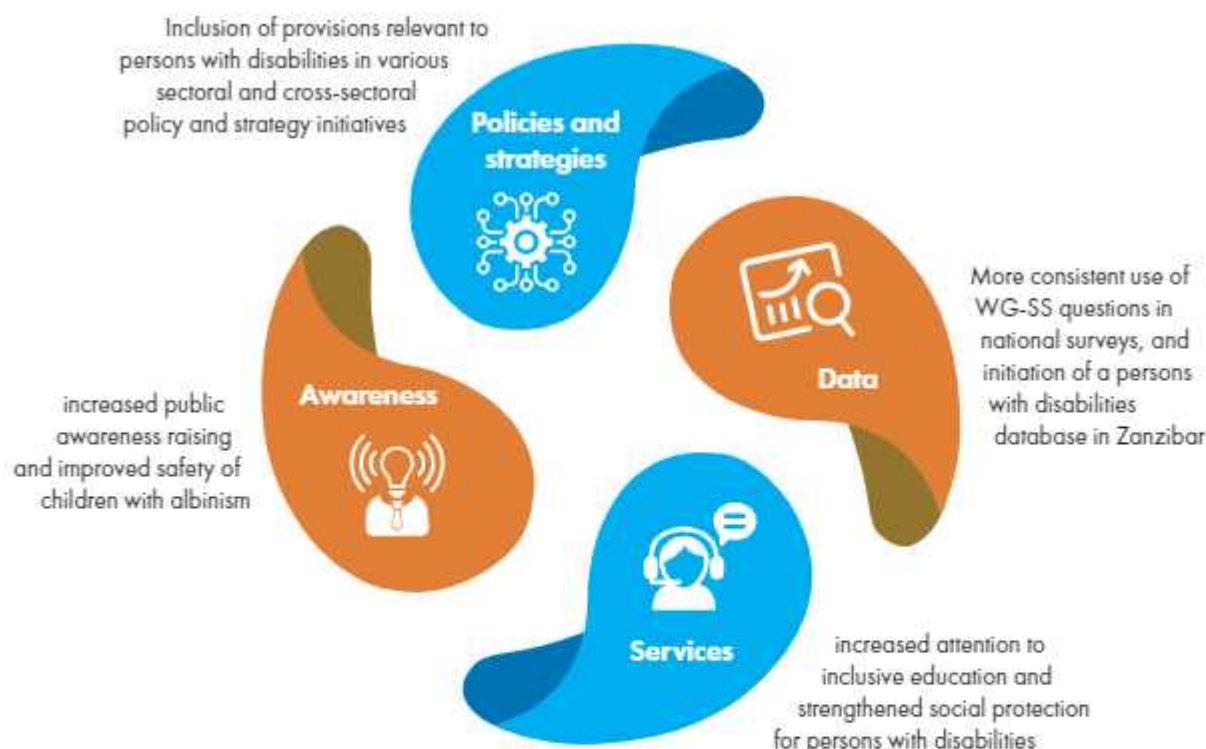
A stakeholder mapping process was completed to assess the capacities (financial, technical and institutional) that exist at national, subnational and community levels to address inclusion of children and young people with disabilities. The stakeholder analysis identified multiple government ministries for Mainland Tanzania with overlapping mandates, indicating lack of coordination across disability-related policies and services. Civil society organisations, and OPDs in particular, are playing significant organising and advocacy roles, but face capacity and funding challenges. With such a robust spread of institutions engaged in disability programming, URT has a great foundation to revolutionise its disability inclusion agenda. However, there is a lack of cross-sectoral and life cycle approaches and an absence of coordination across the sector.

1.6.4 Reliable Data for Planning

The URT has a great need to improve the quality and consistency of national data collection and analysis for greater intersectional accuracy and to include disability and gender issues in collaboration with OPDs. Despite progress in including international standard disability questions on national surveys, significant gaps remain in disaggregated analysis and utilisation of the most recent available data. A new database on persons with disabilities in Zanzibar promises to increase the government's capacity to generate more reliable and comparable disability statistics and to inform social assistance programmes for PWDs. While a lot is already known about the barriers facing children and young people with disabilities there remains a need for high quality research and data on the intersectional challenges facing children and young people with disabilities and their families and inclusive solutions.

1.7 Conclusions and Recommendations

The URT has made significant progress in advancing the welfare of children with disabilities in the last decade. URT's advancements include:





Despite these notable improvements, Children and young people with disabilities continue to face serious challenges in URT. Inadequate and inequitable access to health and nutrition services, social protection supports, education, and employment, combined with exposure to higher risks of violence and abuse create barriers to children and young people with disabilities realising their rights and fully participating in their communities. Girls and women with disabilities, those living in rural areas, and those living in poverty and experiencing other forms of exclusion are further disproportionately marginalised.

At an institutional level, gaps in financial capacity, cross-sectoral coordination, accountability, and data and evidence undermine effectiveness and efficiency of disability inclusion efforts. The URT needs to devise more strategic systems to audit its legislative and policy commitments to inclusive disability development and to the protection of the rights of children and young people with disabilities. This includes ensuring budgetary commitments, aligning policy pronouncements with implementation and monitoring plans, as well as carrying out aggressive public awareness initiatives about disability rights, including engaging with families to challenge negative social norms. It also means living up to policy commitments and adopting intersectional approaches to protect girls and women with disabilities from disproportionate disadvantage. As reiterated in KIIs and FGDs, the URT could improve its output for improving the welfare of the lives of children and young people with disabilities by taking an intersectional approach to disability policy to see how different identities of age, gender, and disability interact to create more extreme forms of marginalisation of children and young people with disabilities. To achieve this, the URT should work closely with OPDs, parents of children with disabilities, and other stakeholders, domestic, regional, and international to harness the necessary resources.

1.7.1 Recommendations

There are several concrete steps the URT could take to solidify its gains in the attainment of human rights for children and young people with disabilities. The first part of these recommendations focus on priority advocacy issues for URT, the second part covers UNICEF-specific opportunities and the third part covers other stakeholders and partners. Addressing these recommendations will require prioritisation, strategic engagement, and cross-sectoral, multi-stakeholder collaboration.

» What are potential priority advocacy issues for Tanzania Mainland and Zanzibar?

- › Harmonise domestic legislation with the CRPD and other international conventions
- › Make changes to children and disability laws to reflect rights of children with disabilities
- › Implement disability inclusive policy and legal reviews
- › Leave no one behind by adopting an intersectional approach
- › Explore the affordability of a Disability Grant to offset material barriers to participation for children and young people with disabilities
- › Improve survey data and analysis through consistent methods, use of the Child Functioning Module, engagement of OPDs, and sex- and disability-disaggregated reporting
- › Improve disability- and sex-disaggregated education and health data

Develop awareness raising and behaviour change campaigns on:



- › Improve community-based rehabilitation and local assistive device development and maintenance
- › Accessibility audits to improve infrastructure
- › Improve the early identification of disabilities and referral services

» Where can UNICEF Tanzania focus technical assistance in the new Country Programme to strategically maximise impact on disability inclusion, for Tanzania Mainland and Zanzibar?

- › Play a convening role, bringing together diverse stakeholders
- › Focus on disability data on children under 5 years of age
- › Collect advocacy-relevant data on children and young people with disabilities

- › Walk the talk: increase employment of persons with disabilities by UNICEF Tanzania
- › Adopt a cross-sectoral approach within UNICEF

» Which partnerships are key to leverage UNICEF's work on disability inclusion?

- › Develop an action learning, institutional strengthening program for OPDs
- › Develop strategic partnerships with research institutions
- › Foster OPD inclusion of children
- › Foster a regional approach to disability inclusion
- › Foster an early identification and disability inclusive health care alliance
- › Foster a CRPD-compliant inclusive education alliance



Introduction

2.1 Conceptual Background

This Situation Analysis provides updated information on the current situation of children (0-17 years) and young people (aged 10-24 years)² with disabilities in the United Republic of Tanzania (URT). The report discusses current laws, policies, and programmes. It then identifies critical issues and existing gaps and barriers facing children and young people with disabilities and uses this evidence to provide recommendations.

According to the population projection for 2021, 44% of the national population in the URT (including both Mainland and Zanzibar) is under 15 years of age, accounting for approximately half of the country's total population (National Bureau of Statistics & United Nations Population Prospects, 2021). According to the 2017/18 Tanzania and 2019/20 Zanzibar HBS, 2.3% children and young people aged 5-24 in Mainland Tanzania and 1.8% in Zanzibar live with disabilities. In the URT, as in many other developing countries, despite the enactment of proactive legislation, children and young people with disabilities face difficulties in having equal access to their physical environment, as well as to health and nutrition care, water and sanitation

services, education and social support systems available to children without disabilities (National Bureau of Statistics, Office of Chief Government Statistician & UNICEF, 2020). Also, children with disabilities are at increased risk of physical, sexual, emotional violence, exploitation, abuse and neglect (Child Welfare Information Gateway & Children's Bureau, 2018). Some of these barriers and deprivations result from attitudes, cultural beliefs and practices that have historically segregated children and young people with disabilities from society; some reflect a lack of knowledge and awareness and missed opportunities for meaningful inclusion (Child Welfare Information Gateway & Children's Bureau, 2018).

Several international, regional and national instruments set standards on the enjoyment of rights of every child, including the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). The global principle that underpins this right is that children with disabilities are children first. At the regional level, the African Charter on the Rights and Welfare of the Child (ACRWC) and the African Charter on Human and Peoples Rights (African Charter) and its additional Protocols also

² UNICEF, other UN agencies, the URT government and the African Union employ a variety of definitions of "young people" and "youth". UNICEF defines "children" as aged under 18 years and "young people" as aged 10-24 years. The category of "young people" is further divided into early adolescence (10-14 years), late adolescence (15-19 years) and young adults (20-24 years). Some UN agencies define "youth" as 15-24 years (UNDESA, n.d.). The African Union and URT define "youth" as 15-35 years. This report predominantly uses the categories and language of "children and young people" per UNICEF definitions. However, the term "youth" is used when referencing specific legislation, policies, or reports that use this terminology.

Box 1: Definition of Disability

Conceptually, the term 'disability' is highly contested and ambiguous. The ambiguity that characterises the term is acknowledged in Article 1 of the CRPD, where disability is not explicitly defined but described as an evolving term. Many people view disability as an evolving term because the term has been dominated by the understanding that disability is a medical condition inherent in a person. In this sense, disability implies the absence or negation of ability (Grue, 2016). Over the last four decades, this medical interpretation of disability has slowly shifted to a more progressive social understanding of disability, as underscored by Article 1 of the CRPD. Article 1 describes persons with disabilities as those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (Art. 1 of UN CRPD, 2006). While the 2010 and 2006 Persons with Disabilities Acts in Mainland Tanzania and Zanzibar have adopted a social perspective in defining disability, the 2009 Law of the Child Act (Mainland Tanzania) and 2011 The Children's Act (Zanzibar) continue to define children with disabilities from a medical perspective. These ideas are discussed in detail in Chapters 2 and 3.

prioritise every African child. This fundamental right is also enshrined at the national level with the enactment of the 2010 Persons with Disabilities Act and the 2019 Law of the Child Act (Mainland Tanzania), and the 2006 Persons with Disabilities (Rights and Privileges) Act and the 2011 Children's Act (Zanzibar).

In 2013, UNICEF commissioned a Situation Analysis of Children with Disabilities in Tanzania, which was intended to provide a 'snapshot' of what was known about children with disabilities in Tanzania and the barriers and challenges they faced. The report discussed relevant legislation, outlined the data available on children and adults with disabilities, and reviewed obstacles and challenges faced by children and young people with disabilities and their families in Tanzania. The report highlighted significant gaps in critical areas such as education, health and rehabilitative care, and social inclusion. The 2013 study also revealed a lack of coordination among existing services. Since 2013, additional literature that provides a more recent perspective of the lives of children with disabilities has been published. The Tanzania Country Office (TCO) Disability Working Group, established in 2020, recommended that the 2013 Situation Analysis of the needs of children with disabilities be updated to contribute to UNICEF Tanzania's Country Programme Document 2022-2027 and serve as a background document for improved disability-inclusive programming.

2.2 Purpose

This study seeks to provide context-specific evidence and updated data to inform the development and

implementation of multi-layered programmatic and policy interventions to advance inclusive development for children and young people with disabilities in URT. By providing a robust assessment of local context on children and young people with disabilities, needs, and capacity, the study will provide a foundation for developing relevant and impactful interventions.

2.3 Objectives

This study aims to update the 2013 UNICEF Situation Analysis of Children with Disabilities in URT based on a review of existing literature. The study has three main objectives:

- » Update the Situation Analysis of Children with Disabilities in Tanzania produced in 2013 based on a review of existing literature, covering changes and critical data gaps related to:
 - » national policy context
 - » definitions and measurements of disabilities currently used in Tanzania (Mainland and Zanzibar)
 - » programmes and services,
 - » barriers faced by children and young people with disabilities
 - » stakeholders and enabling environment, and
 - » data and evidence
- » Update data on the prevalence of children and young people with disabilities

- » Provide recommendations to UNICEF for:
 - › priority advocacy issues
 - › strategic programming opportunities, and
 - › key partnerships.

A complete list of research questions across these objectives is included in the data collection matrix in Annex 2.

2.4 Target Audience

The primary audience for this Situation Analysis is the UNICEF Tanzania Country Office sector programmes and operations. The secondary audience comprises UNICEF's partners: governments, implementing partners, private sector, business owners, schools or organisations that

work with children and young people with disabilities, community, Organisations of Persons with Disabilities (OPDs), other UN agencies and rights holders.

The updated Situation Analysis may also be of interest to current or potential donors investing in disability-inclusive programming in Tanzania, stakeholders who have mainstreamed disability across their institutional and strategic functions, and children with disabilities and their families.

2.5 Conceptual and Theoretical Framework

This study draws inspiration from the UNICEF's Guidelines for Disability Situation Analyses

Foundational concepts and approaches integrated by the study



Box 2: Principles of a Human Rights-Based Approach

A human rights-based approach requires that the following principles be considered:

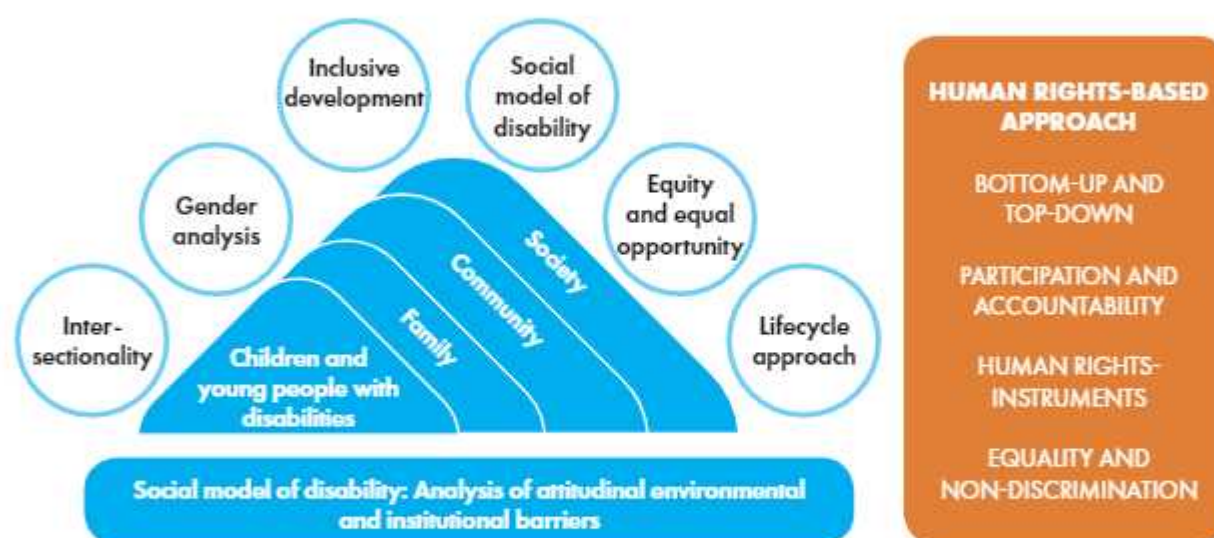
Bottom-Up and Top-Down: policy outcomes and implementation processes must be examined at both the individual and community levels.

Equality and Non-Discrimination: the assessment of disability should demonstrate and account for programmes' impact on the target beneficiaries. Where possible, data needs explicitly to capture this impact and, in our case, their families need to participate fully in the Situation Analysis process without discrimination. An assessment of disability such as the Situation Analysis should be designed cognisant of the needs, capacities, and power imbalances that may affect people with disabilities (PDs), the State, donors, and the general society.

Participation and Accountability: Representatives of all relevant stakeholders should be included in the Situation Analysis. In this case, state actors, organisations of persons with disabilities (OPDs), families of PDs, PDs, international organisations such as UN agencies, and many more must participate and account for their collective effort to implement the CRPD and the CRC. Findings and gaps in these intersectional collaborations inform future activities.

Linkages to Human Rights Instruments: policy outcomes and the outcomes of various projects aimed at achieving an enabling environment and the realisation of human rights, or at least identify how such interventions will contribute to the future realisation of rights. Determining how the outcomes and activities relate to CRC and CRPD standards and recommendations is also an integral part of the Situation Analysis.

Figure 1: Conceptual Framework



Human Rights-Based Approach (HRBA):

A human rights-based approach has an explicit focus on the state as the primary duty bearer and on measuring changes in rights holders' lives (see Box 2) (Gosling et al., 2019). A human rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyse inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress. A HRBA focuses on primary duty bearers (state officials) and their capacity to uphold the rights of boys and girls living with a disability. For human rights to move from recognition to realisation, they need to become part of the everyday practice of local government and other service providers. In accordance with the right to participation enshrined in the CRPD and the slogan of the disability community, "nothing about us, without us", people with disabilities and their families must be engaged and consulted throughout the Situation Analysis process (UNICEF, 2013a). This study incorporates the voices and input of children and young people with disabilities and their families to the greatest extent possible within the project parameters.

Social Model of Disability:

The social model of disability maintains that disability results from interactions between an individual with specific physical, intellectual, sensory or mental health impairment and the surrounding social and cultural environment. Disability is therefore understood as a socio-political construct, whereby the attitudinal, environmental and institutional barriers that inherently exist

within society systematically exclude and discriminate against people with disabilities. If society was more accommodating and aware of the needs of people with disabilities then, the impairment would not be as great a disadvantage. For example, if roads were built with smooth curbs, then people with wheelchairs would be able to travel safely. If speech therapy was offered in all schools then more children with impairments could attend their local school and be able to interact more effectively with society, and this would help to reduce stigma and discrimination. The social model of disability is in line with the CRC and CRPD, and calls attention to the social barriers that prevent children with disabilities from enjoying their human rights.

Intersectionality:

An intersectional perspective helps demonstrate how multiple and intersecting identities (for example, gender, class, kinship, age and severity of disability) can significantly increase the risk of marginalisation (Crenshaw 1989). These identities interact to shape complex social inequalities of subjugation and privilege (Cooper 2016). Any of these identities can act independently or compound and intermesh to create systems of domination and subordination that are harder to overcome than a single identity vector (Garry 2011). The culmination of this effect is that certain identities experience different degrees of inclusion or exclusion from opportunities and resources (Sachs 2019). What this means for children with disabilities in Tanzania is that boys and girls with disabilities face different forms of discrimination depending on where they live, who their parents are, their age, etc (Child Rights International Network, 2018). An intersectional approach considers the experiences of different sub-groups among children with disabilities, some of whom

experience multiple intersecting forms of oppression and marginalisation.

Gender Equality:

Gender is an identity and an intersectional analytical category that is co-constituted along with other categories of oppression such as age, ethnicity, disability, religion, and so on. Gender refers to relations between the sexes and the socially constructed roles and responsibilities that are assigned to men/boys and women/girls in the society.

Gender matters for disability inclusion of children and young people with disabilities because it shapes opportunities and constraints. Globally the female disability prevalence rate is significantly higher at 19.2% compared to 12% for males (United Nations, 2019). Girls with disabilities are particularly susceptible to multiple forms of discrimination and reinforcing layers of discrimination compared to boys with disabilities and girls without disabilities (United Nations Human Rights Council, 2012). Women and girls with disabilities are three times less likely to be educated than men and boys and two times less likely to be gainfully employed (UNDESA, 2019). Girls with disabilities are also less likely to receive health care and assistive devices than boys with disabilities and more likely to experience violence than their male peers with disabilities or girls without disabilities (UNFPA, 2018).

Equity and Equal Opportunity:

For UNICEF, equal opportunity for children and young people with disabilities, means "having an opportunity to survive, develop and reach their full potential without discrimination" (UNICEF, 2013b). Boys/men and girls/women with and without disabilities should enjoy the same rights and opportunities.

Inclusive Development Approach:

UNICEF has a theory of change around social inclusion (Fig 2). This theory of change outlines how children's rights to quality services and participation are supported through legislation (the ratification and implementation of the CRC, CEDAW, and CRPD), social protection and family support, targeting poor and marginalised households, as well as through public finance, community, and private sector initiatives. UNICEF's social inclusion theory of change is relevant to UNICEF's work on children with disabilities.

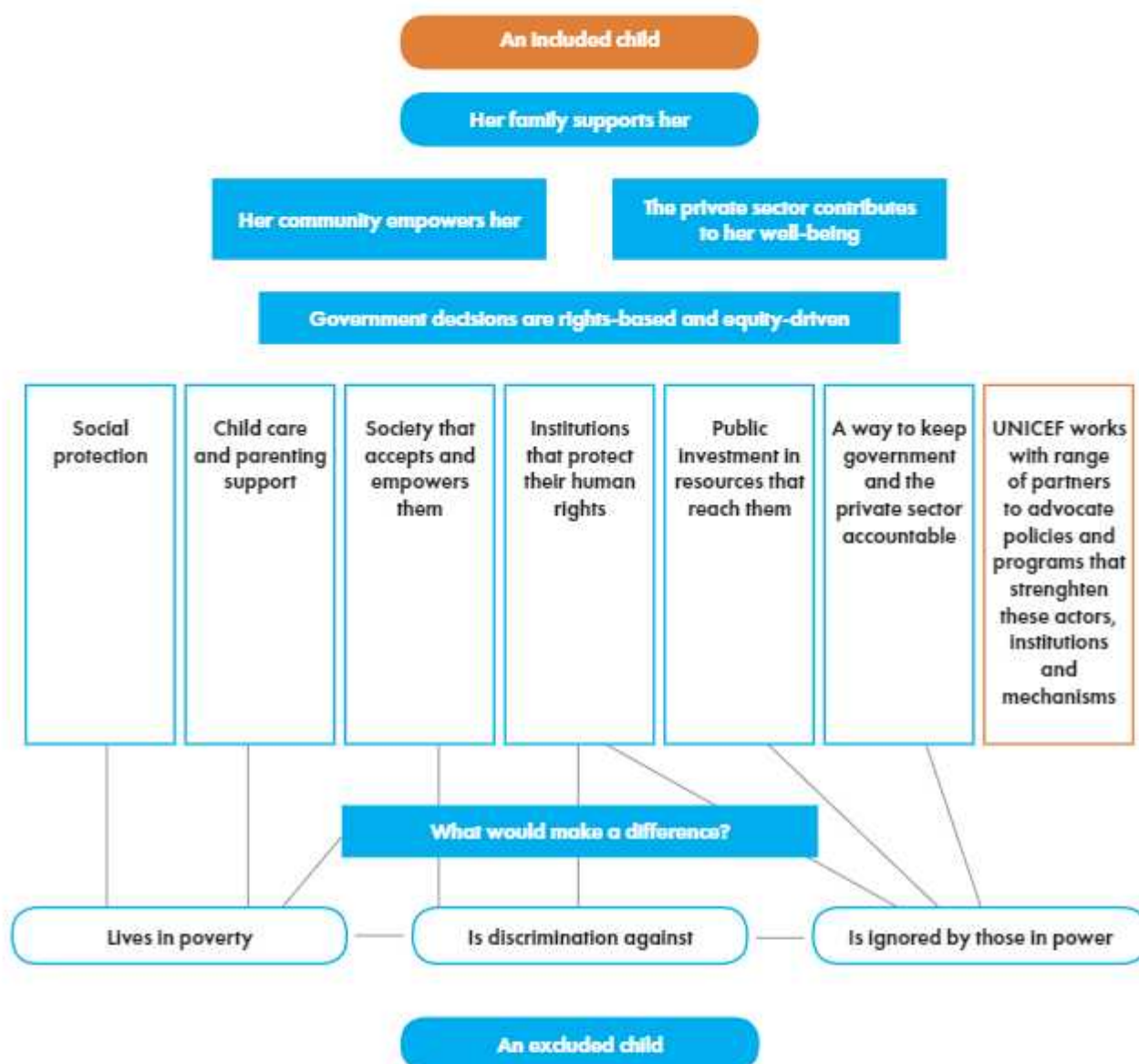
Social inclusion is about realising rights and maximising opportunities for all (Kabeer 2010:9). This requires an exploration of power and relationships and understanding when exclusion is manifested, magnified and reproduced (Gore & Figueiredo 1997:8). Discrimination constitutes a central dimension of social exclusion (de Haan 1999). Inclusion is not only a desired outcome, but must also be central in processes - whether development initiatives or research. This Situation Analysis is grounded in inclusive research practices, and considers dynamics of inclusion and exclusion in both the research processes and findings.

Lifecycle Approach:

The characteristics of exclusion and its effects can accumulate and may only become apparent over time (Atkinson 1998; Sen 2000). Therefore, the prevalence, experience, and barriers related to disability vary across the lifespan. To lay the foundation for an included adult requires resolving the causes and consequences of social inclusion in the younger years. While this Situation Analysis focuses on children and young people, these stages must be considered within the broader context of their lives, mainly as inclusive opportunities in childhood lay a foundation for future community life participation.



Figure 2: UNICEF's Theory of Change for Social Inclusion



Source: Theory of Change Diagram in UNICEF's 2018-2021 Strategic Plan, graphic design adapted by Includovate

2.6 Methodology

This updated Situation Analysis of Children and Young People with Disabilities in the URT focuses on developments between 2013 and 2021. The methodology adopted a mixed-methods approach to identifying new patterns and trends in the situation and barriers experienced by children and young people with disabilities. Literature and document review formed the foundation of the Situation Analysis update. Statistics on the prevalence of disability among children and young people (male and female) were updated through quantitative analysis of existing survey data. Gender is mainstreamed in the study. Although gender non-

conforming children with disabilities might exist in the country, data analysis in the study focused on male and female categories. Findings were triangulated, augmented, and contextualised through key informant interviews (n=19) and focus group discussions (n=12 groups). Finally, a validation workshop with key stakeholders will inform the interpretation of the findings and the generation of recommendations and priorities for future advocacy and programming. A data collection matrix in Annex 2 maps the various data collection and analysis methods to the research questions guiding the Situation Analysis. More information on each data collection process follows.

This study was guided by UNICEF's Guidelines for Disability Situation Analyses (2013b) and Core Guidance: New Generation Situation Analysis (2019).

2.6.1 Literature Review

A structured literature and document review explored new publications since 2013. The initial literature profile came from the document resources recommended by UNICEF in the TORs (included in Annex 3). The literature search was expanded methodically to identify relevant published and grey literature from this core list of documents. The research team searched multiple scholarly databases, including prominent sources like Academic Search Complete, Web of Science, Google Scholar, and Scopus. Information was also gathered from critical organisational websites such as UNICEF, UNDP, USAID, Inclusive Futures, and Action on Disability and Development (ADD) International using various search term combinations to mine relevant literature. An initial search yielded 111 documents, academic journal articles, and book chapters. After applying the screening criteria (see Annex 4), the literature count reduced to 64. However, during the course of the study, the research team added resources recommended by stakeholders and the initially screened literature. The newly added literature was subjected to similar criteria for inclusion and exclusion before it was finally screened in.

As the research team read the literature, it coded its findings along with pre-identified themes based on the research questions and those iteratively identified by the research team during the document reading (see Annex

5). The research team manually coded the literature on an interactive spreadsheet that served as the core codebook for systematic analysis. Additionally, the team conducted targeted searches for updates to key statistics included in the 2013 analysis.

2.6.2 Survey Data Analysis

One of the objectives of the project is to update numbers on the prevalence of children and young people with disabilities in the URT based on recent surveys. Four sources of data were identified and reviewed: the 2019/20 Zanzibar Household Budget Survey (HBS), the 2017/18 Tanzania Household Budget Survey, the 2015/16 Tanzania Demographic and Health Survey (DHS), and the 2014/15 National Panel Survey (also known as the Living Standards Measurement Survey (LSMS) wave 4).

Includovate prioritised the two HBSs (2017/18 for Mainland Tanzania and 2019/20 for Zanzibar) because they are the most recent. The analysis of the HBS datasets covered disability prevalence disaggregated by age, sex, and type of functional limitation. The data analysis approach and methods are further discussed in Chapter 4.

Analysis of the HBS data to explore the associations between disability and other relevant variables such as education and household welfare is beyond the scope of this study due to budget constraints. However, these topics are addressed in this Situation Analysis by drawing on secondary sources and qualitative data. This study also identifies potential areas for future data analysis

Table 1.1: Survey Data Sources

Survey	Data Relevance and Availability
2019/20 Zanzibar HBS	- Data released March 2021 - Questionnaires cover variables necessary to calculate age- and sex-disaggregated disability prevalence, as well as variables on education and household welfare that may be linked to disability
2017/18 Tanzania HBS	- Datasets available on website - Questionnaires cover variables necessary to calculate age- and sex-disaggregated disability prevalence, as well as variables on education and household welfare that may be linked to disability
2015/16 Tanzania DHS	Datasets are publicly available, but survey did not include variables on disability or functional impairments
2014/15 LSMS wave 4	- Datasets are available - Include variables necessary to calculate age- and sex-disaggregated disability prevalence - Variables on education and household welfare are also present but with a higher proportion of missing values, which may limit analysis possibilities

and utilisation, as data paucity around children with disabilities is a barrier to securing funding for programs and technical assistance.

2.6.3 Key Informant Interviews

Key informant interviews (KIs) were used to gather data to triangulate and augment findings from the literature and document review and the secondary data analysis. KIs have provided context, interpretation, and situate the literature review findings within very recent developments and help identify recommendations for strategic priorities and partnerships. The interviews engaged representatives of key government institutions and partner organisations in URT and international experts.

The initial study plan included a maximum of eight to ten KIs. In April 2021, the study was expanded to include up to ten additional ten KIs to ensure data saturation. The sampling approach and target participant groups for KIs are further detailed below. The interview guide (included in Annex 6) uses a semi-structured approach to follow-up on responses. The KIs are distributed geographically between Mainland Tanzania and Zanzibar. The KIs were conducted virtually or in-person depending on the preference, availability, and location of interviewees. Interviews conducted in-person adhered to all relevant COVID-19 precautions. Remote interviews were predominantly conducted by video conference using Zoom, but audio-only web conferencing or phone calls were offered as options to mitigate technical challenges or in response to participant preference.

2.6.4 Focus Group Discussions

Participation is a fundamental element of the rights-based approach that underpinned this study (UNICEF, 2013a). Children and young people with disabilities are the primary stakeholders in this study, yet their voices are often missing from the research that concerns them (Groce, 2013). Including children with disabilities in research with appropriate provisions and adaptations, therefore, contributed to challenging assumptions about them and reducing their marginalisation in society (Wickenden & Kembhavi-Tam, 2014). Engagement with families of children with disabilities is also essential. Parents and caregivers play a central role in caring for children with disabilities and in filling gaps in formal services and support in Tanzania (McNally & Mannan, 2013). Their experiences of both the challenges and the positive dimensions of their lives with their children offer an important perspective on the situation of children with disabilities in URT.

The initial study plan included four focus group discussions (FGDs) to engage important stakeholders: two FGDs with children and young people with disabilities, one with parents and carers of children and young people with disabilities, and one with representatives of various United Nations agencies in Tanzania. In April 2021, the study plan was amended to include eight additional FGDs³ to engage a greater diversity of stakeholders, including children and adolescents in both rural and urban areas, children with different types of disabilities, a more diverse sample of parents and carers, as well as teachers of students with disabilities. A full list of the original four and additional eight FGDs is provided in table 1.3.

The FGD guides were developed and adapted based on each group's specific composition and incorporated flexible, participatory approaches to engage children with different forms of disabilities to maximise the diversity of participants and perspectives. The first four FGDs were facilitated remotely by an Includovate researcher, while staff at local host organisations or schools were physically present to coordinate the groups and support participants. UNICEF provided logistical support as well as Kiswahili-English interpretation for the focus groups in Zanzibar. The successes and challenges encountered in conducting the initial three focus groups informed adjustments in the approach to the remaining FGDs. Includovate engaged a local Tanzanian researcher to conduct the additional nine FGDs in Kiswahili to address the limitations of conducting remote focus groups. The additional eight FGDs were conducted in-person by an Includovate researcher in Tanzania. Includovate worked with local host organisations to coordinate the FGDs, reach participants, and to address COVID-19 precautions.

2.6.5 Sampling Approach

The researchers used a maximum variation purposive sampling approach to identify participants for both the KIs and FGDs. Purposive sampling involves identifying and selecting information-rich cases that can yield in-depth insights relevant to the evaluation rather than empirical generalisations (Patton, 2002). This approach was appropriate given the short time frame, the small sample size, and the goal of augmenting and triangulating findings from the literature review and quantitative data analysis. Moreover, purposive sampling can be tailored to document diversity (Patton, 2002) and allowed the team to ensure the inclusion of a range of participants with different experiences, perspectives, roles, and social locations.

Decisions regarding the selection of individual participants were jointly made with the project sponsor

³ A ninth additional FGD was planned but not feasible due to challenges convening rural participants within budget and timeline constraints.

(UNICEF Tanzania). As part of the preliminary literature and document review, Includovate conducted basic stakeholder mapping and identified potential organisations, government ministries and stakeholders for the key informant interviews. This initial list was shared with UNICEF Tanzania and reviewed by the Disability Working Group. The Disability Working Group identified specific key informants (KIs) within organisations and provided input on prioritising participants from among the list. Considerations in prioritising KIs included: geographic balance (particularly between Mainland Tanzania and Zanzibar); balance between government, non-governmental, and international stakeholders; and prominence in disability inclusion work in URT. Additionally, through document review and referrals within international disability studies networks, Includovate identified international experts to further diversify the KI sample.

The KIs targeted respondents from strategic government institutions and partner organisations in URT including:

- » **Government officials:** Government stakeholders from ministries in URT with responsibilities related to children and young people with disabilities and child protection participated in the KIs.
- » **Organisations of Persons with Disabilities (OPDs):** OPDs are established by and for people with disabilities and are composed of a majority of PWDs in membership and leadership (Young, Reeve & Grills 2016). Relevant OPDs were identified through the document review and recommendations from UNICEF. These are critical stakeholders in disability research.
- » **Other stakeholder organisations/partners:** The KIs also involved a limited number of additional stakeholders with academic, professional or personal expertise and familiarity with the situation of children with disabilities in URT, covering academic, non-governmental, education and training, and private sectors. The initial identification of expert KIs was done through strategic academic experts with reputable disability expertise in URT who later recommended additional KIs. UNICEF Tanzania's Disability Working Group further identified relevant stakeholder organisations in Mainland Tanzania and Zanzibar.

For the FGDs with adults, six to 12 participants are generally accepted as an appropriate number of participants per group so that all participants have an opportunity to contribute to the discussion (Wilkinson, 1998). For the FGDs with children and young people with disabilities, the target number of participants was smaller (consisting of four to eight participants per FGD) to allow ample time for unpressured participation, and Kiswahili and sign language interpretation as needed.

These participant numbers were chosen to maximise interaction while retaining intra-group diversity of perspectives. FGD sampling prioritised achieving gender balance among participants, including conducting a single-sex FGDs with girls among the additional eight added in April 2021.

Table 1.2: Key Informant Interviews

Stakeholder type	KIs	
	Mainland	Zanzibar
Government	3	3
OPDs	3	2
NGOs	3	
Other stakeholders	2	1
International experts	2	
TOTAL	11 Mainland, 6 Zanzibar, 2 international (n=19)	

Table 1.3: Focus Group Discussions

FGD	Target population	Location
1	Primary school aged children with disabilities	Zanzibar
2	Adolescents with disabilities	Mainland
3	Parents/carers of children with disabilities	Zanzibar
4	UN sister agencies	remote
5	Students at Buguruni Primary School for the Deaf	Mainland
6	Students at Salvation Army's Matumaini School in Temeke for Children with Physical Disabilities and Albinism	Mainland
7	Children or adolescents with visual impairments	Mainland
8	Parents/carers of children with disabilities in urban area	Mainland
9	Parents/carers of children with disabilities in rural area	Mainland
10	Teachers of students with disabilities	Mainland
11	Children with disabilities in rural area	Zanzibar
12	Adolescents with disabilities in rural and urban areas	Zanzibar
TOTAL	16-32 FGD participants in Zanzibar, 32-64 FGD participants on Mainland	

2.6.6 Validation Workshop

The final method for gathering stakeholder input will be a validation workshop that will be held towards the completion of the Situation Analysis. At the validation workshop, Includovate will present the study's findings to key stakeholders and facilitate a discussion on interpretation, opportunities and priorities for UNICEF. The workshop will engage both UNICEF staff and other key stakeholders. It will be hosted online via Zoom, allowing for a flexible number of participants.

2.6.7 Ethics in the Research Process

In line with Includovate's ethics policy and the UNICEF Procedure for Ethical Standards in Research, Evaluation and Data Collection (2015), ethical considerations and protection of human rights have been factored into all Situation Analysis components.

Includovate ensured research quality and the safety of our researchers and respondents. All our researchers have been trained on Includovate's child protection policy and hold CITI human subject ethics certificates. The Team Lead, Dr Kristie Druzca, also completed UNICEF's Agora course on Ethics in Evidence Generation. Includovate also established an Internal Ethical Review Board (IRB), which reviewed and approved all human subjects studies. This independent committee was composed of a mix of nationalities, trained researchers or lawyers who were not involved in the project under review. The IRB reviewed the risks associated with the research, with particular attention to vulnerable populations and the measures to protect participant rights. Informed consent procedures and materials were reviewed in detail. As part of our ethical and safe data collection efforts, we also implemented a confidential data storage process. We uploaded data and work products to cloud storage to facilitate collaboration by the international research team. Then the files were password encrypted, providing the password only to those who have confirmed access. The IRB approval letter for this project is included in Annex 7.

2.6.8 Limitations

This Situation Analysis was subject to several limitations. The study's central aim is to update the 2013 Situation Analysis. The extent to which updates are possible depends mainly on the availability of more recent published and publicly available research and data. Significant gaps in current data and published and grey literature limited the details in the analysis. Still, identifying

such gaps represents an important finding in itself and can inform recommendations for further data collection and research.

In order to reduce the impact of this limitation, Includovate requested raw data sets from the Tanzania National Bureau of Statistics and the Office of the Chief Government Statistician of Zanzibar. Includovate obtained raw data sets from the 2017/18 Tanzania HBS and the 2019/20 Zanzibar HBS and conducted original analysis to calculate updated disability prevalence rates. Includovate also reviewed the data sets to identify further opportunities for future analysis of the associations between disability and other factors such as poverty and education. In this way, this Situation Analysis provides a starting point for addressing some of the gaps in reported data on disability in Mainland Tanzania and Zanzibar.

The KIs and FGDs provide valuable insights into the situation of children and young people and their families. However, given the small, purposive sample size and selection of FGD sites driven by feasibility, the findings cannot be assumed to represent the diversity of situations and experiences of children and young people with disabilities across the country. The findings from the KIs and FGDs in 2021 build on the findings from UNICEF's 2013 Situation Analysis of Children with Disabilities in Tanzania, which included a series of in-depth interviews, focus groups and observational field visits engaging teachers, health workers, community-based rehabilitation workers, children with disabilities and their families, as well as intergovernmental and international agencies, government representatives, and OPDs and NGOs (Groce, 2013).⁴ To further reduce any potential low sample size limitations, the findings are complemented and triangulated by other published literature on children with disabilities and their families.

The remote nature of this study due to COVID-19 travel restrictions, can be seen as a limitation. After conducting two FGDs via a smart phone in classrooms, it was determined that a local Kiswahili speaker should be hired to mitigate some of the translation and connectivity challenges. Subsequent FGDs were held face to face.

To ensure a relevant analysis of the data, four members of Includovate's study team are from Africa and two of them are women with disabilities. The validation workshop will be a final valuable opportunity to interpret and triangulate the findings based on stakeholders' expert knowledge and in-country experience and reduce any pending limitations.

⁴ The draft 2013 Situation Analysis Report shared with Includovate by UNICEF (Groce, 2013) does not specify the number of interviews and focus groups conducted nor the total number of participants engaged in the study.



National Legislative and Policy Context

3.1 Introduction

This chapter outlines the legal and policy frameworks relevant to children and young people with disabilities in the URT. Established in 1964, the URT consists of the union of two independent states, the Republic of Tanganyika and the Peoples' Republic of Zanzibar. Zanzibar is an autonomous part of the URT consisting of two islands, Unguja and Pemba. The territory of the URT consists of the whole area of Mainland Tanzania and the islands of Zanzibar, including the territorial waters (Article 2(1), 1977 Constitution).

This national legislative and policy outline is essential to determine whether the URT has sufficiently aligned its domestic laws and policies with international standards, particularly with the provisions that concern children and young people with disabilities. Since the 2013 Situational Analysis did no such assessment, this report contributes by discussing the legal compliance of URT's laws and policies to international standards.

Article 1 of the Universal Declaration on Human Rights (Universal Declaration) declares that "all human beings are born free and equal in rights and dignity" (UN, 1948). This Declaration forms the basis for the human rights of all persons, including children and young people with disabilities globally. This commitment is

reaffirmed in other international and regional human rights treaties such as the United Nations (UN) 1989 Convention on the Rights of the Child (CRC), the 2006 Convention on the Rights of Persons with Disabilities (CRPD) as well as the 1999 African Charter on the Rights and Welfare of the Child (ACRWC) that emphasises the equality and dignity of children and young people with disabilities on an equal basis with all people without disabilities. As a signatory to these international and regional human rights treaties, the URT expresses its commitments to ensuring the rights of children and young people with disabilities within its domestic jurisdiction are guaranteed.

This chapter begins by discussing the essential global and regional human rights treaties concerning children and young people with disabilities to which the URT is a state party (except African Disability Protocol). It then discusses the national laws relating to children and young people with disabilities and the compliance of these laws to their international commitments under CRPD, CRC and CEDAW. The chapter concludes by identifying gaps in the national laws with respect to their international obligations. The recommendations arising out of this analysis are discussed at the end of this report.

Table 2.1: URT's Reporting Record under International and Regional Human Rights Treaties

Year Ratified	Instrument Relating to Children with Disabilities	Key Provisions related to Disability	Reporting Record
1991	CRC	Article 6 recognises the child's inherent right to life Article 2 recognises children's right against discrimination Articles 24 and 28 provides children the rights to accessible education and health Article 23 particularly states the state parties' responsibility to ensure an effective access to education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities to children with disability	Not compliant- The last combined 3rd to 5th report was submitted in January 2012, The latest report (6th State Report) has been due since Jan 2020 and as of April 2021, it is being finalised for submission.
1985	CEDAW	Article 2 recognises women's right to achieve gender equality. General Recommendation 18, particularly, recognises rights of young women and girls with disabilities under the Convention and ensures signatory Government's obligation to provide rights and freedoms on an equal basis without discrimination based on sex and disability.	Not compliant- Last report submitted in 2014, latest report due since March 2020
2009	CRPD	All provisions of the treaty are relevant as they create rights for all persons with disabilities. Some of the key provisions for children and young people with disabilities. include: Article 7 creates specific rights for children with disabilities and outlines three specific obligations for the signatory states. Article 6 and General Comment 3, adopted in 2016, confirm women and girls with disabilities' susceptibility to multiple forms of discrimination. Article 4 creates General Obligation on the state parties to identify intersecting discrimination experienced by all persons with disabilities, and enact specific legislation to ensure equality.	Not compliant- No reporting record
1985	African Charter on Human and Peoples Rights (African Charter)	Article 2 prohibits discrimination based on any status. Article 18(3) prohibits discrimination against women and guarantees the protection of women and children's rights in Africa. Article 18(4) requires all state parties to ensure that older persons and persons with disabilities enjoy special protection.	Not compliant- Last report submitted in 2008, since then 7 reports are due
2003	ACRWC	Article 13 provides specific rights to children with disabilities. The Charter contains multiple general provisions providing rights to children from which children with disability can also benefit.	Not compliant- The Last combined 2nd - 4th report was submitted in 2015, no reporting record since then
2007	Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (Maputo Protocol)	Article 2 holds the state parties responsible to eliminate all forms of discrimination against women, including girls. Article 23 provides specific rights and protection to women with disabilities and holds the state parties responsible to take specific measures towards that effect.	Not compliant- Not submitted any report till date

Year Ratified	Instrument Relating to Children with Disabilities	Key Provisions related to Disability	Reporting Record
-	Protocol to the African Charter on Human and Peoples Rights on the Rights of Persons with Disabilities (African Disability Protocol)	All the provisions of the African Disability Protocol explicitly provide for the rights of children and young people with disabilities in Africa while maintaining the core values of the CRPD. Some specific provisions to highlight include: Article 5 on Non-discrimination, Article 6 on right to equality, Article 7 on equal recognition before the law, Article 8 on the Right to life, Article 27 on women and girls with disabilities, Article 28 on children with disabilities, Article 29 on youth with disabilities	The African Disability Protocol has not entered into force

3.2 International Legislative Framework Relating to Children with Disabilities in the United Republic of Tanzania

As highlighted in the 2013 Situational Analysis, the URT has signed and ratified several international treaties that concern children with disabilities at the United Nations level. A summary of these treaties and their relevance to children with disabilities follows.

3.2.1 The Convention on the Rights of the Child, 1989

The URT signed the CRC in June 1990 and ratified it in June 1991 without reservations. The CRC, adopted in November 1989 and entered into force in September 1990, is the first international legal treaty that directly seeks the realisation of children's rights globally. Some essential rights provided by the Convention for the effective realisation of children's wellbeing, including that of children with disability, include the child's inherent right to life (Art. 6), their right against discrimination (Art. 2), and their rights to accessible education and health (Articles 24 and 28).

As a signatory of the CRC, the URT is obliged under Articles 2 and 23 to ensure all children are entitled to rights and freedoms on an equal basis and without discrimination, including based on sex and disability. These articles relate specifically to the rights and needs of children with disabilities. Article 23 particularly states that the state parties must ensure an effective access to education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities to children with disability. In General Recommendation 9, the Committee on the Convention on the Rights of the Child Committee (CRC Committee) emphasises Article 23(1) that provides for the rights of children with disabilities to enjoy a "full and decent life

that ensures dignity, promotes self-reliance and facilitate active participation in the community" as fundamental to achieving the objectives of the CRC.

As would be discussed below, the URT has acted towards its obligations under Article 4 of CRC and strengthened its efforts to domesticate the CRC provisions into its law by enacting the 2009 Law of the Child Act, specifically for Mainland Tanzania, and the 2011 Children's Act that applies specifically to Zanzibar.

However, the reality of implementation of these rights for children and young people with disabilities on the ground in the URT remains a challenge. For example, in the 2015 Concluding Observations to the URT, the CRC Committee expressed the need for URT to adopt a human rights perspective in all its laws and policies. It noted inefficient protection of children with disabilities' rights and an increased abuse, violence, stigma and exclusion, particularly in rural areas, and especially those children with intellectual and psychosocial impairments. The observations also expressed concerns over inaccessible public infrastructure and inclusive education for children with disabilities and their low primary-school enrolment. It also expressed the need to allocate sufficient resources for realisation of rights for children with disabilities, especially establishment of a specific fund to implement the National Strategy on Inclusive Education. Further, the Committee was particularly concerned that the URT was yet to align all its laws and policies to the CRC. These laws include the Law of Marriage Act, 1971 (Rev. 2002), the Penal Code's Chapter 16 and inheritance laws. The committee, however, didn't assign any reasons behind non-compliance of these laws to the CRC. The CRC Committee expressed concern that discrimination against certain groups of children including children with disabilities still exists in law and practice (CRC Concluding Observations, 2015:5). This concern was also reiterated by the CRPD Committee in Communication No. 22/2014 (See Box 3 below for a summary of the case).

Box 3: Mr X v. Tanzania

An example that demonstrates a challenge in ensuring the equality and non-discrimination of all children and young people with disabilities in the URT is the outcome of the Mr X v. Tanzania case. The case involved a man with albinism who was viciously attacked and mutilated by men because of his albinism. The Tanzanian authorities refused to proceed with the investigation even though Mr X had claimed that he knew the perpetrators. The case was brought before the CRPD Committee. In 2017, the CRPD Committee decided that the URT's failure to investigate, punish and prosecute the perpetrators of such a hideous crime constituted disability-based discrimination in contravention of Article 5 of the CRPD. In its ruling, the CRPD Committee questioned whether the judicial remedies for children and young people with disabilities, particularly albinism, were available, effective, and sufficient in the URT (Communication No. 22/2014).

While CRC is an essential convention for addressing the rights of children, it is insufficient when it comes to addressing rights of children with disabilities. Hence, the convention needs to be read along with the CRPD which is the core international treaty that recognises rights of persons with disabilities, including the specific education, health and accessibility rights of children with disability (under Articles 24, 25 and 9). The compliance of national laws and policies in URT to its international obligations is discussed in Sections 2.5 and 2.6 of this report.

Specifically, in line with its reporting obligations, the URT has submitted state reports indicating measures to improve children's rights, particularly children with disabilities, to the CRC Committee. However, the state is yet to submit its next periodic report to the CRC, which was due on 9 January 2020. This report⁹ which is coordinated by the Ministry of Health, will outline further steps the URT has taken to ensure the guarantee of children's rights, particularly children with disabilities.

3.2.2 The Convention on the Elimination of all Forms of Discrimination Against Women, 1979

The URT signed the CEDAW in July 1980 and ratified it in August 1985 without reservations (United Nations, 2014). The URT also ratified the Optional Protocol in January 2006 (United Nations, 2014). The CEDAW is the first international legally binding instrument entirely dedicated to protecting and promoting women's rights globally (United Nations Audiovisual of International Law, 2009). The treaty, often referred to as the International Bill of Rights for Women, was adopted in December 1979

and came into force in September 1981 (World Health Organisation, 1979). Importantly, because CEDAW is not age-specific, the rights guaranteed in the instrument apply to all females from infancy to old age.

As a signatory of the CEDAW, under Article 2, the URT recognises the women's right to achieve gender equality. The General Recommendation 18, particularly, recognises this right for young women and girls with disabilities and ensures URT's obligation to provide rights and freedoms on an equal basis and without sex and disability-based discrimination. For example, in its General Recommendation 18, 19, 28, 33 and 35, the Committee on the CEDAW discusses the disproportionate exposure of young women and girls with disabilities to all forms of discrimination because of intersecting identities of gender and disability. A similar argument is made in the Joint General Recommendation No. 31 of the CEDAW Committee and the General Comment No. 18 of the CRC Committee on harmful practices issued in 2019. This joint General Recommendation specifically addresses harmful practices that target girls with disabilities.

Nevertheless, despite these commitments, the reality of human rights protection for young women and girls with disabilities shows significant gaps. For example, in its latest concluding observations on the seventh and eighth Periodic Report of the URT in 2016, the CEDAW Committee mentioned the prevalence of harmful practices on girls with disabilities. These harmful practices include the killing and attacks on girls with albinism for ritual purposes and the prescription of sexual relations with girls with disabilities for what is commonly referred to as 'virgin cure'. Virgin cure is based on the belief that young women and girls with intellectual disabilities can cure HIV/AIDS

⁹ As of May 2021, the report has been drafted but has not been submitted as it is under internal government review.

after sexual intercourse. Consequently, the CEDAW Committee requested that the URT take urgent measures to protect persons, mainly women and girls with disabilities.

Specifically, in line with fulfilling its reporting obligations, the URT has submitted state reports indicating measures it has taken to improve women's rights and, in particular, young women and girls with disabilities to the CEDAW Committee. However, the URT is yet to submit its periodic report to the CEDAW due in March 2020. This report, when submitted, is to outline further steps and the progress the URT has made to ensure the guarantee of rights for women and girls, particularly women and girls with disabilities, within its domestic jurisdiction.

3.2.3 The Convention on the Rights of Persons with Disabilities, 2006

The URT signed the UN Convention on the Rights of Persons with Disabilities (CRPD) in March 2007 and ratified it in November 2009 without reservations. The URT also ratified the Optional Protocol in 2009. The adoption of the CRPD in December 2006 and its entering into force in May 2008 signifies the global acknowledgement of persons with disabilities as right holders. The treaty is the first international legally binding treaty that recognises the rights of persons with disabilities globally.

Article 1 of the CRPD, from human rights based understanding, defines persons with disabilities as "persons with long-term impairment which in interaction with various barriers may deter their full and effective participation in society on an equal basis with others". Specifically, Article 7 of the CRPD dedicated to children with disabilities outlines three specific obligations that the URT is bound by as a signatory to the CRPD. These three obligations include: First, to ensure that children with disabilities thoroughly enjoy human rights on an equal basis with children without disabilities. Second, to guarantee the 'best interests' of all children with disabilities in all governmental measures. Third, to ensure that the opinions of children with disabilities are considered in all issues that concern them.

Key informants and some FGDs within and outside government in Mainland Tanzania and Zanzibar confirmed that URT's national legislations and policies comply with the CRPD and that the government has taken important steps to realise rights of children, young people and women with disabilities.

However, the need for improvements were noted by government, OPDs, and UN partners. These improvements included: the need for disability awareness raising; regularly checking laws and policies for CRPD compliance; and identifying and addressing the

implementation gap in policies and legislation. Disability needs and solutions are not stagnant and thus government policies and legislation must include regular reviews to keep up with the changing idea of disability. Almost all interviewees in the FGD with UN partners (FGD 3) stressed on adopting an intersectional approach to see how different identities of age, gender and disability interact to make children with disability marginalised. One interviewee, by adopting life-cycle approach, observed the different obstacles and expectations that children with disabilities face as they grow:

"Initially children with disabilities aren't aware of the discrimination, but as they grow they start becoming aware of the stereotypes against them. The hidden cost for them, like transportation to schools, also increases with time and the need for employment too becomes apparent. Once you're above 18, you need to adjust into the community and be able to do something that gives you an income."

(FGD-3, 14 April 2021, Tanzania Mainland).

A few key informants (KII 1 & 8) expressed appreciation for the government's steps on regularly reviewing laws and policies on disability to check their compliance with CRPD. However, they noted gaps that remain in areas, such as awareness raising and implementation of these policies. One of them (KII 8) suggested that this may be an area where support of partners like UNICEF, may facilitate the government's progress. Another key informant (KII 2), working for an OPD in Zanzibar, highlighted the insufficiency of 2006 Persons with Disabilities Act to reflect all areas of CRPD and there stressed on the need for the legislations and policies to keep up with the changing idea of disability. She observed:

"When you come into our legislation, I think it takes some of the convention areas that are included in this action but it's not enough. It's time to review and accommodate many things now, because it is 2006 until now, there's a lot of years in between, and disability is changing a lot."

(KII 2, 9 April 2021, Zanzibar)

The informant highlighted that the legislation talks about rights of children, girls, women and men's disabilities in general and there is a need to separate some of these issues to adequately address rights of different groups. In the same respect, the CRPD adopts an intersectional perspective and its Article 6 and General Comment

3, adopted in 2016, confirms women and girls with disabilities' susceptibility to multiple forms of discrimination. The General Comment 3, also stressed the historical disregard of young women and girls with disabilities in international and national legislation and policies.

As a signatory to the CRPD, the URT, under Article 4 of CRPD has the General Obligation to pay significant attention to the multiple and intersecting discrimination experienced by all persons with disabilities, including young women and girls with disabilities. This attention includes taking steps involving enacting specific legislation that recognises the multiple and intersecting discrimination faced by young women and girls with disabilities. Admittedly as discussed below, the URT has endeavoured to incorporate the CRPD provisions into its law by enacting the 2010 Persons with Disabilities Act in Mainland Tanzania. The URT is lagging in its reporting obligations. Submitting a state report that outlines the steps URT has taken to guarantee rights for children and young people with disabilities since its ratification of the instrument in 2009, would go a long way to demonstrating URT's unwavering commitment to children with disabilities. The initial state report to the CRPD Committee was due on 9 November 2011 and remains pending.

3.3 Regional Legislative Framework Relating to Children with Disabilities in the United Republic of Tanzania

The URT has signed and ratified several regional human rights treaties that concern children and young people with disabilities at the regional level. The URT is one

of the 54-member states of the African Union (AU), formerly known as the Organisation of African Unity (OAU). These initiatives include the African Decade of Persons with Disabilities (ADPD) that emphasises the full participation, equality and empowerment of people with disabilities in Africa. Another initiative is the Continental Plan of Action for the African Decade of Persons with Disabilities 2010 – 2019, which includes a section dedicated explicitly to children with disabilities. This Plan seeks to ensure the full enjoyment of all their human rights and fundamental freedoms on an equal basis with children without disabilities.

As a state party to these regional conventions, the URT's specific priority actions relating to children and young people with disabilities within its domestic jurisdiction are captured under Table 2.2 below. This table provides an overview of priority actions related to children and youth with disabilities in the Continental Plan of Action for the African Decade of Persons with Disabilities (2010-2019).

3.3.1 The African Charter on Human and Peoples' Rights (African Charter), 1986

The URT signed the African Charter on Human and Peoples' Rights (African Charter) in May 1982 and ratified it in February 1984 following its adoption and entering into force in June 1981 and October 1986, respectively. Article 2 of the African Charter enjoins all states parties to prohibit all forms of discrimination on the grounds of race, ethnic origin, colour, sex, language, religion or any other status, rightly construed to include disability. Further, Article 18(3) forbids discrimination against women and guarantees the protection of women and

Table 2.2: Continental Plan of Action Priority Actions Concerning Children and Youth⁶ with Disabilities

Category	Children with disabilities	Youth with disabilities
Goal	Ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.	Achieve full participation and equal rights for youth with disabilities.
Priority Actions for Member States		
Implement Rights Commitments	Develop programmes to implement provisions of Article 13 of the African Charter on the Rights and Welfare of the Child [1999], which recognises the needs of children with disabilities and their caregivers and the importance of creating a conducive environment that will allow the child to achieve fullest possible integration individual development and cultural and moral development	- Raise awareness on the rights of youth with disabilities - Develop programmes and monitoring mechanisms to ensure young people with disability benefit from the AU Youth Charter - Put the needs and interests of youth with disabilities on the agenda of all national development programmes

⁶ The Continental Plan of Action for the African Decade of Persons with Disabilities 2010– 2019 does not define the age range for "youth." The Africa Union Youth Charter (2006) defines youth as aged 15–35 years.

Category	Children with disabilities	Youth with disabilities
Health	Ensure access for children with disabilities to mainstream health care services and specialised medical facilities	
Education	Adopt full, inclusive, and accessible education policies, programmes and school systems to promote the education of children with disabilities including early childhood development and education	- Promote full, inclusive, and accessible education for youth with disabilities - Eradicate vulnerability through empowerment, education and awareness of youth with disabilities
Sports, culture, technology	Mainstream the needs and interests of children with disabilities, in cultural, sports, recreation and other social programmes	Develop and implement special measures to facilitate full and equal participation of youth with disabilities in training at sports, culture, science and technology
Non- discrimination	Adopt relevant laws/policies and strategies to remove barriers that hinder and or discriminate against the participation of children with disabilities in society	Adopt and implement relevant laws/policies and strategies to remove barriers that hinder or discriminate against the participation of youth with disabilities in society
Information and ICT	Provide training and access to ICT to children with disabilities, their parents and caregivers, and promote access to information, especially for those in rural areas	- Promote training and access to ICTs for youth with disabilities - Promote access to information by youth with disabilities, especially those in rural areas
Inclusion	Ensure provision of services, equal opportunities and inclusion of children with significant disabilities, including children with multiple disabilities	Promote the inclusion of youth with disabilities in all mainstream youth organisations and programs
Parents & Carers	Empower parents, guardians, and caregivers of children with disabilities, through information, training and other supports	
Economic empowerment		- Develop programmes that overcome social and economic isolation and disconnection and remove systemic barriers in the labour market for youth with disabilities - Ensure access to credit facilities for youth with disabilities

Source: Continental Plan of Action for the African Decade of Persons with Disabilities 2010– 2019, pp. 11–12.

children's rights in Africa. Article 18(4) requires all state parties to ensure that older persons and persons with disabilities enjoy special protection. Although the African Charter does not explicitly define disability or mention children with disabilities, it is assumed that the special protection guaranteed to life in Article 4 includes children with disabilities.

In terms of its reporting obligations, the URT under Article 62 of the African Charter holds a responsibility to submit a state report to the African Commission every two years. The URT's reporting on the African Charter, however, has not been consistent. It submitted its last report on the Charter in 2006 and is currently behind by at least seven overdue reports. The Government then must work towards

fulfilling its regional commitment to protect everyone's human rights, including those of children with disabilities, and report the undertaken actions in this regard to the African Commission.

3.3.2 The African Charter on the Rights and Welfare of the Child (ACRWC), 1999

The URT signed and ratified the African Charter on the Rights and Welfare of the Child (ACRWC) in October 1998 and March 2003, respectively. The ACRWC is a regional legally binding treaty that is concerned with protecting and promoting children's rights in Africa. This

treaty adopted in July 1990 and entered into force in November 1999 supplements the provisions of the UN CRC in Africa.

As a signatory to the ACRWC, the URT under Article 13 commits to guaranteeing the rights of children with disabilities. Article 13 offers special measures of protection to every child with a disability in Africa, emphasising the need to ensure their "dignity, promote their self-reliance and active participation in the community." However, while recognising the right, the Article adopts a medical-model approach to disability for the heading refers to children with disability as "handicapped children".

In line with its reporting obligations, the URT has submitted its 2nd, 3rd and 4th Periodic Report to the African Committee of Experts on the Child's Rights and Welfare (African Children's Committee) in October 2015. In this report, the URT mentioned measures it has taken to align its domestic laws and policies with the provisions of the ACRWC. For example, the URT enacted the 2009 Law of the Child applicable to Tanzania Mainland and the 2011 Zanzibar Children Act, where specific provisions of the ACRWC have been incorporated into the law of the land. In its 2018 concluding observations the African Children's Committee highlighted the gap between law and practice and urged the URT to take further action "to avert all kinds of discrimination posed against children who are in marginalised situations including children with disabilities, particularly, children with albinism, and pregnant girls."

Concerning children with disabilities, the African Children's Committee recommended early identification of disabilities among children and continuous access to healthcare support to them, including physical accessibility of healthcare centres. Moreover, the Committee emphasised the need to integrate the needs of children with albinism in the government's healthcare policies and strategies. On the point of inclusive education, the Committee recommended the renovation of primary and secondary schools' infrastructure, like by building ramps, to increase access to education for children with disabilities.

3.3.3 The Protocol to the African Charter on Human and Peoples' Rights of Women in Africa (Maputo Protocol), 2005

The URT signed and ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) in November 2003 and March 2007, respectively. The Maputo Protocol is a legally binding instrument concerned with protecting and promoting the human rights of women and girls in

Africa. The Maputo Protocol's adoption in July 2003 and entering into force in November 2005 signifies efforts at the regional level to eliminate all forms of discrimination against women and girls and achieve gender equality in Africa.

As a signatory to the Maputo Protocol, the URT, in line with Article 2, holds a duty to eliminate all forms of discrimination against women, including girls. Specifically, under Article 23, the URT commits to:

- » Ensure the protection of women with disabilities and take specific measures commensurate with their physical, economic and social needs to facilitate their access to employment, professional and vocational training as well as their participation in decision-making.
- » Ensure the right of women with disabilities to freedom from violence, including sexual abuse, discrimination based on dis-ability and the right to be treated with dignity.

The URT ratified the Maputo Protocol, but it is yet to fulfil its reporting obligations by including a Maputo Protocol section in its state report to the African Commission as encapsulated under Article 26(1). Following the URT's ratification, its initial report to the Maputo Protocol (Part B) was due in 2009 and is still pending.

3.3.4 The Protocol to the African Charter on Human and Peoples' Right on the Rights of Persons with Disabilities (African Disability Protocol)

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (African Disability Protocol) is a legally binding instrument that seeks to protect the human rights of all persons with disabilities in Africa. Adopted in January 2018, the African Disability Protocol's primary goal is to promote, protect and ensure the full and equal enjoyment of all human and people's rights by all persons with disabilities, and to respect their inherent dignity. Specifically, Article 28 is dedicated explicitly to the guarantee of the fundamental rights of children with disabilities. The African Disability Protocol has not entered into force as it is yet to be ratified by at least 15-member states, including the URT. Nine African countries have signed the African Disability Protocol. These countries are: Angola, Burkina Faso, Cameroon and Central African Republic, Gabon, Mali, Rwanda, South Africa and Togo. No country has ratified the treaty yet. It needs 15 ratifications to come into force (African Union, 2018).

3.4 Sub-Regional Legislative Framework Relating to Children with Disabilities in the United Republic of Tanzania

The URT is a member of the East African Community (EAC), a regional intergovernmental organisation to construct a sustainable East African Economic and Political bloc. EAC acknowledges the urgency of empowering persons with disabilities in line with Article 120(c) of the EAC treaty that relates to social welfare. The Article highlights the need to "adopt a common approach towards the disadvantaged and marginalised groups, including children, the youth, the elderly and persons with disabilities through rehabilitation and provision of, among others, foster homes, healthcare, education and training" (EAC, 1999).

As a mechanism of the EAC, the East African Health Research Commission (EAHRC) conciliates and designs the regional agenda on health research and processes its results into policy and practice within the partner states. The EAHRC has a section related to health indicators in the region, and these indicators do not include data related to disability. The Minimum Standards on Comprehensive Services for Children and Young People (MSCS) in the EAC initiative developed in 2017 were established to guide the 2016 EAC Child Policy implementation. The MSCS addresses children and young people with disabilities, predominantly psychosocial, mental and physical disabilities in the region. Also, the MSCS sets different intervention levels depending on the specific

target group to strengthen their resilience, support their growth, development, and protection through cooperation in critical sectors such as health, education, social welfare (EAC, 2017).

3.5 National Legislative Frameworks Relating to Children and Young People with Disabilities in the United Republic of Tanzania

This section provides an overview of the national legislative and policy frameworks relating to children and young people with disabilities. This overview is essential to determine whether the URT has sufficiently aligned its domestic laws and policies with international standards, particularly with the provisions that concern children and young people with disabilities.

The URT continues to make efforts to align its domestic laws and policies, particularly on the provisions concerning children and young people and children with disabilities, with international and regional human rights standards.

The Table 2.4 below discusses and ranks the compliance of national laws to international instruments in providing rights to children and young people with disabilities. It determines compliance based on the presence of specific rights to children and young people with disabilities in the national laws.

Table 2.3: Summary of EAC Policies and Mechanisms

Year	Title	Initiatives related to disabilities
2016	East African Community Child Policy	Intends to strengthen existing inter-country partnerships on the promotion of child rights, child protection and child well-being. Establishes an inclusive approach to provide quality education, health and social protection to children.
2013	EAC Youth Policy	Establishes strategic priority areas and actions to guide the implementation and address youth challenges. The policy targets youth with disability and the right to enjoy the best attainable state of physical and psychological-mental health.
2012	EAC Policy on Persons with Disabilities	Aspires to inform other policies, programmes and sectoral plans among the EAC countries. It promotes the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and promotes the respect for their inherent dignity.

Table 2.4: International Laws on Rights of Persons with Disabilities

State	National Law	CRPD	CRC	CEDAW
Mainland	1977 Constitution	Somewhat compliant: It provides some fundamental rights to "all people" but no such explicit fundamental rights to persons with disabilities. The only mention of rights to persons with disabilities is under Section 11 as directive principles to state policies which persons with disabilities can't claim enforcement for.	Not compliant: It has no specific provisions on rights of children and young persons with disabilities.	Not compliant: It has no specific provision on rights of girls and young women with disabilities.
	Persons with Disabilities Act, 2010	Compliant: As it provides every person with disability, including children and young people with disability, rights to health care, social support, accessibility, rehabilitation, education and vocational training, communication and employment	Compliant: As it provides every person with disability, including children and young people with disability, rights to health care, social support, accessibility, rehabilitation, education and vocational training, communication and employment.	Not compliant: It has no specific provision on rights of girls and young women with disabilities
	The Law of the Child Act, 2009	Somewhat compliant: As while the Act under Section 5 prohibits discrimination against children, including on grounds of disability, it by adopting a medical-model of disability under Section 2 considers disability as only the child's feature that hinders their equal participation.	Compliant: As it provides rights to education, health services, employment and recreation activities, adoption, custody and guardianship to all children including, children with disabilities.	Not compliant: no specific provision on rights of girls and young women with disabilities.
Zanzibar	1984 Constitution	Somewhat compliant: It provides some fundamental rights to "all people" but no such explicit fundamental rights to persons with disabilities. The only mention of rights to persons with disabilities is under Section 10(7) as directive principles to state policies which persons with disabilities can't claim enforcement for.	Not compliant: It has no specific provisions on rights of children and young persons with disabilities.	Not compliant: It has no specific provision on rights of girls and young women with disabilities.
	Persons with Disability Act, 2006	Compliant: As it provides every person with disability, including children and young people with disability, the rights to health care, social support, accessibility, rehabilitation, education and vocational training, communication and employment.	Compliant: As it provides every person with disability, including children and young people with disability, the rights to health care, social support, accessibility, rehabilitation, education and vocational training, communication and employment.	Not compliant: no specific provision on rights of girls and young women with disabilities.
	The Children's Act, 2011	Somewhat compliant: As while the Act has a specific provision of Section 11 that provides right against discrimination and right to education, healthcare, employment and recreational services to children with disabilities, it by adopting a medical-model of disability under Section 2 considers disability as only the child's feature that hinders their equal participation.	Compliant: As it provides rights to education, health services, employment and recreation activities, adoption, custody and guardianship to all children including, children with disabilities.	Not compliant: no specific provision on rights of girls and young women with disabilities.

3.5.1 The 1977 Constitution of the United Republic of Tanzania (As Amended)

Section 12 of the 1977 Constitution of the URT provides that:

- » All human beings are born free, and are all equal.
- » Every person is entitled to recognition and respect for his dignity.

This provision is significant because it is in the Bill of rights and confers freedom and equality for all human beings. It also recognises every person's entitlement to have their dignity respected. Section 13 similarly provides to all persons equality before the law and equal protection without discrimination. While disability and persons with disabilities are not explicitly mentioned in the Bill of Rights, the terms "all persons," "every person", and "all human beings" can be interpreted to include persons with disabilities. Therefore, Sections 12 and 13, which are enforceable rights in the Court of Law, can be interpreted to include children and young people with disabilities. Section 13(5) further provides the government with the right to take purposeful steps towards rectifying the structural discrimination⁷ on various grounds ailing the URT society.

Disability finds a mention in the constitution's Part II that talks about directive principles of state policy. Section 11 directs the government to make appropriate provisions to enforce a persons' right to social welfare, including at the time of their disability. However, since these directives are only directions for the state when it makes laws and policies, they cannot be enforced by the Courts and persons with disabilities cannot claim this right (Weis, 2017). Consequently, there is a need for the URT to amend its constitution in line with its obligations under the CRPD and include Section 11 under the Bill of Rights under which persons with disabilities, including children and young persons with disabilities, can claim enforceability.

3.5.2 The Persons with Disabilities Act, 2010 (Tanzania Mainland)

The Tanzania Mainland passed the 2010 Persons with Disabilities Act to give legal effect to the 2004 National Policy on Disability (Human Rights Council, 2017). The enactment of the Act is of particular significance in reinforcing the Mainland Government's commitment to align domestic legislation to international standards in relation to children and young people with disabilities. It is also significant because it was passed following the

URT's ratification of the CRPD in 2009. This 2010 Act was introduced as part of measures to domesticate the CRPD and harmonise domestic laws pertaining to the rights of persons and children with disabilities. For example, in line with Article 1 of the CRPD, the 2010 Act defines a person with a disability as an individual with impairments whose functional limitations result from attitudinal environmental and institutional factors. This definition is consistent with the CRPD's recognition of disability as socially constructed.

The 2010 Act seeks to promote and protect children and young people with disabilities rights and welfare. For example, Section 6 is particularly significant as it spells out the URT's obligations in relation to children and young people with disabilities.

The Government shall (a) ensure that all persons with disabilities are equal and are fully entitled without any discrimination to the equal protection and benefits of this Act; (b) prohibit all forms of discrimination based on disability and guarantee the persons with disabilities equal and effective legal protection against discrimination on all grounds; and (c) for purposes of promoting equality and elimination of all forms of discrimination, take all appropriate measures to ensure that reasonable changes are provided to persons with disabilities of all ages and gender.

Following from the above, the 2010 Act also contains several provisions dedicated to the protection and promotion of rights, including rights to health care, social support, accessibility, rehabilitation, education and vocational training, communication and employment. By providing these rights the PWD Act complies with its international obligations under the CRC. However, it fails to fulfil its obligations under the CRPD and CEDAW to address the needs of girls and young women with disabilities by not mentioning any specific provision that provides specific rights to girls and young women with disabilities in light of the intersectional discrimination that they face. Further, an interviewee in a focus group discussion mentioned the insufficiency of the Act to operationalise the substantive rights in it and expressed a need for procedural rules to implement the Act. The National Advisory Council for Persons with Disabilities is established to monitor the implementation of the Act.

3.5.3 The Law of the Child Act, 2009 (Tanzania Mainland)

The URT promulgated the 2009 Law of the Child Act applicable to Tanzania Mainland, to give expression to the CRC and the ACRWC and to ensure the effective realisation of the rights and welfare of children and young

⁷ In this report, the authors have interpreted the term "disabilities" in Section 13(5) as fault lines of discrimination ailing the URT society.

people with disabilities. In line with the CRC and the ACRWC, the 2009 Law of the Child Act complies with the right to forbid discrimination on several explicitly listed grounds, including disability. Section 2 adopts a medical model impairment-based definition of disability while defining children with disabilities. Rather than identifying the contribution of the non-inclusive infrastructure and environment towards the child's disability, the definition puts an exclusive burden on the child's physiology and psychology that hinders their equal participation in the society.

Nevertheless, following the example of the CRC and the ACRWC, the Act under Section 5 prohibits discrimination against children, including based on disability. Section 8, further, puts duty on the parent, guardian or any other person having custody of a child, to treat a child with disability in a dignified manner and its sub-section(6) entitles a child with disability to special care, treatment, affordable facilities for his rehabilitation and equal opportunities to education and training wherever possible to develop his maximum potential and be self-reliant. The Act's Section 13, moreover, prohibits subjection of a child to "torture, or other cruel, inhuman punishment or degrading treatment including any cultural practice which dehumanises or is injurious to the physical and mental well-being of a child." The Act has no specific provision for girls and young women with disabilities.

In light of the above analysis, the Act is somewhat compliant with the CRPD. For it is not sufficient for the Act to have a blanket provision of Section 13 that mentions various grounds of degradation to children and provides protection to them without mentioning disability specifically. This consideration becomes important when the Act defines children with disabilities following a medico-model approach. Hence, it would be prudent to update the act by consulting people and children with disabilities. The Act is compliant with the CRC as it provides rights to education, health services, employment and recreation activities, adoption, custody and guardianship to all children including children with disabilities. However, it is not compliant with CEDAW as it provides no special rights to girls and young women with disabilities in recognition of their double-marginalisation.

3.5.4 The 1984 Constitution of Zanzibar

The 1984 Zanzibar Constitution provides all persons some fundamental human rights. For instance, Section 11 confers to every person the entitlement to equality and dignity and Section 12 provides every person with the right to equality and protection before the law without any discrimination. With respect to rights of persons with disabilities, similar

to the 1977 URT Constitution, the term disability is not explicitly mentioned in the Bill of Rights as a fundamental right that can be claimed by persons with disability in the court of law. The terms "all persons" and "every person" however can be interpreted to include persons with disabilities.

Interestingly, as in the URT's Constitution, the term disability finds a mention under Section 10(7) of Chapter two in which the Zanzibar constitution mentions the directive principles of state policy. The Section directs the state to assist persons with disabilities with work opportunities. However, since the right is a directive principle it cannot be enforced in the court of law (Weis, 2017). Hence there is a need for the Revolutionary Government of Zanzibar to amend its constitution in line with its obligations under the CRPD and include Section 10(7) under the Bill of Rights for which persons with disabilities, including children and young persons with disabilities, can claim enforceability.

3.5.5 Persons with Disabilities (Rights and Privileges) Act, 2006 (Zanzibar)

The enactment of the 2006 Persons with Disabilities (Rights and Privileges) Act further strengthens Zanzibar's commitment to align domestic legislation to international standards in relation to children and young people with disabilities. Fundamentally, the Act allows for the full incorporation of the CRPD into Zanzibar's law. In line with Article 1 of the CRPD, the Act defines disability as a state of restricted participation resulting from the interaction between the impairment and environmental, social and attitudinal barriers. The Act is equally progressive in its definition of disability as it recognises that impairments may be temporary, permanent, imputed and intermittent.

The Act seeks to promote and protect the rights and welfare of children and young people with disabilities. For example, Sections 7, 9 and 11 provide for the rights of persons with disabilities to employment, education and health without any discrimination. Part V of the Act establishes the Zanzibar Disability Fund' to benefit children and young people with disabilities. It further establishes the Zanzibar National Disability Council to monitor the Act's implementation and enforcement. A 2012 study found that the work of the Council has, however, been quite limited as the Department of Disability Affairs takes lead on issues like mainstreaming disability (Yokoyama, 2012). The research further observes how the Council functions with limited budget and performs only quarterly meetings and occasional site visits and that the regulations prepared by the Council are yet to be finalised. Includovate could not locate any reports prepared by the Zanzibar Disability Council.

Thus, the Act fulfils its obligations under the CRPD in spirit. However, an implementation gap remains. It also fulfils its international obligations under the CRC by providing every person with disability, including children and young people with disability, the rights to health care, social support, accessibility, rehabilitation, education and vocational training, communication and employment. However, just like the 2011 Tanzania Mainland's Persons with Disabilities Act, it fails to adopt an intersectional perspective and address the needs of girls and young women with disability by not having any specific provision that provides specific rights to them. It thus fails its obligations under the CEDAW.

3.5.6 The Children's Act, 2011 (Zanzibar)

The Revolutionary Government of Zanzibar, in line with its international and regional obligations enacted the 2011 Children's Act which domesticated the CRC and ACRWC. As Sloth-Nielsen (2015) mentions, the comprehensive drafting of the provisions related to children with disabilities has been widely applauded as progressive particularly in relation to children's legislation in the sub-region. However, Section 2 of the Act, just like Mainland Tanzania's Law of the Child's Act, adopts a traditional handicap-based definition of disability while defining children with disabilities. Rather than identifying the contribution of the non-inclusive infrastructure and environment towards the child's disability, the definition puts an exclusive burden on the child's physiology and psychology that hinders their equal participation in the society.

Nevertheless, following the example of the CRC and the ACRWC, Section 6(1) of the Act explicitly forbids any kind of discrimination against children. While disability is not one of the listed prohibited ground for discrimination under Section 6(2), Section 11(1) explicitly prohibits inhumane and degrading treatment of children with disabilities by anyone. Simultaneously, Section 11(2) confers the child with disabilities the rights to special care and protection and effective access to inclusive education, health services, employment and recreation activities. Further, Section 4 considers a child's disability as a factor when determining the best interest of the child in legal cases.

A key informant (KII-2) working with OPDs in Zanzibar observed the need to analyse the Children's Act in light of the disability movements to see how it addresses children with disabilities. She said:

"We need to work more on the Children's Act. I think we need to analyse every disability movement to see how the Act favours children with disabilities. While we think the law is good, in detail we haven't done any analysis."

(KII 2, 9 April 2021, Zanzibar)

This Situation Analysis finds the Act somewhat compliant with the CRPD. It is compliant with the CRC as it provides rights to education, health services, employment and recreation activities, adoption, custody and guardianship to all children including, children with disabilities. The Act, however, isn't compliant with CEDAW as it provides no special rights to girls and young women with disabilities in light of their double-marginalisation.

3.6 National Policies Relating to Children with Disabilities in the United Republic of Tanzania

The URT has developed several national policies that provide guidance both in Tanzania Mainland and Zanzibar in relation to the implementation of the rights of children and young people with disabilities. Some of these policies are discussed below.

3.6.1 2004 National Policy on Disability

The URT's National Policy on Disability developed in 2004 aimed at "providing a conducive environment for persons with disabilities to engage in productive work for their development and utilisation of available resources for improved service delivery" (Ministry of Labour, Youth Development and Sports, 2004). The 2004 Policy defines disability as the inability to participate in community life equally because of physical, mental and social factors. In its definition of a person with a disability, the Policy restricts this definition to a person who has a reduced chance of obtaining and retaining employment because of physical, mental and social factors. The Policy aims to improve the lives of children and young people with disabilities by taking several targeted actions. The Policy, according to the 2020 Inclusive Futures research, had only limited success as it was not properly translated to a Plan of Action.

3.6.2 The 2014 Zanzibar Social Protection Policy

The 2014 Zanzibar Social Protection Policy was formulated to provide crucial policy guidance and interventions for groups that require protection in Zanzibar. This 2014 Policy emphasises the rights of persons and children with disabilities to be free from discrimination and addresses critical issues that affect children and young people with disabilities. One key issue addressed in this Policy is the school drop-out of children, particularly children with disabilities. The Policy proposes a waiver of monetary "contributions" for poor children (including children and young people with disabilities). In 2015, Zanzibar abolished all school fees for secondary school altogether. It also recommends enhancing the existing cash and in-kind transfers to the most needy households with children and children with disabilities. The Policy calls for the strengthening and expanding inclusive education to cover children with physical and intellectual disabilities, but does not provide a definition for inclusive education.

The Policy also attempts to address violence against children by establishing a Child Protection Referral System that intends to provide public education that challenges

social norms condoning violence against children, including children and young people with disabilities. Since children with disabilities are susceptible to violence, successful implementation of this provision from a disability lens will benefit them. Besides, the Policy addresses barriers of access to essential services by children and young people with disabilities. Specifically, it recommends improving physical access to transport, buildings, etc., an intervention from which children with disabilities can also benefit. In terms of employment, the Policy attempts to address discrimination against young people with disabilities through proactive advocacy efforts to prioritise this group in the labour market.

3.6.3 Other Disability-Related Policies and Strategies

Other policies and strategies that relate to ensuring the promotion and protection of human rights for children and young people with disabilities include: the National Disability Mainstreaming Strategy (2010-2015) and Policy on Disability (2010) applicable to Zanzibar. Table 2.5 below provides a summary of Tanzania's disability-related policies and laws while Table 2.6 summarises Zanzibar's disability-related policies.

Table 2.5: Summary of Mainland Tanzania's Disability-Related Policies

Year	Title	Initiatives related to Children with Disabilities
2017/18 – 2021/22	National Action Plan against Violence to Women and Children	Implementation and enforcement of Laws, ensuring the legal system's responsiveness to the needs of vulnerable groups, such as children in contact or conflict with the law, women and children with disabilities.
2018-2021	National Strategy for Inclusive Education	Attention to vulnerable groups is mainstreamed in all objectives, strategies and actions, targeting children with disabilities.
2016/17 – 2020/21	The Second Five Year Development Plan (FYDP II)	Prioritising quality delivery of education and health services, the country's rapid population growth demands investments in social infrastructure, i.e classrooms, health centres, and facilities.
2015 – 2020	Health Sector Strategic Plan (HSSP IV) (Mainland Tanzania)	Access to fundamental services through the communities, for example health care, education, rehabilitation services and assistance in referral to institution-based rehabilitation, ensuring that human resources, equipment and training materials are in place.
2015-2016	National Strategy for Growth and Reduction of Poverty II	Tailored interventions to address social protection issues: the National Social Protection Framework (NSPF), identifies vulnerable groups, whose rights are unprotected, among them orphans, vulnerable children and people with disabilities.
2010-2015	National Disability Mainstreaming Strategy (NDMS*)	
1995	Tanzania Development Vision 2025	The Vision 2025's aim is transitioning from a least developed country to a middle-income country with a high level of human development. In its target High Quality Livelihood, there is a reference to the empowerment of all social groups (men and women, boys and girls, young and old and the able-bodied and disable persons). All social relations that generate inequality will have been reformed.

* This policy finds a mention in multiple reports and policy documents. However, Includovate does not have access to this policy.

Table 2.6: Summary of Zanzibar's Disability-Related Policies

Year	Title	Initiatives related to Children with disabilities
2019	Zanzibar Inclusive Education Policy	The Policy aims to achieve inclusive education in Zanzibar for everyone, including children with disabilities. In furtherance of this, it provides policy actions on advocacy and awareness-raising, assessing and removing barriers to learning, individual learners support, building accessible infrastructure, etc.
2020/21 - 2024/2025	Zanzibar Multi-sectoral Nutrition Strategic Action Plan (ZMNSAP)	The policy envisages to address the issue of malnutrition in Zanzibar, including the emerging issues of diet-related non-communicable diseases. By improving nutrition in children, the policy aims to avoid disability in them.
2017-2022	Action Plan to End Violence against Women and Children	Centres on the primary prevention and early intervention efforts that anticipate violence before it occurs working with communities to address the roots, risks and protective factors related to violence against women and children. Harmful social and cultural norms and practices are addressed as a key output.
2017/18 - 2021/22	Second Zanzibar Education Development Plan (ZEDP II)	The Plan tackles the main issues related to equity, efficiency and learning outcomes as core values. Schools not accommodative for children with learning challenges are addressed as a problem, setting strategic objectives to establish solutions to the issue.
(2013/14 - 2018/19)	Zanzibar Health Sector Reform Strategic Plan III	The Plan's aim is to ensure that delivery of health service is of high quality, accessible to all and at an affordable cost. The HSSP addresses issues of equity challenges, preventive and curative health care targeting the hard to serve key populations and the vulnerable groups, e.g. orphans and other vulnerable children, women and girls RCH care services.
2014	Zanzibar Social Protection Policy	The policy provides interventions for vulnerable groups that require protection in Zanzibar. The groups include persons with disability, women, preschool children, adolescents, children with disability, older people etc.
2016/17 - 2020/21	The Zanzibar Strategy for Growth and Reduction of Poverty, (ZSGRP III): MKUZA III	The Strategy outlines the government's ambitions towards economic and social development. It aims to achieve the Millennium Development Goals, improve living standards and strengthen good governance. Further the strategy aims to improve children and people with disabilities' economic standing, access to infrastructure and vocational skills. It also attempts to reduce violence against them.
2020	Zanzibar Development Vision 2050	The Vision 2050 lays down aspirations that will serve as a guide for future policies on economic, human, and infrastructural development in Zanzibar. The Vision aspires to provide inclusive education for children with disabilities by providing adequate hard and soft infrastructure in schools.

Table 2.8 below summarises the laws, programmes and policies relating to the right to health for all persons with disabilities including children and young people with disabilities in both Tanzania Mainland and Zanzibar.

Table 2.8: Summary of Health-Related Policies and Plans in URT^a

Year	Health Programmes and Policies	Objectives
2015 – 2020	Health Sector Strategic Plan (HSSP IV) (Mainland Tanzania)	The Essential Nutrition Action Approach (ENA) under the HSS Plan aims to reach at least 80% of caregivers through health services. It also aimed to reduce the percentage of underweight children that will reduce from 16% (TDHS 2010) to 11% in 2020. The plan also attempted to reduce the percentage of children with stunting from 42% to 27% by 2020.

^a This table is not exhaustive and other health-related strategic actions, including ones specific to HIV/AIDS, from these policies or additional laws in Mainland Tanzania and Zanzibar are addressed in Chapter 5.

Year	Health Programmes and Policies	Objectives
2016/17 – 2020/21	National Five Year Development Plan (Mainland Tanzania)	a) Early Childhood Care: The Plan for reducing disability among children and improving their early childhood development promulgated Promotion of Maternal Infant and Young Child Feeding practices (MIYCF) including nutrition related WASH, ECD and Health key family practice in order to prevent stunting and improve early childhood development. Specific steps in this regard include: i) Conduct TOT's on SBCC IYCF, WASH, ECD and Health (at regional level) Deliver Services to Children and Support Early Childhood Programmes to Vulnerable Children. ii) Caregivers and educating parents. iii) Promoting and Enhancing awareness to Community on Early Child Development (ECD). iv) Coordination, Monitoring and Evaluation of ECD. b) The Interventions that lead to proper management of acute malnutrition (IMAM) program aimed to reduce (acute) malnourishment among children by: conducting training of trainers on treating severe acute malnutrition (at regional level), training of Health service providers (like- nurses, clinicians) on treating severe acute malnutrition (at district level), etc. c) For improving vitamin and mineral intake, the Plan aimed to: train healthcare staff on anemia prevention among women, adolescents and children (at regional and district level) and provide Vitamin A supplementation and deworming through Child Health Days and routine. d) The Plan attempted to promote enrichment of nutrient density of the diet of young children (aged from 6- 23 months) by carrying out research on the point. e) To monitor and reduce prevalence of HIV/AIDS among children under 15 years of age, the Plan aimed at testing these children.
2013/14- 2018/19	Zanzibar Health Sector Strategic Plan III	The Nutrition Improvement Programme under the Plan aimed to improve nutrition among the children. Some actions that could benefit children with disability include: a) Vitamin A supplementation and deworming to every child aged six months to five years twice yearly; and b) Reducing anemia through routine iron-folate supplementation for pregnant women, deworming and micronutrients supplementation for young children.

Source: Ministry of Health & Social Welfare, 2015 and Ministry of Finance & Planning, 2016

3.6.4 Education-Related Policies and Strategies

Mainland Tanzania and Zanzibar also have education-specific laws and policies in place that have provisions related to children with disabilities (summarised in Table 2.7). A range of views around policies governing the education sector were heard during FGDs and KIIs from regular distribution of assistive devices to inequity/ shortage of supplies.

The children who participated in FGDs expressed an interest in school and associated enjoyment with school

attendance. Their parents described improvements to the socialisation skills and self-functioning of their child as a result of school attendance. In another FGD (FGD-6) a primary school child with hearing impairment observed that they could not write, read and speak and their teacher helps them and their peers learn to speak. In a participatory activity conducted during focus groups, the same number of children suggested school was their favourite place as those who suggested home. In FGD-10, one child related their happiness at school to their family support and the family's appreciation for the child's good performance at school.

Despite this, children or their parents mentioned that there was a lack of trained teachers and trained substitute teachers that caused distress to the children at times. One of the parents in an FGD observed:

"A new teacher came in the other day, and an exam was administered. My child was not given the exam, because the teacher had not been given an update about his special requirements. He has a mixed disability; both physical and intellectual. Previously, someone would read the exam to him and he would respond because he can't read but, in this case, they did not give him that extra support of reading the exam questions out. All new teachers in school should be informed about the needs of the child, because in this case, the substitute teacher wasn't informed and my child missed an exam. He really really cried that day, and this will probably make him fail."

(FGD-2, 24 March 2021, Zanzibar).

The distance to travel to attend schools reserved for children with disabilities (known as 'special schools') was mentioned as a problem by many parent respondents because it was expensive, far and transport was difficult to arrange for children with disabilities.

The CRPD advocates for inclusive schools, where children with disabilities attend schools where children without disability attend. These are often closer to home than 'special schools' and thus avoid transport costs. Additionally, this model contributes towards inclusion because children without disabilities learn to interact with children who have disabilities every day. Zanzibar's Ministry of Education has the opportunity to incorporate principles of inclusive education in the education policy and Education Act (which is being reviewed at the moment, KII-2, DPO Zanzibar). Moreover, the National Strategy for Inclusive Education is innovative and should be reviewed so that lessons learnt about implementing inclusive education in URT are documented. While the URT has all the inclusive education policies outlined in Table 2.7, implementation of the policies remains a challenge.

Table 2.7: Summary of Inclusive Education Laws and Policies in URT

Year	Policy	Summary/ Objectives
2018-2021	National Strategy for Inclusive Education	The Strategy aimed to make education inclusive on multiple levels. Some of the policies concerning children with disabilities include: a) To generate an equitable access to pre-primary education, the Strategy aimed to invest in pre-primary education as a tool to prevent late enrolment, and no enrolment, reduce underachievement, repetition and drop-out of all children, and particularly the most vulnerable and children with disabilities: b) To generate an equitable access to quality basic education for children of all age groups, including vulnerable ones, the Strategy provided for integration of overage and vulnerable children in mainstream education by non-formal and alternative pathways, and flexible learning opportunities. It also provided for training of teachers on working with children with special needs. c) To prevent drop-out among children and completion of their basic education for all including vulnerable groups, the Strategy provided to improve the school system and learning environment. For this purpose it also intended to mobilise local communities to support education of vulnerable children and also to improve availability of inclusive and accessible teaching and learning materials. d) To enhance equity in learning outcomes for all children, adolescents and youth including vulnerable groups, the Strategy proposed to strengthen early identification, assessment and support to learners with special needs.

Year	Policy	Summary/ Objectives
2017/18-2021/22	Zanzibar Education Development Plan II,	From an inclusive perspective, the Plan intended to advance the right to education for children in Zanzibar. Specific action plans for addressing the needs of children with disability are: a) To address the issue of poor quality of and lack of access to personal protective equipment (PPE): The Plan provides for more fully equipped classrooms (WASH and access for disabled). b) To address the issue of inadequate infrastructure and resources: The Plan provides for adequate WASH facilities, particularly for girls and children with disabilities. It further provides for the essential physical facilities for children with disabilities and having teachers with skills who can support them. c) For inclusive primary and secondary education: The Plan provides to update the construction master plan while prioritising the most disadvantaged. It also provides for school health programmes and school feeding programmes for Standards 1–3 in the poorest areas (since many children with disabilities come from poor areas, this policy might benefit them). d) To address the issue of teachers' quality: The Plan provides for in-service training on student assessment processes so that specific problems and relevant support are provided to children, including to children with specific learning challenges.
2014	Zanzibar Social Protection Policy	In addition to food security, this policy aims to address school dropouts by: 1. Waiving monetary 'contributions' for poor children and most vulnerable children (including children with disabilities) 2. Enhancing the existing cash and in-kind transfers to the most vulnerable households, particularly for those with children and children with disabilities. 3. Strengthening and expanding inclusive education to cover children with special education needs.

3.7 Key Findings from the URT Legislative Framework Review

This chapter provided an overview of the international commitments as well as the national legislative and policy frameworks relating to children and young people with disabilities in the URT. This overview was essential as a way to identify the proactive efforts the URT's Government has taken particularly since the 2013 Situational Analysis report to sufficiently align its domestic laws and policies with international standards that concerns children and young people with disabilities.

Despite these extensive legal and policy frameworks, the protection of children and young people with disabilities remains questionable in the URT (United Nations Population Fund, 2018). The URT's seriousness towards its human rights commitment to children and young people with disabilities has been questioned by the CRC Committee in the concluding observations to the URT issued in 2015. Both the Mainland Tanzania and Zanzibar's constitutions fail to adequately align with the CRPD provisions. Rights for persons including children with

disabilities are mentioned under the Directive Principles of State Policies. These policies do not provide explicit rights to persons with disabilities in the Bill of Rights that are justiciable and enforceable in the court of law. While the 2010 and 2006 Persons with Disabilities Acts in Tanzania Mainland and Zanzibar have adopted a social perspective in defining disability, the 2009 Law of the Child Act (Mainland Tanzania) and 2011 The Children's Act (Zanzibar) continue to define children with disabilities from a medical perspective.

Concerning the gender perspective, the disabilities acts and children's acts of both states fail to adopt an intersectional lens and provide specific rights to girls and women with disabilities, hence failing their international obligations under the CEDAW. The acts, however, comply with the CRC by including rights to health care, social support, accessibility, rehabilitation, education and vocational training, communication, and employment. There is a need to amend these laws to more thoroughly align them with their international obligations. As observed by multiple interviewees, there is also a need to review all disability policies every five years and all Acts every ten

years to enable people with disabilities access their rights. The disability sector has been neglected and changing conceptualisations of disability as well as developments such as ICT improvements necessitate regular legislative and policy updates to ensure continued currency and relevance. Review processes represent an opportunity for collaboration and mutual capacity-building between government and OPD stakeholders.

3.8 Conclusion

The Bill of Rights in both the Mainland and Zanzibar do not mention the rights of persons with disabilities as fundamental rights. Rather the rights are mentioned under directive principles of state policy rendering them non-justiciable and non-enforceable in the court of law. URT has a poor reporting record, particularly with regards to regional human rights obligations dealing with children and young people with disabilities. There is a lack of

specific intersectional legislation relating to the specific concerns for girls and young women with disabilities in national laws. Further, there is a poor alignment of national legislation with regional and international obligations relating to children and young people with disabilities. Finally, the chapter reveals that while the CRPD has been domesticated in the Persons with Disabilities Acts in Mainland Tanzania and Zanzibar, there remains a gap in the domestication of specific rights for children with disabilities under the children's Acts in both states. The domestication is especially weak of CEDAW where none of the national legislations recognises the specific rights to girls and women with disabilities. Interviews with the stakeholders also revealed implementation gaps. There is, thus, a need for the URT government to regularly revisit its disability-related legislations and policies by adopting an intersectional and inter-stakeholder approach while keeping the views of children and persons with disabilities at the centre.





Conceptualisation, Definitions and Measurement of Disability in the United Republic of Tanzania

This chapter explores how disability is conceptualised, defined, and measured in URT. Conceptualisations of disability are expressed through formal definitions enshrined in laws and policies, through the way disability is defined and measured in official data collection efforts, and informally through social norms, attitudes, and behaviours. This chapter explores how different understandings of disability are expressed in legislative frameworks in URT, as well as how different understandings come up in social norms and lived experiences of people with disabilities and their families. The chapter concludes with an overview of how disability is defined and measured in key national data collection and reporting initiatives.

4.1 Conceptualisations of Disability in URT

4.1.1. The Charity Understanding

The charity understanding of disability reinforces the idea that children and young people with disabilities are victims who deserve to be pitied. Lethosa (2018) explains how ‘disability as charity’ views persons with disabilities as passive objects of society’s goodwill, welfare and philanthropic efforts. Under this understanding, children and young people with disabilities are viewed as helpless victims who depend on the support of others.

In 2010, the Mainland passed the Persons with Disabilities Act that specifically defines disability as the inability to participate in community life because of physical, mental and social factors. This 2010 Act further recognises a person with a disability as an

‘individual with impairments whose functional limitations result from attitudinal environmental and institutional factors. Similarly, the 2006 Persons with Disabilities Acts (Rights and Privileges) applicable to Zanzibar recognises disability as a state of restricted participation resulting from the interaction between persons with impairments and environmental, social and attitudinal factors. These definitions incorporate the provisions of the Convention on the Rights of Persons with Disabilities (CRPD) into domestic law in URT. It moves the focus from the charity understanding of disability. However, despite the shift in laws, findings from key informant interviews reveal that the charity understanding of disability is still reflected in practice in both Mainland Tanzania and Zanzibar. Findings from key informant interviews demonstrate that while attitudes are slowly changing, there are still perceptions that persons with disabilities, including children and young people with disabilities, are to be helped. For children and young people with disabilities, this means that access to opportunities that children and young people without disabilities sometimes take for granted are usually portrayed as random acts of kindness bestowed on them and not as dividends of rights (UNICEF 2013c).

“For Zanzibar, that’s the Muslim faith which I think partly influences how people view children with disabilities. So I get a very strong feeling of charity as part of the religion - to help the poor, give them money. These charities don’t empower people as people. And I think that’s the way things are in many countries.”

(KII-3, Zanzibar, 24 March 2021)

A key informant from Zanzibar (KII-1) provided a similar perspective. She noted that in the Muslim faith, persons with disabilities are seen as ones who need to be protected and who cannot contribute anything to the society. Some families see the birth of a child with a disability as a curse and do not allow the child to socialise and go to school. This can also lead to the marginalisation and stigmatisation of the child's mother, sometimes leading to divorce. She observed:

"Here in Zanzibar, we as Muslims have traditional beliefs, that all are included. Disability is seen as somebody who needs to be protected. So they are overprotected, because they think that these people need not to go out, the issue of sympathy doesn't contribute anything to the society they live in, they need only to be supported. They have no contribution to the society or in the family. So sometimes they are isolated. But when you are born with disabilities, some families see this as a curse. And the results, family members, especially women who gave birth to a child with a disability are divorced. Sometimes stigmatisation, that's why some families don't take their children outside, they are hidden. Even they don't talk about them. They don't send their children to school, because they feel shy."

(KII-1, Zanzibar, 25 March 2021)

4.1.2. Medical Understanding of Disability

Like many other African countries, in the URT, one of the common ways to view disability is as a medical condition (Stone Macdonald (2012). For example, it is still common for people to think of disability as a condition to be cured and rehabilitated at all costs using scientific and technological measures in order to be considered normal and part of society. Similar to the charity understanding of disability, the medical understanding views the child and young person with a disability as 'disabled' based on the presence of an impairment or a medical diagnosis (Areheart, 2011). With this understanding children and young people with disabilities are identified as 'disabled' because they have visible impairments or have been medically diagnosed by a medical practitioner. The emphasis of the medical understanding is on the individual impairment, focusing on fixing or curing the impairment.

This medical understanding of disability is sometimes still reinforced in the language used in some of the laws and policies existent in the URT. For example, although the 2010 Persons with Disabilities Act applicable to the Mainland incorporates many aspects of the social and human rights understanding of disability, it defines cognitive disabilities as the inability to meet individual and societal needs because of emotional and mental 'retardation'. The use of the terminology 'retardation' emphasises the medical understanding of disability, indicating delayed or slow development that requires some form of clinical intervention (Ziegler, 2020). In addition, the language 'retardation' is derogatory, stigmatising and offensive, particularly to children and young people with intellectual disabilities. Similarly, the language used in Section 8(6) of Mainland's Law of the Child Act, 2009 at times adopts a cure-focused language and employs a medical understanding of disability that assumes all efforts must be targeted solely at rehabilitative health services so that the disability can be fixed. Moreover, the CRPD's inclusive nature explains that 'special' care treatment may lead to further marginalisation of children and young people with disabilities and yet 'special care treatment' language is prevalent in URT policies and practice, as confirmed by KIIs. One key informant explains:

"...whenever I read things, I say, 'Do you mean, children with disabilities? Just say it? Because otherwise, if we say, children with special needs, what does that mean? Who is that? How do I know how to adjust for that?'"

(KII-3, Zanzibar, 24 March 2021)

Research confirms how the URT's investment in rehabilitation services in contrast to a more holistic approach is proof enough that the medical understanding of disability remains pervasive in URT (Inclusive Futures, 2020).

Nonetheless, there is acknowledgement from the KIIs and FGDs of a gradual shift from the medical focus. For example, FGD participants (FGD 3) explained that the disability desk within the Government of Tanzania began in the health ministry and later shifted to the Prime Minister's Office, signifying the URT takes seriously the importance of disability to the nation's overall development. The change, however, also meant implementation challenges at local level in the country. The key informant observed:

"Disability functions at the central level keep on changing. Because about 6 years ago the disability section was under the Minister of Health, but from 2015 the department was transferred to the Prime Minister's office. Doing so takes time and the organisation's culture changes when you transfer something from one organisation to another organisation. We are happy that at least now we have a duty minister responsible for the disabilities. But, on the programming side, it takes time, especially for a country like Tanzania Mainland where we have like 18 local government authorities, but all these local governments are implementing different development activities. But they are under another ministry. So, I think having the department or disability unit is an opportunity. But when it comes to the programming side, there are challenges because of the shifting, ... and then coming back."

(FGD-3, Mainland Tanzania, 14 April 2021)

4.1.3. Religious/Cultural Understanding of Disability

Kajiru and Nyimb (2020) conducted research with the Mang'ari, Maasai and Wachagga tribes in Tanzania and found that negative attitudes towards children and young people with disabilities are common and endorsed by culture and religion. Based on traditional beliefs, children and young people with disabilities are usually hidden because they are believed to be a source of disgrace and shame (KII-6 and Kamga, 2013). In Tanzania, like elsewhere in Africa, children and young people with disabilities are often compelled to take marginalised positions in their societies (Kamga, 2013:222). This finding was confirmed during most key informant interviews and FGDs:

"In some rural societies, children with disabilities are considered a sin/punishment and parents want to hide them."

(KII-9, Mainland Tanzania, 14 April 2021)

"But generically, a category disability has been considered as a misfortune when a family got a child with a disability, that family feels bad. And the community then sympathies with the family as they have been a child with a disability does a misfortune in the far past, they were telling me it means a curse that in this family in the underclass is a punishment from God that they've gotten a child with the impairment that they've endured and if any other parent has done anything, you have to refer to that, "You know, remember when the grandfather was mistaken. So this must have been a punishment to this clan." a helpless child is a burden. They consider it a burden that the child will never support this family."

(KII-5, Mainland Tanzania, 6 April 2021)

Some key informants (KIIs 5, 8, 9) and teacher participants in an FGD (FGD-5) noted that the understanding of disability differs from region to region based on geography, level of urbanisation and prevailing cultural beliefs. An important example is albinism. Due to prevailing cultural stereotypes, albinism is considered a disability in Tanzania, unlike other cultural contexts where it isn't. In this regard a key informant observed:

"The definition of disability is everywhere different. I'm not from Tanzania and in my culture, a person with albinism is not a disabled person. But here by this definition, it's a disabled person. And I can also see why."

(KII-8, Mainland Tanzania, 21 April 2021)

Kajiru and Nyimb (2020) explain how society contributes to the marginalisation of children and young people with disabilities in URT. According to these authors, misconceptions about children with albinism abound and children and young people with disabilities are isolated from community life and prevented from attending because they are viewed as burdensome. The 2019 Human Rights Watch report explains how ritual killings of children with disabilities usually happen because of

misconceptions and traditional beliefs still prominent in the country (Human Rights Watch, 2019). Some of these harmful misconceptions include the belief that persons, and particularly children, with albinism, are not human beings but ghosts (Kajiru & Nyimb: 2020). These children with albinism are seen to be cursed and traditional practices cut their body parts to prevent bad luck (Kajiru & Nyimb: 2020). These body parts are used for ritual purposes because the body parts of children with albinism are believed to conjure wealth and prosperity (Human Rights Watch, 2019). The 'Under the Same Sun' study conducted in 2016 by Human Rights Watch confirms the increase in the number and scale of attacks on children and young people with albinism in URT (Under the Same Sun, 2016).

Some key informants said the practice had stopped, whereas an FGD with UN agencies (FGD-3) reported that it is still occurring in different locations and can be found in police reports. A detailed assessment of prevalence has not been conducted.

"It seems like the government agencies or the UN don't have proper information and documentation about whether killings [of people with albinism] are happening or not, but then you hear about it in police reports. So there is a huge disconnect, because the same point is coming again and again. That means we don't we are not either investigating the issue properly, or there is a lack of intention to even investigate the issue."

(FGD-3, Mainland Tanzania, 14 April 2021)

Similarly, young women and girls with disabilities are disproportionately subjected to discrimination because of stereotyped views. While writing about African women with disabilities Grobbelaar-du-Plessis (2007) found girls with disabilities across the continent are described as "sick, helpless, childlike, dependent, in need of care, incompetent, asexual and genderless" (Grobbelaar-du-Plessis 2007). The virgin cure is an example of the way these discriminatory beliefs manifest in North West Tanzania. This practice happens when men who have contracted HIV/AIDS falsely believe that their healing depends on having sexual relations with girls with disabilities, especially girls living with albinism (Mutugi. K. J., 2017). The exact prevalence of this practice is unknown because the evidence is scant and not always reported as rape. According to FGD respondents, it does still exist in pockets across the URT.

Concerning urbanisation, a key informant (KI-9) highlighted that due to a lack of awareness on disability issues in rural areas, children with disabilities living in these areas are more prone to exclusion than their counterparts living in urban areas. She observed:

"Children with disabilities are more prone to exclusion and marginalisation than in urban areas. Most of the community who are living in urban areas are educated and they are getting this advertisement awareness creation about how the children with disabilities came and why they have disabilities."

(KI-9, Mainland Tanzania, 14 April 2021)

A teacher from an inclusive school in urban Tanzania in an FGD (FGD-5) noted a similar experience. They observed an increased education on disability issues in their community has meant increased acceptability of children with disability, except for a few areas where negative attitudes relating children with disabilities to "bad luck" and "curse" still prevail. One possible motivation that the teacher observed behind parents' positive attitude towards their child with a disability was the government's prioritisation of people with disabilities in higher employment positions. They observed:

"The big thing that makes the community accept is the government. The Government agreed to give them priority even in high positions. We have seen many people with disabilities have got higher positions in the government structures. So even for those who give birth to disabled children nowadays consider them the same as their other child because of the given priority."

(FGD-5, Mainland Tanzania, 22 April 2021)

Cultural and religious beliefs may not always be a source of harmful discrimination. Stone-MacDonald (2012) conducted a study in Lushoto, a rural town in Western Usambara, Tanzania and found that although some negative perceptions about disability persist, some parents believe that children and young people with disabilities are God's plan and become positively overprotective of them. Key informant interviews conducted for this report confirmed this more positive view of disability, as one respondent explained:

"In other societies in Tanzania Mainland, children with disabilities are considered a blessing/gift from God- and parents want to take care of them as part of the family."

(KI-9, Mainland Tanzania, 14 April 2021)

While the evidence is patchy it does suggest that some parts of URT are in breach of Article 8(5) of the 2009 Law of the Child that applies to Tanzania Mainland - children with disabilities should not be subjected to degrading treatments. It also shows the way traditional beliefs can be a force for positive or negative social change.

4.1.4 Social Understanding of Disability

According to the social understanding, disability occurs due to the interaction between the individual and the environment. The social dimension of disability is recognised, according to Article 1 of the CRPD, when the individual impairment interacts with environmental, social and cultural factors posing barriers to accessibility (Art. 1 of UN CRPD, 2006). This understanding highlights the roles that the environment and society play in further marginalising children and young people with disabilities.

With the same perspective, a key informant from Zanzibar observed that a person's disability is not just limited to their physical or intellectual disability but also comes from culture barriers or traditional perception of the parent or the community. She observed:

"When you talk about the disability/disability movement in Zanzibar, we are talking about the hindrance of the persons in doing their daily activities. And this comes from the culture barriers or traditional perception of the parent or the community."

(KII-2, Zanzibar, 9 April 2021)

Several legislative and policy documents in the URT reflect the social understanding of disability. For example, the 2010 Persons with Disabilities Act that applies to Tanzania Mainland defines a person with a disability as "an individual with impairments whose functional limitations result from attitudinal environmental and institutional factors." Similarly, the 2006 Persons with Disabilities (Rights and Privileges) Act specifically applicable to Zanzibar defines disability as a "state of restricted participation resulting from the interaction between the impairment and environmental, social and attitudinal barriers. This demonstrates that with time the URT is recognising the critical role that environment and society play in marginalising children and young people with disabilities, other disability-related laws need to be amended to reflect this understanding.

4.1.5 Human Rights-Based Understanding of Disability

The human rights understanding of disability underpins the CRPD and identifies discriminatory barriers and seeks areas of redress. By signing and ratifying the CRPD, the URT is obliged as a duty bearer to ensure that persons with disabilities including children and young people with disabilities are treated as right holders. State Parties to the CRPD such as the URT have committed to ensuring that all forms of discriminatory actions against persons and children with disabilities are prohibited (Watson, N & Vehmas, S, 2020). The human rights understanding of disability builds on the social understanding of disability.

The definitions of disability contained in the 2010 Persons with Disabilities Act are consistent with the CRPD provisions. Following this understanding involves taking several key steps including, consulting persons and children with disabilities and ensuring their representation in all matters that concern them, mainstreaming disability issues in all government sectors, ensuring their equal access to government services such as health care and education. While URT is mostly legislatively compliant to the CRPD, the implementation of these laws remains a challenge. Respondents particularly discussed the lack of representation of people with disabilities in government and the media and the lack of child and youth associations focused on children with disabilities. A key informant explains,

"I haven't seen or met or read about many people with disabilities, who are in the media and limelight speaking for and about people with disabilities... in the general media and events that I went to before COVID I rarely heard voices of people with disabilities."

(KII-3, Zanzibar, 24 March 2021)

With respect to government's proactiveness in addressing issues relating to persons with disabilities, a couple of interviewees in an FGD observed that:

"The government officials' response is positive, they accept their challenges and try to prioritise."

(FGD-3, Zanzibar, 14 April 2021).

One of the interviewees recalled how the director of one of the government departments called him to ask about the progress of the work that the interviewee is doing on disability rights. A government key informant from

Mainland observed the positive impact of recognition of children with disabilities' talents by their parents due to awareness raising on disability issues by the government. However, despite positive intentions, implementation remains an issue and there is a need for procedural rules to operationalise the Persons with Disabilities Act, 2010 (FGD-3). On the point of inclusivity in schools, a teacher participant from an inclusive school in urban Tanzania during an FGD (FGD-5) noted that the international practice to create special schools for children with disabilities isn't enough for making them feel included with their counterparts without disabilities. They stressed on treating children with disabilities equally like other children. This idea they said was reflected in their school where they have people with disabilities in different positions like teachers and presenters.

4.2 Measurement of Disability in URT

In addition to understanding how disability is conceptualised in laws and society at large, this Situation Analysis assesses how disability is defined and measured in official statistics in Mainland Tanzania and Zanzibar. URT has made significant progress over the last two decades in consistently collecting data on disability according to international standards. The 2002 Population and Housing Census represented the nation's first attempt to measure national disability prevalence (National Bureau of Statistics, 2008). However, the 2002 PHC used just two questions to assess disability ("is [respondent] disabled?" and "if yes, what type of disability?"). These questions, however, were imprecise (leaving it up to the respondents to define "disabled"), potentially stigmatising (not all people living with a functional impairment will identify with the label "disabled"), and resulted in a reported disability prevalence rate for URT of just 2% (National Bureau of Statistics, 2008).

The Washington Group on Disability Statistics was established in 2001 by the United Nations Statistical

Commission with a mandate to improve collection, analysis, and use of disability-related data (Washington Group, 2020). Following close collaboration with national statistical offices, UN agencies, and international organisations, in 2006, the Washington Group released the Short Set on Functioning (WG-SS). The WG-SS consists of six questions focusing on core areas of functioning: seeing, hearing, walking, communicating, remembering, and self-care. The United Nations Statistical Division now recommends the WG-SS as the preferred method for collecting information on disability on national censuses (Washington Group, 2020).

The Washington Group is clear that the WG-SS measures just one factor related to disability - functional impairment - and that an impairment is not the same as a disability, because as per the social model, disability involves the interaction of a person's functional limitations with their environment and resulting exclusion from or barriers to full participation (Washington Group, 2020). Therefore, the Washington Group recommends that the WG-SS questions be analysed alongside measures of participation in society to assess the relationship between types and degrees of functional impairments with exclusion in a given context (Washington Group, 2020). A further limitation of the WG-SS is that the six questions do not exhaustively cover different forms of impairment and may not capture psychosocial disabilities (Development Initiatives, 2020).

URT adopted the WG-SS questions in the 2008 Tanzania Disability Survey (TDS). The survey defined a person as having a disability if they reported having "some difficulty" in two or more of the WG-SS domains, or having "significant difficulty" or "can't do at all" in at least one of the WG-SS domains. The 2012 PHC was the first census in Tanzania to use the WG-SS questions. The most recent round of Household Budget Surveys (HBSs) - 2017/18 in Mainland Tanzania and 2019/20 in Zanzibar - also integrate the WG-SS. Table 3.1 outlines how disability has been measured and reported on in key national surveys and censuses since 2002.

Table 3.1: Disability Measurement in Key National Surveys and Censuses in URT

Year	Survey	Disability Questions and Reporting
2002	Population and Housing Census	2 questions on disability: "is [respondent] disabled?", if so, "what type of disability?" - reported 2% disability prevalence
2008	Tanzania Disability Survey	- WG-SS questions, no question on albinism - Detailed findings reported in the Tanzania Disability Survey Report

Year	Survey	Disability Questions and Reporting
2008/9	National Panel Survey	- Questions on disability: "Are you physically handicapped?"; "In what way are you handicapped?"; "Does your physical handicap in any way limit or prevent activities or work?"; "How does your disability affect your daily activities compared to 12 months ago?" - NPS Wave 1 Report included disaggregation of school attendance by children with and without disabilities, but based on a very small sub-sample of 48 children with disabilities
2012	Population and Housing Census	- WG-SS questions plus question on albinism 2016 Disability Monograph published detailed analysis of disability-related data from the 2012 PHC
2014	Integrated Labour Force Survey	- WG-SS questions plus question on albinism - Published data on persons with disabilities disaggregated by age, sex, location, marital status, and variables related to education and employment status
2014/15	National Panel Survey 4	- WG-SS questions - Main report did not include analysis or reporting on disability-related findings
2017/18	Household Budget Survey (Mainland Tanzania)	- WG-SS questions plus question on albinism - Main report did not include analysis or reporting on disability-related findings
2019/20	Household Budget Survey (Zanzibar)	- WG-SS questions; no question on albinism - Main report did not include analysis or reporting on disability-related findings

Source: National Bureau of Statistics overview of disability statistics sources (<https://www.nbs.go.tz/index.php/en/census-surveys/health-statistics/disability-statistics>).

4.2.1 Inclusion of Albinism in Definitions of Disability

Even since the adoption of the WG-SS in the 2008 TDS, there has been some variation in how disability is defined and measured in official data collection and reporting initiatives. The 2008 Tanzania Disability Survey Report makes no specific mention of albinism, whereas the 2012 PHC included a specific question in addition to the WG-SS that asked if the respondent was "albino" (National Bureau of Statistics and OCGS, 2016). WG-SS focus on functional activity challenges means that the set does not include questions on any other specific condition or medical diagnosis and respondents are not asked if they identify as "disabled". Many people with albinism may be included among those identified as having a disability by the WG-SS, as visual impairment is a common feature of albinism (Mont, 2019). The WG-SS, however, cannot specifically identify people with albinism or other diagnosed conditions.

Albinism is not considered a disability in all countries as the perception of the condition and its impact on human rights and exclusion vary between societies (United Nations Human Rights Council, 2017). In URT

and elsewhere in East Africa, persons with albinism have been subject to high rates of exclusion, discrimination, and violence. It is considered best practice in the region to include a specific question on albinism when collecting data on disability, rather than relying on functional questions such as the WG-SS question on difficulty seeking to capture this population (United Nations Human Rights Council, 2017).

4.2.2 Measuring Disability Among Children

The WG-SS is not designed to be used with children under age 5, and the Washington Group has acknowledged that the WG-SS also misses many children with developmental disabilities over age 5 (Washington Group, 2021). To address this gap, the Washington Group collaborated with UNICEF and introduced the Child Functioning Module in 2016. The Washington Group/UNICEF Child Functioning Module is an adapted question set specifically designed for identifying children with disabilities. It has two sub-modules, one for children aged 2-4 years, and one for children aged 5-17 years (Washington Group, 2020).

Like the WG-SS, the Child Functioning Module assesses difficulty across functional domains, but the domains are slightly different from the WG-SS; vision, hearing, mobility, communication/comprehension, behaviour and learning (all ages); dexterity and playing (2-4 years); and self-care, remembering, focusing attention, coping with change, relationships and emotions (5-17 years). The purpose of the module is to “identify the subpopulation of children who are at greater risk than other children of the same age of experiencing limited participation in an unaccommodating environment” (Washington Group, 2021, “About the CFM”). The Child Functioning Module is now an integrated component of UNICEF’s Multiple Indicator Cluster Survey (MICS).

The review conducted for this Situation Analysis did not identify any studies or surveys in Mainland Tanzania or Zanzibar that utilised the Child Functioning Module. The last MICS in Tanzania was completed in 1996, well before the introduction of the Child Functioning Module.

4.3 Conclusion

This chapter explains global definitions of disability and then narrows to how disability is understood in Tanzania Mainland and Zanzibar. By referencing the literature and triangulating with evidence collected for this study, the chapter emphasises how children and young people with disabilities are treated in URT. Despite the patchy evidence, this chapter reveals that there are differences in the way disability is understood from one region to another and between formal mechanisms such as legislation and informal social norms.

URT has made substantial progress over the last two decades in integrating more consistent measurement of disability into national data collection and reporting. Since 2008, a number of key national surveys have utilised the WG-SS questions to identify prevalence of different forms of functional limitation, in line with international standards. However, URT has yet to utilise the Washington Group/ UNICEF Child Functioning Module, which would facilitate more detailed and accurate data collection regarding children experiencing functional limitations and at risk of exclusion from full participation in society.



**Self Portraits
by children with disabilities who participated
in focus group discussions**



Disability Prevalence in the United Republic of Tanzania

5.1 Introduction

This chapter discusses disability prevalence rates for children and young people with disabilities in the United Republic of Tanzania (URT). Current, adequate, reliable, relevant, and accurate information on the nature and prevalence of disability in the URT remains a challenge. Identifying accurate population-level prevalence rates and numbers of children and young people with disabilities is difficult and largely depends on how disability is identified, defined, and reported. In the past decade, a number of national population surveys have included questions on disability that can be used for prevalence calculations, including the 2012 Population and Housing Survey (PHS), the 2014/15 National Panel Survey, the 2017/2018 Tanzania Household Budget Survey (HBS) and the 2019/20 Zanzibar HBS. A key objective of this Situation Analysis was to calculate updated disability prevalence rates using the most recent available data.

Using data from the 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS, this chapter paints a picture of the disability prevalence rates in Mainland Tanzania and Zanzibar. The chapter provides background on the HBS surveys and the methods used to calculate prevalence rates, then presents disability prevalence rates for Mainland Tanzania and Zanzibar, disaggregated by age, sex, and type of impairment. Finally, these newly calculated prevalence rates are compared to previous reported prevalence in URT as well as global benchmarks.

5.1.1 Methodology

As discussed in section 1.6.2, Includovate assessed multiple national surveys as potential sources of data to calculate disability prevalence in URT. The two latest HBSs were selected as the most recent national surveys that included the standard Washington Group Short Set on Functioning (WG-SS) questions for assessing disability.

Mainland Tanzania's National Bureau of Statistics (NBS) and Zanzibar's Office of the Chief Government Statistician (OCGS) have each conducted five rounds of household budget surveys since 1991. The HBS data series are a major source of information on poverty and other socio-economic indicators at national and sub-national level in both Mainland Tanzania and Zanzibar (Ministry of Finance and Planning - Poverty Eradication Division (MoFP - PED) and NBS, 2019; OCGS, 2020). Both the 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS covered representative samples of the population residing in private residences in the respective jurisdictions, including coverage of all 26 regions on Mainland Tanzania, and the 11 districts of Zanzibar. Key indicator reports on both surveys have been publicly released, but do not cover findings on disability-related indicators (MoFP-PED and NBS, 2019; OCGS, 2020).

Includovate obtained raw datasets covering individual-level (rather than household-level) data for both the

2017/18 Tanzania HBS and the 2019/20 Zanzibar HBS. The HBS data sets were analysed to generate descriptive statistics covering disability prevalence disaggregated by age, sex, and type of functional limitation. Disaggregated data are critical to understanding the distinct needs and experiences of marginalised groups in society (Global Partnership for Sustainable Development Data, 2018). Data disaggregated by sex, age, disability, and other key variables are an essential foundation for capturing the intersections of different forms of marginalisation and the diversity of experiences within broad population groups.

While there are some variations between the two HBSs, the demographics and disability question sets are largely shared across the two, allowing for consistent analysis, reporting, and comparison. The HBSs both use the WG-SS as the core questions to assess disability. As described in Chapter 3, the WG-SS is a set of six questions that ask respondents about the level of difficulty they experience with vision, hearing, mobility, communication, cognition, and self-care. There are inherent limitations in defining disability prevalence based on WG-SS responses alone, as the WG-SS questions measure one dimension of disability - functional impairments - but cannot alone measure the interaction of those impairments with environmental factors that shape impact on participation or exclusion in specific contexts (Washington Group, 2020). Additionally, as noted in section 3.4, the WG-SS questions focus on types of functional difficulties, rather than diagnoses or specific causes of such difficulties. The questions therefore do not yield data on categories of disabilities such as intellectual and developmental disabilities which may manifest in different functional capabilities and challenges for different individuals.

5.1.1.1 Defining Disability

Washington Group guidance on use of the WG-SS to identify people with disabilities recommends that individuals who report "a lot of difficulty" or "cannot perform" to at least one of the six functioning questions, "should be considered a person with disability for the purpose of data disaggregation, particularly for the SDGs" (Washington Group, 2020:p.4). The interpretation of the implication of respondents reporting "some difficulty" with functioning, on the other hand, varies across countries (Washington Group, 2020). Ideally, the WG-SS questions on impairments are analysed alongside indicators related to participation and environment to explore whether moderate impairments interact with social and environmental barriers to impede full participation in society. The Washington Group notes that in some contexts there is justification for including people responding "some difficulty" to one or more WG-SS questions in disability prevalence rates due to evidence that they also face barriers (Washington Group, 2020).

The 2008 Tanzania Disability Survey Report defined disability prevalence to include respondents who reported "a lot of difficulty" or "cannot perform" to at least one WG-SS question, and those who reported "some difficulty" in two or more WG-SS domains ((National Bureau of Statistics, 2008). The 2016 Disability Monograph analysing 2012 PHC data does not specify how overall disability prevalence was calculated. For consistency and to allow comparison across time, for the purposes of this analysis, disability prevalence was defined and calculated in the same manner as in the 2008 TDS Report. Includovate also analysed the WG-SS datasets using a more inclusive criteria. This included anyone who reported at least "some difficulty" in one or more WG-SS domains. The results of the analysis using this broader inclusion criteria provide a comparison point to the disability prevalence calculations that follow the 2008 TDS approach, and illustrate the significance of how disability is defined in shaping prevalence estimates.

5.1.1.2 Differences Between the 2017/18 Tanzania HBS and the 2019/20 Zanzibar HBS

Despite shared use of the WG-SS, there are three key differences between the questions and implementation of the disability sections of two HBSs. One key difference is that the 2017/18 Tanzania HBS section on disability includes a specific question on whether the respondent has albinism ("Is [Respondent] Albino?"), following the WG-SS questions on impairments. Kenya adopted the same approach in its 2019 Population and Housing Census (Mont, 2019). The 2019/20 Zanzibar HBS does not include a question on albinism. By comparison, the 2012 URT PHC included a question on albinism in addition to the WG-SS and was carried out by the same national authorities in Mainland Tanzania and Zanzibar as the HBSs (National Bureau of Statistics and OCGS, 2014).

The Washington Group does not make any recommendation for an international standard on the inclusion of a question on albinism (or any other specific condition or diagnosis) alongside the WG-SS questions. However, a report by the United Nations Human Rights Council's Independent Expert on the enjoyment of human rights by persons with albinism notes that it is "a best practice in the [East Africa] region" to include a separate census category for albinism, distinct from functional limitation categories such as vision impairments (United Nations Human Rights Council, 2017: p.5). In order to allow comparison between overall disability prevalence rates in Mainland Tanzania and Zanzibar, the general prevalence calculations in this chapter used only the WG-SS questions which were consistent across both HBS surveys. Calculations on prevalence of albinism from the 2017/18 Tanzania HBS are reported separately, and

prevalence data on albinism in Zanzibar is referenced from the earlier 2012 PHC for comparison.

A second difference is that in the 2017/18 Tanzania HBS, the WG-SS questions were only asked for household members aged 5 years and older. This approach is in line with the design and guidance on use of the WG-SS (Washington Group, 2019). However, on the 2019/20 Zanzibar HBS the question module on disability does not specify any age limitation, and responses suggest it was asked of all household members including children younger than 5. For comparability, this chapter reports the overall disability prevalence rates for both Mainland Tanzania and Zanzibar for ages 5 and above. For Zanzibar, the age-disaggregated rates include the results for the under 5 age group which are not available for Mainland Tanzania.

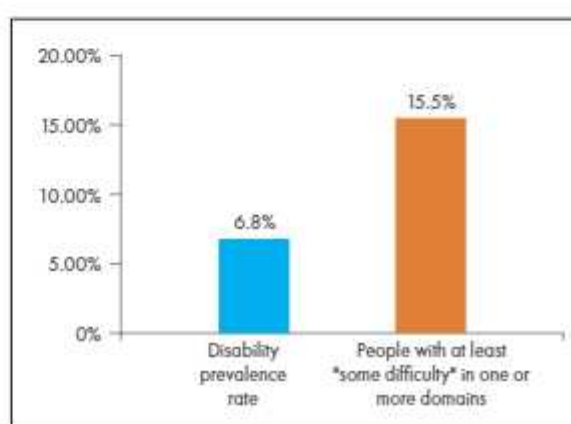
Finally, the 2018/19 Zanzibar HBS includes a “not applicable” response option for the WG-SS questions, while the 2017/18 Tanzania HBS does not. The Tanzania HBS does include a “do not know” response option for the albinism question, but not for the WG-SS questions. For respondents aged 5 and older, the Tanzania HBS had very low rates of missing data on the WG-SS questions (0.1% values missing).¹⁰ This small number of missing values were excluded from the prevalence calculations from the 2017/18 Tanzania HBS. The “not applicable” responses on the 2018/19 Zanzibar HBS are reported in this chapter and generally account for less than 1% of responses, with the exception of the 0-4 years age group which has higher rates of “not applicable” response.

5.2 Disability Prevalence in Tanzania Mainland

Using data from the 2017/18 Tanzania HBS, Figure 4.1 presents the overall prevalence of disability in Tanzania Mainland for respondents aged 5 and older (household members younger than 5 years old were not asked the WG-SS on the survey). The overall disability prevalence rate is 6.8%. This prevalence rate is less than half of the estimated global average disability prevalence of 15% (WHO, 2011). However, it is important to note that most countries that use WG-SS questions tend to report disability prevalence rates between 6-12%, even when using the WG-SS correctly (Mont, 2019). The 15% prevalence estimate in the WHO World Report on Disability was calculated differently, in a way more likely to include people who experience “some difficulty” in a functional domain as having a disability (Mont, 2019). If all respondents who report at least “some difficulty” in one or more WG-SS domains on the 2017/18 Tanzania HBS are included, the disability prevalence rate rises to 15.5%, which is more in line with the global average reported by WHO.

The 6.8% prevalence rate calculated from the 2017/18 Tanzania HBS is also lower than the 7.8% prevalence rate reported in the 2008 TDS Report (National Bureau of Statistics, 2008) and the 9.3% rate reported from the 2012 PHC (National Bureau of Statistics, 2016), both of which also used the WG-SS. These variations between disability prevalence rates derived from different Tanzanian surveys that used WG-SS suggest potential issues with data reliability. URT is not the only country to experience such challenges. Section 4.6 further discusses these prevalence findings in the context of comparable findings from other countries in the region.

Figure 4.1: Overall Prevalence of Disability in Mainland Tanzania for Respondents Aged 5 and Older



Source: The 2017/2018 Tanzania HBS. Note: In the 2017/18 Tanzania HBS, individual-level data are available on each of the difficulties the person faces with regard to seeing, hearing, walking, remembering, self-care, and communicating. Our binary disability variable is calculated based on two different definitions. The first, consistent with that used in the 2008 TDS Report takes the label “Yes” if the person reports “a lot of difficulty” or “cannot perform” to one or more WG-SS domains OR “some difficulty” in two or more WG-SS domains; otherwise the label is “No”. The second calculation assigns the label “Yes” to respondents that report at least “some disability” in one or more WG-SS domains. The calculation does not include responses to the survey question on whether the respondent has albinism.

5.2.1 Disability Prevalence in Mainland Tanzania Disaggregated by Age and Sex

This sub-section presents disability prevalence rates for Tanzania Mainland disaggregated by sex and age. Sex-disaggregated disability data is essential to investigating and addressing the interactions of gender and disability. The overall prevalence of disability among male and female respondents in Tanzania Mainland is around 5.7% and 7.8%, respectively (see Appendix Table 9.1). International studies have similarly reported higher disability prevalence among women than men, though

¹⁰ Out of a total sample of 38,222 individuals aged 5 years or above, 40 individuals have missing values in one or more variables: missing age values for 13 individuals and 27 individuals have missing values for all disability types. Among the individuals with missing values, 3 individuals have missing values for all of their age, sex and disability variables.

global figures estimate a larger gap and higher rates overall (19% prevalence among women compared to 12% prevalence among men (UNESA, 2019)).

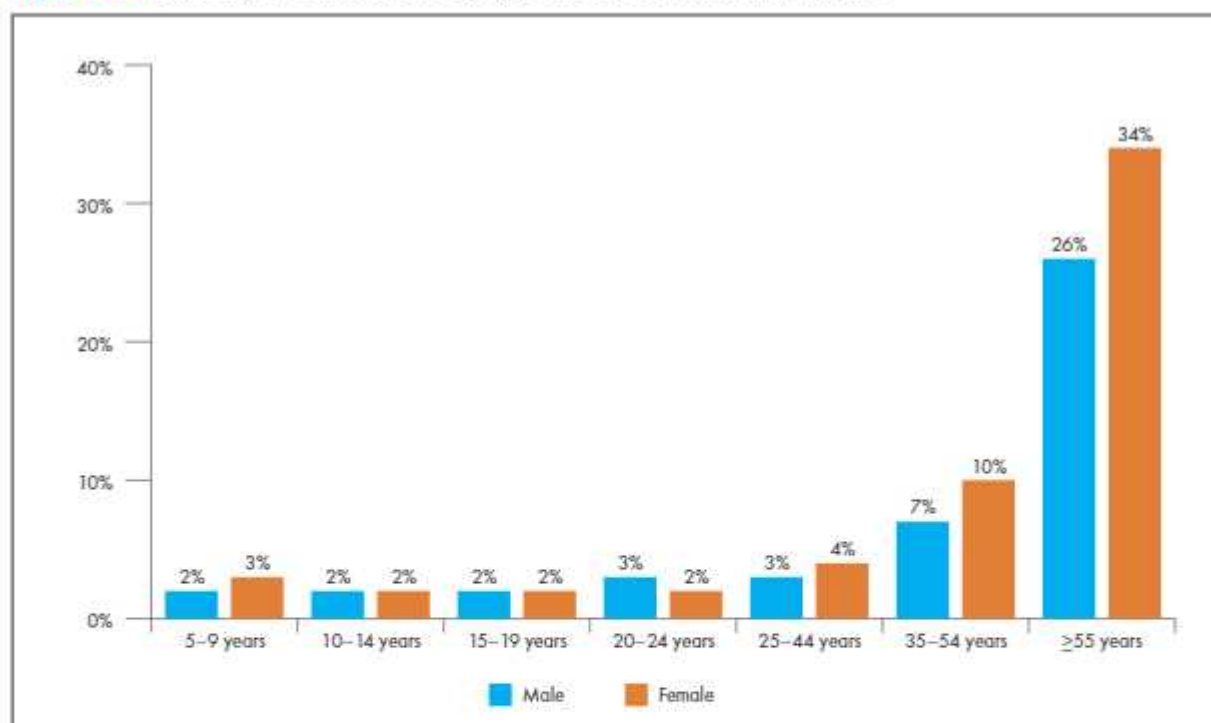
Figure 4.2 presents the prevalence of disability calculated from the 2017/18 Tanzania HBS, disaggregated by sex and age group. Among children and young people aged 5-9, aged 10-14, aged 15-19, and aged 20-24, the disability prevalence rates for both sexes are comparable at around 2% or 3%.¹¹ Prevalence rates of disability increase with age starting in the 25-34 year age group, particularly for women. In the 35-54 year age group, the prevalence rates of disability further rise to 7% for men and 10% for women. These rates increase sharply in the 55+ age group (26% for men and 34% for women). As such, the gap between prevalence rates for men and women emerges in adulthood and increases with age¹². The Washington Group acknowledges that disability prevalence among those aged 5-17 years may be underestimated using the WG-SS due to dynamics of child development and transitions from infancy through adolescence (Tiberti & Costa, 2019:p. 12). If all respondents who report "some difficulty" in any of the WG-SS domains are included, disability prevalence rates rise to 6% for girls and boys in the 5-19 year old age groups.

5.2.2 Disability Prevalence Disaggregated by Disability Type in Mainland Tanzania

The analysis also explored disability prevalence rates by type of impairment, using the six WG-SS questions covering difficulty with seeing, hearing, walking, remembering, communicating and self-care, and the additional question on albinism in the 2017/18 Tanzania HBS. Detailed tables covering each category of disability with prevalence rates disaggregated by age and sex are included in Annex 8.

Table 4.1 summarises the prevalence rates by type of disability for children and young adults aged 5-24 years, and for the general population aged 5 and older for Mainland Tanzania. The table further applies these prevalence rates to 2021 population projections for Mainland Tanzania to estimate the total number of children and the total number of persons living with different types of disabilities. Based on the prevalence rates from the 2017/18 Tanzania HBS and population projections from the 2012 PHC, in 2021 more than 3 million people in Mainland Tanzania are living with a disability, more than half a million (i.e. 611,398) of whom are children and youth aged 5-24 years.

Figure 4.2: Disability Prevalence Rates by Age and Sex for Mainland Tanzania



Source: 2017/2018 Tanzania HBS

¹¹ These age groups were selected to allow alignment with definitions of children, early adolescence (10-14 years), late adolescence (15-19 years), young people (10-24 years), youth (15-24 years) used by UNICEF and other UN agencies (UNDESA, n.d.).

¹² Missing data for children with disabilities below age 5 has implications for early childhood interventions as discussed in section 3.2.2.

Table 4.1: Mainland Tanzania Disability Prevalence Rates and Population Estimates by Type of Disability

Type of disabilities	Children and young people aged 5-24 years		All population aged 5+	
	Prevalence Rate for children and young people	Estimated number of children and young people living with disability (2021)*	Prevalence Rate	Estimated number of persons living with a disability (2021)*
Difficulty seeing	1.5%	405,875	7.5%	3,570,128
Difficulty hearing	1.3%	345,123	2.8%	1,323,896
Difficulty walking	1.2%	317,978	5.9%	2,831,005
Difficulty remembering	1.7%	454,994	4.4%	2,093,137
Difficulty communicating	1.2%	306,345	1.7%	789,318
Difficulty self-care	1.2%	317,978	2.2%	1,046,568
Persons with albinism	0.6%	128,658	0.6%	301,171
Total of estimated persons with disabilities	2.3%	611,398	6.8%	3,255,154

Source: Prevalence rates calculated from the 2017/18 Tanzania HBS, and detailed tables (disaggregated by age and sex) are presented in Annex 8. For prevalence rates of different types of impairments, all respondents who report at least some impairment are included. For the overall estimate of persons with any form of disability, our binary variable for each type of disability a person faces with regard to seeing, hearing, remembering, communicating and self-care takes the label "Yes" if the person responds "some difficulty" OR "a lot of difficulty" OR "cannot perform", otherwise the label is "No". *The estimated number of persons with disabilities were calculated using the 2021 population projections from the NBS & OCGS National Population Projections (2018).

There is a maximum of 0.5% point variation in prevalence rates between different types of functional disabilities among children and young adults (ranging from 1.2% each with difficulty walking, communicating and self-care to 1.7% with difficulty remembering). Variations between prevalence rates are greater among the general population (ranging from 1.7% with difficulty communicating to 7.5% with difficulty seeing). The prevalence of albinism is consistent between children (0.60%) and the general population (0.63%) which is expected as albinism is a congenital condition and cannot be acquired later in life, unlike functional challenges.¹³

As illustrated in the detailed tables in Annex 8, there is very minimal variation between prevalence rates of different types of disabilities for girls and boys aged 5 to 19 years. Sex-based differences in disability prevalence rates become more pronounced in adult age groups. For most types of disability, the prevalence rates for girls and boys in the 5-9 year-old, 10-14 year-old and 15-19

year-old age groups are very close. As shown in Table 4.2 only prevalence rates for difficulties in remembering and communicating in the 10-14 year-old age groups show statistically significant differences between the sexes. In both cases, male children have higher prevalence rates than female children. For the 15-19 year-old age group, recorded prevalence rates are higher for female children than male children across all types of disability. However, the differences in prevalence rates between sexes in this age group are not statistically significant (see Table 4.2). For young adults, Table 4.2 also shows that the prevalence rate of difficulty seeing is higher among female respondents, and this difference is statistically significant. On the contrary, among young adults, male respondents face a statistically significantly higher prevalence of difficulty in self-care than female respondents. The remaining differences in prevalence rates between male and female respondents under each age group are not statistically different from zero.

¹³ Albinism is distinct from vitiligo and other skin disorders that cause hypopigmentation that can develop later in life. It should be noted, though, that the albinism prevalence rates from the 2017/18 Tanzania HBS are based on a question that requires respondents to self-identify (or identify a member of their household) as "albino", rather than on a formal diagnosis. Therefore, it is possible that if vitiligo or another depigmentation condition were perceived by the individual, family, or society to be linked to albinism, respondents with such conditions might respond "yes" to the HBS albinism question.

Table 4.2: Mean Differences in Disability Prevalence across Sex and Age Groups among Children and Young People, Mainland Tanzania

Variables		Mean prevalence rate (%)		Mean Diff. (%)	[95% Conf. Interval]
		Male	Female		
Overall disability	5 - 9 year	2.12	2.55	-0.43	[-1.17, 0.32]
	10 - 14 year	2.08	1.76	0.32	[-0.36, 1]
	15 - 19 year	2.47	2.45	0.02	[-0.87, 0.91]
	20 - 24 year	2.69	2.70	-0.01	[-1.12, 1.11]
Difficulty seeing	5 - 9 year	0.84	0.71	0.12	[-0.31, 0.55]
	10 - 14 year	1.58	1.48	0.10	[-0.51, 0.70]
	15 - 19 year	1.63	1.75	-0.12	[-0.86, 0.62]
	20 - 24 year	2.08	3.26	-1.18**	[-2.3, -0.05]
Difficulty hearing	5 - 9 year	1.09	0.90	0.19	[-0.3, 0.68]
	10 - 14 year	1.26	1.13	0.13	[-0.41, 0.67]
	15 - 19 year	1.84	1.45	0.39	[-0.33, 1.13]
	20 - 24 year	1.68	1.46	0.22	[-0.63, 1.07]
Difficulty walking	5 - 9 year	1.22	0.90	0.32	[-0.18, 0.83]
	10 - 14 year	1.04	0.91	0.13	[-0.36, 0.61]
	15 - 19 year	1.05	1.45	-0.40	[-1.03, 0.24]
	20 - 24 year	1.82	1.80	0.02	[-0.9, 0.93]
Difficulty remembering	5 - 9 year	1.25	1.55	-0.30	[-0.88, 0.28]
	10 - 14 year	1.70	1.10	0.6**	[0.02, 1.18]
	15 - 19 year	1.93	2.50	-0.57	[-1.41, 0.27]
	20 - 24 year	2.49	1.91	0.58	[-0.43, 1.58]
Difficulty communicating	5 - 9 year	0.90	1.24	-0.34	[-0.85, 0.17]
	10 - 14 year	1.29	0.76	0.54**	[0.04, 1.03]
	15 - 19 year	1.21	1.40	-0.19	[-0.84, 0.46]
	20 - 24 year	1.68	1.01	0.67	[-0.12, 1.45]
Difficulty self-care	5 - 9 year	2.32	2.51	-0.20	[-0.96, 0.56]
	10 - 14 year	0.82	0.63	0.19	[-0.23, 0.61]
	15 - 19 year	0.63	0.74	-0.12	[-0.59, 0.36]
	20 - 24 year	0.74	0.22	0.51**	[0.05, 0.98]

** p<0.05

Source: Analysis of 2017/18 Tanzania HBS data.

The prevalence rate of difficulty seeing among children consistently increases across the three age groups: 0.8% for the 5-9 years age group but increases to 1.5% for the 10-14 age group and then to 1.7% for the 15-19 age group. This increase may be due to increased detection of vision impairment among older children, and/or increased vision impairment due to acquired conditions or deterioration of untreated low vision or untreated paediatric cataracts. On the other hand, difficulty with self-care is the one category of disability that shows a marked decrease in prevalence from 2.4% for the 5-9 age group to 0.7% for each of the 10-14 year and 15-19 year age group. This decrease raises the question of whether in the younger age group difficulty with independent self-care is, for some children, a product of their age and developmental stage rather than a persistent functional impairment. The HBS survey scripts are consistent in the way WG-SS questions are phrased, including the question on self-care, however it is also possible that if enumerators deviate from the script or add unscripted prompts or explanations, this could affect responses.

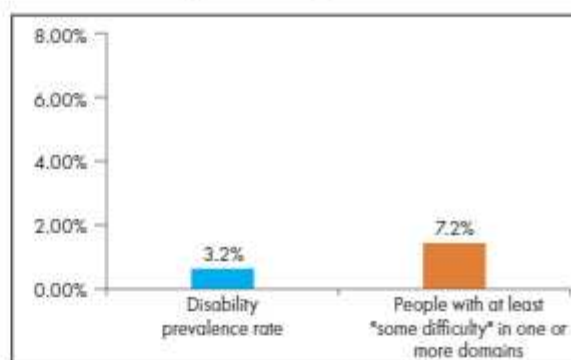
5.3 Prevalence of Disability in Zanzibar

The disability prevalence rates for Zanzibar were calculated using data from the 2019/20 Zanzibar HBS, released in March 2021. Figure 4.3 illustrates that the overall disability prevalence rate for respondents aged 5 and older on the Zanzibar HBS is 3.2% based on the definition of disability consistent with past prevalence calculations in Tanzania. If a more inclusive definition of disability is used, including all respondents who report at least "some difficulty" in one or more WG-SS domains, the overall prevalence rate is 7.2%.

The 3.2% prevalence rate is less than half the 6.8% prevalence rate for Mainland Tanzania using the same definition of disability. While it is possible that this difference could be due in part to variations in administration of the 2017/18 Tanzania HBS and the 2019/20 Zanzibar HBS, previous surveys that were conducted simultaneously in both Mainland and Zanzibar also recorded lower disability prevalence rates in Zanzibar. The 2008 TDS and 2012 PHC both revealed higher disability prevalence in Mainland than Zanzibar, but the reported gaps were narrower (5.9% for Zanzibar versus 7.8% for Mainland in the TDS, and 7.3% for Zanzibar versus 9.3% for Mainland Tanzania in the PHC). Neither the 2008 TDS Report nor the 2016 Disability Monograph posit reasons for the lower disability prevalence rates in Zanzibar compared to Mainland Tanzania.

More exploration is needed to assess the potential reasons behind the different prevalence rates and whether the differences in disability prevalence are associated with other demographic and socio-economic differences between the two jurisdictions. For example PHC data revealed higher rates of disability in rural areas (9.9%) than in urban areas (7.8%) across URT (National Bureau of Statistics, 2016), and Mainland Tanzania has a higher proportion of its population living in rural areas compared to Zanzibar: 70% versus 53% respectively according to the 2012 PHC (National Bureau of Statistics and Office of Chief Government Statistician, 2013). The 2008 TDS Report also noted a variety of differences in household characteristics between Mainland and Zanzibar, including higher rates of food insecurity, involvement in farming, and long distance to household water supply for Mainland households, but does not point to any causal relationship with rates of disability in the two jurisdictions (National Bureau of Statistics, 2008).

Figure 4.3: Overall Prevalence of Disability in Zanzibar for Respondents Aged 5 and Older



Source: The 2019/20 Zanzibar HBS. Note: In the HBS, individual-level data are available on each of the difficulties the person faces with regard to seeing, hearing, walking, remembering, self-care, and communicating. Our binary disability variable is calculated based on two different definitions. The first, consistent with that used in the 2008 TDS Report takes the label "Yes" if the person reports "a lot of difficulty" or "cannot perform" to one or more WG-SS domains OR "some difficulty" in two or more WG-SS domains; otherwise the label is "No". The second calculation assigns the label "Yes" to respondents that report at least "some disability" in one or more WG-SS domains. The calculation does not include responses to the survey question on whether the respondent has albinism.

5.3.1 Disability Prevalence Disaggregated by Age and Sex in Zanzibar

This sub-section presents disability prevalence rates for Zanzibar disaggregated by sex, age and type of disability. The overall prevalence of disability among

male and female respondents in Zanzibar is 3% and 4%, respectively (see Appendix Table 9.10). The higher prevalence among women is consistent with the findings from Mainland, but the prevalence rates for both men and women are lower than those found from the 2017/18 Tanzania HBS.

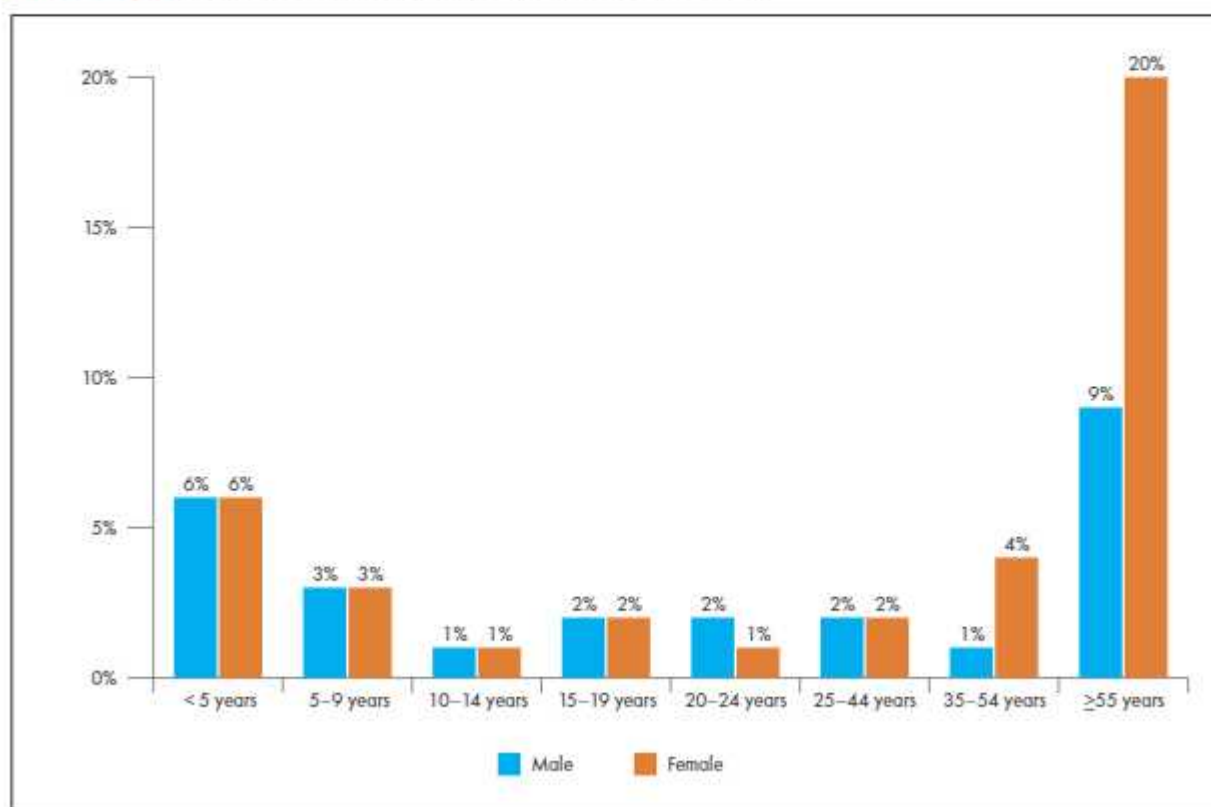
Figure 4.4 presents the prevalence of disability calculated from the 2019/20 Zanzibar HBS, disaggregated by sex and age group. Unlike the 2017/18 Tanzania HBS which did not ask WG-SS questions for household members under 5, the 2019/20 Zanzibar HBS does provide data on these questions for the under 5 age group, although “Not applicable” response rates for this age group were high (around 50%). Among the youngest age groups, there is no significant difference in prevalence rates by sex. Both boys and girls under age 5 have disability prevalence rates of 5.6% and both sexes in the 5-9 year age group have prevalence rates of around 3%. Boys and girls aged 10-14 have prevalence rates of around 1%, and those aged 15-19 have prevalence rates of around 2%. If all respondents in these age groups who report “some difficulty” to any WG-SS domain are included, disability prevalence rates rise to 5% for both girls and boys aged 5-9 years and 3% for girls and boys aged 10-19 years. Male and female young adults (aged 20-24) have prevalence rates of around 2% and 1% respectively, and adults between 25-34 years have prevalence rates of around 2% for both men and women. Zanzibar’s overall prevalence rates for the 5-24 year age groups are in a similar range to the Mainland rates.

The decrease in prevalence from the 0-4 age group to the 5-9 years age group, and again to the 10-14 years age group is in contrast to the findings for Mainland Tanzania which indicated consistent prevalence rates across the age groups under age 19. Further exploration is required to assess whether the drop in prevalence rates across the 0-4, 5-9 and 10-14 age groups is a function of factors related to the survey administration or question interpretation by respondents, or reflective of prevalence, detection, or treatment dynamics in the community that differ from Mainland.

It is possible that the higher rates in the under-5 age group reflect the developmental immaturity of children in this age bracket because the higher rate is largely driven by positive responses to questions on difficulty communicating, remembering, self-care and walking (see Annex 8 for detailed tables of results by age, sex and type of disability). As noted in Chapter 3, the WG-SS questions are not intended to be used with children under age 5 and were not asked of the under-5 age group on the 2017/18 Tanzania HBS. Because the WG-SS questions are not typically used for the under-5 age group, there is little international data to compare directly to the findings from Zanzibar for this age group. The Washington Group-UNICEF Child Functioning Module which is integrated into MICS uses a separate questionnaire for children aged 2-4 years, which does not include questions on remembering or self-care. Additionally, the questions on other functional domains are phrased differently from the WG-SS. Rather than asking generally about difficulty walking, parents/caregivers are asked to consider whether the child has difficulty walking “compared to children of the same age.” The communication questions for children ages 2-4 focus on whether the child understands and is understood by the parent/caregiver, which is more nuanced than the WG-SS question about difficulty communicating (UNICEF, 2016).

As in Mainland, prevalence rates of disability in Zanzibar rise sharply, particularly for women, in the 35-54 age group and 55+ age group. However, the young adulthood age group shows lower prevalence rates in Zanzibar (2% and 1% for male and female respondents respectively) than in Mainland (3% for each male and female respondents). Similarly, the prevalence rate of disability in the 25-34 year age group is one percentage point higher for male respondents and two percentage points higher for female respondents in Mainland than in Zanzibar. As in the findings for Mainland, the gap between prevalence rates particularly for women also increases with age during adulthood and old age in Zanzibar.

Figure 4.4: Disability Prevalence Rates by Age and Sex for Zanzibar



Source: 2019/20 Zanzibar HBS. Definition of disability includes respondents who report "a lot of difficulty" or "cannot perform" to one or more WG-SS domains OR "some difficulty" in two or more WG-SS domains.

5.3.2 Disability Prevalence Disaggregated by Disability Type in Zanzibar

The analysis also explored disability prevalence rates in Zanzibar by type of disability, using the six WG-SS questions covering difficulty with seeing, hearing, walking, remembering, communication and self-care. As noted previously, the Zanzibar HBS did not include a specific question on albinism. Detailed tables covering each category of disability with prevalence rates disaggregated by age and sex are included in Annex 8.¹⁴

Table 4.3 summarises the prevalence rates by type of disability for children aged 5-19 years, and for the general population aged 5 and older for Zanzibar. To be consistent with the age grouping used in analysing the 2017/18 Tanzania HBS, the age group 0-4 years was excluded from this table for Zanzibar. Given the high rates of "not applicable" responses for the under-5

age group on the Zanzibar HBS, the results for the youngest age group are also less reliable.

The table further applies these prevalence rates to 2021 population projections for Mainland Tanzania to estimate the total number of children and young adults and the total number of persons living with different types of disabilities. Based on the prevalence rates from the 2019/20 Zanzibar HBS and population projections from the 2012 PHC, in 2021 an estimated 46,296 people in Zanzibar are living with a disability, 14,290 of whom are children and young adults.

The prevalence of different types of disabilities among children and young adults in Zanzibar ranges from 0.6% with difficulty walking to 1.6% reporting difficulty with self-care. Variations between prevalence rates are greater among the general population (ranging from 0.9% with difficulty communicating to 2.7% with difficulty walking), although the variations are smaller than those observed between prevalence of different types of disabilities in Mainland Tanzania.

¹⁴ A) There are no missing values for age, sex and disability variables in the 2019/20 Zanzibar HBS.

Table 4.3: Zanzibar Disability Prevalence Rates and Population Estimates by Type of Disability

Type of disabilities	Children and young people aged 5-24 years		All population aged 5+	
	Prevalence rate for children and young people	Estimated number of children and young people living with disability (2021)*	Prevalence Rate	Estimated number of persons living with a disability (2021)*
Difficulty seeing	0.7%	5,602	2.4%	35,383
Difficulty hearing	0.8%	6,516	1.3%	18,495
Difficulty walking	0.6%	4,573	2.7%	38,369
Difficulty in remembering	1%	7,659	2%	29,064
Difficulty communicating	1%	8,002	0.9%	13,556
Difficulty self-care	1.6%	12,232	1.7%	23,895
Persons with albinism	no data	-	no data	-
Total of estimated persons with disabilities	1.8%	14,290	3.2%	46,296

Source: Prevalence rates calculated from the 2019/20 Zanzibar HBS, and detailed tables are presented in Annex 8. For prevalence rates of different types of impairments, all respondents who report at least some impairment are included. For the overall estimate of persons with any form of disability, our binary variable for each disability type a person faces with regard to seeing, hearing, remembering, communicating and self-care takes the label "Yes" if the person responds "some difficulty" OR "a lot of difficulty" OR "cannot perform", otherwise the label is "No". *The estimated number of persons with disabilities were calculated using the 2021 population projections from the NBS & OCGS National Population Projections (2018).

As shown in Table 4.4, for Zanzibar, the mean differences in prevalence rates between male and female for each age group are not statistically significant for any of the disability types at the 5% significance level. This means

that there is not strong evidence that any difference observed between male and female prevalence rates are not due to chance.

Table 4.4: Mean Differences in Disability Prevalence across Gender Among Children and Young People, Zanzibar

variables		Mean prevalence rate (%)		Mean Diff.	[95% Conf. Interval]
		Male	Female		
Overall disability	5 - 9 year	2.86	2.68	0.18	[-1.22, 1.57]
	10 - 14 year	1.17	1.08	0.10	[-0.86, 1.06]
	15 - 19 year	1.68	1.56	0.12	[-1.12, 1.36]
	20 - 24 year	1.88	1.24	0.64	[-0.75, 2.02]
Difficulty seeing	5 - 9 year	0.48	0.46	0.02	[-0.57, 0.59]
	10 - 14 year	0.43	0.97	-0.54	[-1.3, 0.21]
	15 - 19 year	0.84	1.04	-0.20	[-1.14, 0.75]
	20 - 24 year	0.68	1.09	-0.40	[-1.46, 0.65]
Difficulty hearing	5 - 9 year	0.76	0.92	-0.16	[-0.94, 0.62]
	10 - 14 year	0.21	0.75	-0.54	[-1.17, 0.09]
	15 - 19 year	0.72	1.43	-0.71	[-1.71, 0.3]
	20 - 24 year	1.20	0.93	0.26	[-0.88, 1.41]

variables		Mean prevalence rate (%)		Mean Diff.	[95% Conf. Interval]
Difficulty walking	5 - 9 year	0.57	0.65	-0.08	[-0.74, 0.59]
	10 - 14 year	0.32	0.00	0.32	[-0.04, 0.68]
	15 - 19 year	0.60	1.04	-0.44	[-1.32, 0.44]
	20 - 24 year	1.03	0.78	0.25	[-0.81, 1.31]
Difficulty remembering	5 - 9 year	0.86	1.20	-0.34	[-1.20, 0.51]
	10 - 14 year	1.17	0.43	0.74	[-0.07, 1.55]
	15 - 19 year	1.20	1.17	0.03	[-1.03, 1.09]
	20 - 24 year	0.68	1.09	-0.40	[-1.46, 0.65]
Difficulty communicating	5 - 9 year	1.14	1.20	-0.06	[-0.97, 0.86]
	10 - 14 year	1.07	0.65	0.42	[-0.41, 1.26]
	15 - 19 year	1.20	1.30	-0.10	[-1.19, 0.99]
	20 - 24 year	0.68	0.78	-0.09	[-1.05, 0.86]
Difficulty self-care	5 - 9 year	3.71	2.87	0.85	[-0.66, 2.36]
	10 - 14 year	1.49	0.43	1.06	[-0.18, 1.95]
	15 - 19 year	0.96	0.52	0.44	[-0.41, 1.29]
	20 - 24 year	0.51	0.62	-0.11	[-0.95, 0.74]

Source: Analysis of 2019/20 Zanzibar HBS data.

5.4 Rural and Urban Disability Prevalence Rates for URT

The 2018 NBS states that the URT population is primarily rural (31.3%) compared to urban (15.8%) (NBS, 2018). The distribution of the poor Tanzanians living below the basic needs line within Mainland Tanzania suggests significant discrepancies between the urban (16.1%) and rural (81%) population in the HBS 2017/18 (National Bureau of Statistics & Ministry of Finance and Planning, 2019). Analysis of data from the HBSs in this study focussed on disaggregation by age, sex and type of impairment in line with the scope and time and budget constraints for this Situation Analysis. The 2016 Disability Monograph, however, also disaggregates disability prevalence by rural and urban locations across URT. The Disability Monograph reported a higher prevalence of persons with disabilities in rural areas at 9.9% compared to 7.8% in urban areas (National Bureau of Statistics, 2016). Despite the higher rates of disability in rural areas, the majority of services are concentrated in urban areas, creating barriers to people with disabilities in rural areas fully realising their rights (National Bureau of Statistics, 2016:p.43).

5.5 Change in Prevalence since 2013

The WG-SS has now been used in several key national surveys to measure disability in URT over the past 13 years. The consistent use of the same question set allows comparison of disability prevalence findings from different surveys over time. The 2008 Tanzania Disability Survey (TDS), the 2012 Population and Housing Census, and the 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS all use the WG-SS. Due to differences in age groupings and survey methodology, these are not perfect comparisons, but all three surveys were major national surveys led by the National Bureau of Statistics for Tanzania and the OCGS for Zanzibar, used the same WG-SS questions and were designed to yield generalisable findings for the URT population. Here, prevalence based on the HBSs is calculated based on the same definition used in the 2008 TDS Report as the 2016 Disability Monograph does not specify its method: respondents who report "a lot of difficulty" or "cannot perform" to one or more WG-SS domains OR "some difficulty" in two or more WG-SS domains are coded as having a disability.

As of the 2013 Situation Analysis, the most recent data available on prevalence were from the 2008 Tanzania Disability Survey. While the 2012 PHC had completed data collection, the results were not released in time for inclusion in the 2013 Situation Analysis.

Table 4.5 and Figure 4.5 compare the disability prevalence rates overall (aged 7+ for the TDS and PHC, aged 5+ for the HBSs), and among children (aged 7-16 for the PHC and aged 5-19 for the HBSs). Table 4.3 shows that the overall disability prevalence rate for Mainland Tanzania increased from 7.8% in 2008 to 9.3% in 2012 and then decreased to 6.8% in 2017/18. The overall disability prevalence rates reported for Zanzibar also follow a similar trend: 5.9% in 2008, 7.3% in 2012 and 3.2% in 2019/20. Further research is required to explore whether the declining prevalence rates for Mainland Tanzania and Zanzibar in 2018-2020, and lower prevalence rates for Zanzibar for all periods, reflect

different population dynamics or differences in data collection and analysis.

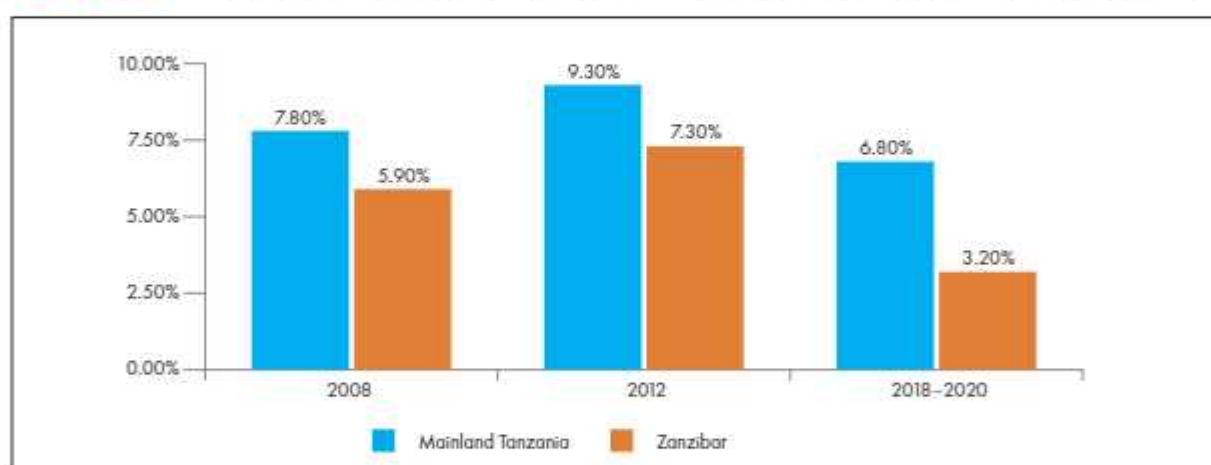
The 2008 Tanzania Disability Survey Report (National Bureau of Statistics, 2008) reported on prevalence of specific types of impairments from the WG-SS among children aged 0-14, but did not report on overall prevalence of any type of disability among this age group. Table 4.5, therefore, only includes prevalence rates among children from the 2012 PHC and the 2017/18 Tanzania and 2019/20 Zanzibar HBSs. Following a similar trend as the overall disability prevalence rate for Mainland Tanzania, the disability prevalence rate among children fell from 8.3% to 2.2%. For Zanzibar, the disability prevalence among children fell from 6.8% in 2012 to 1.9% in 2019/20. Further investigation would be required to determine the extent to which these differences in disability prevalence among children might be influenced by methodological differences in survey administration and analysis between the PHC and the HBS.

Table 4.5: Disability Prevalence Rates for Mainland Tanzania and Zanzibar, 2008-2020

	Source	Age parameters	Prevalence (overall)		Prevalence (children)	
			Mainland	Zanzibar	Mainland	Zanzibar
2008	Tanzania Disability Survey	7+	7.80%	5.90%		
2012	PHC	7+	9.30%	7.30%	8.30%	6.80%
2018-2020	2017/18 Tanzania HBS, 2019/20 Zanzibar HBS	5+	6.8%	3.2%	2.2%	1.9%

Source notes: Tanzania Disability Survey Results as reported in the Tanzania Disability Survey Report (National Bureau of Statistics, 2008: page 5) refers to disability prevalence for those aged 7 and above, and does not report overall disability prevalence among children specifically (it does report prevalence rates of specific types of impairment for 0-14 year-olds but not a total prevalence rate of children living with any type of disability). The 2016 Disability Monograph (National Bureau of Statistics and OCGS, 2016: p. 10-11) reports disability prevalence rates for those aged 7 and above, as well as prevalence rates by age group, allowing calculation of prevalence rates for children age 7-16). The analysis of the 2017/18 Tanzania and 2019/20 Zanzibar HBS data refers to prevalence among children aged 5-19 and the overall population aged 5 and above.

Figure 4.5: Overall Disability Prevalence Rates in Mainland Tanzania and Zanzibar, 2008, 2012, 2018-20



Source: 2008 Tanzania Disability Survey, 2012 PHC, 2017/18 Tanzania HBS, 2019/20 Zanzibar HBS. See Source Notes for Table 4.4 for details. Definition of disability for the 2008 TDS and the 2017/18 and 2019/20 HBSs includes respondents who report reports "a lot of difficulty" or "cannot perform" to one or more WG-SS domains OR "some difficulty" in two or more more WG-SS domains. Definition of disability used to analyse the 2012 PHC data was not stated in the 2016 Disability Monograph.

5.6 Prevalence Rates for Tanzania and Zanzibar in International Context

5.6.1 Inconsistency Across Surveys

The disability prevalence rates calculated from the 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS are lower than those reported from previous URT surveys that used the same WG-SS questions and definitions of disability. The reasons behind these variations are not readily apparent. Even minor changes in the phrasing of questions about disability and the definition of a person with disability between censuses and different surveys within and across countries can impact consistency and reliability of disability data and prevalence rate calculations. URT is not the only country to experience such inconsistencies in findings on disability prevalence between surveys.

If we take the case of Uganda, for instance, The 2012 national census and 2016 Demographic and Health Survey both used the WG-SS questions but found disability prevalence rates of 12.4% and 6.5% respectively (Development Initiatives, 2020: p.19). The 6.5% prevalence rate derived from the Demographic and Health Survey is similar to the prevalence rates from the 2017/18 Tanzania HBS (6.8%). The 2019 Kenya Population and Housing Census also used the WG-SS questions, but found an even lower disability prevalence rate of just 2.2% (Owino, 2020), which is not far off the 3.2% prevalence rate calculated from the 2019/20 Zanzibar HBS.

The Uganda census used only four of the six WG-SS questions whereas the Demographic and Health Survey used all six of the WG-SS questions and the guidance on use of the WG-SS to identify people with disabilities (i.e., people with a lot of difficulty or unable to perform any of the six functioning questions) (Omona et al, 2017). Our analysis of the Tanzania and Zanzibar HBS data also used all six WG-SS questions, but in addition to including people with a lot of difficulty or unable to perform any of the six questions, our analysis also included people with some difficulty in two or more domains to be consistent with the approach used on past URT surveys and reports. These nuanced differences highlight the challenges of establishing truly comparable findings within and between nations.

5.6.2 Prevalence of Different Types of Impairment Among Children

Sections 4.2.2 and 4.3.2 outline the findings from the 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS

respectively on disability prevalence disaggregated by type of impairment. In Mainland Tanzania, prevalence of experiencing at least "some difficulty" in individual WG-SS domains ranges from 1.2%-1.7% of children and young people, while for Zanzibar the range is 0.6% to 1.6%.

As a point of comparison, Table 4.6 outlines prevalence rates for different types of impairments among children aged 5-17 in four sub-Saharan African countries that have recently completed a MICS using the Washington Group-UNICEF Child Functioning Module. The CFM covers the six domains of the WG-SS, but also includes additional functional domains that are not on the WG-SS such as concentrating, anxiety, depression, controlling behaviour, making friends. Table 4.6 provides the disaggregated prevalence rates for difficulty in the six functional domains that are shared by the WG-SS and the CFM.

The prevalence rates for different types of impairment among children found in the 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS are higher than some countries in Table 4.6 and lower than others, but generally in the same range of 0.2-2%. The final column of Table 4.6, provides the percentage of children reporting difficulty in any domain of the CFM. These rates cannot be directly compared with the overall disability prevalence rates calculated based on the WG-SS questions on the HBSs because the CFM includes additional domains and the percentages include children that experience any difficulty in any of the CFM domains.

As in Mainland Tanzania, difficulty with walking was the least common form of impairment among children and youth in Zanzibar. In Mainland, the most common form of disability among children and youth was difficulty remembering, while in Zanzibar it was difficulty with self-care. Among all people aged 5 years or older, the most common forms of disability were difficulty with seeing in Mainland Tanzania and difficulty with walking in Zanzibar, while difficulty with communication was the least common form of disability in both jurisdictions. The MICS findings in Table 4.6 show that there is not consistency between countries in terms of which forms of impairment are most common among children. In Sierra Leone, difficulty walking is the most common form of impairment from the six WG-SS comparable domains, whereas in Zimbabwe, difficulty walking is the least common form of impairment. Difficulty remembering is among the two most common forms of impairment across all four of the countries in Table 4.6, which is consistent with the HBS findings from both Mainland Tanzania and Zanzibar.

Table 4.6: Prevalence Rates of Different Types of Impairments among Children Aged 5-17 Based on MICS Data from Four Countries

Country	MICS Year	Percentage of children (age 5-17 reporting difficulty in CFM domains corresponding to WG-SS domains						Percentage of children (age 5-17) reporting difficulty in any CFM domain
		seeing	hearing	walk- ing	communi- cation	remem- bering	self- care	
Sierra Leone	2017	0.2	0.2	3.2	0.5	1.5	1.0	23.1
Ghana	2017-18	0.5	0.3	1.0	0.7	4.1	1.1	20.7
Lesotho	2018	1.5	0.8	0.3	0.5	1.2	0.3	8.0
Zimbabwe	2019	0.7	0.5	0.3	0.5	1.8	0.5	10.1

Sources: 2017 Sierra Leone MICS Survey Findings Report (Statistics Sierra Leone, 2018); 2017/18 Ghana MICS Survey Findings Report (Ghana Statistical Service, 2018); 2018 Lesotho MICS Survey Findings Report (Bureau of Statistics, 2019); 2019 Zimbabwe MICS Survey Findings Report (ZIMSTAT and UNICEF, 2019).

5.7 Key Findings

This chapter presented data on the prevalence of disability in Mainland Tanzania and Zanzibar, with an emphasis on new analysis of the 2017/18 Tanzania HBS and the 2019/20 Zanzibar HBS. Key findings include:

- » **Methodological inconsistency:** Despite shared use of the Washington Group Short Set questions to identify and measure disability, there were slight variations in how the 2017/18 Tanzania HBS and the 2019/20 Zanzibar HBS approached the disability question sets. The Tanzania HBS added a dedicated question to identify people with albinism while the Zanzibar HBS did not. The Tanzania HBS excluded household members under age 5 from the WG-SS questions, while the Zanzibar HBS asked the WG-SS questions of respondents of all ages but included an extra "not applicable" response option which was used heavily (up to 50% of responses) for the under-5 age group.
- » **Overall prevalence rates:** Based on the 2017/18 Tanzania HBS, the overall disability prevalence rate for Mainland Tanzania is 6.8% for those aged 5+ and 2.3% for children and young adults aged 5-24. The 2019/20 Zanzibar HBS found that 3.2% of the population aged 5+ and 1.8% of children and young adults aged 5-24 are living with a disability. These prevalence rates reflect a definition of disability consistent with that used on past national surveys in URT. This means that across URT, 3.3 million people are living with a disability, including over half a million children.
- » **Definition of disability:** The prevalence rates reported in this chapter include respondents who

reported significant difficulty in at least one functional area, or moderate difficulty in at least two functional areas. This definition is consistent with international guidance from the Washington Group, and previous prevalence calculations in URT. However, Washington Group guidance for interpreting WG-SS data leaves room for countries to determine how to interpret responses of "some difficulty" given that even moderate functional impairments could interact with environmental factors resulting in barriers to participation in some contexts (Washington Group, 2020). Compared to the 6.8% disability prevalence rate on Mainland based on the internationally-aligned definition, 15.5% of respondents aged 5 and older live with at least "some difficulty" in one or more of the WG-SS domains. For Zanzibar, 7.1% of respondents live with at least "some difficulty" in one or more areas, compared to the 3.2% who meet the definition of having "a lot of difficulty" or being "unable to perform" one function or having "some difficulty" with two or more functions. Further exploration of the associations between moderate functional difficulties and indicators of participation and barriers could inform a more nuanced interpretation of the ways in which different degrees and types of impairment interact with societal and environmental barriers to shape experiences of inclusion and exclusion in URT.

- » **Data reliability:** Data from censuses and surveys (within and across countries) should be used with caution because of differences in the phrasing of questions about disability and the definition of a person with disability. As such, prevalence rates from various data sources and reports may not be comparable. Both Uganda and Kenya have also adopted WG-SS questions to assess disability on key

national surveys, but have found varying disability prevalence rates even between surveys using these consistent questions. Moving forward, having identical questions about disability in censuses and nationally representative surveys, and utilising transparent, consistent definitions of disability in analysing data from these surveys will improve spatial (i.e. cross-country) and temporal (i.e., over time within a country) comparisons of disability prevalence rate. Use of the CFM would also provide an additional source of internationally comparable data which could help triangulate findings from other national URT surveys and censuses.

- » **Sex differences:** In both Mainland Tanzania and Zanzibar, women have higher prevalence rates of disability than men. In Mainland, 7.8% of women live with a disability compared to 5.7% of men. In Zanzibar, 4% of women live with a disability compared to 3% of men. The finding that disability prevalence is higher among women than men is in line with global estimates, although both Mainland Tanzania and Zanzibar report a narrower difference than has been estimated by some international reports (UNESA, 2019). Prevalence rates among children, however, do not show significant differences between boys and girls in either Mainland or Zanzibar.
- » **Age trends:** In both Mainland Tanzania and Zanzibar, disability prevalence increases in adulthood and rises steeply among older adults. While Mainland data shows the increase starting among the 20-24 age group, the Zanzibar prevalence rates stay consistently low until the 35-54 year age group, particularly women face an increase in prevalence rates. Most specific types of impairments show similar trends of increasing prevalence with age. Prevalence of albinism stays consistent among children and adults in Mainland Tanzania; as a genetic condition it is not acquired with age. The other exception is difficulty with remembering and self-care, which have relatively higher rates of prevalence reported among the youngest age categories in Mainland Tanzania and Zanzibar respectively, potentially reflecting the normal developmental skills development of very young children, rather than lasting impairment.
- » **Types of disabilities:** The most common type of disability reported for children in Mainland Tanzania was difficulty remembering, while in Zanzibar it was difficulty with self-care. For adults, difficulty seeing was the most common form of disability in Mainland Tanzania while difficulty walking was the most common disability in Zanzibar. For children, overall prevalence rates for each individual type of disability are low (0.5%-1.8% prevalence for each). These findings are not out of line with varied findings from other sub-Saharan African countries that have

completed recent MICS including the CFM to assess disability in children.

- » **Trends over time:** The prevalence rates from the 2017/18 and 2019/20 HBSs were compared with earlier findings from the 2008 TDS and the 2012 PHC, both of which also used WG-SS to measure disability. For both jurisdictions, the first two surveys show a rise in prevalence rates between 2008 and 2012, whereas the HBSs show a decline in prevalence rates in the 2018-2020 period. Further investigation is required to assess whether methodological differences in data collection and/or analysis are in part responsible for the differences over time and between jurisdictions.

5.8 Conclusion

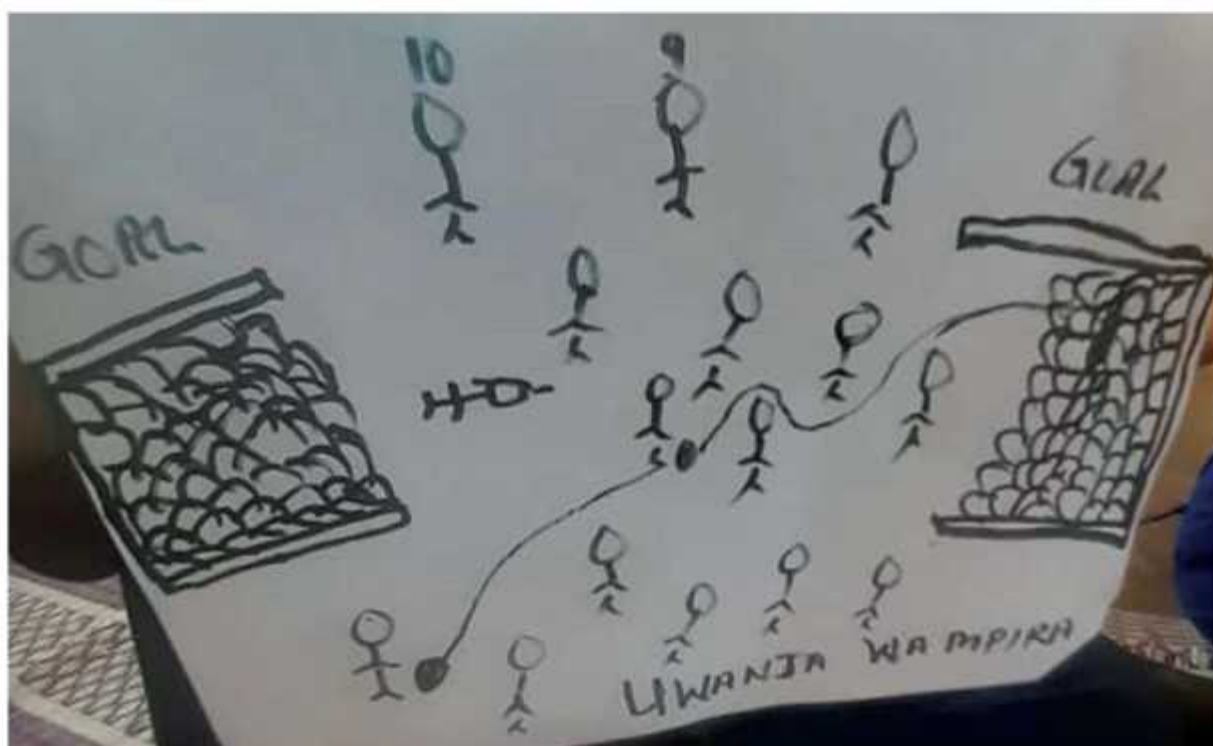
Up-to-date data on disability prevalence rates is vital to effective advocacy and planning, and to the appropriate design and implementation of inclusive policy and programme interventions. The consistent inclusion of WG-SS questions in various national surveys since 2008 is a key advancement for Mainland Tanzania and Zanzibar. The WG-SS is an international standard for identifying and measuring disability for those aged 5 and above. The use of this consistent question set permits comparisons across time and jurisdictions, both domestically and internationally.

However, a drawback of the WG-SS questions is that they are not intended for use with children younger than age 5 and they are not specifically tailored to identifying disability among children. The lack of reliable data on children younger than 5 years is a noteworthy gap given the importance of early screening, identification and intervention for young children with disabilities to human capital development and life chances. As noted in the previous chapter, the Washington Group/UNICEF Child Functioning Module is an adapted question set specifically designed for identifying children with disabilities. It has two sub-modules, one for children aged 2-4 years, and one for children aged 5-17 years (Washington Group, 2020). Integration of the Child Functioning Module in future HBS rounds and other key surveys in URT could strengthen data on children with disabilities and facilitate disability disaggregation of data on SDGs that apply to children.

Further research is needed to inform interpretation of some of the findings in this chapter. The analysis revealed lower disability prevalence rates in Zanzibar compared to Mainland Tanzania across all types of disability, age groups, and sexes. However, further contextual information, interpretation and triangulation is required to assess whether these variations reflect differences in the

opportunity to disaggregate by other variables of interest such as urban vs. rural location. While the 2016 Disability Monograph analysed disability-related findings from the 2012 PHC in depth, there has not yet been similarly detailed analysis and reporting on disability data from the 2017/18 Tanzania HBS and the 2019/20 Zanzibar HBS. This chapter represents a starting point by outlining findings on disability prevalence disaggregated by age, sex, and type of impairment, but the HBS data sets present possibilities for further exploration.

In addition to the variables explored in this chapter, the HBS survey data sets for both Mainland Tanzania and Zanzibar offer opportunities for further analysis and exploration of the relationships between disability and indicators related to household socio-economic status, education, employment and more. There may also be the



"My favourite place to be"
by children with disabilities who participated in
focus group discussions



Realising Rights: Interventions and Barriers in the United Republic of Tanzania

6.1 Introduction

This chapter discusses the national policy context and interventions that the URT Government has undertaken in selected areas of human rights for children and young people with disabilities since the drafting of the last situational analysis in 2013, with focus given to the following specific rights clusters: health; nutrition; employment; education; freedom from exploitation, violence and abuse; and social protection. Under each rights cluster, a brief discussion of the normative framework is provided to establish the expected standard and obligations for each right. Key programmes and services that the URT has undertaken in efforts to implement the specific right clusters are outlined and barriers / challenges to fulfilling these rights are discussed. Lastly, this chapter provides key findings and conclusions.

6.2 The Right to Health

Children and young people with disabilities are entitled to health on an equal basis with others. Article 25 of the CRPD requires member states to provide persons with disabilities, including children and young people with disabilities, the right to enjoy the highest attainable health care and health services (CRPD, Art 25). For the CRPD, the highest attainable standard of health and wellbeing is vital for a full and productive life for persons with disabilities, including children and young people with disabilities. In addition to this right, the CRPD in Article 26 reaffirms the rights

of persons with disabilities to effective participation in society. For example, it reaffirms the need to ensure access to rehabilitation, independent living services and assistive technology and devices (CRPD, Art 26). Article 26 also mentions the need to promote community-based, long-term care services for those facing the loss of independence. This means ensuring that children and young people with disabilities have access to, for example, appropriate assistive devices such as wheelchairs or hearing aids.

In line with its international obligations and specifically the CRPD, the URT has enacted legislation to enforce adherence to the rights to health for persons with disabilities including children and young people with disabilities. For example, Article 26 of the Mainland's 2010 Persons with Disabilities Act provides that:

(1) Every person with a disability shall have the right to enjoy the attainable standard of health care services without any discrimination. (2) Every health facility whether public or private shall not deprive a person with disability the right to health care service and shall take all reasonable and necessary measures to ensure access for such (a) person to health services.

Similarly, Article 8(5) and (6) of the 2009 Law of the Child Act applicable to Mainland provides that:

(5) A person shall not treat a child with disabilities in an undignified manner. (6) A child with disabilities shall be entitled to special care, treatment, affordable facilities

for his rehabilitation and equal opportunities to education and training wherever possible to develop his maximum potential and be self-reliant.

Specifically, the 2006 Persons with Disabilities Act (Rights and Privileges), and the 2011 Children's Act relating to Zanzibar contain provisions that specifically grant rights to 'special' care and access to healthcare services for persons with disabilities including children and young people with disabilities.

6.2.1 General Health Status

Children and young people with disabilities are as susceptible to contract general health ailments such as malaria or measles as any other young person and child. Indeed, the 2019 UNDESA report found that children and young people with disabilities may have an increased susceptibility to diseases depending on the severity of their disability. Existing chronic health conditions may contribute to disability and vice versa. This makes it crucial for children and young people with disabilities to access all general and public health care efforts.

However, as established in the 2013 situational analysis report, children and young people with disabilities are accorded lower priority in general health efforts. The report found that access to general health care in URT was varied depending on what clinical services are reviewed. The report mentioned how many general health clinics, HIV testing centres or feeding programmes rarely or never see a child with a disability. The report concluded that implementation of general health-care services was difficult because of the poor quality and unavailability of the services, particularly with geographical access more likely to affect children and young people with disabilities.

6.2.2 Programmes and Services Relating to Realising The General Health Status For Children and Young People With Disabilities since 2013

Children and young people with disabilities in Tanzania continue to face challenges in accessing general health services. Progress in this area has been limited since 2013 and the empirical and secondary data suggests challenges remain in several key areas:

- » Disability related services: assistive devices
- » Disability related rehabilitative services
- » Disability and sexual and reproductive services
- » Disability related health insurance services

- » Disability related medications for example, immunisations
- » Disability and mortality
- » Disability and HIV/AIDS
- » Disability and Early detection and Diagnosis

6.2.2.1 Disability Related Services: Assistive Devices

Children and young people with disabilities, particularly those who have physical disabilities, are more likely to have mobility difficulties than their peers without disabilities (Edwards and McCluskey, 2010). Article 26(3) of the CRPD demands that state parties "promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation". Article 20 of the CRPD equally places an obligation on state parties to ensure that people with disabilities including children and young people with disabilities have access to personal mobility so they can achieve independence at an affordable cost and at a suitable time of their choice (UN 2008).

Under the CRPD, the URT has a clear obligation to ensure that assistive devices are available, affordable, adaptable and accessible. Efforts to provide assistive devices have been made through the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT). CCBRT is a Tanzanian health care organisation which works to prevent disability, provide affordable medical and rehabilitative services, and aid empowerment of people with disabilities and their families. Evidence suggests that in 2002, the Zanzibar Government established the Zanzibar People with Disability Fund to assist people with disabilities access loans for activities such as self-employment and to purchase assistive devices (Tanzania Human Rights Report, 2017). Further evidence captured from key informant interviews suggests that there is a budgetary allocation for the purchase of assistive devices in Zanzibar. It is unclear whether these budgetary allocations are separate from the Disability Development Funds. Nonetheless, what is certain from the KIIs and FGDs findings is that there are insufficient funds to purchase assistive devices:

"The government allocated a budget for them, that department responsible for disability in the purchase of these assistive devices, distributed to them. But the budget they've got is not enough. So whatever they have, they distribute to them."

(KII-1, Zanzibar, 26 March 2021)

Even when support funds are set up to help impoverished families to access the devices, the money is not enough:

"What we have done is seek donor support ... Unfortunately, we need to ask for small contributions from families and not all families can contribute towards a wheelchair. So we're asking for really small money and, if possible, we give the wheelchairs for free, but we also have costs in order to fit them."

(KII-8 Mainland 6 April 2021)

Parents of children with disabilities in Zanzibar confirmed that the cost of registering for government support funds is prohibitive. Even registering for a disability identification card (which provides cheaper transport, assistive devices and health services) was said to cost just over USD 1 per month (2500 TSH). This is a heavy cost for a benefit card for those living on the poverty line.

Despite the URT efforts to provide cost effective assistive devices in Zanzibar and Mainland, issues of affordability, usability and adaptability of assistive devices remain. The cost of assistive devices is prohibitive for many families, as this KII explains.

"The technology is not really available, we have to import or post everything, nothing's manufactured in Tanzania. We import most of the devices from South Korea from India, China, some things from Sweden. ... And when you find them available in the shops, they are expensive, where a parent or family cannot afford to buy them for their child."

(KII-5, Mainland, 6 April 2021).

All respondents felt that there was a shortage of assistive devices in URT, regardless of the disability as expressed in these quotes:

"...Lack of assistive devices for children like spectacles..."

(FGD-7, Parents of children with disabilities, Mainland, 22 April 2021).

"There is still a huge challenge ...[with] wheelchairs because the cost is really beyond the means of the average person."

(FGD-2 Parents of children with disabilities, Zanzibar, 24 March 2021)

"We have auditory and intellectual disabilities, they need support machines to be able to write and perform in an office."

(FGD-2 Parents of children with disabilities, Zanzibar, 24 March 2021)

Parents of children who have been successful at securing assistive devices commented that inaccessible infrastructure is another barrier that limits the effectiveness of assistive devices for children and young people with disabilities. KIIs with government and NGOs confirmed this

"...sometimes you may find they don't use these assistive devices because of unfriendly infrastructure or buildings that are not accessible to them."

(KII-1, Zanzibar, 26 March 2021)

Maintenance of assistive devices is another area of concern. In Mainland for instance, repairs are privately done by the family members (National Bureau of Statistics (NBS) 2008), but whether this is because of the lack of local maintenance options, the prohibitive prices for maintenance, or the dominant preference for people to repair their own devices is unknown.

Under the CRPD, the affordability, usability, adaptability and accessibility of assistive devices is a human right. Yet, the above evidence demonstrates some of the key challenges that children and young people with disabilities encounter when accessing assistive devices in the URT.

6.2.2.2. Disability Related Habilitation and Rehabilitation Services

Article 26 of the CRPD requires state parties to "organise, strengthen, and extend habilitation and rehabilitation services and programmes in the area of health." In addition, in line with Article 26(2) state parties are required to provide initial and continuing training for professionals working in rehabilitation services. Habilitation is important in helping children and young people with congenital disabilities acquired in early childhood learn how to live with these disabilities (Human Rights Council, 2019). Rehabilitation helps persons and children who suffer functional impairments learn how to perform their daily activities (Human Rights Council, 2019). These two interventions are crucial in helping children and young people who have acquired an impairment or suffered a functional loss live independent lives and be fully included in all aspects of society.

In Mainland Tanzania, the 2015-2020 Health Sector Strategic Plan (HSSP-IV) mentions that the MOHSW in collaboration with non-governmental partners, would strengthen community-based rehabilitation (CBR) that would support and provide services for children and young people with disabilities (MOHSW, 2015). The 2015-2020 Health Sector Strategic Plan (HSSP-IV) represents the first time a comprehensive effort is made to "make reliable cost estimates, prioritise interventions based on available resources and define realistic targets for the health and social welfare sector" (MOHSW, 2015). The main goal of the HSSP-IV is "to reach all households with essential health and social welfare services, meeting, as much as possible, the expectations of the population, adhering to objective quality standards, and applying evidence-informed interventions through efficient channels of service delivery" (MOHSW, 2015).

According to the HSSP-IV, children and young people with disabilities would gain access to fundamental services such as health care, education and rehabilitation services through their communities. The communities would assist in referring children and young people with disabilities to community-based rehabilitation services (MOHSW, 2015). The HSSP-IV promises to ensure an improvement in the identification of persons in need and the care for these groups in the communities through the Local Government Authorities (LGAs).

In addition to LGAs, the HSSP IV mentions the role of NGOs in delivering CBR.

Other proposals outlined in the HSSP-IV include:

- » Raising awareness on CBR.
- » Developing CBR guidelines.
- » Providing training to LGAs.
- » Ensuring rehabilitation experts are integrated at all levels of care including the renovation of vocational rehabilitation training centres so that human resources, equipment and training materials are in place (MOHSW, 2015).

For the HSSP-IV period, an additional 600 health facilities are expected to be constructed (MOHSW, 2015). As this will be insufficient for the population size, HSSP-IV also aims to increase the number of health centres and dispensaries in rural communities to improve geographical accessibility in areas that are often overlooked and underserved.

An evaluation of the HSSP-IV would provide crucial lessons learned and evidence of success. A comprehensive Monitoring and Evaluation Strengthening Initiative (MESI) has been initiated by the MOHSW since 2009 (MOHSW, 2015). However, it is unclear from

interviews and the documentation analysis if there are plans to evaluate the HSSP-IV. Speculatively, the HSSP-IV is more likely to be replaced by a new HSSP-V for another four or five year period, rather than have an evaluation commissioned. As of June 2021, a National Rehabilitation Strategy Plan is in the final stages of development.

Similarly, the Zanzibar Health Sector Strategic Plan III 2013/14-2018/19 (NHSSP-III) aims to provide the highest standard of health services to its citizens guided by the principles of access, equity, affordability and human rights. The ultimate goal for NHSSP-III is to increase access to comprehensive health services to more than 80% of the population in Zanzibar. This was to be achieved through an infrastructure development plan which supports equity and sustainability in preventive maintenance and rehabilitative services on disability. The scope of service delivery comprises promotive, preventive, curative and rehabilitation care services provided at various levels in the country. This is because more than 95% of the population lives within a five-kilometre distance from a nearby public health facility (Ministry of Health Zanzibar, 2013).

6.2.2.3. Availability of Rehabilitative Services for Children and Young People in URT

According to empirical findings, there are five day care rehabilitation centres that offer treatment and care for children and young people with disabilities in URT all in mainland Tanzania (Gigoni, et al, 2016). This includes Comprehensive Community Based Rehabilitation (CCBRT) hospitals, healthcare organisations that work to prevent disabilities, provide affordable medical and rehabilitative services, and aid economic empowerment for children with disabilities and their families (Hansen et al, 2013). For example, in the Mainland, Kilimanjaro Christian Medical Centre (KCMC), provides necessary health services to the Northern Zone of Tanzania and serves as a national teaching hospital. In Zanzibar, there is Mnazi Mmoja Hospital (on Unguja island) with a department of occupational therapy for children with neurological disorders. Through this facility, children with disabilities are able to access rehabilitation services (World Unit, 2014; 2013/14-2018/19 Zanzibar Health Sector Strategic Plan III). It is unclear from research findings if a similar department exists in Abdulla Mzee Hospital on Pemba island. Similarly, there is a National Eye Care Program (NECP) co-ordinated by the MOHSW that was established to reduce visual impairment and blindness on the Mainland. The program seeks to address human resources, appropriate equipment, supplies for eye/visual health delivery services. The program is aligned with the WHO Global Vision 2020 initiative goals- Ministry of Health.

Gigoni et al (2016) mapped out eleven rehabilitation facilities in a quantitative survey in the URT. Findings are summarised in Table 5.1.

Table 5.1: Features of Selected Rehabilitation Facilities in URT

Name of Centre	Region	District	Service coverage	Nature of the facility
Monduli Rehabilitation Centre (huduma ya walemavu)	Arusha	Monduli	Arusha and Part of Manyara region	Day and Boarding Rehabilitation Centres
CCBRT – Dar es Salaam	Dar es Salaam	Kinondoni	Dar es Salaam city (Ilala, Kinondoni and Temeke Districts)	Day Centre
Makambako CBR unit	Njombe	Makambako	Makambako town	Day Centre
Zanzibar Association for the People with Disability (ZAPD)	Zanzibar	Did not specify	Zanzibar	Did not specify
Karagwe CBR Program (KCBRP)	Kagera	Kayunga	Kyerwa and kayunga districts	Rehabilitation Centre
Inuka CBR Wanging'ombe	Njombe	Wanging'ombe	Southern highlands of Tanzania	Rehabilitation Centre
Mbeya CBR Simama	Mbeya	Mbeya	Mbeya city	Did not specify
Sambamba	Iringa	Iringa	Iringa (Pogolo area)	Day Centre
CCBRT Moshi	Kilimanjaro	Moshi	Moshi town, urban, parts of Hai, Same and partly Rombo districts	Rehabilitation Centre
Youth with Disability Community Program (YDCP)	Tanga	Tanga	Tanga city	Day care Rehabilitation Centre
Gabriella Children's rehabilitation Centre	Kilimanjaro	Moshi	National	Rehabilitation Centre

Source: Gilgani et al (2016)

The findings from this study indicate a need for improved rehabilitative service delivery in URT. Out of eleven facilities included in the study, ten (10/11) provide CBR services, only one out of the eleven facilities (1/11) is covered by national health insurance services. Four out of eleven facilities (4/11) have been registered, five facilities have not been registered and the registration of the other two facilities is ongoing. According to the study, the registration authority varied from one facility to another: some were registered by the MOHSW and others by the Ministry of Internal Affairs. Further, out of the eleven rehabilitative services that were included in the study, seven (7/11) provide rehabilitation services to children with mixed disabilities. Three (3/11) provide rehabilitation services to adults and children with mixed (mental, physical and neurological) disabilities. One rehabilitation centre (Gabriella Children's Rehabilitation Centre) (1/11) specialises in care for children with intellectual disabilities nationwide (Gilgani et al, 2016). In light of the geographical location, the quality of the rehabilitative services provided, plus, logically, the number of clients, along with the number of waitlisted clients should be examined to determine the adequacy of services.

6.2.2.4. Disability Related Sexual and Reproductive Health Services

Young people with disabilities have the same sexual reproductive needs as young people without disabilities. In fact, according to the WHO (2009) people with disabilities may actually have greater needs for SRH education and care than people without disabilities due to their increased susceptibility to abuse. Yet, young people with disabilities are less likely to have access to appropriate sexual and reproductive health services. The limited access to information, education and services related to sexual and reproductive health is a threat to children and young people's lives, including children and young people with disabilities. This threat stems from the misconception that young persons with disabilities do not have sexual relationships or desires for a family.

The CRPD has several provisions that relate to the provision of sexual and reproductive health and rights of women with disabilities including young women and girls with disabilities. These rights include Article 6 on the rights of women and girls with disabilities, Article 9 on

accessibility, Article 12 on equal recognition before the law, Article 23 on family life and Article 25 on the right to health. As a state party to the CRPD, the URT is required to take measures that would ensure people with disabilities particularly young women and girls with disabilities have access to health services that are gender-sensitive. In line with Article 25, state parties are required to provide young women and girls with disabilities, "the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health" (CRPD, Article 25, Murungi and Durojaye, 2015).

The URT is one of ten countries with the highest frequency of teenage pregnancy. Yet, evidence suggests that the crucial sexual and reproductive health (SRH) services remain inadequate. Nkata et al (2019) point to how contraceptive use among teenagers, with or without disability, is as low as 8.6% with severe barriers to accessing reproductive health information and care (Nkata et al, 2019). Specifically, the contraceptive use for young women and girls with disabilities is unknown but it is possible to speculate that contraceptive use would be lower for young women and girls with disabilities because of existing misconceptions about disability and sexuality.

A 2021 study done in Mainland Tanzania examined how sexual reproductive health services respond to the characteristics of adolescent females with disabilities, found that the studied adolescents are capable of more engagement in their SRH service access, but that the characteristics of the providers and systems do not respond well to their needs. The findings of this study broadly support previous work that demonstrates that when accessing SRH services, young people with disabilities face issues of confidentiality and mistreatment, communication and discrimination along with physical inaccessibility, (Mesitiislehto, V, Katsui, H and Sambaiga, R, 2021).

Similarly, a 2018 situation analysis report on youth with disabilities and their sexual and reproductive health and rights to family planning services in Zanzibar found that:

- » 62.9% of the respondents (n300) reported encountering challenges in accessing SRH/FP services because of discrimination either associated with their age, gender and/or disability, or a combination of all three.
- » Other challenges to accessibility included: "inadequate level of privacy and confidentiality, equipment and negative attitudes from family members, guardians, health care workers and doctors; early marriages and gender disparities, inadequate number of training and capacity building programmes on SRH and family planning programmes at all levels and legal barriers" (Revolutionary Government of Zanzibar, the Global Fund & UNFPA, 2018: 7, 17).

- » 49.6% of respondents were not aware of where to get integrated user friendly SRH/FP services in Unguja and Pemba.
- » 50.4% of respondents reported that they had never accessed user friendly SRH services because of multiple reasons documented in the study including: homophobia among health care workers, social cultural norms, poor infrastructure and stigma.
- » 53.1% of respondents reported that they were not satisfied with SRH/FP services provision in their communities (Revolutionary Government of Zanzibar and the Global Fund, UNFPA, 2018: 7, 17).

This evidence provided above highlights the need for further action to address the SRH needs of young people with disabilities. While the full picture of SRH issues for young people with disabilities in URT is not yet clear, it is safe to assume that there are significant unmet needs.

6.2.2.5 Disability Related Services: Health Insurance

Medical and health insurance services are crucial in the realisation of the right to health for persons with disabilities including children and young people with disabilities. In line with Article 25(e) of the CRPD, the URT as a state party is required to prohibit all forms of discrimination against persons with disabilities in health insurance services. The URT is also required to provide health insurance in a fair and reasonable manner.

In an effort to improve access to health services, URT enacted four publicly owned health insurance schemes namely: the National Health Insurance Fund (NHIF); the Social Health Insurance Benefit under the National Social Security Fund (NSSF); the Community Health Fund (CHF) and the Tiba Kwa Kadi (TIKA). The mandatory NHIF scheme was implemented for civil servants (World Bank Group, 2018). The health insurance scheme for civil servants is funded through a 6% payroll deduction, equally distributed between employers and employees. The NHIF covers 7.2% of the population, and even though it started as a scheme for civil servants, private sector employees and self-employed are free to voluntarily join the scheme. The yearly fee for non-civil servants is a lump-sum contribution of TSh 1,501,200 (US\$672.60) per household. The benefits package offered by the NHIF is more comprehensive and includes outpatient and inpatient care. Service providers are reimbursed for the services offered to NHIF beneficiaries on a fee-for-service basis (World Bank Group, 2018). With less than 1% of civil servants identifying as having a disability, this insurance does not benefit them as much as it could if employment numbers in the civil service increased (Kibaki, 2016).

Similarly, the CHF is a voluntary prepayment insurance fund for health care. It has been rolled out to 167 out of 184 councils operating under Local Government Authorities (LGAs) through NHIF coordinators. Participants pay for an annual membership which entitles them to access basic medical care and medicine without paying additional co-payments. The National Government subsidises these funds through a matching subsidy. The CHF subscription costs and the services covered are defined by district governments. As of March 2018, coverage under the CHF was 25% of the population. This is a significant increase from 2011, when only 7.9% of the population were covered. However, the 2016 Disability Monograph found that about 5.6% of all families headed by a person with disabilities was a member of the NHIF and CHF. Similarly, according to the Ifaraka Health Institute, BMZ & GIZ, 2013 report on Inclusion of Persons with Disabilities in the Health Financing System in Tanzania, reveals that about 33.3% persons with disabilities had subscribed to CHF and NHIF. However, access to health insurance schemes remains a challenge because this report further highlights that only 9% of the persons with disability in Tanga municipality and Nachingwea district have access to the scheme (Ifaraka Health Institute, BMZ & GIZ, 2013).

The Disability Monograph identified urban/rural disparities. About 14.9% of families headed by persons with disabilities in Mainland's urban areas had a membership in at least one of the Social Security Scheme compared to 7.6% in rural areas. Similarly, 15.5% of Zanzibar families headed by a person with disabilities were members in one of the Social Security Schemes compared to 9.4% families in the Mainland (Disability Monograph, 2016). However, disaggregated data of people with disabilities benefiting from the NHIF and CHF schemes is unknown because the existing data in URT does not have such data.

The above statistics indicate that health insurance for children and young people with disabilities remains a challenge in URT. This point is supported by the 2013 study conducted by Ifaraka Health Institute, BMZ and GIZ, which identified financial barriers as a key issue of particular concern for people with disabilities living in Tanzania to access health services. The study also indicated that exemptions from user-fees for persons with disabilities would increase their access to health services. Initial findings from KIIs and FGDs suggest that in Zanzibar, people with disabilities are offered some form of medical exemptions and free services in public hospitals. However, according to the findings, although they receive free services because of an insurance card, the services are either poor or there are still out of pocket expenses.

"Our major challenge is health, it is hard to get health insurance for our children, it is also hard to get complete free treatment. Technically health services are free but sometimes when you have a really big problem, you have to pay for other costs."

(FGD-2, Zanzibar, 24 March 2021)

"I got a referral, to go Wimbili National Hospital that is in Mainland from Zanzibar. But on reaching there, I had to use my own money and the experience was not good because I had to use lots of money. It reached a time when I couldn't afford most things. And at the end of the day, I stopped using the hospital services and went back home."

(FGD-2, Zanzibar, 24 March 2021)

6.2.2.6 Disability Related Medications: Immunisation

Article 25 of the CRPD provides that the persons with disabilities including children and young people with disabilities have the right to 'the enjoyment of the highest attainable standard of health without discrimination based on disability.' For the CRPD, this means that children with disabilities are to be granted access to health services available to all children such as immunisation. This provision is also reaffirmed by Article 25(b) that provides that persons with disabilities including children and young people with disabilities should have access to health services that includes "early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities."

The UNICEF (2013) Situational Analysis report identified the URT's participation in several childhood immunisation campaigns along with the general exclusion of children with disabilities from these programmes. However, the "Reaching Every Child" (REC) strategy was reported to be particularly successful because it targeted 'unreached' groups especially children with disabilities (UNICEF, 2013). The REC strategy is a part of the Reach Every District (RED) approach developed by the WHO, UNICEF and partners in 2002 as part of efforts to reach the unreached, unvaccinated and under-vaccinated communities (WHO, 2008). The REC strategy was adopted in the URT in 2012 as part of efforts to achieve the Immunisation and Vaccine Development (IVD) goals (Hakororo, Mwenda and Seugendo, 2018). Most children with disabilities both on the Mainland and on Zanzibar appear to have been immunised through this campaign.

The Maternal and Child Survival Program (MCSP, 2019) documented its work with the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC)/ Immunisation Vaccine) as well as the IVD to strengthen the delivery of the Mainland's routine immunisation services from 2014-2019. The MCSP interventions have focused on

- a. Helping the IVD realise its national immunisation agenda.
- b. Strengthening the capacity of regional and council health teams to effectively manage immunisation services.
- c. Implementing the Reaching Every Child (REC) in 19 underperforming councils.
- d. Introducing new and underutilised vaccines nationwide.
- e. Advising on logistics system (MCSP, 2019).

These are important interventions considering that according to Manyanga and Mtae (2017), immunisation is the second most fundamental human right. Immunisations are widely considered as the most effective public health intervention globally for the protection and promotion of lives and good health (Manyanga and Mtae, 2017). Evidence suggests that in the Ngorongoro district of Tanzania for instance, digital platforms such as the Tanzania Immunisation Registry (TImR) are employed within the health sector to trace children who miss their vaccinations because they live in nomadic areas (Juma, 2019).

In 2015-16, the Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) examined vaccination and other health-related issues in young children in URT. This survey found that 75% of children aged 12-23 months receive all the recommended vaccines and 2% of children who did not receive vaccines (National Bureau of Statistics & Office of Chief Government Statistician, 2016). The survey further demonstrated urban/rural disparities by pointing out that children in urban areas were more likely to get all the required vaccine doses than children from rural areas (National Bureau of Statistics & Office of Chief Government Statistician, 2016). The above statistics raise important questions relating to children with disabilities in URT. One, the survey provides statistics for children that are not disaggregated by disability. It is unclear whether children with disabilities were included in the survey. Two, without accurate and reliable disability disaggregated data, the actual number of children with disabilities that have been immunised in both Mainland and Zanzibar is unknown. Yet, research confirms that certain immunisations given in childhood (e.g. polio and tuberculous meningitis) can prevent disabilities. This means that for children with disabilities the lack of, or inadequacy of, vaccinations could potentially create more disabilities.

6.2.2.7. Disability and Mortality

A United Nations Development Group 2011 report has found that mortality rates for children with disabilities under five years old are disproportionately greater in developing countries (UN; 2011). The report further emphasises how children with disabilities have an increased chance of dying not just because of other contributing medical conditions such as depression but also because of accessibility difficulties and disability related stigma. However, URT specific data on this topic is absent.

According to the WHO cooperation strategy in Tanzania 2016-2020: There has been an improvement in maternal health and a reduction of under-five infant and neonatal mortality. The report further highlights an increase in Vitamin A supplementation, and improved nutritional status of children. However, the report is not disaggregated by disability and maintains that maternal and neonatal mortality remains poor across URT.

6.2.2.8. Disability and HIV/AIDS

Article 25 of the CRPD confers on persons with disabilities, including children and young people with disabilities, the right to enjoy the highest attainable health care including HIV education, prevention and treatment (CRPD, Art 25).

According to the HSSP-IV conceived by the MOHSW, the prevalence of HIV is declining gradually (MOHSW, 2015). The 2012 Tanzania HIV and Malaria Indicator survey (THMIS) identified a decrease in HIV prevalence from the previous THMIS 2008, from 5.7% to 5.3% (MOHSW, 2015). Nonetheless, the HSSP-IV further mentions the rising numbers of HIV infected patients. By 2014, Mainland Tanzania is reported to have 1,411,829 of its population living with HIV, of whom 28% are children under 14, and 11.2% of whom are young people aged 15-24 with nearly 80,000 new HIV infections occurring yearly (MOHSW, 2015). Similarly, out of the 65,000 infections diagnosed in 2017 in Tanzania, 18% is reported to be the result of mother to child transmission (UNICEF, 2019). The 2016-2017 Tanzania HIV Impact Survey (THIS) further reports HIV/AIDS prevalence among young people aged 15-24 years old in the URT is 1.4% - 2.1% among females and 0.6% among males (National Bureau of Statistics, 2017).

These statistics are essential in painting the number of young people infected with HIV/AIDS in URT. However, (like many other studies) the data was not disaggregated by disability.

The HSSP-IV notes that while Disease Control Programmes in HIV/AIDS have been successful in early detection and treatment, preventive measures need to be improved.

Through the HSSP-IV, the URT envisages controlling HIV/AIDS in the Tanzanian population in general through testing programmes aimed at testing children under fifteen years old (MOHSW, 2015). This raises questions in relation to children and young people with disabilities. First, it is not clear whether these are population-wide tests and would include children and young people with disabilities. Second, it is not clear whether the test would be consensual. Additionally, in underscoring the gendered dimensions of HIV/AIDS globally, a 2017 UNAIDS report indicates that men with disabilities are 1.48 times and women with disabilities are 2.21 times more likely to be infected with HIV when compared to men without disabilities. This increased susceptibility can be linked to persistent discrimination and exclusion. This situation is further worsened for young women and girls with disabilities who experience increased exposure to HIV/AIDS through harmful practices such as the 'virgin cure' practised in some areas of URT (Mutugi. K. J, 2017). This inequality begins when girls are young. The HSSP-IV recognises the disproportionate discrimination of women and girls with disabilities to contracting HIV/AIDS compared to men with disabilities.

The 2013 HIV/AIDS (Prevention and Management) Act was promulgated in Zanzibar to tackle issues such as discrimination and social stigma against children and young people with disabilities infected with HIV/AIDS. This 2013 Act is further strengthened by the Zanzibar National HIV and AIDS Strategic Plan III (2016-2021) on HIV and AIDS.

6.2.2.9. Disability and Early Detection and Diagnosis

The CRC and CRPD both provide for the rights of children with disabilities to enjoy these rights on an equal basis with children without disabilities, and the right to develop to the maximum extent possible (CRPD, 2006). According to a 2012 WHO and UNICEF discussion paper, access to the appropriate and suitable support, such as early childhood interventions would assist in promoting meaningful participation in the society.

Early detection and diagnosis of disability is essential for the first three years of children's lives. Research has shown that if disability is not detected and identified early, it can have a long term impact which might threaten development and prevent children from reaching their full potential. The importance of early identification in ensuring access to adequate health care services, medical rehabilitative interventions and social protection is evident. For this reason, a 2012 WHO and UNICEF discussion paper documents that because children with developmental delays or disabilities and their families are not provided with timely and appropriate early intervention, support and protection, they tend to encounter severe difficulties with lifetime consequences, such as increased poverty and profound exclusion.

Mapunda et al (2017) propose four factors to process identification and intervention of children and young persons with disabilities. These factors include: a) defining the disability; b) planning possible intervention strategies for the children; c) implementing these interventions; d) evaluating the progress of the children.

The URT Government in adopting the 2004 National Policy on Disability recognises the importance of early identification reinforced by early interventions in minimising the impact of disability in children (National Disability Policy, 2004, Mapunda, et al, 2017). The government in Mainland Tanzania through the MoHCDGEC adopted the 2017 National Health Policy. One of the policy objectives is to reduce morbidity, mortality and disability as a result of non-communicable diseases. The Mainland Tanzania government acknowledges that although early detection through regular medical examination promotion efforts have begun, it is still limited. One of the reported successes of the 2010-2015 National Disability Mainstreaming Strategy is the development of Guidelines on Early Identification and Interventions for Children with Special Needs in 2013. According to the HSSP-IV introduced by the MOHSW, the National Guideline for early identification and interventions for children with disabilities in Tanzania Mainland was finalised in 2016 (MOHSW). However, there is very limited information on these Guidelines making it difficult to assess its impact.

Similarly, concrete steps to integrate early detection and intervention programmes including strengthening available data from the health and education sectors has been taken by Zanzibar's Department of Disability Affairs. However, it appears that these programmes are limited to the education sector in Zanzibar. There is limited information on the specific health related early detection interventions and programmes that have been initiated in the health sector in Zanzibar (According to the Mid-Term Evaluation see UNICEF Tanzania, 2020). This raises serious concerns for children and young people with disabilities in Zanzibar considering that early detection and diagnosis of disability should be a cross-cutting issue. Empirical evidence from KII interviews conducted confirm that the challenges with early detection and diagnosis of disability remain:

"I think (the) early identification of children with disabilities would be the big one. Even before birth, especially for Zanzibar, because the health facilities are, so limited. And so I think even the initial diagnosis or identification of some type of delay or disability, and the early response... all gets delayed, which makes things worse later on."

(KII-3, Zanzibar, 24 March 2021)

"There is (a) challenge with the health sectors' intervention, there is no special service or intervention for children or people with disability. These children have more needs compared to other children. Intervention is needed from when these children are born. Close intervention is needed for these children, but sometimes they fail to get it and the disability increases."

(KII- 1, Zanzibar, 26 March 2021)

Findings from FGD with children and young people with visual impairments confirm the difficulties with early detection and diagnosis of disability in URT.

"I was born with normal sight but once I reached 3 years old suddenly my eyes lost vision. My mother decided to take me to hospital but my father denied her, because he didn't want me (to see again). My mother escaped and took me to hospital and we stayed there for a long time. The doctors advised my mother to take me to India but she didn't have enough money and decided to go to the hospital....."

(FGD-8, Mainland, 25 April 2021)

One participant of the FGD noted how the absence of health specialists on early detection and diagnosis resulted in the complete loss of sight

"....when I grew up, my parents explained to me that; Jess, when you were a kid your eyes were good but once you reached 2.5 year, we went to visit your mother's parents and it's there your vision was lost. My mother took me to the hospital for the first time, but the hospital was under the Roman Catholic Church and my mother works there. The hospital did not have a specialist and my mother asked them to help me and they gave me some medication that resulted to sightless problem."

(FGD-8, Mainland, 25 April, 2021)

Consequently, progress in early detection and diagnosis of disabilities in URT has been clearly limited (Education Development Trust & UNICEF, 2016). Most children with intellectual and developmental disabilities are not identified early enough making it difficult to benefit from early intervention services and support. The study found that there is no standardised and comprehensive

approach to identifying children with disabilities, and that identification remains subjective and ad hoc (Education Development Trust & UNICEF, 2016). This difficulty is buttressed by the evidence from the 2018 African Children Committee's concluding observations to the URT which urges the URT to begin early identification of disabilities and provide continuous access to health care for children with disabilities (ACRWC, 2018).

6.2.3 Challenges and Barriers to Accessing Health Services for Children and Young People with Disabilities

1. General Health Status and Services

As stated above, children and young people with disabilities still find it challenging to access health services. According to the 2017 National Health Policy, Mainland Tanzania has inadequate palliative services. The policy indicates that there are imbalances in the provision of palliative care and this is attributed to a lack of knowledge and skills on palliative care, unavailability of medicines for handling chronic pain and insufficient financial resources targeted to deliver palliative care (Ministry of Health, Community Development, Gender, Elderly and Children, 2017). Some of the specific challenges related to general health services faced by children and young people with disabilities in both Mainland Tanzania and Zanzibar include the following:

a. Accessibility

Access to general health centres and services for children and young people with disabilities remains a challenge. This point is echoed in the 2018 African Children Committee's concluding observations to the URT. The URT was asked to ensure that health centres were physically accessible to children with disabilities (ACRWC, 2018). Accessibility to health centres, services and care is hampered by geographical access without assistive devices such as wheelchairs, ramps and sunscreen and glasses (in the case of children with albinism). Most of the KIIs respondents identified the accessibility of health services as a challenge. One particular respondent mentioned:

"Children with disabilities lack their right to health because their parents cannot send them to hospital. Most people who have families with disabilities are very poor. And they can't access some of the social services like health services, so, I can say that there is a need for empowerment on this issue."

(KII-14, Zanzibar, 5 May-2021)

Accessibility to healthcare services for children and young persons with disabilities remains a challenge. For children and young persons with hearing disabilities, this is compounded by the scarcity of trained healthcare providers in handling matters of disability. A key informant highlighted that young people with hearing impairments in the absence of a translator fail to express their healthcare concerns to the doctors who aren't trained in sign language. He observed:

"... other challenge is in health services where most of the youth (with disabilities) attend the hospitals but they fail to express their problems because there is no translator. We don't have doctors that are being trained in sign language and understand it."

(KII-11, Zanzibar, 27 April 2021)

b. Availability

Quality healthcare, health centres and health services might be unavailable in rural areas and might be unreachable for children and young people with disabilities who live in these areas. The unavailability of health services is confirmed by KIIs and FGDs:

"Health programmes are inadequate, non-inclusive, and there's a problem in the health sector for these children with disabilities."

(KII-1, Zanzibar, 26 March 2021)

"So, not all services, I cannot say that they are available, but some are available."

(KII-14, Zanzibar, 5 May 2021)

c. Adaptability

Health care and services for children and young people with disabilities are not adequately adaptable to meet their health needs. This challenge is clear given the African Children Committee's remark in its 2018 concluding observations to the URT to ensure that the needs of children with disabilities particularly children with albinism are incorporated into health policies and to develop proactive strategies to tackle their 'special' skin, sight and other needs (ACRWC, 2018).

d. The retention of skilled health-care professionals

The African Children's Committee in its 2018 concluding observations reiterated the need for the URT to ensure health centres have skilled and qualified health care professionals to provide service for children and young persons with disabilities (ACRWC, 2018). To improve service delivery, skilled health-care professionals need to be retained (2018 Zanzibar Health Budget Brief)

e. Limited finances

Several children and young people with disabilities cannot afford quality health care services, particularly when exorbitant out of pocket expenses, including travel expenses, are required to access specialised treatment. In Zanzibar for instance, where health services are reported to be free, out of pocket expenses still remain a challenge. This point is consistent with findings from the FGD conducted with parents of children and young people with disabilities:

"Children with disabilities should have the right to be able to get completely free treatments. Although technically health services are free sometimes when you have a really big problem. There are other costs that come into play, for example, transport."

(FGD-2 Parents of children with disabilities, KII-3, Zanzibar, 24 March 2021)

2. Disability Related Rehabilitation Services

In terms of rehabilitation services, findings from a 2015 impact assessment survey on rehabilitative services conducted by the Tanzania Federation of the Disabled Peoples' Organisation (SHIVYAWATA) found several barriers to accessing rehabilitation services. The 2015 survey involved 360 persons with disabilities (211 male and 149 female) respondents from five regions in Mainland Tanzania: Dar-es-Salaam, Kilimanjaro, Mwanza, Dodoma and Mbeya. A summary of the barriers highlighted in the study include:

- » Inadequate rehabilitation services have forced many people with disabilities to seek alternatives that mostly involve travelling to the neighbouring regions for better services. This also means that many centres received an influx of patients from areas outside their jurisdictions, imposing a greater burden on rehabilitation workers and creating a delay in service provision.

- » Rehabilitation centres require payment for devices and services, not always affordable for children and young people with disabilities and their families.
- » The survey documented feelings of dissatisfaction with the time spent accessing rehabilitative services arising from the long procedures and queues in all rehabilitation centres.
- » Each rehabilitation centre is not necessarily the same as another, and services vary in quality (Tanzania Federation of the Disabled Peoples' Organisation: SHIVYAWATA, 2015).

3. Disability Related Sexual and Reproductive Health Services

In terms of sexual and reproductive health services for young persons with disabilities, misconceptions about disability and sexuality as well as harmful social stigma hinder access to these services for young persons with disabilities. Most of the KIs identified problems with sexual and reproductive health services:

"[...] Young people for instance, there is sexual reproductive health but sometimes they are not totally included in the programs and most of them don't know their health status."

(KI-1, Zanzibar, 26 March 2021)

One respondent in particular mentioned the challenges that girls with disabilities face when seeking sexual and reproductive health services:

"We have seen some anecdotal evidence that suggests that girls with disabilities are seeking services or services in relation, for example, to sexual and reproductive health related methods, often all exposed to risk for sexual harassment, exploitation and assault within their communities. These girls are married away earlier and more frequently than other girls in the community. And then when they do look to reproductive health services, they are stigmatised within the communities and often neglected when it comes to accessing resources."

(FGD-3, URT and International, 14 April 2021)

4. Disability Related Health Insurance Services for Children and Young People with Disabilities

Findings from an FGD with parents of children with disabilities show that health insurance particularly for children and young people with disabilities remains a challenge: "The issue with health is around health insurance..... In terms of benefits, yes, sometimes they know, they need the disability card to be able to get free transport." The health card also covers transportation to and from health facilities (dalla dalla) (FGD-2 Parents of children with disabilities, Zanzibar, 24 March 2021).

5. Disability Related Medications – Immunisation and Vaccinations

- » There is a lack of information on early intervention and disability screening for children with disabilities aged below 5 years old.
- » Data on the health status for young persons with disabilities generally, and children with disabilities particularly, in both administrative data and surveys is of poor quality because there is no disaggregation for disability.
- » Limited knowledge and research exists on the actual number of children with disabilities who have received their vaccinations especially when compared to children without disabilities.
- » Stigma and discriminatory attitudes towards children with disabilities might mean they are hidden and miss out on essential immunisation services.

6. Disability Related Early Detection and Diagnosis of Disabilities in URT

As discussed above, most children with intellectual and developmental disabilities are not identified in a timely fashion making it difficult to benefit from early intervention services and support in the URT.

6.2.4 Gaps in Accessing Health Care Services for Children and Young People with Disabilities Since 2013

The following key areas have been identified as needing urgent attention in accessing the right to health and health services in URT.

- » Drawing from the CRPD, affordability, availability and adaptability of assistive devices is necessary to promote access for children and young people with disabilities. More attention and funding of assistive devices and technologies is needed.
- » Additional information is required on the availability of local solutions or locally made assistive devices to meet the market demand and supply needs in the country.
- » More evidence-based research is required to answer the question of whether subsidies for disability related services such as rehabilitative services and assistive devices for children and young people with disabilities is a viable solution. The question that emerges is whether such subsidy-based solutions would encourage a shift back to the charity approach

to disability. In addition, there is a need to question whether what children and young people with disabilities require are additional cure focused rehabilitation centres or more self-empowering and affordable centres.

- » Urgent attention is required to ensure guidelines are in place on early identification and diagnosis of disability.
- » More evidence-based research is required on Zanzibar's recently launched five year (2021 - 2025) Digital Health Strategic Plan. The goal of this strategy is to increase the provision of safer, equitable, accessible, efficient, and effective health services at all levels through proper use of affordable digital health technologies (World Health Organisation Africa, 2020).

6.2.5 Summary Table on the Right to Health

Table 5.2: Summary Table on the Right to Health

Rights Cluster	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Right to health- General Health Services	2015-2020 Health Sector Strategic Plan (HSSP-IV)	Zanzibar Health Sector Strategic Plan III 2013/14-2018/19 (NHSSP-III) Zanzibar Health Sector Strategic Plan IV 2020/21-2024/25 2021-2025 Digital Health Strategic Plan	Discrimination in health service provision Concerns about the availability, accessibility, affordability, acceptability and adaptability of general health services	More evidence based audit and evaluation of Health Sector Strategic Plans in both the Mainland and Zanzibar	There is need for evidence based audit and performance based health indicators on the availability, accessibility, affordability, acceptability and adaptability of general health services for children and young people with disabilities in both the Mainland and Zanzibar
Disability related health services; Assistive devices	Comprehensive Community Based Rehabilitation in Tanzania (CCBRT)	Zanzibar People with Disability Fund	Concerns about the affordability, availability, adaptability and maintenance of assistive devices	More evidence based research on the availability of local solutions or locally made assistive devices to meet the market demand and supply needs in the country	There is a need for more cost effective and locally available assistive devices in both the Mainland and Zanzibar

Rights Cluster	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Rehabilitation services	2015-2020 Health Sector Strategic Plan (HSSP-IV) Comprehensive Community Based Rehabilitation in Tanzania (CCBRT)	Zanzibar Health Sector Strategic Plan III 2013/14-2018/19 (NHSSP-III) 2021-2025 Digital Health Strategic Plan.	Concerns about the affordability and availability of rehabilitative services	More evidence-based research is required to answer the question of whether subsidies for disability related services such as rehabilitative services is a viable solution.	There is a need for more improved and cost effective rehabilitative services that target children and young people with disabilities in both the Mainland and Zanzibar
Sexual Reproductive Health Services	2015-2020 Health Sector Strategic Plan (HSSP-IV)	Integrated user friendly Sexual Reproductive Health Services in Unguja and Pemba.	Inadequate and inaccessible sexual and reproductive health (SRH) services Harmful social norms that exist about disability and sexuality	More evidence based research on the gendered dimensions of Sexual Reproductive Health Rights (SRHR) and the link between SRHR and violence against women (VAW)	The need for improved SRH services and increased accessibility of SRH services and family planning methods The need for a two track approach to SRH services that includes mainstreaming SRH services into all health sectors and provision of specialised SRH services The need for increased agency for young people with disabilities in relation to SRH services.
Disability related health insurance services	National Health Insurance Fund (NHIF); Social Health Insurance Benefit National Social Security Fund (NSSF); Community Health Fund (CHF) Tiba Kwa Kadi (TIKA).	National Health Insurance Fund (NHIF); Community Health Fund (CHF) Zanzibar New Health Financing Strategy	Limited number of children and young people with disabilities and their families have access to health insurance and social protection services. Concerns about disability identification cards which causes difficulties in accessing government funded health insurance and social protection services.	More health insurance and social protection interventions that target and benefit children and young people with disabilities and their families. Evidence based research on the number of children and young people with disabilities and their families who have access to health insurance and social protection services.	The need for more sustainable health insurance schemes and social protection cash transfers that would target and benefit children and young people with disabilities and their families.

Rights Cluster	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Immunisation	"Reaching Every Child" (REC) strategy The Maternal and Child Survival Program (MCSP) Tanzania Immunisation Registry (TImR)	"Reaching Every Child" (REC) strategy	Disability disaggregated data on the number of children with disabilities that have been immunised is largely unknown. Rural and urban disparities exist in the number of children with disabilities that have been immunised.	More evidence based research, audit and evaluation is needed on the number of children with disabilities is immunised particularly compared to children without disabilities.	There is a need for accurate disability disaggregated data on the actual numbers of children with disabilities that have been immunised. There is a need to prioritise early detection and diagnosis of disability as this intervention would ensure children with disabilities are immunised in a timely fashion.
Mortality	Could not find specific programmes or interventions that targets mortality of children and young people with disabilities.	Could not find specific programmes or interventions that targets mortality of children and young people with disabilities.	Poor neonatal and maternal mortality rates are evident but actual disability disaggregated mortality figures are unknown. Disability disaggregated data on the mortality of children and young people with disabilities is needed.	Preventive and protection programmes and interventions to prevent and curb the mortality of children and young people with disabilities. More evidence based research is required on the causes of mortality of children and young people with disabilities.	There is a need for specific interventions to prevent and curb the mortality of children and young people with disabilities.
HIV/AIDS	2015-2020 Health Sector Strategic Plan (HSSP-IV) Disease Control Programmes in HIV/AIDS	Zanzibar 2013 HIV/AIDS (Prevention and Management) Act 2016-2021 Zanzibar National HIV and AIDS Strategic Plan III	Persistent discrimination based on disability and HIV/ AIDS status making it difficult to access HIV/AIDS treatments.	More evidence based research is required on the number of children and young people with disabilities who have contracted HIV/ AIDS.	There is a need for the mainstreaming of HIV/ AIDS in all sectors of the health system to ensure these services are accessible particularly to children and young people with disabilities who have contracted HIV/ AIDS.
Early detection and diagnosis	2010-2015 National Disability Mainstreaming Strategy 2013 Guidelines on Early Identification and Interventions for Children with Special Needs	Could not find specific programme(s) on early detection and diagnosis in Zanzibar.	Early detection and diagnosis of disability interventions are usually delayed, limited, subjective and ad-hoc.	More attention is required to ensure timely and comprehensive early detection and diagnosis of disability interventions.	The need for early detection and diagnosis of disability interventions to be treated as a cross-cutting and multifaceted issue.

Rights Cluster	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Gendered dimensions	Could not find targeted programmes that specifically coordinates and ensures gender mainstreaming in the health system.	Could not find targeted programmes that specifically coordinates and ensures gender mainstreaming in the health system.	Gender mainstreaming programmes and interventions in the health sector are generally poor and uncoordinated.	Gap in gender mainstreaming programmes and interventions in the health sector	Disability and gender mainstreaming is a crucial and cross-cutting issue that must be considered to ensure the rights to health are enjoyed.

6.3 The Right to Adequate Nutrition

The CRPD contains several provisions that relate to nutrition. For example, Article 25 on health and Article 28 on adequate standard of living and social protection relate to nutrition for persons with disabilities including children and young people with disabilities. Article 11 of the International Covenant on Economic, Social and Cultural Rights also provides for the right to adequate food. This provision is emphasised in General Comment 12 on the right to food.

In the Mainland, 95 out of 100 children born in 2021 reach age 5, but 32 out of 100 children are stunted due to malnutrition which puts them at a higher risk of developing cognitive and physical limitations that have the potential to last their lifetime (WHO, 2020). Studies mention a correlation between malnutrition and disability (Groce et al, 2014 and Holden J & Corby N, 2019). Groce et al (2014) argues that children need good nutrition to avoid the risk of undernourishment which has potential to cause disability. Indeed, research has shown that generally, children with disabilities do not fully benefit from government health programs mainly because the URT's health sector is not adequately inclusive (Inclusive Futures, 2020). Furthermore, because children with disabilities typically come from low-income families, acquiring nutritious food required for healthy growth is difficult. Inadequate vitamins and malnutrition in children can mean increased susceptibility to infections or diseases that can trigger physical, sensory or intellectual disabilities (Groce et al, 2014).

"[...] The government should provide balanced diet and nutrition in school, especially for children with disabilities. For example the children with disabilities come from poor families and cannot [afford] a balanced diet."

(FGD-7, Mainland, 23 April 2021)

According to the UNICEF (2013b) Children with Disabilities report, malnourishment can cause visual impairment in children and estimates that around 250,000-500,000 children under five years are in danger of being visually impaired annually due to lack of vitamin A globally. The 2015-16 TDHS-MIS survey report recorded that 58% of children in URT are anaemic (National Bureau of Statistics & Office of the Chief Government Statistician, 2019). The 2018 Tanzania National Nutrition Survey particularly underlined how maternal undernutrition and underweight during pregnancy contributes to low-birth-weight in babies. Children who are underweight at birth are at greater risk of death during the first 12 months of life, and those who survive, are likely to remain undernourished, putting them at higher risk of developing chronic disabilities.

"Close intervention is needed for the children and young with disabilities, but sometimes they fail to get it and the disability increases. The issue you may find is that these children are born malnourished."

(KII-1, Zanzibar, 26 March 2021)

Specifically, in terms of children's nutritional status, stunting is common among children who are very small at birth (51%). In URT, one in three under five years are stunted and this is an indicator of persistent undernutrition (National Bureau of Statistics & Office of the Chief Government Statistician, 2019). Children from underweight mothers represent 40% of the cases while 40% are those from poor families. The 2015-16 TDHS-MIS states that 58% of children in URT are anaemic and that anemia is especially high among children aged 9-11 months and those whose mothers are illiterate. In the area of childhood illness, diarrhea is the most prevalent disease among children aged 6-11 months (22%) and children under five years (43%). Further evidence from the 2018 Tanzania National Nutrition survey indicates that children born underweight are likely to develop cognitive disabilities which has an impact on education and employment opportunities and eventually affects the country (NBS & OCGS, 2019).

6.3.1 Programmes and Services Relating to Promoting Adequate Nutrition for Children and Young People with Disabilities

Several efforts have recently been taken to tackle the high levels of malnutrition and to improve the nutritional status of children including children with disabilities in the URT. These efforts are essential for children and young people with disabilities considering the link between malnutrition and disability. Some of these efforts include:

- » The 2011/12-2015/16 National Nutrition Strategy applicable to the URT mentions that special attention needs to be given to most 'vulnerable' children (MVC) because such children find it challenging to have access to proper nutritious food due to a lack of or inadequate family care and comprehensive supportive programs. The Strategy defines MVC to include children with disabilities, orphans, children separated from their parents, child labourers, street children, and children infected or affected by HIV and AIDS.
- » Mainland Tanzania is committed to improving the nutrition status of children as indicated in the National Five-Year Development Plan II (2016-2021) which contains key nutritional targets to improve maternal, infant and young child feeding practices (Prime Minister's Office, 2016). The Plan sets out to coordinate several interventions that would lead to proper acute malnutrition management. This intervention is essential considering the number of malnourished children with disabilities in the country. The program aims to conduct training of trainers (TOT) on the treatment of severe malnutrition at the regional level, training of health service providers (e.g., nurses

and clinicians) on the treatment of severe malnutrition at district level.

- » The 2016/17 – 2020/21 National Five Year Development Plan sets out interventions such as Vitamin A supplementation and deworming through Child Health Days and routines to improve vitamin and mineral intake and train health staff on anaemia prevention among women, adolescents, and children at regional and district levels. Other interventions look for ways to promote the enrichment of nutrient density of the diets of young children. Research in matters relating to enrichment of nutrient density of the diets of young children aged six to twenty-three months is conducted.

Similarly, under the 2015-2020 Health Sector Strategic Plan (HSSP-IV) (MOHSW, 2015), the Essential Nutrition Action Approach (ENA) aimed to reach at least 80% of caregivers through health services (World Health Organisation, 2013). It was projected that the percentage of underweight children would reduce from 16% (TDHS 2010) to 11% in 2020. The ENA further aimed to reduce the percentage of stunted children from 42% in 2010 to 27% in 2020. Figures from the 2018 Tanzania National Nutrition Survey conducted in both the Mainland and Zanzibar, indicate that stunting among children under five years old reduced from 42.0% in 2010 to 34.7% in 2014 to 34.4% in 2015 to 31.8% in 2018 (NBS & OCGS, 2019). In Zanzibar alone, stunting in 2018 is 23.5%. This survey does not disaggregate disability, a missed opportunity for robust disability data.

Furthermore, a 2016-2021 National Multi-Sectoral Nutrition Action Plan (NMNAP) adopted by the Mainland stipulates the obligation of the Ministry of Health, Gender, Elderly and Children to achieve the following objectives in relation to nutrition:

- » To strengthen food and nutrition services for discriminated groups, including MVC, people with disabilities, the elderly and people living with AIDS (Prime Minister's Office, 2016).
- » To integrate nutrition components in school health, reproductive health and other relevant programs, remote integration of nutrition objectives in social protection programs.
- » To promote household-based strategies to increase food and nutrition security and promote nutrition supportive behaviours and discourage behaviours that are barriers to improving nutrition.

Specifically, for Zanzibar, there is the Zanzibar Health Sector Strategic Plan III, 2013/14- 2018/19 which has a Nutrition Improvement Programme. Some strategies in the program for children with disabilities include: ensuring Vitamin A supplementation and deworming to every child

aged six months to five years twice yearly and reducing anaemia through routine iron-folate supplementation for pregnant women, deworming and micronutrients supplementation for young children (Ministry of Health-Zanzibar, 2013). In addition, the 2020/2021-2024/2025 Zanzibar Multisectoral Nutrition Strategic Action Plan (ZMNSAP) was developed. The ZMNSAP replaces the 2014-2018 Zanzibar National Multi Sectoral Nutrition Strategy (ZNMS). The recent ZMNSAP is aimed at addressing the high rates and all forms of malnutrition in Zanzibar. The ZMNSAP has set out 14 nutrition objectives to be achieved by 2025. One of these objectives includes reducing the prevalence of stunting among children under five years old by 25% from 23.5% in 2015/16 to 18% in 2024/2025.

The above outlined nutrition-based programmes raise important questions relating to children and young people with disabilities in URT. First, it is uncertain how some of these nutrition-based programmes specifically target children and young people with disabilities with unmet nutritional needs in both the Mainland and Zanzibar. Findings from literature indicate that some of these nutrition-based programmes and objectives are primarily aimed at preventing disabilities that could result from malnutrition. Second, without accurate and reliable disability disaggregated nutrition-based data, the actual number of children and young people with disabilities who are malnourished in both Mainland and Zanzibar is unknown. Third, an evaluation of these nutrition-based efforts and programmes is required to provide critical lessons learned and evidence of the success of the nutrition-based programmes.

6.3.2 Challenges and Barriers to Promoting Adequate Nutrition for Children and Young People with Disabilities Since 2013

Findings from literature review have shown that programmes that focus on malnutrition reduction in Tanzania have remained under-prioritised (NBS & OCGS, 2019). The slow pace of nutrition-specific programmes is attributed to both contextual and programmatic factors such as:

- » Inadequate governance on specific nutrition interventions.
- » Low functional and institutional capacity to meet specific nutritional goals at all levels.
- » Low coverage of high impact nutrition specific and sensitive interventions.
- » Inadequate skilled human resource capacity which affects the quality of interventions (NBS & OCGS, 2019).

In addition, evidence has identified other challenges to include the low awareness by policy makers about the effects of malnutrition; the limited budgetary and resource allocations; inadequate focus on the community and life course for instance reaching communities with large scale nutrition interventions has been slow and some groups such as adolescent girls with disabilities are not covered in the NMNAP (Prime Minister's Office, 2016).

Another challenge identified by the 2018 Tanzania National Nutrition Survey is that although children and women with disabilities were included in the survey, some of the data collected was recorded as missing. Missing data recorded was measured based on physical deformity that prevented the measurement of child's or woman's anthropometric measurements (weight, height or Mid-Upper Arm Circumference (MUAC)) (NBS & OCGS, 2019).

Another major barrier relating to the nutrition needs of children and young people with disabilities is the lack of data, poor quality of data and lack of linkages between financial documents and systems (Oxford Policy Management, 2018). An additional challenge is the link between poverty and nutrition. Evidence from the National Bureau of Statistics (NBS) and UNICEF in the 2019 Tanzania Child Poverty report mentions that children aged 0-23 months are affected by malnutrition (45%) due to the high rate of stunting among children under five years (National Bureau of Statistics & United Nations Children's Fund, 2019). This evidence is consistent with the 2019 Child Poverty Report in Zanzibar. According to the report, children aged 24-59 years are the most undernourished. The report further found that based on individual dimensions, deprivation incidences are highest in the sanitation and nutrition dimensions; in nutrition, amongst these two age groups: 0-23 months (68.7%) and 24-59 months (69.1%).

Further, evidence from a 2014 Research titled "Towards Eliminating Malnutrition in Tanzania: Nutrition Vision 2025" identified several challenges to promoting nutrition generally in URT (Kavishe, 2014). Some of these identified challenges include:

- » Weakened application of nutrition strategies.
- » Low awareness of malnutrition as a challenge at all levels.
- » Weak nutrition accountability mechanisms at all levels in URT.
- » Vitamin A deficiency, Iodine deficiency disorders, and anaemia: These deficiencies present a challenge considering that it holds the potential to increase the number of children with mild or severe intellectual disabilities.

- » The high rates of stunting in Tanzania Mainland and Zanzibar. As stated above, stunted children hold an increased risk of developing cognitive and intellectual disabilities.
- » The low birth weight of children in the Mainland and Zanzibar is another significant barrier. According to the 2018 Tanzania National Nutrition Survey, the prevalence of low birth weight in Mainland was 6.3%. In Zanzibar, the survey reports that the percentage of births with a reported birth weight less than 2.5 kg was 8.3%. The implication for disability is evident considering that children born with low birth weight hold an increased likelihood to become stunted and to have cognitive disabilities and a lower IQ.

6.3.3 Gaps in Promoting Adequate Nutrition for Children and Young People with Disabilities Since 2013

According to the Tanzania National Nutrition Survey 2018, women who are undernourished at conception or during pregnancy contribute to low birth weight babies. And fetuses who are undernourished in the womb are susceptible to death during their early months and years.

But those who survive are likely to remain undernourished throughout their lives, and to suffer a higher incidence of chronic disease, including disability. Children born underweight also tend to have higher risk of cognitive disabilities and a lower IQ, affecting their performance in school and their level of productivity (NBS & OCGS, 2019). Thus, this is a key gap in the implementation programs of NMNAP to address the issues of maternal nutrition to avoid disability health factors.

The following key areas have been identified as needing urgent attention in accessing nutrition for children and young people with disabilities.

1. Gaps in specific programmes and services for children and young people with disabilities relating to nutrition in the Mainland and Zanzibar.
2. Gaps in updated research and data on nutrition for children and young people with disabilities.
3. Limited research and impact assessment on specific interventions that the Mainland and Zanzibar have taken with respect to ending stunting and low birth weight and how this contributes to disability prevalence.

6.3.4 Summary Table on the Right to Adequate Nutrition

Table 5.3: Summary Table on the Right to Adequate Nutrition

Right Clusters	Main programmes and interventions (URT)	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Right to Nutrition	2011/12-2015/16 National Nutrition Strategy	2016/17-2020/21 National Five Year Development Plan 2015-2020 Health Sector Strategic Plan (HSSP-IV) Essential Nutrition Action Approach (ENA) 2016-2021 National Multi-Sectoral Nutrition Action Plan (NMNAP)	2013/14-2018/19 Zanzibar Health Sector Strategic Plan III 2020/2021-2024/2025 Zanzibar Multisectoral Nutrition Strategic Action Plan (ZMNSAP)	High rates of stunting and widespread anaemia contributes to the rates of disability. Disability disaggregated nutrition data is absent or of poor quality.	Gaps in specific programmes, services and data relating to nutrition in both the Mainland and Zanzibar.	There is a need for targeted interventions that focus on the specific nutritional needs of children and young people with disabilities.

Right Clusters	Main programmes and interventions (URT)	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Gendered dimensions	Could not find any specific nutrition based programme and intervention with a gender focus.	Could not find any specific nutrition based programme and intervention with a gender focus.	Could not find any specific nutrition based programme and intervention with a gender focus.	Not only is disability disaggregated nutrition data absent or of poor quality but gender focus is limited.	Gap in specific programmes, services and data relating to nutrition with a gender focus in both the Mainland and Zanzibar.	There is a need for targeted interventions that focus on the specific nutritional needs of girls and young women with disabilities.

6.4 The Right to Employment

Article 27 of the CRPD provides that state parties *recognise the right of persons with disabilities to work on an equal basis with others*. This creates an obligation on states parties to recognise the right of persons with disabilities, including young people with disabilities to work freely and to be accepted in the labour market and in a work environment that is open, inclusive and accessible to people with disabilities (CRPD, Art 27). As discussed in Chapter 2, the constitutions of both the Mainland and Zanzibar, under their directive principles of state policies, mention the state directive to make appropriate provisions for the realisation of the right to work for persons with disabilities, including young people with disabilities. Section 10(7) of the Zanzibar constitution requires the state to facilitate employment opportunities for people with disabilities. However, since these guidelines are directive principles they cannot be enforced in the court of law (Weis, 2017). People with disabilities in the URT then claim their right to work through specific policies and legislations targeted for their welfare, such as- Disabled Persons Employment Act of 1982, and 2010 and 2006 Persons with Disabilities Act in the Mainland and Zanzibar.

Despite the enactment of these laws, people with disabilities, including young people with disabilities, often face marginalisation and discrimination when trying to access employment opportunities (Johansson, 2014). The negative stereotypes associated with people with disabilities make it easier for young people without disabilities to get jobs compared to young people with disabilities. This increases the income gap between the two groups pushing the latter towards poverty and economic dependence on others and the state (Zanzibar Social Protection Policy, 2014). The 2012 PHC census shows that in the URT 70.2% of persons with disability were employed, 27.1% were economically inactive and just

2.7% were unemployed. The overall employment rates are higher in rural areas (74.8%) than in urban areas (58.2%). They are also higher in Mainland Tanzania (70.7%) than Zanzibar (49.9%).

As would be discussed in the subsection below, despite these progressive legislations, persons with disabilities, including young people with disabilities, continue to face challenges in accessing employment opportunities (Inclusive Futures, 2020). Research shows that caregivers of children and young people with disabilities can also have difficulties finding and maintaining employment as well as accessing government financial support programs to help support their children (Johansson, 2014).

6.4.1 Programmes and Services Relating to Promoting Employment for Young People with Disabilities

As a state party to the CRPD, the URT has made some efforts to promote employment of young persons with disabilities in the labour market. The passing of Persons with Disabilities Act, 2010 applicable to the Mainland is an example. Section 31 of the Act obligates both public and private sector employers, with twenty or more employees, to reserve a 3% employment quota for persons with disabilities. In addition, Sections 7 and 8 of Zanzibar's Persons with Disabilities Act, 2006 obligates the Zanzibar government to ensure that (young) persons with disabilities have a right to work and be gainfully employed. The 2014 Zanzibar Social Protection Policy further guides the Zanzibar government to support the establishment of disability grants for persons with inadequate support and who are unable to work, and to support disability awareness campaigns and advocate for the prioritisation of people with disabilities in the labour market.

According to the 2014 Integrated Labour Force Survey applicable to Mainland Tanzania, the overall employment rate for young people aged 15-24 years is 66.2% (National Bureau of Statistics, 2014). In a similar survey report for Zanzibar, the overall employment rate for this age group is reported as 73% (Office of Chief Government Statistician, 2014). In contrast to these figures, the 2016 Disability Monograph indicates that 21.5% (comprising 11.1% females and 10.5% males) of young people with disabilities aged 15-24 in the URT have access to various forms of employment as presented in Table 5.4 (National Bureau of Statistics, 2016). Although the employment rates from the 2014 Labour Force Survey and the 2016 Disability Monograph are from different sources and may reflect variation in calculation methods, the comparison is still significant. These figures demonstrate that in the URT, young people without disabilities aged 15-24 years old are more likely to be employed compared to their counterparts with disabilities.

Table 5.4 shows that the majority of young persons with disabilities are engaged in agriculture, services work, shops and stall sales work. While the prevalence in agriculture could be attributed to the fact that about 65% of the total URT population works in agriculture, it could also reflect a lack of employable vocational skills among young people with disabilities (World Bank, 2021). This idea was supported by one of the key informants (KII-3) who noted that vocational training may not be actively promoted or encouraged for young people with disabilities. She observed:

"I don't think that young people (with disabilities) in adolescence are really promoted or encouraged to join vocational training. And then as you get to 18, the big issue is jobs and work. And that is an issue for so many young people in Zanzibar. One of the big pushes of the government is to try to find employment for people, and they consider it a priority. But sometimes we get lost in that because it becomes a huge thing."

(KII-3, Zanzibar, 24 March 2021)

Another key informant (KII 8) provided a different perspective. She noted that people with disabilities might be trained, however, due to prevailing biases of employers they may fail to find employment as provided under Section 31 of the Mainland's Persons with Disabilities Act, 2010. She, thus, emphasised the need for the active government monitoring of the Act's implementation.

"The government is not yet supporting or enforcing the Disability Act,...This makes the employers quite relaxed, and means that a lot of people with disabilities are not being employed, while they actually have been trained. And that's where the government is not looking at it - to step up and to take the responsibility."

(KII-8, Mainland, 21 April 2021)

Table 5.4: Percentage Distribution of Employment among Young Persons with Disabilities 15-24 Years Old

Occupation type	Male	Female
Administrators and Professionals	0.1	0.1
Technicians, Clerks and small business	0.4	0.4
Service workers, shop and stall sales workers	0.5	0.7
Street vendors and related workers	0.2	0.2
Crafts and related workers	0.5	0.3
Farmers, livestock and fisheries	7.2	7.9

Source: PHC 2012 data reported in the Tanzania Disability Monograph, 2016.

The 2018 Formal Sector Employment and Earnings Survey for Mainland Tanzania notes that persons with disabilities, including young people with disabilities, form only 0.2% of the total workforce in the formal sector (National Bureau of Statistics, 2018). Table 5.5 shows that in both the private and public sectors men with disabilities have higher representation than women with disabilities. It also indicates a higher representation of both men and women with disabilities in the private sector than in the public sector. Ntamanwa (2015) notes the prevalence of perceptions on low productivity of people with disabilities in the URT. Participants with disabilities in the study noted that their fellow staff members perceived them as burdens because of the assistance that they need from their coworkers (Ntamanwa, 2015). Participants also reported being subjected to verbal slurs which the head of the department would ignore or support. The study also noted the struggle of some women with disabilities in achieving higher education and not getting promotions despite meeting all qualifications. Other people with disabilities also shared the same experience of difficulty in accessing promotions.

Table 5.5: Distribution of Regular Employees with Disability by Sector and Sex, Tanzania Mainland, 2016

Sector	Employees with Disability (number)			Percent of Employees with Disability			Total Regular Employees	Employees with Disability to Total Regular Employees (%)
	Male	Female	Total	Male	Female	Total		
Private	1,411	1,011	2,423	35.9	25.7	61.6	1,568,022	0.2
Public	910	603	1,512	23.1	15.3	38.4	848,010	0.2
Total	2,321	1,614	3,935	59.0	41.0	100.0	2,416,032	0.2

Source: Formal Sector Employment and Earnings Survey, 2018.

The caregivers of people with disabilities may lose their jobs due to discrimination in the society and the community members may be reluctant to purchase goods and services from them, especially, when they carry a child with a disability (Johansson, 2014). Furthermore, they may find it difficult to maintain formal employment due to absenteeism resulting from caregiving responsibilities (Johansson, 2014).

One of the policy actions that the Zanzibar government envisaged to take for increasing employment of persons with disabilities is Zanzibar Strategy for Growth and Reduction of Poverty (MKUZA III). To enhance entrepreneurial capacity of people with disabilities, the strategy suggests a Youth Employment Initiatives program that would promote incubation for entrepreneurs by establishing an incubation centre. While such proposals

are important, the URT government's efforts on enhancing employment for young people with disabilities are not as comprehensive as their efforts on other thematic areas such as inclusive education and health. There is a need in Zanzibar for expanded inclusive employment policies and their effective implementation that enable economic independence of people with various disabilities.

6.4.2 Challenges and Barriers to Realising Employment for Young People with Disabilities Since 2013

Findings from the research show that challenges for persons with disabilities in URT continue to exist while accessing employment and livelihoods across sectors.

Some of these challenges include:



To combat these challenges, the URT must focus on factors that can enable persons with disabilities to lead a life of economic independence. These factors, as pointed out by a 2020 study, include education, support of family members, positive attitudes, and entrepreneurship opportunities (Inclusive Futures, 2020).

6.4.3 Gaps in Realising the Right to Employment for Young People with Disabilities Since 2013

The following key areas have been identified as needing attention in accessing the right to employment for young people with disabilities in URT.

1. Gaps in employment services for young persons with disabilities
 - › Insufficient targeted employment services for young people with disabilities
 - › Insufficient support for caregivers of children with disabilities who lose their jobs because of disability-based discrimination. Families with low paying jobs are too poor to provide the intensive care that some children with disabilities require.
2. More nuanced research is required to identify how young persons with disabilities are affected by employment services by impairment type, depending on the severity of their disability and the impact on caregivers and parents in the Mainland and Zanzibar.

6.4.4. Summary Table on the Right to Employment

Table 5.6: Summary Table on the Right to Employment

Rights Clusters	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Right to Employment	Article 31-34 of the 2010 Persons with Disabilities Act	Zanzibar Strategy for Growth and Reduction of Poverty (MKUZA III). Youth Employment Initiatives program	Limited employment opportunities for young people with disabilities	Insufficient targeted employment related programmes and services for young people with disabilities More nuanced research is required to identify how young persons with disabilities are affected by employment services by impairment type, depending on the severity of their disability and the impact on caregivers and parents in the Mainland and Zanzibar.	There is a need for stringent implementation of the laws and policies on affirmative actions and quotas on employment.

Rights Clusters	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Gendered dimensions	No clear programme and intervention that focuses on ensuring increased employment opportunities for young women with disabilities.	No clear programme and intervention that focuses on ensuring increased employment opportunities for young women with disabilities.	Compared to women without disabilities and young men with disabilities, young women with disabilities have fewer and limited employment opportunities particularly in the formal sector.	Gaps in existing research on the actual number of young women with disabilities who have a form of employment.	Greater employment opportunities for young women with disabilities.

6.5 The Right to Quality and Inclusive Education

Article 24(1) of the CRPD provides for the rights of persons with disabilities to education. Specifically, this article recognises the right of persons with disabilities including children and young people with disabilities to be educated without discrimination and based on equal opportunity. The article also stipulates the requirement of state parties to ensure an inclusive education system essential for the 'full development of the human sense of dignity and self-worth and the creativity of persons with disabilities' (CRPD, Art. 24(1)). UNICEF describes inclusive education for children with disabilities as an educational system that emphasises accommodation for all students irrespective of abilities and at all levels of education (UNICEF, 2007). In line with Article 24(2) of the CRPD, several principles provide the basis for the realisation of this right. These include non-exclusion from the general education system, non-discrimination, and reasonable accommodation. Article 24(3) also provides for the right of persons with disabilities including children and young people with disabilities to develop life and social skills to ensure they can participate fully and equally in society. Article 24(4) requires state parties to ensure training and employment of teachers. Lastly Article 24(5) reaffirms the right of persons with disabilities including children and young people with disabilities to access various forms of tertiary education and lifelong learning.

6.5.1. Programmes and Services Relating to Realising the Right to Quality and Inclusive Education for Children and Young People with Disabilities

Children and young people with disabilities remain disproportionately under-represented in schools. In Mainland Tanzania, for example, 51.3% of children with disabilities attend school compared to 52.4% children without disabilities. In rural areas, the proportion of children without disabilities who attend school is 49.2% compared to 36.2% of children with disabilities (National Bureau of Statistics & Office of Chief Government Statistician, 2016). As the CRPD affirms, inclusive education is a fundamental principle for creating equal socio-economic participation for children and young people with disabilities. Several children with disabilities expressed happiness for being in school, often contrasting the school experience with prior experiences of discrimination and isolation. For example, asked why their dominant feeling was happiness during a FGD, children said:

I selected happy feelings in order to gain the lost hope after losing hope when I failed to get the best school that suits my disability.

(FGD-8, Mainland Tanzania, 1 May 2021)

This comes once I found a school, because my parents didn't want to send me to school because they didn't have money but my sister used her money to take me to this school. So this was the source of feeling happy.

(FGD-8, Mainland Tanzania, 1 May 2021)

Estimates of school enrolment rates vary across different sources. However, the Mainland and Zanzibar have established strategies to ensure equitable and inclusive education. Since 2013, the following plans and programmes have been established (MoEST, 2018).

Amongst these Plans and Programmes for the Mainland and Zanzibar include the:

- » 2016/17-2020/21 Education Sector Development Plan.
- » National Strategy for Inclusive Education.
- » Second Zanzibar Education Development Plan (ZEDP II).
- » The Primary Education Development Program.
- » The Secondary Education Development Program.
- » The Teacher Development and Management Strategy.
- » The Adult Education and Non-Formal Education Strategy.

In 2013, the URT joined the Global Partnership for Education (GPE) with a GPE grant of \$94.8 million for the implementation of the Literacy and Numeracy Education Support Program (Education Sector Development

Committee, 2018). Through these strategies and sub-sectoral plans, Tanzania's school enrolment for both children with and without disabilities has improved. According to the MoEST (2019) in the Education Sector Performance Report (2018-2019) for Mainland Tanzania, the number of children with disabilities has increased in the education sector. Table 5.7 shows the education gap between primary and secondary as well as the variation between boys and girls education attainment level:

Specifically for Zanzibar, the Second Zanzibar Education Development Plan demonstrates that children with disabilities have higher rates of school exclusion than children without disabilities. Some of the barriers facing children with disabilities are the narrow conceptualisation of disability inclusive education, lack of appropriate physical infrastructure, shortages of teaching and learning materials (MoEST, 2017). To achieve an inclusive education, having accurate data on the materials and resources needed would help the government shape the response in this area. Using the 2012 HBS census data, the 2019 Zanzibar Inclusive Education Policy indicates a 3-4% disability prevalence rate among 0-19 year-olds, suggesting a significant number of children and young people with disabilities remain excluded from public and private schooling at all levels. The Policy outlines eight key areas through which it plans to achieve inclusive education. One key area worthy of mention is the 2019 Inclusive Education Policy which recognises the need for individual support for learners with disabilities. The Policy states that disability and age-appropriate assistance would be provided to ensure learners can access all levels of education on an equal basis with others. It mentions that consistent with its obligation to provide reasonable accommodation to facilitate learning for all, it would provide assistive devices, augmented methods of communication and software to ensure that learners

Table 5.7: Children with Disabilities in Primary and Secondary School, 2018-2019

Type of disabilities	Primary			Secondary		
	Boys	Girls	Total	Boys	Girls	Total
Visual Impairment	688	493	1,181	283	211	494
Hearing Impairment	3,869	3,343	7,212	900	878	1,778
Physical disability	8,920	6,257	14,806	1,913	1,343	3,256
Intellectual Impairment	8,920	6,257	15,177	63	35	98
Albinism	1,394	1,384	2,778	629	572	1,201
Deaf blindness	433	373	806	71	46	117
Autism	1,091	755	1,846	27	15	42
Low vision	3,322	2,527	5,849	1,665	2098	3,763

Source: Education Sector Performance Report, 2019

can fully participate in educational activities. There is limited information on whether the actions outlined in the 2019 Policy have been implemented or remain aspirational. Nonetheless, initial findings from KIIs and FGDs conducted show that learners with disabilities still face challenges accessing inclusive education on an equal basis with others:

"The issue of inclusive education is also about quality, Quality Inclusive Education. They should be given enough equipment materials, teachers are well trained, not only two weeks of training, and then you say, 'Oh, she's a professional'. So all these should be priority issues. Children need support, for example, children from poor families don't have access to educational materials, uniforms, shoes, all things which are very crucial to support him or her for schooling. Even wheelchairs, or safety devices, brain machines, laptops, whichever special programmes."

(FGD-4, Zanzibar, 25 March 2021).

According to the 2016 Disability Monograph (using data from the 2012 PHC), children aged 5 to 24 years of school attendance age indicated that there is minimal difference between children with and without disabilities (National Bureau of Statistics & Office of Chief Government Statistician, 2016). The report shows that 60% of children with disabilities aged 5-24 years old were attending school in Zanzibar compared to 62.7% of children without disabilities. In Mainland Tanzania, 51.3% of children with disabilities were attending school compared to 52.4% children without disabilities (National Bureau of Statistics & Office of Chief Government Statistician, 2016). A more notable difference applies to rural areas, where the proportion of children without disabilities who were attending school was 49.2% compared to 36.2% of children with disabilities. Generally, the 2016 Monograph noted a higher literacy rate among males with disabilities (69.6%) compared to females with disabilities (60.1%). However, the study showed a greater literacy rate among females (girls) with disabilities aged 10-14 years old at (80.3%) than males (boys) with disabilities (77.3%).

The 2016 Monograph reveals that school attendance for children with disabilities is higher in urban areas (60.9%) than (36.2%) in rural areas. The higher school attendance in urban areas is attributed to favourable education facilities and a high economic status of some urban based families with children and young persons with disabilities. The findings indicate that school attendance has improved for both children with and without disabilities in URT compared to what was identified in the 2013 Situation Analysis (National Bureau of Statistics & Office of Chief Government Statistician, 2016).

6.5.2 Inclusive Education and Early Detection and Diagnosis of Children and Young People with Disabilities

The government of Mainland Tanzania through the MoEST adopted the 2018-2021 National Strategy for Inclusive Education. The Education Support and Resource Assessment Centres (ESRAC) was developed by the MoEST with one of its objectives being the promotion of early identification and assessment of children with disabilities. This 2018-2021 National Strategy mentions its key objectives in relation to inclusive education. Specifically, Objective 4 of the National Strategy provides for the improvement of equity in learning outcomes for all children, adolescents and youth including marginalised groups, to promote achievement in basic and secondary education. To achieve this objective, it outlines in its strategy 4.1, the need to strengthen early identification, assessment and support to learners with disabilities. The National Strategy intends to work towards improving the screening system at pre-primary level to enable early identification of children with disabilities. Similarly, in Zanzibar the MoEVT in the 2019 Zanzibar Inclusive Education Policy mentions the importance of early identification and intervention in school enrolment and overall learning potential of the children and young persons with disabilities. Since July 2020, Tanzanian Shillings (TZS) 20m has been disbursed for education activities, TZS 1m for treatment/medical support and TZS 94m in the form of loans (UNICEF Tanzania, 2020). Not only is this program working across sectors, but it has increased access to pre-primary, primary and secondary education for the most marginalised children, including children with disabilities from the welfare grant.

6.5.3 The Gender Dimensions of Education

As well as helping girls to realise their potential, education can serve as a protective mechanism for girls with disability who are at risk of sexual violence. According to the 2016 Education Statistics in the Pre-primary, Primary, and Secondary Education Statistics in the school, enrolment of boys with disabilities in primary schools was higher than the enrolment of girls with disabilities in 2013, 2014 and 2016. The 2017-18 Tanzania HBS indicates that the primary school net enrolment ratio is 83% and that of secondary school is 33.7% (National Bureau of Statistics, 2019a). Further, the ESDP 2016/17-2020/21 states that the enrolment for girls is higher compared to that of boys and boys often drop out of school to support their families with livestock rearing.

Girls, on the other hand, drop out of school when transitioning from primary to secondary school. According to UNICEF Tanzania's 2020 Education for All Out of

School Children in Zanzibar, teenage girls drop out of school and low enrolment can be attributed to early marriage, health related problems such as pregnancy, HIV/AIDS and hygiene (menstruation). The report identified the establishment of a unit at the Ministry of Education in Zanzibar that identifies young mothers who have left school, provides them with psychosocial support and re-enrols them in school. A 2018 Mapping Study conducted by the Zanzibar Ministry of Education and Vocational Training, Milele Zanzibar Foundation and UNICEF, reported that 75% of pregnancy cases during the last three years resulted in the pupil dropping out from school and that 16% of all primary and secondary schools have had at least one pregnancy or early marriage case during the last three years.

6.5.4 Challenges and Barriers to Realising the Right to Quality and Inclusive Education for Children and Young People with Disabilities Since 2013

1. Challenges to Accessing Education at All Levels

The MoEST (2018) indicates in the Education Sector Development Plan (ESDP) 2016/17-2020/21 that around 400,000 school-aged children with disabilities live in Mainland Tanzania. However, only 42,783 are registered in primary and 8,778 in secondary schools (Ministry of Education Science and Technology, 2018).

Despite the efforts made by the government, many children with disabilities do not get the chance to access education. The education gap affects both boys and girls with all types of disabilities (MoEST, 2018). A 2018 Mapping study conducted by the Zanzibar Ministry of Education and Vocational Training, Milele Zanzibar Foundation and UNICEF provided evidence on the disproportionate exclusion of children with disabilities from school. The 2018 study compared enrolment data of children with disabilities with disability rates among the population demonstrating much higher rates of exclusion from schools. According to the 2018 study, a large percentage of children with disabilities (sight, hearing, or motor impairments) are excluded from school, and such children constitute about 1% of total school enrolment.

2. Challenges to Accessing Inclusive Education

- » Emphasis for inclusive education ends at primary level making it difficult for children and young people with disabilities to join secondary education and institutes of higher learning.

- » Evidence from the 2019 Zanzibar Inclusive Education Policy emphasises the reality on the ground where there are special units to support children and young persons with disabilities but the inclusive education approach is not appropriately and suitably incorporated because of inadequate teacher training and facilities. The Policy further noted the challenges with inaccessible ICT equipment. Staff are not properly trained to use ICT equipment or use alternative communication methods such as sign language or Braille.
- » Challenges with education funding, specifically inadequate funding and resources to ensure the full incorporation of inclusive education in the URT.
- » The existing 'special' schools in both the Mainland and Zanzibar appear to be inconsistent with the CRPD. 'Special' in the context of disability can lead to discrimination.
- » Negative and discriminatory attitudes towards children and young people with disabilities.
- » Information, geographical and environment inaccessibility: The long distance to schools including the unavailability and inaccessibility of public transport systems pose challenges to learners with disabilities. Findings from the FGD with parents of children with disabilities confirm the inaccessibility of public transport systems:

"...challenges like wheelchair because the kid does not have a wheelchair so when it comes to transporting her from place to place especially from school to school. It is kind of difficult, because it's very difficult to carry the child. Sometimes they have to walk long distances because they cannot get transport."

(FGD-2, Zanzibar, 24 March 2021)

- » Inadequate funding for the appropriate and accessible infrastructure in schools and classrooms for children and young people with disabilities.
- » Inadequate teachers with specialised training on inclusive education for children and young people with disabilities in URT. This point is supported by a 2018 Mapping study conducted by the Zanzibar Ministry of Education and Vocational Training, Milele Zanzibar Foundation and UNICEF that observed how teachers lack training for inclusive education. The 2018 study identified how less than 20% of schools have at least one teacher with some training on how to identify and teach children with disabilities, and only 8% of all schools reported having at least one teacher trained in gender-responsive pedagogy (GRP).



- » Lack of teaching and learning materials. This point is buttressed by a 2018 Mapping study conducted by the Zanzibar Ministry of Education and Vocational Training, Milele Zanzibar Foundation and UNICEF that showed the provision of teaching and learning materials for children and young persons with disabilities is far from adequate. The 2018 study identified that, of the schools that enrol children with disabilities, only 7.6% have material for sight-impaired children, 2.5% have material for hearing-impaired children, only 30% of all school entrances and in-use classrooms are accessible, and 15% of functional toilets are accessible.

Findings from the FGD with parents of children with disabilities confirm and summarise some of the listed challenges to realising inclusive education:

"The first issue was wheelchairs, the second one was learning materials like books, the other one was transport. The other thing was the issue of not having enough teachers for inclusive education. The other issue was about the lack of Braille machines and then there is the other issue of supporting children to get tuition for the out of school additional learning."

(FGD-2, Zanzibar, 24 March 2021)

6.5.5. Gaps in Realising the Right to Quality and Inclusive Education for Children and Young People with Disabilities Since 2013

There are many challenges to providing a CRPD aligned inclusive education system in Tanzania. Mainland and Zanzibar face similar challenges, and these include:

- » An over reliance on 'special' schools that segregate children with disabilities from children without disabilities.
 - This results in long and expensive transportation and does not help the community understand how to interact with children who have disabilities.
 - There is no incentive for local schools to enrol children with disabilities.
 - Even with this 'special' school model there is a shortage of assistive devices, accessible classrooms and trained teachers.
 - Rural areas face less enrolment of children with disabilities than urban areas because the distances that need to be traveled to reach a 'special' school are longer and more costly than urban areas (and the rural population is more impoverished).

- » There is evidence that mainstream schools are not inclusive of their existing pupils either - children drop out of school for many reasons including the need to work and teenage pregnancy.

The evidence for an inclusive education system in terms of the barriers and challenges to learning for children and young people with disabilities and the costing of an inclusive versus special school model are missing.

6.5.6. Summary Table on the Right to Quality and Inclusive Education

Table 5.8: Summary Table on the Right to Quality and Inclusive Education

Rights Clusters	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Right to quality and inclusive education	2016/17-2020/21 Education Sector Development Plan. The Primary Education Development Program. The Secondary Education Development Program. The Teacher Development and Management Strategy.	National Strategy for Inclusive Education. Second Zanzibar Education Development Plan (ZEDP II) 2019 Zanzibar Inclusive Education Policy	Efforts to make education inclusive remain at the primary level. 'Special' schools existing in both Mainland and Zanzibar seems to be inconsistent with the CRPD provisions and may lead to discrimination.	Evidence for an inclusive education system in terms of the barriers and challenges to learning for children and young people with disabilities and the costing of an inclusive versus special school model is missing.	There is a need for more concrete efforts aimed at ensuring inclusive education at all levels of education in both Tanzania Mainland and Zanzibar.
Quality and inclusive education and early detection and diagnosis	2018-2021 National Strategy for Inclusive Education. The Education Support and Resource Assessment Centres (ESRAC)	2019 Zanzibar Inclusive Education Policy	Early detection and diagnosis of disability in the education sector is still largely limited and ad-hoc.	Gaps still exist relating to the early detection and diagnosis of disability amongst learners with disabilities particularly learners with developmental and intellectual disabilities.	Early detection and diagnosis of disability needs to be a cross-cutting and multifaceted issue.
The gendered dimensions	No clear programme and intervention to ensure that girls with disabilities remain in school.	Re-enrolment unit Zanzibar Ministry of Education It is still unclear the specific programmes and interventions that the Unit takes to ensure girls and young women with disabilities remain in schools.	Girls and young women with disabilities still face challenges in school attendance.	A lot of data on education is gathered in both Mainland and Zanzibar but the gap exists where this data is not disaggregated by gender, disability and age.	There is a need for accurate and reliable education and school enrolment data that is disaggregated by gender, disability and age.

6.6 Rights to be Free from Exploitation, Violence and Abuse

Compared to children and young people without disabilities, children and young people with disabilities are particularly susceptible to violence and all forms of discrimination because of their disability. Article 16 of the CRPD requires all state parties to take all necessary legislative, administrative, social and educational steps to ensure that persons with disabilities, including children and young people with disabilities, are protected from all forms of exploitation, violence and abuse.

6.6.1 Exploitation, Violence and Abuse of Girls with Disabilities

Globally, women and girls with disabilities are disproportionately affected by violence and all forms of discrimination (Inter-American Development Bank, 2019). The CRPD in Article 16 recognises the gendered dimensions of violence, abuse and exploitation. It requires all state parties to take all necessary steps to protect persons with disabilities, including children and young people with disabilities. The Mainland and Zanzibar have made several efforts to ensure that children and young people with disabilities are free from exploitation, violence and abuse. Section 5 of the 2010 Persons with Disabilities Act that applies to the Mainland forbids all forms of disability-based discrimination. Article 8(5) of the 2009 Law of the Child provides that *children with disabilities should not be subjected to degrading treatments*. Similarly, Section 11 of the 2011 Children's Act in Zanzibar explicitly prohibits inhumane and degrading treatment of children with disabilities by anyone.

6.6.2 Gender and Disability

When gender and disability intersect, women with disabilities face double and sometimes multiple forms of discrimination. Grobbelaar-du-Plessis (2007) demonstrates that women and girls with disabilities tend to encounter more discrimination than women without disabilities. For example, according to a 2017 ADD research, nine out of ten girls with intellectual disabilities were sexually violated without family and community members intervening (ADD, 2017).

Article 6 of the CRPD recognises the multiple and intersecting forms of discrimination that women and girls experience daily. Specifically, General Comment 3 on Article 6 adopted by the CRPD Committee in 2016 complements this article by expressing concern about the violence, sexual and reproductive health and rights and discrimination committed against women and girls with disabilities globally. According to the General Comment, women and girls with disabilities encounter

these violations on account of their gender, disability, and other factors, which are not adequately addressed in legislation and policies of most countries (Inter-American Development Bank, 2019).

6.6.3 Programmes and Services Relating to Realising the Right of Children and Young People with Disabilities to be Free from Exploitation, Violence and Abuse

Although the Government of Mainland Tanzania has shown some commitment to ending violence against women through the adoption of a 2017/18-2021/22 National Action Plan to End Violence Against Women and Children in Tanzania, it is not clearly laid out how the Plan intends to end discrimination that women and girls with disabilities face daily. There are no specific laws that explicitly criminalise multiple and intersecting forms of disability and gender-based discrimination that women and girls with disabilities face daily in the country. Nevertheless, the Government of the Mainland Tanzania has taken some measures to end the violence committed against children and young people with disabilities. The 2013-2017 National Costed Plan of Action for the Most Vulnerable Children was operationalised to provide child protection services and services to children out of family care, children with disabilities, and children in conflict with the law. The 2017/18 - 2021/22 National Action Plan to End Violence against Women and Children in Tanzania (NPA-VAWC) has also been adopted to develop a Women and Child Online Protection Programme. This Programme is expected to orient decision makers, religious leaders, local leaders and private sectors on efforts to end violence against women and children.

Zanzibar has also taken steps to address violence against women and children through the 2017-2022, National Plan of Action to address violence against women and children and through the 2014 Zanzibar Social Protection Policy (which specifically aims to address the issue of violence against school-age children). While the National Action Plan does not have particular steps to address violence against children with disabilities, some of the general action plans from which children with disabilities can benefit include: development of Women and Child Online Protection programme and orientation of stakeholders including decision makers, religious leaders, local leaders and private sectors representatives to inculcate positive behaviour for children; strengthening and institutionalisation of the Child Helpline and available referral mechanism; creating safe school spaces by training students and teachers on the rights of children. Moreover, a Child Protection

Referral System aimed at providing public education to challenge social norms condoning violence against children is to be established.

The accessibility of these online protection and helpline services for children and young people with disabilities needs to be monitored and assured. An example of measures to end violence against children is the C-Sema which runs the National Child Helpline together with the URT Government. It has two helpline call centres; one in Zanzibar and the other one in the Mainland. These helpline call centres work towards helping children who need care and protection through a toll free 116 telephone number available in URT. However, very little is known about accessibility of these helpline services for children and young people with disabilities.

6.6.4 Challenges and Barriers to Realising the Right of Children and Young People with Disabilities to be Free from Exploitation, Violence and Abuse

As shown above, the Mainland and Zanzibar have general policies and laws prohibiting disability-based discrimination. However, according to a 2017 study on the drivers of violence against children and positive change in Tanzania and Zanzibar, there are still challenges particularly for violence against children with disabilities (MOHCDEGC, MZumbe University, University of Huddersfield and UNICEF, 2017). This study found that isolation and neglect of children with disabilities was prevalent, along with killings of children with disabilities. Generally, children with disabilities were more susceptible to violence because communities tend to ignore any acts of violence committed against them. Laws and policies do not specifically address the multiple and intersecting discrimination that disproportionately affect young women and girls with disabilities.

Research connects early marriage to violence and FGM to disabilities. A 2017 ADD research documents how girls and young women with disabilities in Mainland Tanzania are forced to marry spouses who many times become perpetrators of all forms of violence including domestic, sexual and economic violence. This study also found that FGM has the potential to cause disabilities in girls and young women without disabilities and increase the severity of disabilities in girls and young women with disabilities (MOHCDEGC, MZumbe University, University of Huddersfield and UNICEF, 2017). More studies should be commissioned on the various manifestations of violence against girls and women with disabilities particularly prevalence of sexual abuse, female genital mutilation and forced sterilisation of women and girls with intellectual disabilities in the URT.

A 2018 research dissertation conducted in Zanzibar found the following to exacerbate the exploitation, violence and abuse of children and young people with disabilities (Hamad PA, 2018):

- » There is a lack of implementation of the 2006 Persons with Disabilities (Rights and Privileges) Act particularly for young women with disabilities.
- » Family members who are supposed to protect young women with disabilities from violence can sometimes be perpetrators of this violence and makes it difficult for violence to be reported for fear of reprisals.
- » Organisations of Persons with Disabilities (OPD) often focus their interventions and attention on women with disabilities in urban areas to the detriment of women with disabilities living in rural areas.
- » Police and the criminal justice actors do not take reports of violence on young women with disabilities seriously.

As discussed in previous sections, the social norms that consider children with disabilities to have less rights than children without disabilities shapes the support available.

6.6.5 Gaps in Realising the Right of Young Women and Girls with Disabilities to be Free from Violence, Abuse, Neglect and Exploitation Since 2013

Since 2013, little progress has been made on addressing the violence, abuse, neglect and exploitation of young women and girls with disabilities. This will be a difficult problem to address due to the intersecting norms that surround gender inequality and disability inequality and the ways they combine and mix with other inequality vectors such as discrimination in the law and rural poverty. The following are found to be necessary to begin to address the violence, abuse, neglect and exploitation of young women and girls with disabilities:

- » **Address harmful and negative social norms:** Prevalent discriminatory and stigmatising attitudes towards gender and disability in both the Mainland and Zanzibar makes girls and young women with disabilities increasingly susceptible to sexual violence and domestic violence.
- » **Empower girls and young women with disabilities:** Group based empowerment programs (Kapinga et al., 2019), microfinance, community engagement (UNESCO, 2020) and economic empowerment (Vyas, 2013) can prevent and reduce women's and girl's experiences of violence. What this

means for young women and girls with disabilities requires further study.

- » **Disaggregate statistics by gender and disability:** There is a need for disability disaggregated data on the actual numbers of girls and women with disabilities who experience these kinds of violence to ensure targeted and proactive preventive measures.
- » **Produce advocacy statistics:** Commissioning studies that produce advocacy figures that make an investment argument can help in raising awareness for the issue and the need for action. For example, “economists found that investing in the elimination of gender-based violence is one of the 19 most cost-effective SDG targets” (Women Deliver, n.d.).
- » **Increase research and funding:** More research is required on the root causes of violence and abuse of women and girls with disabilities and the way this can intersect with other discriminatory and harmful norms such as early and forced marriages.
- » **Develop multifaceted Criminal Justice Response:** There is a need for criminal justice actors especially law enforcement officers to be more responsive to gender and disability based violence. Multifaceted and well-coordinated approaches by the criminal justice system to ensure that girls and young women with disabilities who are violated get the much needed support and redress.
- » **Develop an intersectional response:** There is need for improving legislation in both the Mainland and Zanzibar so that it covers intersectional discrimination and violence faced by young women and girls with disabilities.
- » **Consult women and girls with disabilities:** Programmes and services that focus on violence against women generally do not pay sufficient attention and address the specific interests and concerns of women and girls with disabilities.

6.6.6. Violence and Abuse of Children with Albinism

Children with albinism are disproportionately affected by violence and different forms of discrimination in the URT (United Nations Population Fund, 2018). According to the 2016 United Nations Independent Expert on the Enjoyment of Human Rights by Persons with Albinism, children with albinism are more likely to be abandoned, stigmatised and marginalised because of their looks and other disability factors connected with their condition, such as impaired eyesight and sensitive skin (United Nations, 2016b).

The 2019 Human Rights Watch report linked the numerous forms of discrimination faced by children with albinism in the URT to the misleading perception that their body parts hold supernatural powers that bring good luck and wealth. This belief is reinforced by evidence documented by the United Nations Independent Expert on the Enjoyment of Human Rights by Persons with Albinism in 2016, describing how children with albinism are often targets of violence because of superstitious beliefs that the innocence of a victim from whom body parts are taken increases the potency of the potion for which the body parts are used. Because of these beliefs, traditional healers and sorcerers in many East African countries often hunt children with albinism for human sacrifice (Human Rights Watch, 2019). Children with albinism face stigma and discrimination and mutilation or murder by traditional doctors. Further, many children with albinism are denied the right to attend education by their parents and caregivers as means of protection (Under the same sun, 2016).

The United Nations Independent Expert on the Enjoyment of Human Rights by Persons with Albinism 2016 report highlighted that gender is a significant factor in the severity of discrimination experienced by women and girls with albinism (Human Rights Council, 2016). She explains that women and children with albinism are particularly susceptible to violence manifesting as intersecting and multiple forms of discrimination (Human Rights Council, 2016). In addition, children are particularly targeted for ritual killings and women and girls are sometimes victims of sexual violence. This increased vulnerability is spurred by the misconception that having sexual relations with a young woman or girl with albinism can heal HIV/AIDS.

In Article 16, the CRPD addresses the violence and mandates all state parties to take all necessary legislative, administrative, social and educational steps to ensure that persons with disabilities including children and young people with disabilities are protected from all forms of exploitation, violence and abuse.

6.6.6.1. Programmes and services relating to realising the right of children and young people with albinism to be free from exploitation, violence and abuse

Based on the 2017/2018 HBS statistics, there are approximately 128,000 (0.6%) children and young people with albinism in Mainland Tanzania (HBS, 2017/2018).

The 2016 Under the Same Sun report found that since 2006 there have been 158 reports of violence against people with albinism in Tanzania including 76 killings, 63 survivors, one abduction and 18 grave violations

(Human Rights Watch, 2016). In addition, the African Committee of Experts on the Rights & Welfare of the Child in their 2016 investigative report about children with albinism state that there are currently 32 holding centres for children with albinism in mainland Tanzania and that there are no cases of death reported from the shelters. The Buhangija Center in Shinyanga District holds 405 children with disabilities of which 301 (156 boys and 146 girls) are children with albinism, 40 (27 boys and 13 girls) children with visual impairment and 64 (30 boys and 34 girls) children with hearing impairment (African Committee of Experts on the Rights & Welfare of the Child, 2016).

Apart from being the targets of violence, children with albinism also experience sunburn that affects their skin and can cause skin cancer before they reach the age of 40 years old. This argument is consistent with a 2019 report that demonstrates a high morbidity and mortality of

children with albinism at an early stage due to skin cancer (Tanzania Albinism Society & Karagwe Community Based Rehabilitation Programmes report, 2019).

The Government of the URT has taken some measures to end the violence committed against children with albinism (See Section 5.6.3 above). Recent findings from an empirical study conducted by a World Report 2020 show that attacks and abductions of children with albinism have reduced since 2015. This point was reiterated in the key informant interviews. According to the KIs "there are no more killings of children with albinism in the country" (KI15, Tanzania Mainland 6 April 2021). However, there is some evidence that suggests that families of children with albinism continue to live in fear in the URT (Human Rights Watch, 2020). Moreover, the UN FGD commented that evidence of such violence and killings can be found in police reports across the URT.

6.6.6.2. Challenges and barriers to realising the right of young children and young people with albinism to be free from exploitation, violence and abuse since 2013



6.6.6.3 Gaps in realising the right of children and young people with albinism to be free from exploitation, violence and abuse since 2013

Current research and information deduced from the key informant interviews suggest that there are no more

killings of children and young people with albinism. However the discriminatory and stigmatising attitudes that reinforce such violence and killings still remain. This means that unless stringent efforts are taken by the law enforcement and criminal justice system in this area, the possibility of the killings to resurface remains.

6.6.7 Summary Table on the Right to be Free from Exploitation, Violence and Abuse

Table 5.9: Summary Table on the Right to be Free from Exploitation, Violence and Abuse

Rights Cluster	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Right of children and young people with disabilities to be free from exploitation, violence and abuse	2017/18-2021/22 National Action Plan to End Violence Against Women and Children (NPA-VAWC) 2013-2017 National Costed Plan of Action for the Most Vulnerable Children	2017-2022, National Plan of Action 2014 Zanzibar Social Protection Policy	Negative and discriminatory attitudes reinforce violence and abuse. Certain groups for example, girls and young women with disabilities experience increased violence and abuse. Lack of specific intersectional laws that explicitly criminalise multiple forms of disability based discrimination and violence. Long term implications of violence especially for children and young people with albinism.	Gaps in research on specific root causes of violence against children and young people with disabilities.	The need for specific intersectional laws that explicitly criminalise multiple forms of disability based discrimination and violence.

6.7 The Right to Social Protection

Article 28 of the CRPD requires state parties to promote the right to social protection for persons with disabilities, including children and young people with disabilities, through measures that intersect with other rights clusters addressed in this chapter including ensuring access to “appropriate and affordable services, devices and other assistance for disability-related needs.” It obligates states parties to uphold, among others, the rights of persons with disabilities and to ensure that they have “an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and [have] the continuous improvement of living conditions” on an equal basis with others without any discrimination. By adopting an intersectional framework, the Article further requires states parties to ensure access to social protection programmes and poverty reduction programmes for persons with disabilities, particularly for women and girls with disabilities and older persons with disabilities.

Persons with disabilities and their families in URT are more likely to experience poverty, food insecurity, and vulnerability to different forms of shocks than the general population (Tiwarei et al., 2019). The 2016 Disability Monograph indicates that living conditions are generally better in households headed by persons without disabilities than the ones headed by persons with disabilities based on key standard of living indicators. For instance, 14.7% of households headed by a person with disabilities use electricity compared to 20.0% of households headed by a person without disabilities. Similarly concerning toilet facilities, 32.9% of households headed by a person with disabilities use pit latrine without washable/soil slabs compared to 29.8% of households headed by a person without disabilities (National Bureau of Statistics and OCGS, 2016).

The programmes, services, barriers, and challenges discussed in this chapter’s previous sections on health insurance, rehabilitation, nutrition, and employment are relevant to the realisation of the right to social protection for persons with disabilities. Hence, this section attempts to tie the various rights available to persons with disabilities, particularly children with disabilities, under the overarching theme and right of social protection.

6.7.1 Programmes and Services Relating to Realising the Right to Social Protection for Children and Young People with Disabilities

The URT government has taken proactive steps to fulfil its obligations to provide social protection under the

CRPD’s Article 28. As noted in section 5.2.2.5., the URT government has enacted multiple publicly owned social insurance schemes. The National Social Security Fund (NSSF), provides pension, unemployment, and health insurance coverage for employees in sectors of the economy that do not fall under government employee pension schemes. NSSF benefits include retirement benefits, maternity benefits, social health insurance, and “invalidity pension” which aims to “guarantee income security to the insured person who has permanently lost his earning capacity, resulting from accident or illness” (NSSF, 2021). The URT government also operates the NHIF, CHF, and TIKa which provide health insurance. Research, however, reveals that about 33.3% persons with disabilities had subscribed to CHF and NHIF (Ifaraka Health Institute, BMZ & GIZ, 2013). There is, thus, a need for the URT government to direct efforts for increasing the accessibility of these social protection schemes for persons with disabilities.

Zanzibar also has its own dedicated social protection policy and programmes. The Zanzibar Social Policy (2014) lists four objectives of social protection in Zanzibar: “to contribute to minimum income security, to provide adequate protection against life-course shocks and livelihood risks, to extend basic social services, for all citizens and residents of Zanzibar and to strengthen multisectoral coordination of all stakeholders working on social protection” (p. 14). The aim is to reduce poverty, deprivation and vulnerability and to improve access to health, education among beneficiaries. The government of Zanzibar offers two main social protection schemes: the Productive Social Safety Nets (PSSN) and the Zanzibar Universal Social Pension programmes. These programs are non-contributory benefits that provide cash or in-kind support to impoverished persons and persons with disabilities. In the case of PSSN, the programme has also been designed to create productive linkages within local economies. In addition, social assistance programmes are categorised into programs (i) conditional cash transfers, (ii) unconditional cash transfers (iii) social pensions; (iv) in-kind transfers; (v) school feeding; (vi) public works; (vii) fee waivers and targeted subsidies; and (viii) other social assistance programmes (Revolutionary Government of Zanzibar & UNICEF, 2018). The Zanzibar Government also established the Zanzibar People with Disability Fund in 2002 to assist persons with disabilities access loans for activities such as self-employment and to purchase assistive devices (Tanzania Human Rights Report, 2017). However, parents of children with disabilities interviewed for this Situation Analysis indicated that access to these funds remains an issue due to high registration costs.

Evidence from empirical research shows that despite these schemes outlined above, social protection schemes and services are not regarded as a priority. According to a KII:

"Priority issue is, I think, social protection. Social protection for children with disabilities or (young) people with disabilities. Because, these children are facing many problems. And they need cash transfer. As I've said before, they have families of more than one child they need support. So social protection, safety nets should be given priority."

(KII-1, Zanzibar, 25 March 2021)

Apart from these schemes, as discussed earlier in this chapter, Mainland Tanzania's 2015-2020 Health Sector Strategic Plan (HSSP-IV) includes provisions to strengthen community-based rehabilitation (CBR) that would support and provide services for children and young people with disabilities. Under the plan, the MOHSW of the Mainland government was tasked to implement the program in collaboration with non-governmental partners. As noted previously, there is no publicly available evaluation of the HSSP-IV implementation to assess the extent to which its CBR provisions have been implemented.

With respect to employment, the Mainland government through its Persons with Disabilities Act (2010) attempted

to promote employment of young persons with disabilities. The Act's Section 31 obligates both public and private sector employers, with twenty or more employees, to reserve a 3% employment quota for persons with disabilities. The Zanzibar government also envisaged increasing employment of persons with disabilities through Zanzibar Strategy for Growth and Reduction of Poverty (MKUZA III). The strategy suggests a Youth Employment Initiatives program to enhance the entrepreneurial capacity of people with disabilities by establishing an incubation centre. Due to the absence of publicly available reports and evaluations, it is unclear whether the Youth Employment Initiatives proposed in MKUZA III have been implemented and have benefited people with disabilities. While these targeted employment initiatives are important steps in addressing employment barriers, the URT government's efforts on enhancing employment for people with disabilities, including young people with disabilities, are not as comprehensive as their efforts on other thematic areas such as inclusive education and health.

6.7.2. Challenges and Barriers to Realising The Right to Social Protection for Children and Young People with Disabilities

Challenges for children and young people with disabilities in accessing social protection continue to exist in the URT.

Some Challenges Include:

1. Lack of accessibility of disability-related health insurance and social security services for persons with disabilities in general and children and young people with disabilities in specific.
2. Inadequate financial support schemes, such as cash transfers and social pension for children with disabilities and their families; particularly in the Mainland. Barriers to access to assistive devices, a point highlighted by children with disabilities and their parents interviewed for the study.
3. Lack of targeted employment support and vocational programs for children and young people with disabilities. This affects the standard of living of persons with disabilities and their families, contributing to their poverty in the long run.
4. Low coverage of high impact nutrition specific and sensitive interventions for children and young people with disabilities and inadequate governance on specific nutrition interventions.

There are significant gaps in coverage of households with members with disabilities by social security schemes. The 2016 Disability Monograph found that 10% of all families headed by a person with a disability were members of one of the social security schemes in the URT. The Monograph further identified the presence of rural/urban disparities in access to social security schemes by persons with disabilities. The findings indicated that while on an average persons with disabilities have a lower access to Social Security Schemes, the access is higher in urban areas (Mainland: 14.9%, Zanzibar: 15.5%) than rural areas (Mainland: 7.6%, Zanzibar: 9.4%). As noted in section 5.2.2.5, financial barriers as a key issue of concern for people with disabilities living in Tanzania to access health services (Ifaraka Health Institute, BMZ & GIZ, 2013). There is a need for both the Mainland and

Zanzibar to direct efforts towards increasing accessibility of social security schemes for persons with disabilities and their families, especially in the rural areas.

To combat these challenges, the URT must adopt an intersectional approach to ensure that children and young people with disabilities coming from various backgrounds can access their rights. Further, given the intersecting nature of rights under the spectrum of social protection, the government must also adopt an inter-stakeholder approach and utilise the strengths of various stakeholders, like- parents of children and young people with disabilities, non-governmental organisations, various ministries under the government, etc to ensure access of rights of children and young people with disabilities.

6.7.3. Gaps in Realising the Right to Social Protection for Children and Young People with Disabilities

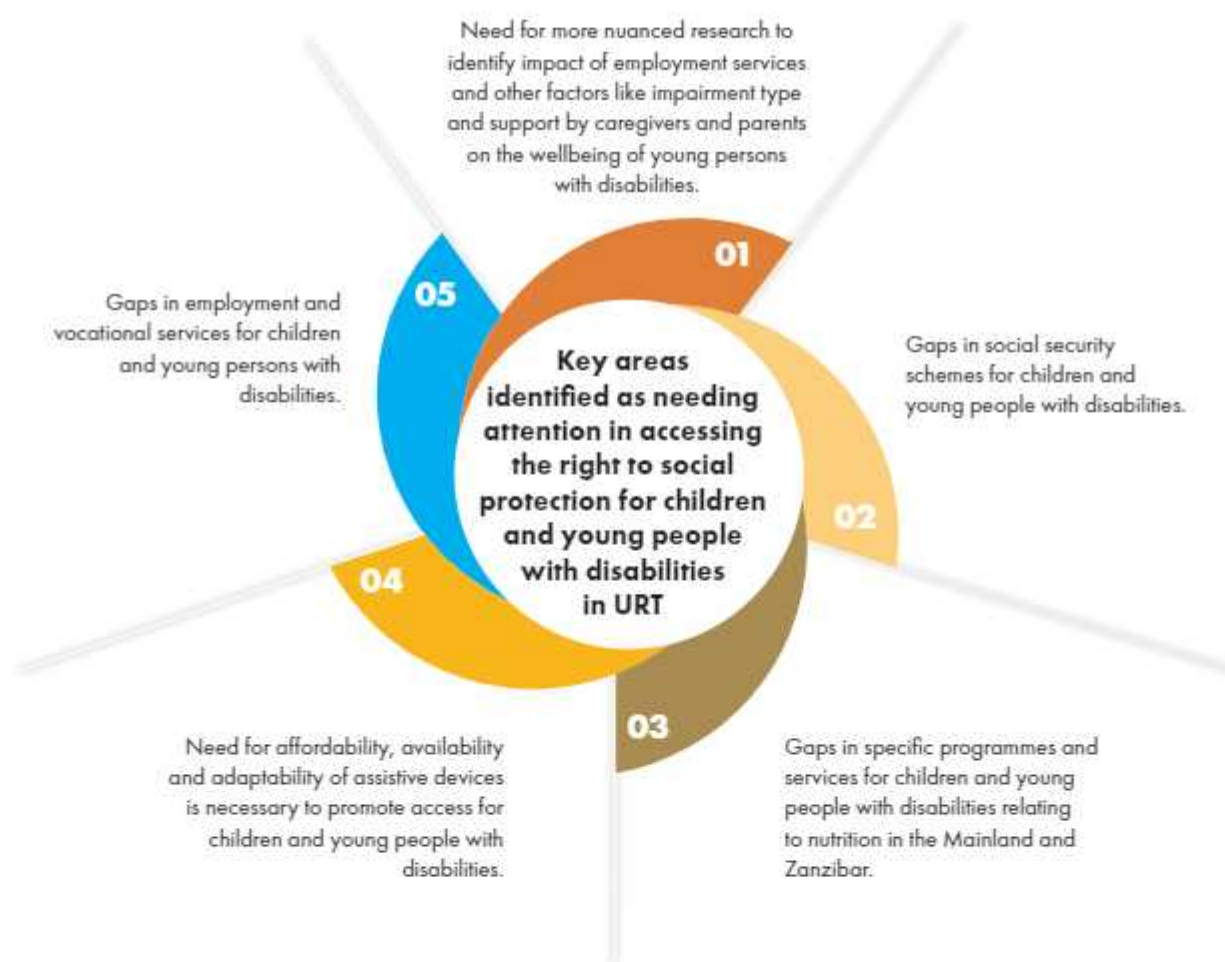


Table 5.10: Summary Table on the Right to Social Protection

Rights Cluster	Main programmes and interventions (Mainland)	Main programmes and interventions (Zanzibar)	Main challenges and barriers	Main gaps	Recommendations
Right to social protection	National Social Security Fund (NSSF) 2015-2020 Health Sector Strategic Plan (HSSP-IV) National Social Protection Framework (2016)	Productive Social Safety Nets (PSSN) Zanzibar Universal Social Pension programmes. Zanzibar 2014 Social Protection Policy	Limited number of children and young people with disabilities and their families have access to social security schemes and other social protection programmes. Insufficient social protection programmes and services that are cross cutting and intersecting with other services. Concerns about disability identification cards which causes difficulties in accessing government funded social protection services.	More social protection interventions that target and benefit children and young people with disabilities and their families. Evidence based research on the number of children and young people with disabilities and their families who have access to social protection services.	Need for more social protection cash transfers that would target and benefit children and young people with disabilities and their families. Address the gaps and barriers to access health, nutrition, employment and income support programs that contribute to social protection.

6.7.4. Summary Table on the Right to Social Protection

Realising the right to social protection and adequate standard of living for children and young people with disabilities requires cross-sectoral interventions and services. Key programmes, interventions, barriers, and gaps outlined in earlier sections of this chapter are also relevant to social protection, including: health insurance, rehabilitation services, assistive devices, employment supports, and nutrition supports.

6.8 Key Findings and Conclusions

This chapter discussed programmes and services that the URT has implemented in an effort to guarantee the rights for children and young people with disabilities. It started with the right to health care and covered access, assistive devices, habilitation and rehabilitation services, sexual reproductive health services, health insurance services, immunisation, mortality, HIV/AIDS, early detection and diagnosis and found that while some progress has

been made in advancing the rights to health of children and young people with disabilities in URT since 2013, considerable challenges and gaps remain. There is a need for health services to be more accessible, affordable and adaptable for children and young people with disabilities. This includes improving access to assistive devices. Notably, inadequate access to, and unaffordability of, assistive devices is having an adverse impact on children and young people with disabilities. This adverse impact includes mobility, ability to access health care services and ability to realise independence. While anecdotal evidence suggests assistive devices are unaffordable, further investigation is required to fully understand the reasons for the poor availability of assistive devices in both the Mainland and Zanzibar, and whether local solutions exist.

There is a demand for improved and increased number of rehabilitation centres and services in URT. Gaps in provision of habilitation and rehabilitation services persist with services oftentimes unaffordable for families. Lack of local services also means that families have to travel to neighbouring jurisdictions to access services, contributing

to higher costs, longer wait times and overcrowding. Misconceptions about disability and sexuality, as well as stigma and discrimination, inaccessible health facilities and information mean that young people with disabilities are missing out on crucial sexual and reproductive health services. The URT needs to take a proactive approach to addressing this gap, for example by partnering with OPDs to provide better services that meet the needs of persons with disabilities.

According to the MOHSW, HSSP-IV is considered as a masterpiece document that was designed to foster collaboration, accountability, coordinate, governance at national and level in the supply chain with various stakeholders to address crossing cutting related to health among children, disability, youth, elderly among others. Further, HSSP-IV goal was to review the health facilities standard infrastructure guidelines to guide Local governments in more balanced infrastructure development, ensuring that facilities are constructed and rehabilitated to meet accreditation standards. To ensure that newly constructed and refurbished facilities will ensure adequate space for storage of pharmaceuticals and medical products, private treatment rooms for patients and for delivery of pregnant women. Construction of disability friendliness infrastructures to enable persons with disabilities to access services. Therefore, there is the need for an evaluation of the HSSP-IV in the key areas of health service provision particularly for children and young people with disabilities.

Additionally, findings evident in the chapter indicate challenges accessing health insurance for children and young people with disabilities and their families. These challenges are evident considering that only about 10% of disability reported households are reported to have some form of health insurance. To encourage early detection and diagnosis of disability, disability screening and early intervention programs must be prioritised. Training of healthcare professionals, and raising awareness in communities more broadly, will be fundamental to achieving rights to health for children and young people with disabilities.

Furthermore, key findings in this chapter show that high rates of stunting and widespread anaemia in children across Tanzania, associated with poor nutrition, may also be contributing to the rates of disability. Findings exposed how some nutrition-based programmes and objectives are primarily aimed at preventing disabilities that could result from malnutrition. Also, the need for accurate and reliable disability disaggregated nutrition-based data was emphasised. This disability disaggregated data would help to better understand the actual number of children and young people with disabilities who are malnourished in both Mainland and Zanzibar. An evaluation of nutrition-based efforts and programmes

in both Mainland and Zanzibar is necessary to provide critical lessons learned and evidence of the success of nutrition-based programmes. Further research is needed here to better understand the linkages between poor nutrition and disability, and the gaps in programmes and service for children and young people with disabilities relating to nutrition.

There are currently limited employment opportunities for young people with disabilities in URT due to discrimination, limited education opportunities, non-inclusive working conditions and non-enforcement of existing employment laws. Difficulty in accessing assistive devices and the absence of reasonable workplace accommodations for young people with disabilities further exacerbates their ability to access available employment opportunities. To address this, targeted employment services for young persons with disabilities are required as well as more in-depth research on how young people with disabilities are affected by employment services by impairment type and severity. The impact of caring for a person with disabilities on employment and income outcomes also needs further investigation.

Inclusive education is not readily available in URT. All efforts to make education inclusive remain at the primary level. Many schools/classrooms are inaccessible to persons with disabilities – due to the distance and inaccessible transportation and school infrastructure. Insufficient learning materials particularly for learners with visual impairments remains a challenge. Social stigma and misconceptions about persons with disabilities ability to learn/thrive in a classroom environment also contribute to poor educational outcomes for children and young people with disabilities. Lack of disability specific training amongst educational professionals and inadequate access to assistive devices are critical issues that need to be addressed if equity for persons with disabilities is to be realised.

Prominently, inadequate access to, and unaffordability of, assistive devices including access to learning materials particularly for children with visual impairments is having an adverse impact on the rights to quality and inclusive education of children and young people with disabilities. This adverse impact includes mobility, ability to access education at all levels and realise independence. Further evidence indicates that the inclusive education approach is not appropriately and suitably incorporated in URT because of inadequate teacher training and facilities at all education levels.

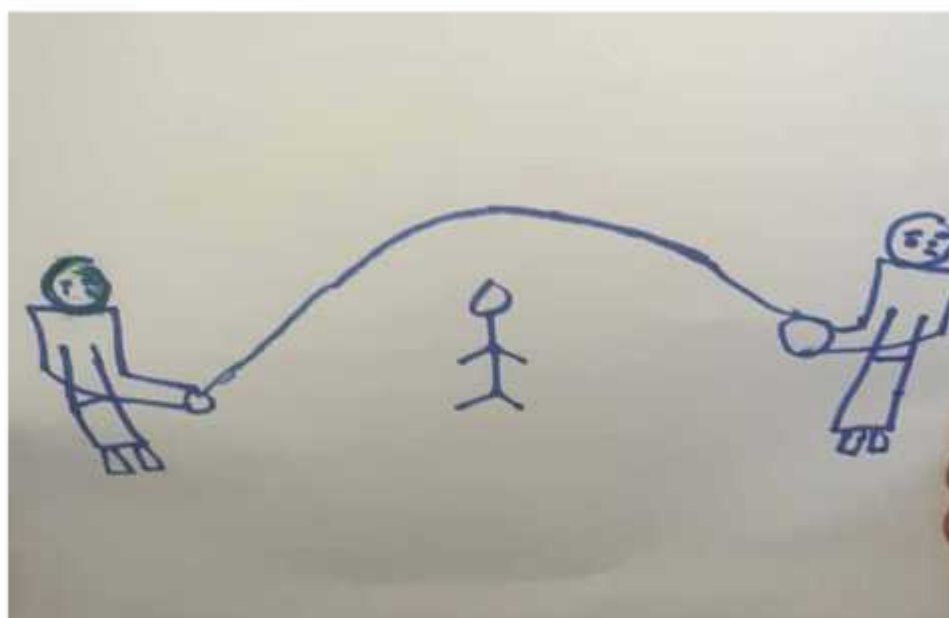
Specifically, this chapter revealed that discrimination against children and young people with disabilities remain widespread in the country. While there are general policies and laws prohibiting disability-based

discrimination in place, this chapter exposes the gendered dimensions of discrimination and violence. There is a lack of specific laws that explicitly criminalise multiple and intersecting forms of disability and gender-based discrimination that women and girls with disabilities face daily in the country. While empirical research supports the idea that killings of children and young people with albinism have considerably reduced, there is evidence of hidden fears and anxiety about possible resurgence of violence in the URT.

The right to adequate social protection schemes and services in both the Mainland and Zanzibar remain challenging. Empirical evidence from the KIs and FGDs support literature that indicates a need for improvement

in social security schemes including the need to treat social protection services as a cross cutting and intersectional issue.

In conclusion, it is evident that the URT has taken commendable measures in the key areas discussed above. Nonetheless, access to health and education services remain limited and employment opportunities for young persons with disabilities are scarce. Initial empirical evidence underscores the need for increased and proactive efforts in programmes and services to ensure the enjoyment of these rights by children and young people with disabilities in URT and disaggregated administrative data to ensure that access by children and young people with disabilities to services is monitored.



Self Portraits
by children with disabilities who participated in focus group discussions



Enabling Environment

7.1 Introduction

This section looks at existing social, institutional and political factors (e.g., social norms, institutional capacities at all levels of government, accountability and coordination mechanisms, policy, and legal frameworks) that could potentially support the creation of an enabling environment for the realisation of the rights of children and young people with disabilities. The section lays out factors that facilitate and hinder the realisation of rights. The enabling environment includes issues such as the use of data and evidence, stakeholder and institutional capacities, and discrimination and exclusion. First, the section discusses existing social norms and how they impact children and young people with disabilities. It also discusses best practices within the region as well as what resources are available locally and within the region for URT's replication. It then discusses existing stakeholder capacities and their disposition to support various levels of disability inclusion in URT.

7.2 Factors Supporting or Hindering the Rights of Children and Young People with Disabilities

There are many factors (social, institutional, and political) that prevent and support the advancement of rights for children with disabilities in URT. Before considering institutional and political factors, it is

necessary to consider social norms and their impact on the rights of children and young people with disabilities. In a country with over 100 ethnic groups, the cultural influence on the understanding of disability is diverse. Although attitudes towards persons with disabilities have changed significantly in the last two decades, perceived causes of disability still have an important role in forming attitudes and the treatment of children with disabilities. Stone-MacDonald (2012) categorises these causal factors shaping East Africans' attitude to disability into three: traditional animism's belief that disability is punishment for parents' bad deeds or a result of witchcraft by other community members; Christian beliefs that disability is an act of God's will; and medical determinism's belief that parents' intake of modern medicine could result in disability. Stone-MacDonald (2012) also found that there are taboos that, when broken, are thought to cause a disability. For example, having sexual intercourse during pregnancy is a taboo among some ethnic groups, and breaking it could cause the child to have a disability. Another belief is that laughing at people with disabilities could cause an individual to have a child with a disability himself or herself (Stone-MacDonald, 2012). Various KII and FGD participants confirmed that culture and religion have a significant influence on the social conceptualisation and behavioural attitudes towards disability. A KII participant with a lived disability experience remarked:

"In the past, they were calling me a curse. That this family is under a curse; It's a punishment from God that they've gotten a child with an impairment. The curse is a punishment to the clan for the wrongs that someone in the family did in the past. The family considers the helpless child a burden and keeps them behind closed doors; not even allowing the child to socialise with the other children of their age."

(KII-5, Mainland, 6 April 2021)

In some cases, the language is negative and reinforces discrimination. For instance, the term for schools predominantly attended by children with disabilities is "special schools". As KII - 3 from Zanzibar (March 22, 2021) remarked, this instils a feeling of "otherness" in the children rather than breaking the barriers that inclusive education seeks to remove. The key informant remarked:

"And also, the whole language around disability is something that I struggle with sometimes... how children with disabilities are called special children..., it's these words that I'm not sure exactly what is meant. And so I, whenever I read things, I said, "Do you mean, children with disabilities? Just say it? Because otherwise, if we say, children with special needs, what does that mean? Who is that? How do I know how to adjust that?" This drives me crazy."

(KII-3, Zanzibar, 24 March 2021)

Discriminatory norms are changing, at least in terms of language. Terms used to describe people with disabilities sometimes derive from categories typically reserved for non-humans (Devlieger, 1998; Mashiri, 2000). Some disability scholars (e.g. Mashiri, 2000; Stone-MacDonald, 2012) note that it is only recently that people in Tanzania started using more positive terms like "ulemavu" for disability in general and the terms "asiyeona" and "asiyesikia" to refer to an individual who cannot see or one who cannot hear. In Tanzania, the term "watoto wenye ulemavu," meaning children with disabilities, is relatively new in daily language (Stone-MacDonald, 2012). These newer terms are a departure from words in the ki-vi noun class that are normally used to reference objects rather than people.

Despite evidence of some change, many discriminatory social norms remain significant. A growing body of literature confirms that social norms continue to contribute to the discrimination and stigma facing children with

disabilities in the communities, schools, and other public places in URT. Starting at the family level, most mothers of children with disabilities are single mothers, as fathers are more likely to abandon their families if they have a child with a disability (UN Women, 2020). A society that sees such children as a curse from God would unlikely express positive acceptance of a child with a disability as an integral member of the family with full participatory rights.

These negative stereotypes also affect parents' attitudes to seek essential services such as education, healthcare and recreation. As parents try to make meaning of their child's disability, they draw on cultural beliefs and values as well as their understanding of normative development (Skinner & Weisner, 2007). As one KII-5, an adult and leader of an OPD and a person with a disability from the Mainland observed,

"The shame associated with disability and the family's lack of belief in their child's worth means no education for the child. Even after seeing me as a person with blindness, people don't believe that a child with blindness can ever go to school. Hence, sometimes we have to resort to the police to force the parents or caregivers to take their children to school."

(KII-5, Mainland, 7 April 2021)

Part of this attitude could stem from the lack of nearby educational facilities that accept visually impaired students. This leads to an increased cost in transportation and thus the overall cost of educating a child with disabilities is more than educating a child without disabilities. At the same time, many parents who were interviewed are very aware of their child's rights and are frustrated by society's attitude, and lack of awareness around how to interact with and develop children with disabilities. One parent explained how he makes sure that he teaches his child to be independent. He trains him to help with the cooking, to help with the ironing, even if he sometimes burns the clothes (FGD-2, Zanzibar, 24 March 2021).

The attitudes of social service providers, who are the gatekeepers to improved livelihoods for persons with disabilities, are informed by social norms. In the FGDs with children with disabilities, some children used words such as "fear", "anger", "disappointment" to express how they felt about how society treated them.

Parents of children with disabilities recounted rejection from schools, discrimination at health facilities, and poor service provision for various services from the government. They also mentioned having to deal with their child's

emotional and mental wellbeing as a result of the discrimination faced.

"...all of us are susceptible to being disabled at any point in our lives. So, we need to love each other whether we have a disability or not. This is what I tell my child to raise her spirits because sometimes she feels a little bit down."

(FGD-2, parents of children with disabilities, KII-3, Zanzibar, 24 March 2021)

The impact of negative stereotypes and discrimination has damaging and lasting effects on the health of the children with disabilities and their families.

Not all social norms are bad. Some can be a force for positive change. In some cases, social norms such as beliefs that disability comes from God have led to greater acceptability and care for children with disabilities. For example, among the Maasai, children with disabilities are seen as treasures from God needing extra attention (Stone-MacDonald, 2012). Such positive norms could be harnessed to advance the HRBA for the welfare of children with disabilities. Many KIIs commented that government officials have an interest and understanding of disability rights and are eager to expand disability programming across the government system. These are critical resources that could be harnessed to drive a serious disability rights agenda with meaningful impact across the government system. Adopting a strengths-based approach that builds upon the positive attitude prevalent in the URT is advised.

Social norms can change with concerted awareness raising. For example, Shivyawata, the umbrella for OPDs in URT, in collaboration with Tanzania Albino Society (TAS), have engaged in advocacy to end violence against persons with albinism. This has increased the visibility of children with albinism in URT. The entrenched social norms, beliefs, attitudes toward persons with disabilities in the URT require more shrewd responses from the government, partner organisations, and OPDs to create more acceptability for persons with disabilities. The UN Women 2020 report observes, the awareness-raising campaigns have had a significant impact on children with disabilities, for example those with albinism, are now accepted in many places. Children with albinism who were mostly hidden a decade ago are now taken to school, and even attending university.

Social norms are important for shaping attitudes towards children with disabilities. For this reason, Article 8 of the CRPD demands that member states undertake awareness

raising activities to educate their citizens about disability and to create an atmosphere of respect for persons with disabilities. Already, the work of OPDs, government, and other actors have made a significant impact in reversing negative norms and stereotyping. Building upon successes, positive social norms and harnessing strengths while advocating for changes to discriminatory social norms will help create an enabling environment for disability inclusion.

7.3 Institutional and Political Factors

Since 2013, the URT has shown important progress in political and institutional determination to improve the welfare of persons with disabilities in general, and that of children and young people in particular. Throughout the KIIs and FGDs, participants observed the openness of government ministries to engage on issues of concern for disability inclusion such as: increased budget support to education, health, employment, and social protection for children and young people with disabilities.

7.3.1 Relationships with NGOs and OPDs

One of the most noticeable institutional spaces created is for NGO activity both in providing services directly to persons with disabilities and in influencing government policy outcomes. NGO activity has been supported by the government's openness to the enhancement of policy decisions for disability inclusive development. International NGOs have helped the government to create an inclusive education model for schools. International NGOs are working to raise parents' awareness on the education of children with disabilities. They are also training teachers on inclusive education. Some of these international NGOs include ADD International, Sense International, and Sightsavers. Sense International has been working with students with hearing and visual impairments. They train teachers and teaching assistants, and provide teaching and learning resources to teachers and learners. International NGO participants in KIIs reported positive collaborative relationships with the governments of both the Mainland and Zanzibar. Local and international NGOs have an important advantage over the government because they reach the remotest parts of the country where government services are scanty. Their research and feedback is crucial for re-examination of government service delivery and for improving systems of government. In the words of one KII, NGOs:

"[...] are helping the government to support the teachers and students with disabilities to provide training in using assistive devices. Sometimes they provide findings which were not known by the government, because those organisations are still working in the rural areas .. then we are sitting down [together] and discussing and finding the solution to such challenges."

(KII-9, Mainland, 14 April 2021)

Second, the government has been progressively engaging more with OPDs for participation in various policy processes. It has expanded its inclusive education initiatives and also improved public awareness and education about the rights of persons with disabilities. Public awareness about albinism has resulted in less violence and killings of children and young people with albinism and, subsequently, increased participation of children and young people with albinism in education and other public activities. Almost all KII participants acknowledged the government's improved disposition to enhancing the rights of persons with disabilities using various policy instruments such as the training of teachers in inclusive education, expansion of access to healthcare, public awareness and sensitisation, among others. As one KII observed,

"When I look at the education aspect, the Ministry of education has accepted the issue of inclusive education in Zanzibar, that all learners including disabilities are fully accepted and they are enrolled. So, the government is very positive on this issue. ... That is one and also in the area of health also is good, because of the advocacy work that has been done to ensure that the rights of persons with disabilities are observed. So, most of the issues now seem to be very positive, including the education aspects, the health aspect, and other societal areas. So, I can say, people with disabilities are now included in every aspect of life, even if there are some challenges."

(KII-8, Mainland, 21 April 2021)

7.3.2 Disability Inclusion in Leadership and Politics

The URT is also progressively increasing the visibility of persons with disabilities in senior government leadership positions. Representation of persons with disabilities at policy decision-making levels has increased. In Zanzibar, one member of the House of Representatives was a

woman with a hearing impairment who relied on an assistant using sign language to translate proceedings in the chamber. In Mainland, a person with a disability was a Permanent Secretary in one ministry and a former Minister was a person with albinism.

Despite these positive developments with the URT's political and institutional positions, there are still several political and institutional hurdles that should be addressed. The first is that the URT has many policy positions and legislation that it does not implement. This shows weak political commitment to pursue rights of children and young people with disabilities. For example, according to KIIs, Mainland Tanzania does not meaningfully enforce the 3% employment quota for persons with disabilities and employers do not take the law seriously. The government also faces a challenge of well-trained human resources in managing disability inclusive policies and programmes. Across the board, the URT has very few staff in their offices with the capacity to handle disability programming. In Zanzibar, however, through the efforts of the Department of Disability Affairs, there is a disability focal person in most Ministries. Concerning efforts by the OPDs, they lack the technical expertise to lobby for government services and to hold the government to account, often relying on consultants from outside the country.

7.3.3 Financial Support for Disability Inclusion

Tanzania's National Social Security Policy highlights the importance of social assistance as a form of support for groups such as people with disabilities, elderly people and unsupported parents and children who are unable to provide for their own minimum needs. In the effort to increase the coverage of social security the government has drafted various plans and strategies like the National Social Protection Framework (NSPF), National Employment Policy (2007), the National Food Security Policy and Disaster Management Policy, the National Aging Policy (2003), the Child Law Act (2009), the Persons with Disability Act (2009) (United Nations Tanzania 2015), and the National Strategy for Growth and Reduction of Poverty (NSGRP, also referred to as MKUKUTA) but despite URT commitment to address disability inclusion and poverty, there is still much to be done because most of the social security in URT is heavily dependent on donor aid and support for its disability policy implementation. This raises the question of sustainability of disability policy implementation. It also raises the question of the ethics of disability programming if it is project-based. For example, who will train the teachers after a project ends? How will children with disabilities feel if their rehabilitation support suddenly ends? Another challenge is the persistence of statistical data gaps on children and young people with

disabilities. This is challenging for successful planning and interventions from both government and other stakeholders (United Nations University, 2018).

7.3.4 Coordination Mechanism

The coordination approach significantly contributes to ensuring functional, efficient, effective and strategic leadership implementation of both government and other stakeholder programs and goals. Proper coordination reduces possibilities for conflict at all levels of the policy cycle, including avoiding overlapping mandates within and across government departments and ministries. Although the URT has made significant impact in inclusive programs, there still exists some gaps.

- » There is a gap in establishing local coordination mechanisms involving government and civil society across sectors like education, health and protection. Creating such coordination enables better referrals and data sharing between services, ensuring persons with disabilities get the most appropriate support. It also maximises output of the different expertise of local actors.
- » Another challenge is lack of empowerment mechanisms for persons with disabilities and their families to act as role models and become their own advocates within communities, challenging discriminatory attitudes and stigmatisation of persons with disabilities and their families. This includes, for example, supporting persons with disabilities to deliver training to community members and parents of children with disabilities, on the importance of those children accessing education, or building the capacities of families to advocate on behalf of their children with disabilities for improved local services.
- » There is limited collaboration between different government organs, civil society, OPDs and community actors on the conceptualisation and rolling out of disability services and policy interventions. This inconsistent collaboration affects successful disability programs and data on disability.
- » Most OPDs and government service providers are understaffed, making it hard to adequately coordinate with overlapping actors and to adequately deliver services.

6.3.2 Accountability Mechanism

Accountability is a vital tool to assess work and performance of institutions and organisations because it defines the roles and obligations for all the stakeholders. It also demands results and sets the expectation and the role of each actor within an institution or organisation (Oxfam, 2016).

According to the Economic and Social Research Council (2016), in 1999, URT formulated the National Framework for Good Governance (NFGG) as a guide to institute good governance, integrity and accountability. This framework defines 'good governance' as "the exercise of official powers in the management of the country's resources in an effort to increase and utilise such resources for the betterment of life". Further, the NFGG argues that national development is based on local, national and international partnership and good governance. The NFGG focuses on the following: (1) participation of the people in decision-making; (2) constitutionalism, rule of law, protection of human rights and administration of justice; (3) a legal and regulatory framework for private sector development; (4) gender equity; (5) accountability, transparency, and integrity in the management of public affairs; (6) electoral democracy; and (7) greater public service capabilities to deliver services efficiently and effectively. In order to achieve the objectives set by NFGG, the URT has implemented various governance reforms. These include the Public Service Reform Programme, the Local Government Reform Programme, the Legal Sector Reform Programme and the Public Financial Management Reform Programme. In addition, specific programmes have been implemented to improve service delivery through decentralisation. These programmes constitute the policy and strategic framework for enhancing accountability, transparency and integrity in the use of public resources and to improve service delivery (Economic and Social Research Council, 2016).

Institutions that focus on accountability and governance in URT include the Ethics Secretariat, the Prevention and Combating of Corruption Bureau and the Commission for Human Rights and Good Governance. Other accountability institutions include the Public Procurement Regulatory Authority, the National Audit Office and the Parliamentary Watchdog Committees. With specific regard to local governments and accountability, the National Audit Office produces annual reports that are concerned with governance and local government authorities (LGAs). Additionally, URT has also enacted laws that require leaders and senior public officials to disclose their incomes and assets to the Ethics Secretariat as a measure to instil integrity in public life (Economic and Social Research Council, 2016).

Despite the numerous reforms on good governance and accountability mechanism and also being a member of the Open Government Partnership (OGP) initiative that aims at promoting transparency, accountability, citizen empowerment, URT still encounters number of challenges ranging from corruption, lack of infrastructure, poor access to information, technocratic procedures, power imbalances, low capacity and a lack of citizen participation. These challenges have ripple effects on the successful implementation of disability policies and

on the actualisation of rights for children and young people with disabilities.

7.4 Capacity to Address Inclusion of Children and Young People with Disabilities

A stakeholder mapping process was completed to assess the capacities (financial, technical and institutional) that exist at national, subnational and community levels to address inclusion of children and young people with disabilities. The stakeholder mapping is divided into categories of government, OPD, civil society organisations, and international organisations, all of which have different strategic institutional capacities to address disability inclusion. While information was gathered via a google search, documentation analysis and KIs, a more formal stakeholder mapping process akin to an action learning program (that builds capacity while studying institutional capacity and improving coordination) is recommended.

All mapped stakeholder groups address unique but overlapping areas of disability programming, illustrating the lack of coordination within the disability sector. In Mainland Tanzania, the Ministry of Education, Science, Technology and Vocational Training have a National Strategy for Inclusive Education 2018-2020 that aims to promote an inclusive education system that removes the barriers limiting the participation and achievement of all learners. Other national-level institutions covering this issue of inclusive education include government institutions like the Special Need Unit of the Ministry of Education, Science, and Technology (Mainland), and the Department of Social Welfare in the Ministry of Health and Social Welfare (Mainland). Overlapping mandates lead to a duplication of work. Annex 9 further outlines each stakeholder their programs and capacity.

Accompanying these government institutions are numerous NGOs, civil society, and international organisations and initiatives. The OPDs, for example, are galvanised by the Tanzania Federation of Disabled People's Organisation (SHIVYAWATA). SHIVYAWATA aims to unite all Disabled Peoples' Organisations (DPOs) and the Pro-Disability Organisations (PDOS) for effective lobbying and advocacy work, coordinate with the Government, political parties and the public so as to provide required and appropriate services to persons with disabilities on time, motivate, encourage and assist the formation and registration of DPOs and PDOS as well as ensuring the existence of the already registered DPOs and PDOS, provide advisory role to members (PWDs) of SHIVYAWATA and advocate for mainstreaming the disability in public and private sector.

Many of the organisations working on disability inclusion rely upon passionate, hardworking people, and their programs and the whole sector are underfunded. There are a number of organisations of and for people with disabilities in Tanzania (see Annex 9). Other significant organisations in Dar es Salaam are the Disabled Organisation for Legal Affairs and Social Economic Development (DOLASED) and the Information Centre on Disability (ICD). In Zanzibar, the Organization of People with Disabilities in Zanzibar (UWZ), Zanzibar Association for People with Developmental Disability (ZAPDD) and the Department for Disability Affairs are also significant in addressing and advocating for the rights of persons with disability. Before funds are increased there is a need to build the capacity for increased programs and funds, especially of OPDs as well as their capacity for advocacy and coordination.

With limited programs and funds the sector must be efficiently and effectively coordinated. The URT 2019 Local Government Finance Act requires that local governments allocate 10% of the revenue they raise for funding interest-free loans to women, youth and persons with disabilities (4% to women, 4% to youth, 2% to persons with disabilities) (URT, 2019:p.40, section 37A). This is commendable and NGOs have a role to play in ensuring accountability for this commitment. This means NGOs need to understand government budgetary processes.

Limitations in assessing institutional capacity are noted from this mapping process. Financial, technical and institutional capacity is hard to assess from secondary data. Moreover, asking questions directly cannot always help to identify capacity gaps. A more iterative process with institutional assessments, along with access to audits and evaluations is needed to ascertain financial, technical and institutional capacity. The capacity to adopt a cross-sectoral approach that also considers age groups/ life cycle, gender and disability type requires deeper exploration.

With such a robust spread of institutions with components of disability programming or, indeed, completely devoted to disability programming, URT has a great foundation to revolutionise its disability inclusion agenda. However, there is a lack of cross-sectoral and life cycle approaches and an absence of coordination across the sector. Building politician and policy maker awareness, by facilitating greater connections with OPDs and others with a lived experience of disability is a must. As a multi-sectoral policy and programming rights-based institution, UNICEF has a key coordinating and convening role to play across sectors and levels.

7.5 Reliable Data for Planning

The URT has a great need to improve the quality of national census and other national level studies for greater intersectional accuracy and to include disability and gender issues in collaboration with OPDs. Over the last decade, both the National Bureau of Statistics (Mainland) and the Office of the Chief Government Statistician (Zanzibar) have made significant progress in using the Washington Group Short Set questions, in line with international standards. Even where the WG-SS questions are used, though, key indicator reports on national surveys often do not include reporting on disability-related indicators. Existing national published statistics on disability predominantly rely on the 2012 national census and the 2008 Tanzania Disability Survey, despite the existence of more recent national surveys that also utilised the WG-SS questions, such as the 2014/15 National Panel Survey, the 2017/18 Tanzania HBS, and the 2019/20 Zanzibar HBS. The 2008 TDS was a landmark study when it was completed, but was conducted over a decade ago and is unlikely to accurately reflect the current situation. Without accurate, reliable, and coherent data, it is difficult for URT to design and implement comprehensive disability inclusive policy interventions that reach all children and young people with disabilities.

There are, however, important efforts in collecting disability-specific data (see Chapter 3 for information on measurement of disability in URT and Chapter 4 for prevalence calculations). Various government ministries and agencies such as the Department of Disability Affairs (Mainland and Zanzibar) collect disability data. UNICEF (2020) observes a new dynamism within the Department for Disability Affairs (DDA). Disability focal persons have received cross-cutting training on disability, and a new database has been established on people with disabilities that includes data on both type(s) and severity of disability although the database (with 16,000 people registered) doesn't cover all PWDs in Zanzibar. This database will increase the government's capacity to generate more reliable and comparable disability statistics and to mainstream disability data collection into national statistics systems, form the basis for social assistance programmes for PWDs and align with international disability measurement standards.

Given the emphasis placed by respondents on early detection and intervention, there is a need to further integrate and strengthen the data available from health and education programs. More cross-sectoral programs that generate reliable nationwide data are needed.

While a lot is already known about the barriers facing children and young people with disabilities there remains a need for high quality research and data on

the intersectional challenges facing children and young people with disabilities and their families and inclusive solutions. Complex forms of inequality and exclusion make it hard (or even impossible) for children and young people with disabilities to realise their potential.

7.6 Regional Best Practices Programme Approaches

There are many best practices in Eastern and Southern Africa that URT could take advantage of to further the rights of persons with disabilities. While most of these best practices are not children-specific, their application has a direct impact on the rights of children and young people with disabilities. Since Tanzania enjoys a geographic privilege to be a member of both the East African Community as well as the Southern African Development Community, it has a larger pool of peers to draw lessons from.

Example 1: Rwanda and access to healthcare: One of the greatest needs for children with disabilities is easy and frequent access to healthcare. Adequate access to, and availability of, healthcare services could prevent disability and, in case where early identification occurs, delay or prevent chronic disability. In Rwanda, "85% of people with disabilities have active health insurance with coverage of males and females at 84% and 86%, respectively. In fact, the health insurance coverage among persons with disabilities in the country is only 2% lower than that of their abled counterparts" (UN Women, 2020: 45). This has translated into very high enrolment levels and coverage for persons with disabilities, including children with disabilities across the country.

Example 2: Uganda and employment: Despite Uganda's many challenges in realising the full enjoyment of rights for children with disabilities, the country has made some commendable steps in the right direction. First, following the constitutional requirement for the government to promote the educational development of children and young people with disabilities, the Ministry of Education has strong inclusive education guidelines that promote the education of children with disabilities in Uganda. Second, the Government of Uganda has also taken serious measures to make sign language a national issue, training teachers and interpreters of sign language. Third, the government has implemented measures to promote affirmative action to increase the representation of persons with disabilities in the education system, up to university level. For example, all boards of public universities are mandated to have a member with a disability to represent persons with disabilities to boost their representation. In addition, 4.5 points are awarded to applicants with disabilities to all public universities to boost their enrolment

chances. Thirdly, Uganda has disability focused local elections and reserved seats for people with disabilities to ensure their political representation.

Example 3: Kenya and social security: In compliance with the CRPD principles, many countries around the world ensure that persons with disabilities have equitable access to social security and social assistance through existing programmes. In East Africa, Kenya is a good example of a country that has institutionalised social security and guaranteed budgetary commitment to financing the programme. Kenya's 2010 constitution (Article 43(1) (e)) safeguards the rights of all Kenyan citizens to social security, and various funds have been established and institutionalised to deliver this right. In adherence to its Persons with Disabilities Act, Kenya has established the National Development Fund for persons with disabilities. Further, Kenya is piloting the Persons with Severe Disability Cash Transfer Programme.

Kenya also has several other initiatives aimed at improving the lives of the persons with disabilities, including children and families of children with disabilities. For example, the National Government Affirmative Action Fund provides bursaries to children and young people with disabilities. This incentivises children with disabilities to pursue their education knowing that support is available to further their education. Furthermore, the government requires that all government departments reserve 2% of their procurement budget for businesses owned by persons with disabilities. There is also the National Development Fund that provides cash transfers to support families with vulnerable persons and families of persons with disabilities are among the target population. The robustness of these measures ensures the capturing of intersectional needs of disability, including gender and age.

Example 4: South Africa and affirmative action: Like Kenya, South Africa has a strong Social Security Act (2004) that guarantees support to ease additional care expenses for families with children and adults with disabilities. The Act offers a supplementary grant-in-aid for disability grant recipients who require full-time attendance by another person owing to their physical or mental disabilities. The support also extends to the provision of assistive devices such as wheelchairs and hearing aids. In addition, the South African Government has removed import tax for cars and other assistive devices for persons with disabilities to increase their affordability. The government has also added the category of "business with persons with disabilities-owned businesses, along with women and black-owned businesses" in points allocation in public tenders. These measures collectively work together to improve the welfare of families of children and young people with disabilities, as well as to create livelihood opportunities for them, including in education, employment and in entrepreneurship.

Study tours to impactful African countries or regional conferences would help to promote high achieving countries and give struggling countries regional role models to emulate.

7.7 Conclusion

This chapter discusses institutional, social, and political factors that prevent and support the advancement of rights of children and young people with disabilities in URT. The chapter demonstrates that since 2013, URT has taken important steps in improving the welfare of children and young people with disabilities. International NGOs have particularly played an important role in rolling out educational programmes at various levels that have enhanced inclusive education programming. Also, the governments of both Mainland Tanzania and Zanzibar have demonstrated openness to working with OPDs, creating more room for OPDs' participation in various policy processes.

In political governance, URT is progressively increasing the visibility of persons with disabilities in senior government and legislative positions. This plays a significant role in shaping the positive minds of children and young people with disabilities who could see themselves in similar positions in future. Role modelling plays a significant role in incentivising children and young people with disabilities to have a positive outlook to life.

Further, the chapter discusses the challenges in the coordination and accountability mechanisms within the governance systems, including in broader stakeholder relations. Beyond these challenges, URT has good learning opportunities within the East African and Southern African regions with examples in Rwanda, South Africa, and Uganda. The URT has a huge opportunity to harness its local resources and those within the donor community and international networks to drive a transformative disability inclusion agenda across the country. There are several areas URT should look at to create a better enabling environment for the enjoyment of rights for children and young people with disabilities.

First, URT has a challenge to transform negative social norms that continue to inhibit progress in inclusive education, access to health, and freedom from public shame of children and families of children with disabilities. The URT should strengthen partnerships with OPDs, human rights NGOs, and public institutions to raise awareness about the rights of children and young people with disabilities. The governments of Mainland Tanzania and Zanzibar should create more predictable support systems for families to incentivise them to increase the visibility of children with disabilities in public spaces. With a good policy infrastructure in place, URT should show more

budgetary and political commitment to enforcing laws that perpetrate violence and harmful cultural practices on children and young people with disabilities.

The second point is the development and, in some cases, the improvement of the disaggregated data to understand the accurate numbers, varieties, and intersectional factors of children and young people with disabilities in URT. The lack of data promotes further exclusion of children (Global Partnership for Education, 2018) and reduces the opportunity for advocacy. Discriminatory norms in society need to change for meaningful social inclusion of children with disabilities to prevail. Greater coordination across the sector is needed. There are many opportunities for UNICEF and other cooperating partners to influence the disability inclusion agenda in the URT.

The third is the alignment of policies with political will. The enhancement of coordination mechanisms so that all stakeholders' efforts are streamlined, avoiding

duplication and overlaps, require serious political will and technical investment. While this might not be achieved overnight, URT could benefit from UNICEF and other donor partners' technical guidance in creating efficient coordination of the policy infrastructure, programmes, and actors' participation. The URT, however, also needs to work to improve the efficiency of its policy implementation by enforcing the various anti-corruption instruments to deter wastage of financial and human resources. While it is URT's responsibility to strengthen its own coordination mechanisms, the donor community could influence this process and offer technical assistance to the host government.

The chapter has further shown that URT has erected important institutional mechanisms that it could leverage, with more political commitment and investment in coordination of various institutional and organisational players, to advance the rights of children and young people with disabilities.



"My favourite place to be"
by children with disabilities who participated in
focus group discussions



Conclusion

Although children and young people with disabilities continue to face multiple challenges, the URT has made significant progress in advancing the welfare of children with disabilities in the last decade. Particularly, there are notable advancements since the last Situation Analysis in 2013. Some of those advancements include the improved safety of children with albinism, increased public awareness raising, efforts towards education of children with disabilities, the continued implementation of the National Strategy for Growth and Poverty Reduction 2010-2015 (MKUKUTA II), the Zanzibar National Growth and Poverty Reduction Strategy, 2010-2015 (MKUZA II), MKUNZA III (2015-2020), the National Disability Mainstreaming Strategy, 2010-2015, and strengthening social protection for people with disabilities. Mainland Tanzania has also set up an employment quota of 3% for persons with disabilities, despite challenges of enforcement and its limited application to the public sector.

Despite these notable improvements, legislative and policy gaps remain. The Bill of Rights in both the Mainland and Zanzibar do not mention the rights of persons with disability as fundamental rights. Rather the rights are mentioned under directive principles of state policy rendering them non-justiciable and non-enforceable in the court of law. URT has a poor human rights reporting record, particularly with regards to regional human rights obligations dealing with children and young people with disabilities. Many Acts, even those dating back 8 years fail to adopt an intersectional perspective and

are not compliant with CEDAW as they do not provide special rights to girls and young women with disabilities in light of their double-marginalisation. Some domestic laws still reflect the medical understanding of disability. However, the 2010 Persons with Disabilities Act applicable to the Mainland draws from the social and the human rights understanding of disability in their definitions of disability and represents a commitment by the Government to shift from the medical and charity understanding of disability still prevalent in the URT. While the URT's commitment is evident and commendable, the application of these laws across the country remains inconsistent.

URT has made substantial progress over the last two decades in integrating more consistent measurement of disability into national data collection and reporting. Regional, age and gender variations were found. In both the Mainland and Zanzibar, women have higher prevalence rates of disability than men. In Mainland, 7.8% of women live with a disability compared to 5.7% of men. In Zanzibar, 4% of women live with a disability compared to 3% of men. Among children, prevalence rates are consistent between girls and boys. In both the Mainland and Zanzibar, disability prevalence increases in adulthood and rises steeply among older adults. While Mainland data shows the increase starting among the 20-24 age group, the Zanzibar prevalence rates stay consistently low until the 35-54 year age group. The most common type of disability reported for children in the Mainland was difficulty remembering, while in Zanzibar it was difficulty with self-care.

There are differences in the way disability is understood from one jurisdiction to another and by survey. These differences in conceptualisations have implications for the way children and young people with disabilities are treated and their life chances. If prevalence rates include the WG-SS respondents who reported “some difficulty” in any functional domain, then the overall disability prevalence rate for those aged 5+ rises from 6.8% to 15.5% for Mainland Tanzania and from 3.2% to 7.1% for Zanzibar.

The lack of reliable data on children younger than 5 years is a noteworthy gap given the importance of early screening, identification and intervention for young children with disabilities to human capital development and life chances. A limitation of the WG-SS questions is that they are not intended for use with children younger than age 5 and they are not specifically tailored to identifying disability among children. Integration of the Child Functioning Module in future HBS rounds and other key surveys in URT could strengthen data on children with disabilities and facilitate disability disaggregation of data on SDGs that apply to children. Moreover, the HBS survey data sets offer opportunities for further analysis and exploration of the relationships between disability and indicators related to household socio-economic status, education, employment, urban/rural and other intersectional variabilities.

Children and young people with disabilities continue to face serious challenges in URT. Social norms based on cultural beliefs and religion continue to influence strong negative attitudes and treatment of children with disabilities. Having a child with a disability is seen as a shame or curse and often leads to abandonment of the child and their mother by the father. More than half of children with disabilities do not attend school as a result of their health or activity limitations. Illiteracy among Tanzanians with a disability is 48%, compared to 25% among those without one. Although URT in principle has policies on inclusive education, this is only practiced in a limited number of schools due to a lack of human and other resources. Children and young people with disabilities remain disproportionately underrepresented in school enrolment and completion rates, translating into lower rates of employment and independent livelihoods in older age.

The challenges children with disabilities face accumulate over time and by identity vector. There is a general lack of assisting devices such as wheelchairs, and hearing aids, which reduce educational outcomes and employment options. The prohibitive costs of these devices mean that children from better off families have greater life chances than those born to impoverished parents. Rural areas have less access to services than urban areas, meaning children with disabilities in rural areas lack access to diagnosis and

treatment. Girls face more extreme violence, exploitation and abuse than boys. The fact that women and girls with disabilities suffer from higher risks of sexual and gender-based violence renders considerable urgency to improving awareness, prevention and treatment. Certain types of disabilities such as cognitive impairments are less accepted by society, and others such as albinism face more extreme physical violence.

People with disabilities often live in severe poverty due to the challenge of securing a steady income amid widespread exclusion. According to the Tanzanian Federation of Disabled People's Organisations, with only 3.1% receiving income from paid employment, households headed by persons with disabilities experience greater levels of poverty. Like adults with disabilities, children with disabilities face accessibility challenges to public infrastructure, including transportation, public buildings, and recreation spaces not built to accommodate persons with disabilities. The exclusion of people with disabilities from the workplace, either through discrimination or inaccessible work environments, costs URT approximately \$480 million per annum, representing 3.8% of the country's GDP (Comprehensive Community Based Rehabilitation in Tanzania, 2021). This seriously hinders social and economic development not just for children (and adults) with disabilities and their families, but for the country as a whole.

There are a number of organisations of and for people with disabilities in Tanzania. With such a robust spread of institutions engaged in disability programming, URT has a great foundation to revolutionise its disability inclusion agenda. UNICEF has a key coordinating and convening role to play across sectors and levels. Before funds are increased there is a need to build the capacity for increased programs and funds, especially of OPDs as well as their capacity for child rights, advocacy and coordination. More generally, there is a lack of cross-sectoral and life cycle approaches and an absence of coordination across the sector.

In conclusion, the URT needs to devise more strategic systems to audit its legislative and policy commitments to inclusive disability development and to the protection of the rights of children and young people with disabilities. This includes ensuring budgetary commitments, aligning policy pronouncements with implementation and monitoring plans, as well as carrying out aggressive public awareness initiatives about disability rights, including engaging with families to challenge negative social norms. It also means living up to commitments to employment quotas for people with disabilities as well protecting girls and women with disabilities from disproportionate disadvantage. As reiterated in KIIs and FGDs, the URT could improve its output for improving the welfare of the lives of children and young people with disabilities by taking an intersectional

approach to disability policy to see how different identities of age, gender, and disability interact to create more extreme forms of marginalisation of children and young people with disabilities. To achieve this, the URT should work closely with OPDs, parents of children with disabilities, and other stakeholders, domestic, regional, and international to harness the necessary resources.

8.1 Recommendations

There are several concrete steps the URT could take to solidify its gains in the attainment of human rights for children and young people with disabilities. These factors are important for UNICEF's new Country Programme to understand. The need is great and so is the need for prioritisation and strategic engagement. The first part of these recommendations focus on priority advocacy issues for URT, the second part covers UNICEF-specific opportunities and the third part covers other stakeholders and partners. A preliminary action plan initiated at the validation workshop is included in Annex 10.

A. What are Potential Priority Advocacy Issues for Tanzania Mainland and Zanzibar?

1. **Harmonise Domestic Legislation with the CRPD and other International Conventions:** Although URT is a signatory to the CRPD and has domestication legislation, the Situation Analysis shows that there are still gaps with domestic legislation. The URT's National Policy on Disability of 2004 predates the CRPD. The URT needs to import the rights of persons with disabilities from the directive principles of state policy to the Bill of rights as fundamental rights in both Mainland Tanzania and Zanzibar that can be enforced in the court of law. While policy instruments are crucial for the success of individual plans, they are rendered weak if not anchored in constitutional provisions. While this is a cross cutting issue for multiple stakeholders, including donors and various government ministries, the Prime Minister's Office should take the lead.
2. **Make changes to children and disability laws to reflect rights of children with disabilities:** Although the URT has made some progress in domesticating the CRPD and other international protocols, it still needs to adapt its local laws to reflect the rights of children with disabilities. Guaranteeing these rights for children with disabilities would create obligations, for example, for health insurance schemes and for infrastructure accessibility in schools (e.g., toilets) and public spaces. Implementing such reforms requires multisectoral efforts, including the involvement of the ministries in charge of health, education, gender, youth, elderly, and legal issues. This responsibility, however, falls directly under the Prime Minister's Office.
3. **Implement disability inclusive policy and legal reviews:** Both the Mainland and Zanzibar have made commendable efforts in advancing the welfare of children with disabilities, especially through progressive legislation and policies. There is a need to understand what is working and where success is limited. In some cases, implementation of legislation and policy may be the problem, or it may be the way the policy is drafted, or a combination (e.g., Mainland Tanzania has a legal 3% employment quota for persons with disabilities, but it does not enforce the requirement in the public sector and it is not enforceable in the private sector). In other cases, URT has made good effort but with little captured result. *Ensuring disability inclusive reviews and evaluations of policies would help to capture lessons learnt and areas for improvement.*
4. **Leave no one behind by adopting an intersectional approach:** The 2010 and 2006 Person with Disabilities Acts of both the Mainland and Zanzibar fail to adopt an intersectional lens and to provide specific rights to girls and women with disabilities, contrary to their international obligations under the CEDAW. For example, there is need for research on the intersectional links between violence against women and SRHR. Currently, the Mainland is reviewing the National Plan of Action to prevent violence against women and girls while Zanzibar is reviewing the National Plan of Action to End Violence Against Women and Children (NPA-VACW), presenting good opportunities to advocate for linking these policies with disability. At the same time, there is a need for legislative guidelines on rights to SRHR particularly for young women with disabilities. Further, there are differences in age, location and disability types that all require corresponding interventions. All policies - especially those relating to disability - should adopt an intersectional approach that understands the specific barriers affecting identity categories by: gender, disability type, age, location and how different combinations of these categories can lead to more extreme forms of exclusion that are harder to overcome. The Ministry of Health should take the lead in these intersectional approaches.
5. **The importance of disability-poverty intersection:** There is a correlation between incidence of disability and poverty. Social policy experts have shown that social protection can be a powerful tool for social inclusion, especially for lower income groups of society. In URT, as evidenced from repeated observations from parents of children with disabilities, material poverty weighs heavily on many families of children with disabilities. *The URT should explore the*

affordability of a Disability Grant, which could offset material barriers of children with disabilities from active social and economic participation.

6. **Improve survey data:** Discrepancies in methodologies and definitions across and between data sets lead to inaccurate data and make the data incomparable with global standards. The URT could draw lessons for collecting such statistics from its regional peers such as Uganda that have already advanced disability data standards. Collaborating with OPDs and using the Washington Set of questions to generate internationally comparable standards is advised. Further, national survey data should have unambiguous sex-disaggregated analysis. Such data should explore whether the lack of difference between disability prevalence rates for girls and boys varies by type of disability and explain what happens across the life cycle. It should explain reasons behind the sex difference that emerges in middle adulthood and widens by older adulthood. Looking at risk factors for disability and whether there are differences between boys and girls in terms of these risk factors, has implications for policy responses and advocacy issues. *The URT should improve the quality of its national census and other national level studies to include disability and gender disaggregation and the Washington Group child functioning module questions. Working with other actors such as the Ministry of Policy and Parliamentary Affairs, in Mainland Tanzania, NBS should take the lead in this initiative while OCGS should be the lead actor.*
7. **Improve education and health data:** The lack of data can be solved in many ways. Health and education sectors already collect a lot of data but this is not always disaggregated by disability, gender and age. *Any information management system improvements in health and education should integrate and disaggregate disability data.*
8. **Develop awareness raising and behaviour change campaigns:** One of the most critical needs for advancing the rights of children with disabilities in URT is public education and awareness raising about disability, including albinism. Countering deep-seated negative norms, stereotypes, and stigma requires equally aggressive intersectional efforts led by the government in collaboration with OPDs and other key stakeholders. These should include more voices from women and children with disabilities to tell their own stories (UN Women, 2020). The following key awareness raising/behaviour change campaigns are needed:
 - » Early screening and diagnosis days (e.g., at designated places such as schools, paediatric hospitals, and community public health centres).

- » Developing narratives around disability inclusion and gender equality.
- » Countering sexual and gender-based violence against women and girls (and also boys) with disabilities.
- » Use role modelling for positive image creation (e.g., showcase employed people with disabilities or high profile achievers with disabilities).
- » Involve religious and traditional leaders in advocacy/behaviour change.
- » Capacity building for influential leaders (elders and tribal leaders too) to communicate key messages and to eliminate stereotypes and misinformation and negative taboos.
- » Encourage quota systems at all levels of governance and in key decision making areas across society, e.g., parliament, and political party electoral adoptions.

9. **Improve community-based rehabilitation and local assistive device development and maintenance:** Rehab services are expensive and still institutionalised in many cases. Families with children with disabilities can only receive the needed services in a limited number of places which are expensive to travel to. Assistive devices are purchased overseas rather than supporting local markets and innovations. *Develop a localisation plan for disability services such as rehabilitation and assistive device development and maintenance that includes a decentralised approach and monitoring visits to local communities.*
10. **Accessibility audits to improve infrastructure:** Infrastructure such as classrooms, ICT, road, bank and health facilities are not always accessible to children with disabilities. An audit done by the Controller and Auditor General (2019) on coordination and provision of basic learning and teaching requirements for special needs education (SNE), and the contribution of MoEST's quality assurance activities in the delivery of Special Needs Education for the financial year 2014/2015-2017/2018 found inadequate inspections in special needs schools. The audits also found a shortage of SNE skilled school quality assurers, inadequately monitored examinations for pupils with special needs, inadequate consideration of the needs of pupils with special educational needs, inadequate provision of SNE teaching and learning requirements among others. Therefore, the URT should
 - » mandate accessibility audits for all infrastructure projects and buildings.

- » establish a sustainable model for funding SNE activities and mobilising funds for SNE
- » develop programmes that will facilitate the increase in number and utilisation of SNE teachers in the country
- » above all else, ensure that these audits and provisions of teaching and learning requirements are done in all schools to advance CRPD-compliant inclusive education requirements which go beyond SNE.

11. **Improve the early identification of disabilities and referral services:** With regard to early identification, first, there is a need for specific revisions in the law and policies such as the National Policy on Disability, 2004 to provide for early identification and intervention in an actionable format. Early identification of disabilities can prevent chronic disability and enable appropriate educational support. These facilities need to be local and built into existing services (e.g., prenatal and newborn babies at health centres; early childhood learning centres; primary schools; or designated public health centres). *Early identification should be integrated into regulations and guidelines of health facilities and made available locally. This should be accompanied by the training of community health workers and community health volunteers.* Second, since children (e.g., under 5 year old) rely on parents' understanding and having the ability and acceptance to report having a child with an impairment, there are opportunities to cross-check self-reported information from families with medical data (growth monitoring, medical services, etc). For Zanzibar, the community health volunteers could be empowered with some capacity to start simple referrals for young children who may be presenting evidence of an impairment. Also, the government could engage with baby clinics around early identification and referrals.

8.1.1. B. Where can Unicef Tanzania Focus Technical Assistance in the New Country Programme to Strategically Maximise Impact on Disability Inclusion, for Tanzania Mainland and Zanzibar?

12. **Play a convening role:** UNICEF should bring people working on disability inclusion together to share and learn from each other. This will improve coordination and capacity across the sector, as well as help with networking and building alliances for change. As observed by participants during the validation workshop, convening multi sectoral actors together

is key for bringing about reforms. It is through such collaboration that success stories are shared, and collective problems, goals, and objectives identified. UNICEF could play the role of the convener for these actors.

13. **Focus on disability data for under 5 years:** The Washington Group/UNICEF Child Functioning Module is an adapted question set specifically designed for identifying children with disabilities. It has two sub-modules, one for children aged 2-4 years, and one for children aged 5-17 years (Washington Group, 2020). Integration of the Child Functioning Module in key surveys in URT could strengthen data on children with disabilities and facilitate disability disaggregation of data on SDGs that apply to children. *Including a chapter on disability in the HBS Key Indicators Report as well as in the Child Poverty in Tanzania and Child Poverty in Zanzibar publications produced in collaboration with UNICEF are other ways to improve data on children with disabilities.*
14. **Collect advocacy data:** This recommendation has two related aspects. The first is that local research and evidence can also be a powerful driver of advocacy and awareness raising. For example, Box 4 highlights research on the negative economic impacts for low- and middle-income countries. Comparable figures for URT could bring together human rights and economic development arguments and support advocacy for inclusion of children and young people with disabilities. The second is that UNICEF and other donors, in collaboration with actors such as the Ministries of Policy, Parliamentary Affairs, Labour, Employment and Youth, and OPDs could help harmonise research methodologies for more consistent data both in Mainland Tanzania and in Zanzibar. Currently, there are inconsistent data reflections of disability prevalence among children and young people in both geographical territories. Effective policy interventions require more consistency and predictability in measurement.
15. **Walk the talk.** UNICEF Tanzania should increase the number of people with disabilities employed in their offices. Consider starting an internship program for youth with disabilities.
16. **UNICEF cross sectoral approach:** UNICEF Tanzania has a disability working group which is commendable. Ensuring that the UNICEF office adopts a cross-sectoral approach to disability inclusion can happen through sourcing a disability resource person during the next CPD process will enhance knowledge and skills of all stakeholders in addressing the needs of children with disability. If UNICEF does this internally then it will have a ripple effect externally.

Box 4: The The Cost of Excluding People with Disabilities from Education

A 2014 systematic review of the evidence on the costs of exclusion and gains of inclusion of people with disabilities in low- and middle-income countries highlighted evidence from a variety of studies on the economic implications of disability-inclusive education (Banks & Polack, 2014):

- » In Bangladesh, reductions in wage earnings attributed to lower levels of education among people with disabilities and their child caregivers were estimated to cost the economy US\$54 million per year.
- » In Nepal, the inclusion of people with sensory or physical impairments in schools was estimated to result in a rate of return of around 20%.⁵
- » In a similar study in the Philippines, increased schooling was associated with higher earnings among people with disabilities, generating an economic rate of return to education of more than 25%.¹⁴⁹
- » In China, estimates indicated that each additional year of schooling for people with disabilities leads to a wage increase of approximately 5% for rural areas and 8% for urban areas.⁶

"Exclusion from education may lead to lower employment and earning potential among people with disabilities. Not only does this make individuals and their families more vulnerable to poverty, but it can also limit national economic growth."

(Banks & Polack, 2014:p.ii)

8.1.2. C. Which Partnerships are Key to Leverage UNICEF's Work on Disability Inclusion?

17. **Develop an action learning, institutional strengthening program for OPDs:** This will help OPDs be ready for grants by having the right governance in place and be stronger advocates. The Tanzanian Federation of Disabled People's Organisations in both the Mainland and Zanzibar, with the support of other OPDs and other stakeholders should lobby the government to entrench disability rights in the constitution and national policies. The capacity of OPDs for advocacy, governance and their absorptive capacity requires improvement. *Working closely with OPDs to understand their internal governance and institutional strengths and weaknesses could help in holding the URT to account, while also strengthening OPD capacity in advocacy and mobilisation.*
18. **Develop strategic partnerships with research institutions:** Research is needed to better understand the linkages between poor nutrition and disability, and the gaps in programmes and service for children and young people with disabilities relating to nutrition. *By building partnerships with government statistician institutions and academic institutions and even think*

tanks to improve disability data, the quality and availability of disability inclusive data will improve.

19. **Fostering OPD inclusion of children:** Women and young people are significantly underrepresented by OPDs. UNICEF should undertake proactive engagement with OPDs to explore partnership models that would allow for meaningful engagement of young people with disabilities, as per the principles of the CRPD. This engagement would also explore opportunities for capacity building and advocacy on (a) alignment of national legislation with regional and international obligations relating to children and young people with disabilities, and (b) improvements in domestication of international treaties and implementation of domestic laws and policies related to children and young people and children with disabilities.
20. **Foster a regional approach to disability inclusion.** At a regional level, UNICEF should engage the EAC to incorporate disability in regional conventions and indicators. For example, the EAHRC health indicators do not include disability. Study tours across Africa to share disability inclusion good practices and lessons learned would also help to develop a regional approach to disability inclusion. Briefing URT ministers before regional events with data on disability inclusion and advocacy figures will help make URT a leading

voice on disability inclusion as well as promote regional awareness for the issue.

21. **Foster an early identification and disability inclusive health care alliance:** Given how important early identification is to life chances, there is a need for a special committee/unit to be established on this topic. It should be government led and include private, public, non-government, and UNCT members who self-select to participate and collaborate on this important topic.
22. **Foster a CRPD-compliant inclusive education alliance:** While URT has adopted important legislation to advance inclusive education such as the Zanzibar Education Policy of 2006 and Zanzibar Inclusive Education Policy of 2019, the current practices of inclusive education are incongruent with the CRPD's conception of inclusive education. Inclusive education is neither "institutionalisation"

of children with disabilities in "special schools" nor a mere clustering of children in one space. Nor is it a mere distribution of assistive devices. It is a more complex process of creating an enabling environment that takes away the inherent barriers to equitable access and participation of children with different disabilities. It entails sufficient training of teachers, public sensitisation and awareness raising, participation of family members, and adaptable use of facilities tailored to the students' needs. URT needs proportionate efforts, and corresponding financing, for training teachers in inclusive and gender sensitive disability education. Both the Mainland and Zanzibar also need to address the specific needs of categories of disabilities within the education sector (e.g., learning for children with intellectual disabilities). The Ministry of Education should take the lead in these reforms as well as in documenting budgetary commitments towards inclusive education support.



Annex 1: Reference List

African Committee of Experts on the Rights & Welfare of the Child (2016) *Report on Investigative Mission on the Situation of Children with Albinism in Temporary Holding Shelters - Tanzania*. Addis Ababa, African Committee of Experts on the Rights & Welfare of the Child. Available at: <https://www.refworld.org/pdfid/5811f7234.pdf>

African Union (1990) *African Charter on the Rights and Welfare of the Child*. Addis Ababa, African Union. Available at: https://au.int/sites/default/files/treaties/36804-treaty-african_charter_on_rights_welfare_of_the_child.pdf

African Union (1999) *The African charter on the rights and welfare of the child*, The African Union: Legal and Institutional Framework: A Manual on the Pan-African Organization. Available at: https://www.un.org/en/africa/osaa/pdf/au/afr_charter_rights_welfare_child_africa_1990.pdf

African Union (2005) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*. Maputo, African Union. Available at: https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf

African Union Commission Department of Social Welfare (2010) *Continental Plan of Action for the African Decade of Persons with Disabilities 2010 – 2019*. Addis Ababa, African Union commission Department of social Welfare. Available at: https://au.int/sites/default/files/pages/32900-file-cpoa_handbook_audp.english_-_copy.pdf

Amartya. S (2001) *Development as Freedom*. London, Oxford University Press. Available at: <https://econpapers.repec.org/RePEc:oxp:books:9780192893307>

Aldersey, .H.M (2012) Family perceptions of intellectual disability: Understanding and support in Dar es Salaam. *African Journal of Disability*, 1(1), pp. 1–12. doi: 10.4102/ajod.v1i1.32

Areheart, .A.B (2012) *The Anticlassification Turn in Employment Discrimination Law*, *Alabama Law Review*. 193. Knoxville, University of Tennessee. Available at: http://works.bepress.com/brad_areheart/6/

Atkinson, A. B & Hills, J (1998) *Exclusion, employment and opportunity*. CASEpaper, Atkinson, A. B. and Hills, John(eds.) (4). Centre for Analysis of Social Exclusion, London School of Economics and Political Science, London, UK. Available at: http://eprints.lse.ac.uk/5489/1/exclusion%2C_employment_and_opportunity.PDF

Banks, M. & Polack, S. (2014) *The economic costs of exclusion and gains of inclusion of people with disabilities evidence from low and middle income countries*. International Centre for Evidence in Disability. Available at: https://www.cbm.org/fileadmin/user_upload/Publications/Costs-of-Exclusion-and-Gains-of-Inclusion-Report.pdf.

Beall, J & Piron, L. H (2005) *DFID Social Exclusion Review*. London, The London School of Economics and Political Science. Available at: <https://cdn.odi.org/media/documents/2301.pdf>

Bickenbach, J., Posarac, A., Cieza, A. & Kostanjsek, N (2015) *Assessing Disability in Working Age Population A Paradigm Shift : from Impairment and Functional Limitation to the Disability Approach*. Washington DC, World Bank. Available at: <http://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>

Bureau of Statistics. (2019) *Lesotho Multiple Indicator Cluster Survey 2018*, Survey Findings Report. Maseru, Lesotho: Bureau of Statistics. Available at: https://mics-surveys-prod.s3.amazonaws.com/MICS6/Eastern%20and%20Southern%20Africa/Lesotho/2018/Survey%20findings/Lesotho%202018%20MICS%20Survey%20Findings%20Report_English.pdf.

Child Rights International Network (2018) *Discrimination and the CRC*. Available at: <https://www.crin.org/en/guides/introduction/discrimination-and-crc> (Accessed: 6 April 2021)

Child Welfare Information Gateway & Children's Bureau (2018) *The risk and prevention of maltreatment of children with disabilities*. Washington DC, Child Welfare Information Gateway. Available at: <https://www.childwelfare.gov/pubPDFs/focus.pdf>

Christoffel-Blindenmission (2017) *Disability Inclusive Development Toolkit CRPD*. Bensheim, Christoffel-Blindenmission. Available at: https://www.cbm.org/fileadmin/user_upload/Publications/CBM-DID-TOOLKIT-accessible.pdf

Comprehensive Community Based Rehabilitation in Tanzania (2021) <http://www.ccbrrt.or.tz/programmes/disability/disability-in-tanzania/>.

Cooper, B (2016) *Oxford Handbooks Online*. Edited by Disch, L & Hawkesworth, M. London: Oxford University Press. doi: 10.1093/oxfordhb/9780199328581.013.20

De Haan, A (1999) *Social Exclusion: Towards an Holistic Understanding of Deprivation*. London, Department for International Development. Available at: <https://gsdrc.org/document-library/social-exclusion-towards-an-holistic-understanding-of-deprivation/>

Devlieger, P. J (1998) Physical "disability" in Bantu languages: Understanding the relativity of classification and meaning. *International Journal of Rehabilitation Research*, 21(1), pp. 51–62. doi: 10.1097/00004356-199803000-00005

East Africa Community Customs Union (2017) *Common External Tariff 2017 Version*. Nairobi, East Africa Community Customs Union. Available at: <https://ugandatrades.go.ug/media/EAC Common External Tariff 2017 .pdf>

East African Community Secretariat (2017) *The East African Community Child Policy (2016)*. Arusha, East African Community Secretariat. Available at: <http://repository.eac.int/bitstream/handle/11671/2013/EAC Child Policy.pdf?sequence=1&isAllowed=y>

East Africa Community Secretariat (2013) *East African Community Youth Policy*. Arusha, East Africa Community Secretariat. Available at: <http://meac.go.ke/wp-content/uploads/2017/03/EAC-Youth-Policy.pdf>

East African Community Secretariat (2012) *EAC Strategic Plan for Gender, Youth, Children, Persons With Disability, Social Protection and Community Development (2012-2016)*, East African Community. Arusha, East African Community Secretariat. Available at: <https://www.ilo.org/dyn/natlex/docs/MONOGRAPH/94021/110206/F705470476/INT-94021.pdf>

East African Community Secretariat (1999) *The Treaty for the Establishment of the East African Community*. Arusha, East African Community Secretariat. Available at: https://www.eala.org/uploads/The_Treaty_for_the_Establishment_of_the_East_Africa_Community_2006_1999.pdf

Education Development Trust & UNICEF (2016) *Eastern and Southern Africa regional study on the fulfilment of the right to education of children with disabilities*. Berkshire, Education Development Trust. Available at: <https://www.unicef.org/esaro/Regional-children-with-disabilities-UNICEF-EDT-2016.pdf>

Expanding Social Protection (ESP) (2018) *Uganda's Senior Citizen's Grant – Disability Response*. Available at: <http://socialprotection.go.ug/wp-content/uploads/2018/07/Disability-response-in-the-Senior-Citizens-Grant-1.pdf>

Foundation of Civil Society (2019) *Publications for Foundation of Civil Society*. Available at: <https://thefoundation.or.tz/publication/> (Accessed: 10 March 2021).

Garry, A (2011) Intersectionality, metaphors, and the multiplicity of gender. *Journal of Feminist Philosophy*, 26(4), pp. 826–850. doi: 10.1111/j.1527-2001.2011.01194.x

Ghana Statistical Service (2018) *Multiple Indicator Cluster Survey (MICS 2017/18), Survey Findings Report*. Accra, Ghana: Ghana Statistical Service. Available at: https://mics-surveys-prod.s3.amazonaws.com/MICS6/West%20and%20Central%20Africa/Ghana/2017-2018/Survey%20findings/Ghana%202017-18%20MICS%20Survey%20Findings%20Report_English.pdf

Gigliani, F & Swai, E (2016) Situation Analysis on Rehabilitation Policy: A Possible Way to the Implementation of the Disability Act. *SSRN Electronic Journal*, (January), pp. 0–99. doi: 10.2139/ssrn.2776759

Global Partnership for Education (2018) *Disability and Inclusive Education: A Stocktake of Education: A Stocktake of Education Sector Plans and GPE-Funded Grants*. Washington DC, Global Partnership for Education: Available at: <https://www.globalpartnership.org/sites/default/files/2018-07-gpe-disability-working-paper.pdf>

Global Partnership for Sustainable Development Data (2018) *A commitment to ensure that no one is left behind in the pursuit and measurement of social and economic progress*. Washington DC., Global Partnership for Sustainable Development Data & Inclusive Data Charter. Available at: https://www.data4sdgs.org/sites/default/files/2018-08/IDC_onepager_Final.pdf

Gore, C & Figueiredo, J (1997) *Social exclusion and anti-poverty policy: A debate*. Geneva, International Labour Organisation. Available at: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.130.260&rep=rep1&type=pdf>

Government of Tanzania & United Nations Children's Fund (2018) *HEALTH BUDGET BRIEF 2018-Tanzania*. Dar es Salaam, Government of Tanzania & United Nations Children's Fund. Available at: <https://www.unicef.org/esa/media/2331/file/UNICEF-Tanzania-Mainland-2018-Health-Budget-Brief-revised.pdf>

Grobbelaar-du, P. L (2007) African women with disabilities: The victims of multilayered discrimination. *Sabinet African Journals*, 22(2), pp. 405–421. doi: 10.10520/EJC97946

Groce et al (2014) Malnutrition and disability: Unexplored opportunities for collaboration. *Paediatrics and International Child Health*, 34(4), pp. 308–314. doi: 10.1179/2046905514Y.00000000156

Grue, J (2017) Now you see it, now you don't: A discourse view of disability and multidisciplinary. *ALTER, European Journal of Disability Research*. Association ALTER, 11(3), pp. 168–178. doi: 10.1016/j.alter.2017.05.002

Hansen, A.M.W., Chaki, A. P. & Mlay, R (2013) Occupational therapy synergy between Comprehensive Community Based Rehabilitation Tanzania and Heifer International to reduce poverty. *African Journal of Disability*, 2(1), pp. 1–7. doi: 10.4102/ajod.v2i1.48

Hofman, R. H. & Kilimo, J S (2014) Teachers Attitudes and Self-Efficacy Towards Inclusion of Pupils With Disabilities in Tanzanian Schools. *Journal of Education and Training*, 1(2), p. 177. doi: 10.5296/jet.v1i2.5760

Holden, J & Corby, N (2019) *Disability and nutrition programming : evidence and learning*. London, UKaid. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818123/query-6-disability-and-nutrition.pdf

Human Rights Watch (2020) *World report | 2020*. Washington DC., Human Rights Watch .Available at:https://www.hrw.org/sites/default/files/world_report_download/hrw_world_report_2020_0.pdf.

Human Rights Watch (2019) *IT FELT LIKE A PUNISHMENT' Growing Up with Albinism in Tanzania*. Ukerewe Island, Human Rights Watch. Available at: https://www.hrw.org/sites/default/files/supporting_resources/201902drd_tanzania_albinism_brochure.pdf

Human Rights Council (2016) *Report of the Independent Expert on the enjoyment of human rights by persons with albinism*. Geneva, United Nations. Available at: <https://www.refworld.org/pdfid/56c43e9f4.pdf>

Ifakara Health Institute, BMZ., & GIZ. (2013) Inclusion of Persons with Disabilities in the Health Financing System in Tanzania. Dar es Salaam, Ifakara Health Institute, BMZ. & GIZ Available at: https://www.firah.org/upload/notices2/avril2014/ihl_report_final_revised_aug_2013_.pdf

Inclusive Futures & Institute of Development Studies (2020) *Disability Inclusive Development Tanzania Situational Analysis June 2020 update*. Brighton, Institute of Development Studies. Available at:https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/15509/DID%20Tanzania%20SITAN%20_%20June%202020.pdf?sequence=1&isAllowed=y

Inter-American Development Bank (2019) *Violence against Women and Girls with Disabilities: Latin America and the Caribbean*. Washington, D.C., Inter-American Development Bank. Available at: <https://publications.iadb.org/en/violence-against-women-and-girls-disabilities-latin-america-and-caribbean>

International Commission of Jurists (1985) *Human and Peoples' Rights in Africa Human and The Right African Charter*. Nairobi, International Commission of Jurists. Available at: <https://www.icj.org/wp-content/uploads/1986/04/Africa-human-and-peoples-rights-conference-report-1986-eng.pdf>

International Labour Organisation (2006) *The Persons with Disabilities (RIGHTS AND PRIVILEGES) ACT 2006_Zanzibar*. Zanzibar, International Labour Organization. Available at: https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=82418&p_country=TZA&p_classification=08

International Labour Organisation & Irish Aid (2014) *Breaking the Vicious Circle of Disability and Extreme Poverty*. Geneva, ILO-Irish Aid Partnership Programme on Disability Available at: https://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/event/wcms_313833.pdf

Kabeer, N (2010) *Can the MDGs provide a pathway to social justice? The challenge of intersecting inequalities*. Brighton & New York, Institute of Development Studies & MDGIF. Available at: http://www.mdgfund.org/sites/default/files/MDGs_and_Inequalities_Final_Report.pdf

Kamga, T. R, Chagomoka, T & Kouame, C (2013) Nutritional Evaluation of Five African Indigenous Vegetables. *Journal of Horticultural Research*, 21(1), pp. 99–106. doi: 10.2478/johr-2013-0014

Kapiga, S., Harvey, S., Mshana, G., Hansen, C.H., Mtolela, J., Madaha, F., Hashim, R., Kapinga, I., Mosha, N., Abramsky, T., Lees, S., and Watts, C. (2019). A social empowerment intervention to prevent intimate partner violence against women in a microfinance scheme in Tanzania: findings from the MAISHA cluster randomised controlled trial. *Lancet Glob Health* 2019; 7: e1423–34.

Kimberle, C (1989) Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics [1989]. *Feminist Legal Theory: Readings in Law and Gender* 1989 (1): 57–80. Edited by Katharine T. B & Rosanne, K. New York: Routledge. Available at: doi:10.4324/9780429500480

Johansson, E (2014) *Impaired child, disabled parent? Parents' Perception of having a Child with Disability in Dar es Salaam, Tanzania*. Masters Thesis. Lund University, Scania. Available at: <http://lup.lub.lu.se/luur/download?func=downloadFile&recordId=4438609&fileId=4459628>

Joint United Nations Programme on HIV and AIDS (2017) *Disability and HIV*. Geneva, Joint United Nations Programme on HIV and AIDS Available at: https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf

Juma, S. (2018) *Developing Inclusive Education Policy and Practice in Zanzibar: Collaborative Action Research*. Yliopisto, University of Jyväskylä. Available at: https://jyx.jyu.fi/bitstream/handle/123456789/57790/978-951-39-7424-4_vaitos12052018.pdf?isAllowed=y&sequence=1

Legal and Human Rights Centre (2017) 'Unknown Assailants': A Threat to Human Rights. Dar es Salaam & Zanzibar, Legal and Human Rights Centre Available at: <https://www.humanrights.or.tz/assets/attachments/1524659401.pdf>

Leonard Cheshire. (2018) *Disability Data Review: A Collation and Analysis of Disability Data from 40 Countries*. Available at: https://www.disabilitydataportal.com/fileadmin/uploads/lcdp/Documents/report-web_version.pdf

Manyanga, D & Mtae, H (2017) Assessment of Social Factors That Hinders Infants of Unmarried Young Women to Access Immunization Programme Interventions in Dar es salaam, Tanzania. *American Scientific Research Journal for Engineering, Technology, and Sciences (ASRJETS)*, 30(1), pp. 226–259. Available at: https://asrjetsjournal.org/index.php/American_Scientific_Journal/article/view/2619/1109

Mapunda, P.H., Omollo, A.D. & Bali, T.A (2017) Challenges in identifying and serving students with special needs in Dodoma, Tanzania. *International Journal of Child Care and Education Policy*, 11(10). doi: 10.1186/s40723-017-0036-8

Mashiri, P. (2000) Street remarks, address rights and the urban female: Socio-linguistic politics of gender in Harare. *The Journal of Humanities of the University of Zimbabwe*, 27(1), pp. 1–4. doi: 10.4314/zjh.v27i1.674

McCluskey, U (2010) *Understanding the self and understanding therapy: an attachment perspective*, Context. Available at: <http://www.unamcccluskey.com/wp-content/uploads/2011/03/Article-for-Context-Magazine2.pdf>

McNally, A & Mannan, H (2013) Perceptions of caring for children with disabilities: Experiences from Moshi, Tanzania. *African Journal of Disability*, 2(1), pp. 1–10. doi: 10.4102/ajod.v2i1.21

Mesätlehto, V., Katsui, H., & Sambaiga, R. (2021) Disparities in accessing sexual and reproductive health services at the intersection of disability and female adolescence in Tanzania. *International Journal of Environmental Research and Public Health*, 18(4). <https://doi.org/10.3390/ijerph18041657>

Ministry of Education and Vocational Training (2017) Zanzibar Education Development Plan II 2017/2018–2021/2022. Zanzibar, Ministry of Education and Vocational Training. Available at: http://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/zanzibar_zedp_ii.pdf

Ministry of Education, Science & Technology (2016) *National Guideline for Water, Sanitation and Hygiene for Tanzania Schools*. Dar es Salaam, Ministry of Education, Science & Technology. Available at: <https://www.unicef.org/tanzania/media/1526/file/National%20Guideline%20for%20Water,%20Sanitation%20and%20Hygiene%20for%20Tanzania%20Schools.pdf>

Ministry of Education Science & Technology (2017) *National Strategy for Inclusive Education 2018-2021*. Dar es Salaam, Ministry of Education Science & Technology, President's Office Regional Administration and Local Government. Available at: http://www.tzdp.gov.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/education/Key_Sector_Documents/FINAL_Inclusive_education_strategy_2018-04-19_-_formatted__main_text_only_.pdf

Ministry of Education, Science & Technology (2018) *Education Sector Development Plan (2016/17-2020/21)*. Dar es Salaam, Ministry of Education, Science & Technology Available at: <https://www.globalpartnership.org/sites/default/files/2019-04-gpe-tanzania-esp.pdf>

Ministry of Education, Science & Technology (2019) *Education Sector Performance Report(2018/2019)*. Dar es Salaam, Ministry of Education, Science & Technology. Available at: https://www.globalpartnership.org/sites/default/files/document/file/2020-05-Tanzania%20Mainland-ESP-IR_0.pdf

Ministry of Finance & Planning (2019) *Voluntary National Review (VNR) 2019 - Empowering People and Ensuring Inclusiveness and Equality*. Dar es Salaam, Ministry of Finance and Planning . Available at : https://sustainabledevelopment.un.org/content/documents/23429VNR_Report_Tanzania_2019_FINAL.pdf

Ministry of Finance & Planning (2016) Tanzania-National Five Years Development Plan 2016/17 - 2020/21: "Nurturing Industrialization for Economic Transformation and Human Development." Dar es Salaam, Ministry of Finance & Planning. Available at: https://www.cabri-sbo.org/uploads/files/Documents/tanzania_2016_planning_external_national_plan_author_region_english_.pdf

Ministry of Finance and Planning - Poverty Eradication Division (MoFP- PED) and National Bureau of Statistics (2019) *Tanzania Mainland Household Budget Survey 2017-18: Key Indicators Report*. Dodoma, Tanzania. Available at: <https://www.nbs.go.tz/index.php/en/census-surveys/poverty-indicators-statistics/household-budget-survey-hbs/413-the-2017-18-household-budget-survey-key-indicators-report>

Ministry of Health, Community Development, Gender, Elderly & Children (2017) *The National Health Policy*. Dar es Salaam, Ministry of Health, community development, gender, elderly, and children. Available at: http://www.tzdp.gov.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/JAHSR_2017/8.The_Nat_Health_Policy_2017_6th_24_October_2017.pdf

Ministry of Health, Community, Development, Gender, Elderly and Children (2016) *Action Plan To End Violence Against Women and Children in Tanzania 2017/18-2021/22*. Dar es Salaam,. Available at: <https://www.unicef.org/tanzania/media/496/file/tanzania-2016-NPA-VAWC.pdf>

Ministry of Health & Social Welfare (2015) *Ministry of Health & Social Welfare Health Sector Strategic Plan 2015-2020: Reaching All Households with Quality Health Care*. Dar es Salaam, Ministry of Health & Social Welfare. Available at: http://www.tzdp.gov.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/Key_Sector_Documents/Induction_Pack/Final_HSSP_IV_Vs1.0_260815.pdf

Ministry of Health & Social Welfare (2012) National Nutrition Strategy JULY 2011/12 – JUNE 2015/16. Dar es Salaam, Ministry of Health & Social Welfare. Available at: https://extranet.who.int/nutrition/gina/sites/default/filesstore/TZA_2011_National_Nutrition_Strategy.pdf

Ministry of Education Science & Technology (2017) *National Strategy for Inclusive Education 2018-2021*. Dar es Salaam, Ministry of Education Science & Technology, President's Office Regional Administration and Local Government. Available at: http://www.tzdpd.or.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/education/Key_Sector_Documents/FINAL_Inclusive_education_strategy_2018-04-19_-_formatted__main_text_only_.pdf

Ministry of Health-Zanzibar (2013) *Zanzibar Health Sector Strategic Plan III 2013/14-2018/19*. Zanzibar, Revolutionary Government of Zanzibar. Available at: https://tanzania.um.dk/~media/tanzania/documents/health/zanzibar_strategic_plan_14-18.pdf?la=en

Ministry of Labour Youth development and sports (2004) *National Policy on Disability 2004, Policy Review*. Dar es Salaam, Ministry of Labour Youth development and sports. Available at: https://www.tanzania.go.tz/egov_uploads/documents/NATIONAL_POLICY_ON_DISABILITY_sw.pdf

Mont, D (2019) *Are People With Albinism Included In The Washington Group Questions*? Murungi, N. L & Durojaye, E (2015) 'The Sexual And Reproductive Health Rights Of Women With Disabilities In Africa: Linkages Between The Crpd And The African Women's Protocol', In Ngweni, C, Plessis, G. I., Combrinck, H & Kamga, D. S (ed.) *African Disability Rights Yearbook*. 3rd edn. Pretoria: Pretoria University Law Press. Available at: http://globaldisability.org/wp-content/uploads/2015/11/adry_2015_3_full_text.pdf

Mutugi, K. J (2017) A cultural-Contextual Assessment of the use of Social Marketing Approach in HIV/AIDS. Thesis, University of East London, Borough of Newham. Available at: <https://repository.uel.ac.uk/download/57dc0517bb2ca533158e0a627e797787daef9d1c83b626a142127f8d12f3d53d/5771739/Jackie%2520Whole%2520piece%2520proofread%2520final%2520%252018.pdf>

Murungi, N. L & Durojaye, E (2015) The Sexual And Reproductive Health Rights Of Women With Disabilities In Africa: Linkages Between The Crpd And The African Women's Protocol, In Ngweni, C, Plessis, G. I., Combrinck, H & Kamga, D. S (Ed.) *African Disability Rights Yearbook*. 3rd edn. Pretoria: Pretoria University Law Press. Available at: http://globaldisability.org/wp-content/uploads/2015/11/adry_2015_3_full_text.pdf

Mwaijande, V.T (2014) *Access to education and Assistive devices for children with physical disabilities in Tanzania*. MIS Thesis, Oslo and Akershus University College of Applied Science, Norway. Available at: https://oda.oslomet.no/bitstream/handle/10642/2267/Mwaijande_Violet.pdf?sequence=2&isAllowed=y

National Bureau of Statistics (2008) Tanzania 2008 Disability Survey Report. Dar es Salaam., National Bureau of Statistics. Available at: http://www.tzdpd.or.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/education/TANZANIA_2008_DISABILITY_SURVEY_DRART_REPORT_NOVEMBER30.pdf

National Bureau of Statistics (2014) *Tanzania Mainland-Integrated Labour Force Survey 2014 Analytical Report*. Dar es Salaam, National Bureau of Statistics. Available at: <https://s3-eu-west-1.amazonaws.com/s3-sourceafrica.net/documents/118113/Tanzania-Integrated-Labour-Force-Survey-2014.pdf>

National Bureau of Statistics (2018) Tanzania HIV Impact Survey (THIS)-2016-2017, Report. Dodoma, National Bureau of Statistics. Available at: <https://www.malecircumcision.org/resource/tanzania-hiv-impact-survey-2016-2017-final-report>

National Bureau of Statistics (2018) *Formal Sector Employment and Earnings Survey, 2016*. Tanzania Mainland, National Bureau of Statistics. Available at: https://www.nbs.go.tz/nbs/takwimu/labour/EES_2016_REPORT.pdf

National Bureau of Statistics (2019) *HOUSEHOLD BUDGET SURVEY 2017-18_Mainland Tanzania: Key Indicators Report*. Dodoma, National Bureau of Statistics. Available at: https://www.nbs.go.tz/nbs/takwimu/hbs/2017_18_HBS_Key_Indicators_Report_Engl.pdf

National Bureau of Statistics (2019b) *Tanzania National Nutrition Survey 2018*. Dodoma, National Bureau of Statistics. Available at: https://www.unicef.org/tanzania/media/2141/file/Tanzania_National_Nutrition_Survey_2018.pdf

National Bureau of Statistics, Ministry of Finance and planning, World Bank, UN Women, Global Affairs Canada, UNICEF & Irish Aid (2019) *Household Budget Survey 2017-18_Mainland Tanzania*. Dodoma,. National Bureau of Statistics & Ministry of Finance and Planning. Available at: https://www.nbs.go.tz/nbs/takwimu/hbs/2017_18_HBS_Key_Indicators_Report_Engl.pdf

National Bureau of Statistics & Office of the Chief Government Statistician (2019) *Tanzania National Nutrition Survey 2018*. Dodoma, National Bureau of Statistics & Office of the Chief Government Statistician. Available at: https://www.unicef.org/tanzania/media/2141/file/Tanzania_National_Nutrition_Survey_2018.pdf

National Bureau of Statistics and Office of the Chief Government Statistician (2014). *Basic Demographic and Socio-Economic Profile*. Dar es Salaam and Zanzibar: Ministry of Finance (Tanzania) and Ministry of State, President's Office (Zanzibar). Available at: http://tanzania.countrystat.org/fileadmin/user_upload/countrystat_fenix/congo/docs/2012%20Tanzania%20Population%20and%20Housing%20Census-Basic%20Demographic%20and%20Socio-Economic%20Profile.pdf

National Bureau of Statistics and Office of Chief Government Statistician (2013) *Population Distribution by Age and Sex Report*. Dar es Salaam and Zanzibar: Ministry of Finance and President's Office. Available at: http://tanzania.countrystat.org/fileadmin/user_upload/countrystat_fenix/congo/docs/Population%20Distribution%20by%20Age%20and%20Sex%20Report-2012PHC.pdf

National Bureau of Statistics, Ministry of Finance & Office of Chief Government Statistician (2016) *Disability Monograph*. Dar es Salaam, National Bureau of Statistics. Available at: <http://www.rodra.co.za/images/countries/tanzania/research/Tanzania%20Disability%20Monograph%202016.pdf>

National Bureau of Statistics, Office of Chief Government Statistician & UNICEF (2020) *2018 School Water, Sanitation and Hygiene Assessment*. Dodoma, National Bureau of Statistics . Available at: <https://www.unicef.org/tanzania/media/2356/file/National%20School%20WASH%20Report%202020.pdf>

National Bureau of Statistics & Office of Chief Government Statistician (2013) *2012 Population and Housing Census*. Dar es Salaam & Zanzibar, National Bureau of Statistics & Office of Chief Government Statistician Available at: http://www.tzdp.gov.or.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/water/WSDP/Background_information/2012_Census_General_Report.pdf

National Bureau of Statistics, Ministry of Finance & Planning Dar es Salaam and Office of Chief Government Statistician, Ministry of Finance & Planning Zanzibar (2018) *National Population Projections*. Available at: <https://www.nbs.go.tz/nbs/takwimu/census2012/Projection-Report-20132035.pdf>

National Bureau of Statistics & United Nations Children's Fund (2019a) *Child Poverty in TANZANIA*-Report based on 2014/2015 National Panel Survey. Dodoma, National Bureau of Statistics & United Nations Children's Fund. Available at: <https://www.unicef.org/tanzania/media/2106/file/UNICEF-Tanzania-Child-Poverty-Report-2019.pdf>

National Bureau of Statistics & United Nations Population Prospects (2021) *World Population Review Tanzania Population 2021 (Live)* Available at: <https://worldpopulationreview.com/countries/tanzania-population> (Accessed: 6 April 2021)

National Social Security Fund (2021) *Invalidity Pension*. The United Republic of Tanzania, National Social Security Fund. Available at: <https://www.nssf.or.tz/benefits/invalidity-pension>

NBS, MoF, OCGS, MoS, PoSH & GGZ (2014) *Basic demographic and socio-economic profile*. Dar es Salaam & Zanzibar, National Bureau of Statistic, Ministry of Finance, Office of Chief Government Statistic, Ministry of State, President's Office State House & Good Governance Zanzibar. Available at: http://tanzania.countrystat.org/fileadmin/user_upload/countrystat_fenix/congo/docs/2012_Tanzania_Population_and_Housing_Census-Basic_Demographic_and_Socio-Economic_Profile.pdf

Nkata, H, Teixeira, R & Barros, H (2019) A scoping review on sexual and reproductive health behaviors among Tanzanian adolescents. *Public Health Reviews*. Public Health Reviews, 40(4), pp. 1–15. doi: 10.1186/s40985-019-0114-2

Ngilangwa, D. P., Rajesh, S., Kawala, M., & Nyagero, J (2016) Accessibility to sexual and reproductive health and rights education among marginalized youth in selected districts of Tanzania. *Pan African Medical Journal*, 25(Suppl 2), pp. 1–7. doi: 10.11604/pamj.supp.2016.25.2.10922

OCGS & UNICEF (2018) *Zanzibar Health Budget Brief*. Zanzibar, OCGS & UNICEF. Available at: <https://www.unicef.org/tanzania/media/1321/file/UNICEF-Zanzibar-2018-Health-Budget-Brief.pdf>

Office of Chief Government Statistician (2014) *Integrated Labour Force Survey 2014*. Zanzibar, Office of Chief Government Statistician. Available at: <http://www.ocgs.go.tz/php/ReportOCGS/LFS%202014%20Final.pdf>

Office of Chief Government Statistician (2020) *Key Indicators Report: 2019/20 Household Budget Survey*. Zanzibar, Office of Chief Government Statistician. Available at: http://www.ocgs.go.tz/php/ReportOCGS/2019_20_HBS_Key_Indicators_Report.pdf

Omona, J., Asimwe, J.B., & Andrew State, E. (2017) *Disability and Development Variables for People with Disabilities in Uganda*. Bridging the Gap Secondary Data Analysis. Makerere University. Available at: https://www.ucl.ac.uk/epidemiology-health-care/sites/iehc/files/Uganda_-_secondary_data_analysis.pdf

Owino, E. (2020) *Status of disability in Kenya: Statistics from the 2019 census*. Bristol: Development Initiatives. Available at: <https://devinit.org/resources/status-disability-kenya-statistics-2019-census/>

Parliament of the United Republic of Tanzania (2010) *The Persons with Disabilities Act 2010*. Dodoma, Parliament of the United Republic of Tanzania. Available at: <http://parliament.go.tz/polis/uploads/bills/acts/1452071737-ActNo-9-2010.pdf>

Pattoni, M. Q (2002) Two Decades of Developments in Qualitative Inquiry: A Personal, Experiential Perspective. *Journal of Indexing and Metrics*, 1(3), pp. 261–283. doi: 10.1177/2F1473325002001003636

Prime Minister's Office (2016) *The Tanzania National Multisectoral Nutrition Action Plan (NMNAP) 2016-June 2021*. Dar es Salaam, Prime Minister's Office Available at: <https://www.unicef.org/tanzania/media/456/file/Tanzania-2016-NMNAP.pdf>

Revolutionary Government of Zanzibar (2014) *Zanzibar Social Protection Policy*. Stone Town: Revolutionary Government of Zanzibar.

Revolutionary Government of Zanzibar (2017) *Zanzibar Strategy for Growth and Reduction of Poverty (MKUZA III)*. Stown Town: Revolutionary Government of Zanzibar.

Revolutionary Government of Zanzibar, the Global Fund, and UNFPA (2018) *Situational analysis for youth with disability on sexual and reproductive health and rights of family planning services in Zanzibar*. Stone Town: Revolutionary Government of Zanzibar, the Global Fund and UNFPA.

Revolutionary Government of Zanzibar - Ministry of Education and Vocational Training (2019) *Zanzibar Inclusive Education Policy*. Stown Town: Revolutionary Government of Zanzibar.

Revolutionary Government of Zanzibar & United Nations Children's Fund (2019) *HEALTH BUDGET BRIEF 2019 / 2020 ZANZIBAR*. Zanzibar, Revolutionary Government of Zanzibar & United Nations Children's Fund. Available at: <https://www.unicef.org/esa/media/8441/file/UNICEF-Tanzania-Zanzibar-2020-Health-Budget-Brief-revised.pdf>

Skinner, D & Weisner, T (2007) Sociocultural studies of families of children with intellectual disabilities. *John Wiley & Sons*, 13(4). doi: 10.1002/mrdd.20170

Shivayawata (2015) *Impact Assessment of Physical Rehabilitation Services in Tanzania*. Dar es Salaam, Shivayawata. Available at: <http://observatoire.fatoafrique.org/observatoire/wp-content/uploads/2016/04/Impact-Assessment-of-Physical-Rehabilitation-Services-in-Tanzania.pdf>

Statistics Sierra Leone. (2018) *Sierra Leone Multiple Indicator Cluster Survey 2017, Survey Findings Report*. Freetown, Sierra Leone: Statistics Sierra Leone. Available at: https://mics-surveys-prod.s3.amazonaws.com/MICS6/West%20and%20Central%20Africa/Sierra%20Leone/2017/Survey%20findings/Sierra%20Leone%202017%20MICS%20Survey%20Findings%20Report_English.pdf

Stone- MacDonald, A. (2012) Cultural Beliefs about Disability in Practice: Experiences at a Special School in Tanzania. *International Journal of Disability, Development and Education*, 59(4), pp. 393–407. doi: 10.1080/1034912X.2012.723947

Tanzania Albinism Society & Karagwe Community Based Rehabilitation Programmes (2019) *The 2019 Baseline Survey on Socio-Economic Status of Persons with Albinism and their Households in the Lake Zone*. Dar es Salaam, Tanzania Albinism Society & Karagwe Community Based Rehabilitation Programmes. Available at: https://www.tas.or.tz/webmak/wp-content/uploads/2019/10/Lake-Zone_Tanzania-2019-BS-PwA-1.pdf

Thomas, J., Holbro., & Young, D. (2013) *A Review of Sanitation and Hygiene in Tanzania*. Dar es Salaam, Maji Safi kwa Afya Bora Ifakara. Available at: <https://assets.publishing.service.gov.uk/media/57a08a2fed915d3cfd000628/tanzania-sanitationreview.pdf>

Tiberti, M. & Costa, V. (2019) *Disability Measurement in Household Surveys: A Guidebook for Designing Household Survey Questionnaires*. Washington DC: World Bank. Available at: <http://documents1.worldbank.org/curated/en/456131578985058020/pdf/Disability-Measurement-in-Household-Surveys-A-Guidebook-for-Designing-Household-Survey-Questionnaires.pdf>

Tiwari, S., Savastano, S., Imprata, M., & Winters, P.C. (2019) *Rural Economic Activities and Persons with Disabilities in Sub-Saharan Africa*. Rome: International Fund for Agricultural Development. Available at: <https://webapps.ifad.org/members/eb/128/docs/EB-2019-128-R-7.pdf?attach=1>

USAID, National Bureau of Statistics, Office of Chief Government Statistician, Irish Aid, Global Affairs Canada, UNICEF & UNFPA (2016) *Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015-2016*. Dar es Salaam, National Bureau of Statistics. Available at: <https://dhsprogram.com/pubs/pdf/fr321/fr321.pdf>

Under the Same Sun (2016) *People With Albinism and the Universal Periodic Review of Tanzania.. Dar es Salaam, Under the Same Sun*. Available at: [https://www.google.com/search?client=safari&rls=en&sxsrf=ALeKk03SK1Hm2yH85o4ucSIhxK1dSIvIQ%3A1608583635339&ei=OwnhX-ubFIOYlwTNhrKABw&q=People+With+Albinism+and+the+Universal+Periodic+Review+of+Tanzania+2016&oq=People+With+Albinism+and+the+Universal+Perio.file:///Users/irenemutambo/Downloads/UTSS_UPR25_TZA_E_CoverPage%20\(2\).pdf](https://www.google.com/search?client=safari&rls=en&sxsrf=ALeKk03SK1Hm2yH85o4ucSIhxK1dSIvIQ%3A1608583635339&ei=OwnhX-ubFIOYlwTNhrKABw&q=People+With+Albinism+and+the+Universal+Periodic+Review+of+Tanzania+2016&oq=People+With+Albinism+and+the+Universal+Perio.file:///Users/irenemutambo/Downloads/UTSS_UPR25_TZA_E_CoverPage%20(2).pdf)

UNICEF (2020) *Mid-term Evaluation of the Zanzibar Social Protection Policy: Final Report*. Dar es Salaam: UNICEF Tanzania Country Office.

United Nations (2006) *United Nations Convention on the Rights of Persons with Disabilities (CRPD)*. Geneva, International and European Labour Law. Available at: https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf

United Nations (2011) *Including the rights of persons with disabilities in United Nations programming at country level A Guidance Note for United Nations Country Teams and Implementing Partners*. New York, United Nations. Available at: http://www.un.org/disabilities/documents/iasg/undg_guidance_note.pdf

United Nations Human Rights Council (2017) *Report of the Independent Expert on the enjoyment of human rights by persons with albinism on her mission to the United Republic of Tanzania Note*. New York, United Nations. Available at: <https://reliefweb.int/sites/reliefweb.int/files/resources/1722910.pdf>

UNICEF (2013a) *Children with Disabilities-Health*. New York, United Nations Children's Fund Available at: https://www.unicef.org/disabilities/files/Final_Flyer_Health_-_27_May.pdf

UNICEF (2013b) *Children with Disabilities-Nutrition*. New York, United Nations Children's Fund Available at: https://www.unicef.org/disabilities/files/Final_Flyer_Nutrition.pdf

UNICEF (2016) *Module on Child Functioning: Questionnaires*. Washington Group and United Nations Children's Fund. Available at: <https://data.unicef.org/resources/module-child-functioning/>

UNICEF (2020) *Child disability and COVID-19 - UNICEF, United Nations Child Education Fund*. Available at: <https://data.unicef.org/topic/child-disability/covid-19/> (Accessed: 9 March 2021).

UNICEF Tanzania (2020) *Mid-term Evaluation of the Zanzibar Social Protection Policy: Final Report*. Dar es Salaam: UNICEF Tanzania Country Office.

United Nations Department of Economic and Social Affairs (UNDESA) (2018) *Promoting Inclusion through Social Protection: Report on the World Social Situation 2018*. New York: United Nations Department of Economic and Social Affairs. Available at: <https://www.un.org/development/desa/dspd/wp-content/uploads/sites/22/2018/07/1-1.pdf>

UNDESA (n.d.) Fact Sheet: *Definition of Youth*. New York: United Nations Department of Economic and Social Affairs. Available at: <https://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf>.

UNFPA (2018) *Young Persons With Disabilities: Global Study on Ending Gender-Based Violence, and Realising Sexual and Reproductive Health and Rights*. New York, United Nations Population Fund. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/51936_-_UNFPA_Global_Study_on_Disability_-_web.pdf

United Nations High Commissioner for Refugees (2015) *CHILD PROTECTION ISSUE BRIEF Children with Disabilities*. Geneva, United Nations High Commissioner for Refugees. Available at: <https://www.refworld.org/pdfid/55cc4a564.pdf>

United Nations Human Rights Council (2012) *Report of the Human Rights Council*. New York, United Nations. Available at: https://www.ohchr.org/Documents/HRBodies/HRCouncil/A-67-53-Add-1_en.pdf

United Nations Tanzania (2016) *United Nations Development Assistance Plan II (2016/2017-2020/2021)*. Dar es Salaam, United Nations Tanzania. Available at: https://tanzania.un.org/sites/default/files/2019-12/UN%20Development%20Assistance%20Plan%20%28UNDAP%20II%29_2016-2021.pdf

United Republic of Tanzania (2005) *The Constitution of The United Republic of Tanzania, Assembly*. Dar es Salaam, United Republic of Tanzania. Available at: *The Constitution of the United Republic of Tanzania of 1977*

United Republic of Tanzania (2019) *The Local Government Finance Act*. Dodoma: United Republic of Tanzania. Available at: https://www.tira.go.tz/IMAGES/headers/CHAPTER_290-THE_LOCAL_GOVERNMENT_FINANCE_ACT-01.pdf.

UN Women (2020) *Mapping of Discrimination against Women and Girls With Disabilities in East & Southern Africa*. Nairobi, UN Women. Available At: <https://Africa.Unwomen.Org/En/Digital-Library/Publications/2020/04/Mapping-Of-Discrimination-On-Disabilities-In-esar>

Vyas, S. (2013) *Estimating the Association between Women's Earnings and Partner Violence: Evidence from the 2008–2009 Tanzania National Panel Survey*. Washington, DC: World Bank.

Washington Group (2020a) *Disability Measurement and Monitoring using the Washington Group Disability Questions*. Washington DC., Washington Group on Disability Statistics Available at: <http://www.washingtongroup-disability.com/>

Washington Group (2020b) *An Introduction to the Washington Group on Disability Statistics Question Sets*. Washington DC., Washington Group. Available at: https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/An_Introduction_to_the_WG_Questions_Sets__2_June_2020_.pdf

Washington Group (2021) *WG / UNICEF Child Functioning Module (CFM)*. Available at: <https://www.washingtongroup-disability.com/question-sets/wgunicef-child-functioning-module-cfm/> (Accessed: 18 April 2021).

Watson, N & Vehmas, S (2020) *Routledge Handbook of Disability Studies*. Nick Watson and Simo Vehmas (ed.) Routledge Handbook of Disability Studies. 2nd edn. New York: Routledge. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK558161/>

Weis, K. L (2017) Constitutional directive principles. *Oxford Journal of Legal Studies*, 37(4), pp. 916–945. doi: 10.1093/ojls/gqx015

Wickenden, M. and Kembhavi-Tam, G. (2014) Ask us too! Doing participatory research with disabled children in the global south. *Childhood*, 21(3), pp. 400–417. doi: 10.1177/0907568214525426

Wilkinson, A. (1998) Empowerment: theory and practice. *Personnel Review*. MCB UP Ltd, 27(1), pp. 40–56. doi: 10.1108/00483489810368549

Women Deliver (n.d.) Dramatically reduced gender-based violence and harmful practices. Women Deliver [website]. Available at: <https://womendeliver.org/investment/dramatically-reduce-gender-based-violence-harmful-practices/>

World Bank Group (2018) *Universal Health Coverage: Tanzania's effort to overcome barriers to equitable health service access*. Washington DC., World Bank Group. Available at: <http://documents.worldbank.org/curated/en/820591516179637357/pdf/122815-WP-RDC-Tanzania-pages-fixed-PUBLIC.pdf> (Accessed: 12 May 2021).

World Bank (2019) *Tanzania's Path to Poverty Reduction and Pro-Poor Growth*, World Bank. Available at: <https://www.worldbank.org/en/country/tanzania/publication/tanzanias-path-to-poverty-reduction-and-pro-poor-growth> (Accessed: 9 March 2021).

World Health Organisation (2009) *Promoting sexual and reproductive health for persons with disabilities*, World Health Organisation. Geneva, World Health Organisation. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/srh_for_disabilities.pdf

World Health Organisation (2013) *Essential Nutrition Actions: Improving maternal, newborn, infant and young child health and nutrition*. Geneva, World Health Organisation. Available at: https://apps.who.int/iris/bitstream/handle/10665/84409/9789241505550_eng.pdf?sequence=1&isAllowed=y

World Health Organization (2011) *World Report On Disability*. Geneva, World Health Organisation. Available at: https://www.who.int/disabilities/world_report/2011/report.pdf

WHO Regional Office for Africa (2016) *WHO country cooperation strategy 2016-2020 Tanzania*. Brazzaville, WHO Regional Office for Africa. Available at: https://apps.who.int/iris/bitstream/handle/10665/254890/ccs_tza-2016_2020_en.pdf?sequence=1&isAllowed=y

World Health Organisation (2020) *WHO Tanzania Country Office: Biennial Report 2018-19*. Dar es Salaam, World Health Organisation Regional Office for Africa. Available at: <https://www.afro.who.int/publications/who-tanzania-country-office-biennial-report-2018-19>

Young, R, Reeve, M & Grills, N (2016) The functions of disabled people's organisations (DPOs) in low and middle-income Countries: A literature review. *Disability, CBR and Inclusive Development*, 27(3), pp. 45–71. doi: 10.5463/DCID.v27i3.539

Ziegler, A. S & Hadders-Algra, M (2020) Coaching approaches in early intervention and paediatric rehabilitation. *Developmental Medicine and Child Neurology*, 62(5), pp. 569–574. doi: 10.1111/dmcn.14493

Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). *Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report*. Harare, Zimbabwe: ZIMSTAT and UNICEF. Available at: https://mics-surveys-prod.s3.amazonaws.com/MICS6/Eastern%20and%20Southern%20Africa/Zimbabwe/2019/Survey%20findings/Zimbabwe%202019%20MICS%20Survey%20Findings%20Report-31012020_English.pdf.

Annex 2: Data Collection Matrix

Category	Questions	Data Collection/Analysis Method						
		Lit/ Doc Review	Survey Data Analysis	KIIs	FGDs – Children ^a	FGD – Parents	FGD – UN	Validation Workshop
1. Policy Context & Implementation	1.1 To what extent are national legislations and policies compliant with and aligned to the Convention on the Rights of Persons with Disabilities (CRPD),	X		X			X	
	1.2 To what extent is the government taking steps to realise the rights of children, young people and women with disabilities. Refer to CRPD Concluding Observations as a reference for compliance.	X		X		X	X	X
	1.3 To what extent are the rights of children and young people with disabilities and their families articulated in national policies?	X						
	1.4 What is the government's approach to the education of children and young people with disabilities in policy and practice, i.e., inclusive education, integrated education or special schools?	X		X			X	X
2. Definitions and Measurement	1.1 How have disabilities been defined and measured in Tanzania (laws, policies, programmes, surveys and census)?	X	X					
	1.2 To what extent are these definitions and measurements aligned to international standards?	X	X	X				X

^a The guide for the two Focus Group Discussions with children and young people with disabilities will be modified and adapted based on the age and abilities of participants. The guide will be open-ended and flexible, designed to engage young participants, follow their lead, and gently guide the discussion without forcing participation. Therefore, the questions covered in these FGDs may vary between groups.

Category	Questions	Data Collection/Analysis Method						
		Lit/ Doc Review	Survey Data Analysis	KIs	FGDs – Children ¹⁸	FGD – Parents	FGD – UN	Validation Workshop
3. Prevalence	1.1 What are the major or most prominent disabilities in Tanzania?	X	X					X
	1.2 What are the prevalence rates of different types of disability among children and young people in Tanzania Mainland and in Zanzibar?	X	X					
	1.3 Has prevalence changed since 2013?	X	X					
4. Barriers	1.1 To what extent are children and young people with disabilities and their caregivers excluded from participation in society based on social and cultural practices, and beliefs?	X		X	X	X	X	X
	1.2 To what extent do children and young people with disabilities have the same level of participation as children and young people without disabilities?	X			X	X		
	1.3 What are the immediate, underlying and structural barriers and bottlenecks to the well-being of children and young people with disabilities and to accessing and utilising basic social services and other critical resources?	X		X	X	X		X
	1.4 How do outcomes and barriers differ when comparing children and young people with disabilities and children and young people without disabilities?	X				X		
	1.5 How do outcomes and barriers differ across subgroups of children and young people with disabilities (e.g., girls, indigenous, or adolescents) by geographical areas, during humanitarian situations and in development contexts?	X				X		

Category	Questions	Data Collection/Analysis Method						
		Lit/ Doc Review	Survey Data Analysis	KIs	FGDs – Children ¹⁶	FGD – Parents	FGD – UN	Validation Workshop
	1.6 Which are the most deprived groups of children, young people and parents with disabilities in terms of access and facing negative attitudes?	X						
	1.7 What forms of deprivation and exclusion do they face?	X						
5. Stakeholders & Enabling Environment	1.1 What capacities (financial, technical and institutional) exist at national, subnational and community levels to address inclusion of children and young people with disabilities?	X		X		X	X	
	1.2 What existing social, institutional and political factors (e.g., social norms, institutional capacities at all levels of government, accountability and coordination mechanisms, policy, and legal frameworks) could potentially support the creation of an enabling environment for the realisation of the rights of children and young people with disabilities?	X		X		X	X	X
6. Programmes & Services	1.1 To what extent is the physical, communication and information environment accessible for people with disabilities?	X			X	X	X	X
	1.2 To what extent are mainstream services and programmes inclusive of and accessible to children and young people with disabilities?	X		X	X	X	X	X
	1.3 Have health; water, sanitation and hygiene (WASH); nutrition; education services; and programmes taken measures to be more inclusive?	X		X			X	

Category	Questions	Data Collection/Analysis Method						
		Lit/ Doc Review	Survey Data Analysis	KIs	FGDs – Children ¹⁸	FGD – Parents	FGD – UN	Validation Workshop
	1.4 To what extent do social protection measures exist and are inclusive of and reach children and young people with disabilities and their families?	X		X		X	X	X
	1.5 To what extent are families of children and young people with disabilities aware of these social protection measures?	X				X		
	1.6 Are specialised services for children and young people with disabilities available in the country (such as rehabilitation and provision of assistive devices)?	X		X	X	X	X	
7. Data and Evidence	1.1 To what extent is disability-disaggregated data collected in the country (at the national, subnational and community level), such as in administrative data systems?	X	X	X			X	
	1.2 To what extent is the data used for decision-making?	X		X			X	
	1.3 Is there relevant research and evidence or best practices programme approaches available in the region?	X		X			X	
	1.4 How can the country programme draw upon and align to best practices in the region?			X			X	X
8. Recommendations	1.1 What are potential priority advocacy issues for the Tanzania and Zanzibar respectively?	X		X			X	X
	1.2 Where can UNICEF Tanzania focus technical assistance. In the new Country Programme to strategically maximise impact on disability inclusion, for Tanzania Mainland and Zanzibar respectively?	X		X			X	X
	1.3 Which partnerships are key to leverage UNICEF's work on disability inclusion?			X			X	X

Annex 3: Terms of Reference

TERMS OF REFERENCE FOR INTERNATIONAL INSTITUTIONAL CONSULTANCY TO UPDATE SITUATIONAL ANALYSIS OF CHILDREN AND YOUNG PEOPLE WITH DISABILITIES IN THE URT

Summary

Title	SITUATIONAL ANALYSIS OF CHILDREN AND YOUNG PEOPLE WITH DISABILITIES IN TANZANIA 2020
Purpose	To update a 2013 situational analysis of children and young people with disabilities in the URT
Location	URT
Duration	60 days over the time period January - February 2020
Reporting to	Social Policy Specialist ZFO (Disability Working Group Focal Point)

Introduction

According to the population projection for 2020, children (0-17) are 28.8 million which is 49.9-50% of the total population. Children with disabilities make up 3.5% of this number or approximately 1 million infants, children and adolescents. In Tanzania, as in much of the developing world, despite proactive legislation, children with disabilities face difficulties in having equal access to their physical environment, as well as to health and nutrition care, water and sanitation services, education and social support systems available to children without disabilities. In addition, children with disabilities are at increased risk of physical, sexual, emotional violence, exploitation and neglect. Some of this is the result of attitudes, cultural beliefs and practices that have historically segregated children and young people with disabilities from society; some reflects lack of knowledge and awareness and missed opportunities for meaningful inclusion. Inclusion for children and young people with disabilities will often call upon dedicated resources and support systems that are already stretched thin and are not well coordinated. However, the cost to the individual, family and society over the course of a lifetime for children and young people with disabilities who remain socially marginalised, unable to access education, and lacking in training for future employment or citizenship far outweighs short-term investments needed to ensure that children and young people with disabilities have a good start in life. If these barriers are not addressed, it will leave thousands of children with disabilities and their families without the resources, knowledge or systems of care and support needed for CYPWD to reach their potential and contribute to Tanzanian society.

In 2013, UNICEF commissioned a *Situational Analysis of Children with Disabilities in Tanzania*, which was intended to provide a 'snapshot' of what is known about children with disabilities in Tanzania and what are the barriers and challenges they face. The report reviewed barriers and challenges faced by children and adolescents with disabilities and their families in Tanzania, presented relevant legislation and data available on children and adults with disabilities and highlighted significant gaps in key areas such as education, health and rehabilitative care and social inclusion. Since 2013, additional literature has been published on children with disabilities as well as surveys that can provide a more recent perspective of the lives of children with disabilities, including 2017/18 Household Budget Survey (HBS) in the Mainland and 2019/20 HBS in Zanzibar. The Tanzania Country Office (TCO) Disability Working Group established in 2020, has recommended that the 2013 situational analysis of the needs of children with disabilities be updated in order to contribute to UNICEF Tanzania's Country Programme Document 2022-2027 and serve as a background document for improved disability inclusive programming.

Overall Objective of the Assignment

To generate up-to-date evidence on the situation of children (0-under 18) and young people (10-24 years) with disabilities in the URT, and make actionable recommendations for improved disability inclusive programming for the UNICEF Tanzania Country Office.

Specific Objectives

- 1) To update the Situational Analysis of Children with Disabilities in Tanzania produced in 2013 based on a review of existing literature and to highlight different definitions and measurements of disabilities currently used in Tanzania (Mainland and Zanzibar), key data gaps on barriers, stakeholders, enabling environment, programmes, services, policies data and evidence. See table below for detailed questions and consideration under each heading.

Definitions and measurements of disabilities	1. How have disabilities been defined and measured in Tanzania (laws, policies, programmes, surveys and census)? 2. To what extent are these definitions and measurements aligned to international standards? 3. What are the major or most prominent disabilities in Tanzania?
BARRIERS	1. To what extent are children and young people with disabilities and their caregivers excluded from participation in society based on social and cultural practices, and beliefs? 2. To what extent do children and young people with disabilities have the same level of participation as children and young people without disabilities? 3. What are the immediate, underlying and structural barriers and bottlenecks to the well-being of children and young people with disabilities and to accessing and utilizing basic social services and other critical resources? 4. How do outcomes and barriers differ when comparing children and young people with disabilities and children and young people without disabilities? 5. How do outcomes and barriers differ across subgroups of children and young people with disabilities, resulting in double deprivations, (e.g., girls, indigenous, or adolescents) by geographical areas, during humanitarian situations and in development contexts? 6. Which are the most deprived groups of children, young people and parents with disabilities in terms of access and facing negative attitudes? a. What forms of deprivation and exclusion do they face? b. What are the determining factors that give rise to and perpetuate their exclusion? 7. It is important to note that children and young people with disabilities may face some specific barriers depending on the nature of their disability
Stakeholders & Enabling Environment	1. What capacities (financial, technical and institutional) exist at national, subnational and community levels to address inclusion of children and young people with disabilities? 2. What existing social, institutional and political factors (e.g., social norms, institutional capacities at all levels of government, accountability and coordination mechanisms, policy, and legal frameworks) could potentially support the creation of an enabling environment for the realization of the rights of children and young people with disabilities?

Programmes & Services	1. To what extent is the physical, communication and information environment accessible for people with disabilities? 2. To what extent are mainstream services and programmes inclusive of and accessible to children and young people with disabilities? a. Have health; water, sanitation and hygiene (WASH); nutrition; education services; and programmes taken measures to be more inclusive? 3. To what extent do social protection measures exist and are inclusive of and reach children and young people with disabilities and their families? a. To what extent are families of children and young people with disabilities aware of these social protection measures? 4. Are specialised services for children and young people with disabilities available in the country (such as rehabilitation and provision of assistive devices)? 5. How are the voices of children and young people with disabilities and their families or their representative organizations incorporated into the design and planning of national/local strategies and programmes? 6. How satisfied are children and young people and their families with the current services and programmes?
Policy	1. To what extent are national legislations and policies compliant with and aligned to the Convention on the Rights of Persons with Disabilities (CRPD), and to what extent is the government taking steps to realize the rights of children, young people and women with disabilities. Refer to CRPD Concluding Observations as a reference for compliance. 2. To what extent are the rights of children and young people with disabilities and their families articulated in national policies? 3. What is the government's approach to the education of children and young people with disabilities in policy and practice, i.e., inclusive education, integrated education or special schools?
Data & Evidence	1. To what extent is disability-disaggregated data collected in the country (at the national, subnational and community level), such as in administrative data systems? 2. To what extent is the data used for decision-making? 3. Is there relevant research and evidence or best practices programme approaches available in the region? 4. How can the country programme draw upon and align to these?

2) To update numbers on the prevalence of children and young people with disabilities based on recent surveys.

3) To provide recommendations on:

- a) priority advocacy issues for Tanzania the Mainland and Zanzibar respectively.
- b) areas that UNICEF can focus technical assistance in the new Country Programme, for the Mainland and Zanzibar respectively, and which partnerships are key to leverage UNICEF's work.

Methodology

The preparation of a situation analysis will be informed by various sources of information, including: - UNICEF Guidelines for Disability Situation Analyses

- Current policy documents related to disabilities of the Mainland and Zanzibar - Literature produced between 2013 and 2020 on People and Children with Disabilities in the Mainland and Zanzibar (please see Annex for full list).

- An analysis of relevant data from surveys conducted in the Mainland and Zanzibar, including the Household Budget Survey;
- Remote consultations with the strategic actors in URT:
 - o In Zanzibar, Department of Disability Affairs (2nd Vice President's Office), PORALGSD, Office of the Chief Government Statistician, Ministry of Labour, Empowerment, Elders, Women and Children.
 - o In Mainland Tanzania, Disability Affairs Office at the Prime Minister's Office, PORALG, National Bureau of Statistics, Ministry of Health and Social Welfare.
 - o UN Agencies, bilateral institutions and DPOs
- Review meetings with the UNICEF TCO Disability Working Group

Tasks, Deliverable and Time Frame

The development of the Programme document will require the following tasks to be accomplished and deliverables (In bold):

- 1) Conduct literature review
 - Acceptable inception report (not exceeding 5000 words)
- 2) Ongoing literature review, remote consultation with key stakeholders.
 - First draft
- 3) Integration of comments from the Disability Working Group on first draft.
 - Revised draft
- 4) Presentation to TCO & submission of final documents.
 - Final Situational Analysis of Children and Young People with Disabilities in Tanzania 2020 - Powerpoint presentation
 - Draft for development into Infographics pamphlet

The timeline and payment schedule are as follows:

The consulting institution shall carry out the assignment under the supervision of the UNICEF Social Policy Specialist - ZFO. The Disability Working Group will be the Advisory Group and be closely involved at each stage of the assignment. The Disability Working Group is made up of representatives from all sections within UNICEF. Its objective is to identify and address the programmatic needs to support the full and meaningful inclusion of children and young people with disabilities across all programme implementation in a manner that promotes the children and young people's development and participation in line with their potential and evolving capacities. Among its specific objectives is to develop a holistic multi-sectoral plan for the inclusion of children and young people with disabilities throughout TCO programming and make recommendations to TCO's upcoming Country Programme Document (CPD) exercise, based on monitoring and programming evidence compiled by the group.

Qualifications

The assignment will be conducted by an **international consulting institution**. The **institution** will have a track record in the field of people with disabilities and will be assessed based on the following criteria:

The firm or institution will propose a team leader with the following profile:

- | |
|---|
| At least Master's degree in social sciences, policy analysis or other relevant fields of study relevant to disability inclusion |
| Proven track record in assessments and analyzing issues pertaining to the inclusion of children with disabilities |

Great attention to details, analysis and presentation of data collection and research findings, as well as excellent writing skills in English.

Previous experience of working with persons with disabilities in Tanzania is an advantage.

Minimum 10 years for work experience and specialization in disability inclusion and gender programming. Specifically, in implementing disability inclusion within emergency context and within country strategies and programs.

The Team leader will be supported by team members with relevant complementary skills, competencies, and experiences. Experience working in Tanzania or another East African country is an asset. Team members who are themselves stakeholders (parents or persons with disabilities) are highly encouraged.

Payment Schedule

Payments will be made upon submission and acceptance of the specified deliverables in the table above under section **TASKS, DELIVERABLE AND TIME FRAME**. UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/output is incomplete, not delivered or for failure to meet deadlines.

Assessment / Selection Process and Method

Interested consulting institutions will be assessed on the basis of a **technical and financial** proposal. The financial proposal should be prepared in US\$, should include all related costs (travel etc) and contain a breakdown for each component of the proposed work deliverables, based on an estimate of time taken, which needs to be stated. The budget narrative must explain the assumptions behind all cost estimates.

The proposals will go through a technical and financial evaluation to determine their merits for this assignment. The technical proposal will have a weight of 70%, while the financial proposal will have a weight of 30%. Technical proposals should attain a minimum of 50 points to qualify and be considered for financial review.

General Conditions: Procedure and Logistics

- The consultant team will be expected to provide their own materials such as computer and office supplies, except in the event of a consultation workshop.
- If applicable, all travel within Tanzania will be arranged by the consulting institution. The members of the consulting institution will not have authorised access to UNICEF transport, except where accompanied by a UNICEF staff.
- The consultant team will ensure that they have health insurance that includes coverage for medical evacuation.
- The consulting institution should conduct this assignment remotely, including consultations and workshops (for a list of detailed visits, refer to TASKS, DELIVERABLE AND TIME FRAME section above).

Recommended Reference List on Disability

Global

Policy development: An analysis of disability inclusion in a selection of African Union policies UNFPA (2018) **YOUNG PERSONS WITH DISABILITIES: GLOBAL STUDY ON ENDING GENDER-BASED VIOLENCE, AND REALISING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS**

UNESCO (2018) **Education and Disability: Analysis of Data from 49 Countries**

Disability and Development Report: Realizing the Sustainable Development Goals by, for and with persons with disabilities – 2018

Outcome document of the high-level meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond

Towards an Inclusive and Accessible Future for All - Voices of persons with disabilities on the post 2015 development framework, UNPRPD - 2013

UN Secretary General Report on the Status of the Convention on the Rights of the Child - 2011 UN Omnibus resolution on the Rights of the Child on CWD - 2011

World Report on Disability - WHO - 2011

Including the rights of persons with disabilities in UN programming at country level - UNDP - 2011

External Links

UN Secretariat on the Convention on the Rights of Persons with Disabilities (CRPD)

Convention on the rights of Persons with Disabilities (CRPD)

Explanation of disability in the CRPD

OHCHR Training material on the CRPD

DISTAT - United Nations Disability Statistics Database

Mainstreaming disability in the development agenda: Resources

UNICEF Publications

Please note, additional guidelines in video format are available at
https://www.unicef.org/disabilities/index_71294.html

UNICEF Guidelines for Disability Situation Analyses - Guidance - 2013

COVID-19: Considerations for Children and Adults with Disabilities

We are pleased to share a guidance note on considerations for children and adults with disabilities in the COVID-19 response. The guidance describes what we need to know about the situation of persons with disabilities in COVID-19 response, and what we need to do in five key points. The guidance will be revised as the situation evolves.

English - Spanish - Arabic - Russian - Accessible word - EPUB - Braille - Easy to Read - HTML(zip) Infographic: Considerations for children and adults with disabilities

COVID-19: Engaging with Children and Adults with Disabilities

Tips for UNICEF country offices and partners on key considerations when planning to engage with children and adults with disabilities for COVID-19 response.

Word - Accessible word - PDF - EPUB - Braille - Easy to Read - HTML(zip) - Russian

Guidance on strengthening disability inclusion in Humanitarian Response Plans - 2019 Persons with disabilities are disproportionately affected by humanitarian crises and face significant barriers to accessing humanitarian assistance. This guidance presents steps to be taken to better reflect the needs and capacities of persons with disabilities in Humanitarian Needs Overviews and Humanitarian Response Plans, in order to inform a more inclusive humanitarian response.

The guidance was developed jointly by UNICEF, OCHA, UNHCR, IOM, WFP and WHO, with support from the UK Department for International Development (DFID).

Inclusive ECD and ECI global survey - 2019

RISE institute, UNICEF and the ECD Task Force (ECDtf) of the Global Partnership on Children with Disabilities (GPCwd).

Tips on communicating with children with disabilities - 2019

Practical information on how to speak with a child or adolescent with a disability

Good Practices in the provision of Accessible and Inclusive WASH services - UNICEF Country Offices - 2015

The report highlights key programmes and activities that show innovation and best practice in reaching and empowering children and adults with disabilities in relation to WASH.

UNICEF Accessible and Inclusive WASH Mapping [PDF]; [e-Pub]; [HTML-zip file]; [Daisy-zip file] UNICEF Accessible and Inclusive WASH Matrix [PDF]; [e-Pub]; [HTML-zip file]; [Daisy-zip file]; WASH and Disability -Mapping Good Practices Brochure [PDF]; [e-Pub]; [HTML-zip file]; [Daisy-zip file];

Assistive Technology for Children with Disabilities - 2015

Creating Opportunities for Education, Inclusion and Participation

[Daisy- zip file] [HTML- zip file] [ePub] [Easy to read - PDF]

Two pager on Disability in SDGs - 2015

Issue Brief: the rights of children with disabilities

Take Us Seriously: Engaging Children with Disabilities in Decisions Affecting their Lives - 2015 [PDF] [Easy to Read PDF] [ebook] [HTML - zip file] [Daisy - zip file]

Spanish [PDF] French [PDF]

Assistance to Victims of Land Mines and Explosive Remnants of War - 2014

Guidance on Child Focused Victim Assistance

The State of the World's Children 2013: Children with Disabilities

[English] [French] [Video Summary]

Thematic Flyers: Education; Health; Child protection; HIV/AIDS; Nutrition;

Data collection; Water, sanitation and hygiene (WASH); Gender; ECD; Nutrition

Factsheet on Children With Disabilities - 2013

Provides a global snapshot of the key issues affecting the lives of children with disabilities and an overview of evidence currently available.

Using the human rights framework to promote the rights of children with Disabilities: Discussion Paper - 2013

An analysis of the synergies between CRC, CRPD and CEDAW – 2013

Available at: https://www.unicef.org/disabilities/files/Synergies_paper_V6_Web_REVISED.pdf Spanish [PDF] French [PDF] [Daisy - zip file] [HTML - zip file] [ePub]

Inclusive nutrition for children and adults with disabilities - 2013

Evidence-based article, published online in The Lancet, August 19, 2013 by Nora E Groce, Marko Kerac, Amy Farkas, Werner Schultink, Rosangela Berman Bieler. The article provides strong links between nutrition, disability, poverty and human rights.

Early Childhood development and Disability: A discussion paper. UNICEF and WHO - 2012

The Right of Children with Disabilities to Education - 2012

A Rights-Based Approach to Inclusive Education

Guidance for Establishing a National Partnership on Children with Disabilities (NPCwd) - 2012

HIV and AIDS and Disability - Towards an AIDS-Free Generation - 2012

Promoting Community- Based Strategies for and with Children with Disabilities

Monitoring Child Disability in Developing Countries - Results from the Multiple Indicator Cluster Surveys - 2008

Despite the global interest in child disability, relatively little is known about the situation of children with disabilities, particularly in developing countries. As a first step toward addressing this paucity of information, UNICEF recommended inclusion of a disability module, the Ten Questions screen for child disability, in its Multiple Indicator Cluster Survey (MICS).

It's About Ability, An explanation of the Convention on the Rights of Persons with Disabilities - 2008 . This publication explains the Convention on the Rights of Persons with Disabilities to children. It's main purpose is to empower children, with and without disabilities, to play their part in challenging discrimination and promoting the Convention's principles.

Innocenti Digest No. 13 Promoting the Rights of Children with Disabilities - 2007

The Innocenti Digest on Promoting the Rights of Children with Disabilities attempts to provide a global perspective on the situation of the some 200 million children with disabilities. The Digest is based on reports from countries across regions and from a wide range of sources.

Tanzania

- » Tanzania Disability Survey Report 2008
- » Tanzania Population and Housing Census 2012 (2012 PHC)
- » 2012 PHC: Disability Monograph
- » Impact-Assessment-of-Physical-Rehabilitation-Services-in-Tanzania, 2015
- » Disability Inclusive Development Tanzania Situational Analysis June 2020 update
- » The Persons with Disabilities (Rights and Privileges) Act, 2006
- » The Persons with Disability Act, 2010
- » The Children's Act, 2011
- » The Law of the Child Act, R.E 2019
- » The United Republic of Tanzania's National Policy on Disability
- » Inclusion of persons with disabilities in social protection. Policy analysis, Tanzania (2015) Disability Rights in Tanzania, SIDA, 2014
- » Applied research concerning inclusion of persons with disabilities in systems of social protection: Social Protection Policy Analysis, Tanzania, GIZ, 2015
- » Disability Movement in Tanzania and Status, Shivyawata, 2015
- » Inclusion of Persons with Disabilities in the Health Financing System in Tanzania
- » SITUATIONAL ANALYSIS OF INCLUSIVE EDUCATION IN KENYA AND TANZANIA, July 2015 Inclusion of People with Disabilities in the United Republic of Tanzania, Factsheet, ILO
- » Inclusive Education Development in Zanzibar: The 2018 evaluation of the NAD/NFU-supported project (ppt) Developing Inclusive Education Policy and Practice in Zanzibar: Collaborative Action Research
- » TOR Disability Needs Assessment/Situational Analysis in Northern Tanzania Arusha, Kilimanjaro, Manyara & Tanga Regions

Mapping of Data on disability in Surveys, Reporting Systems and Other Documents

Data Source	Tanzania	Mainland	Zanzibar
Tanzania Disability Survey Report 2008	X	X	X
Tanzania Population and Housing Census 2012 (2012 PHC)	X	X	X
2012 PHC: Disability Monograph	X	X	X

Data Source	Tanzania	Mainland	Zanzibar
National Panel Survey (NPS 4 module on disability available BUT not included in main report)	X	X	X
Mainland Household Budget Survey		X	
Zanzibar Household Budget Survey			X
School WASH Assessment 2018 (table 4.6 page 35; table 5.4 page 45; table 6.5 page 66)	X	X	X
Basic Education Statistics of Tanzania (BEST)		X	
Education Statistical Abstract			x
The United Republic of Tanzania's National Policy on Disability			
Inclusion of persons with disabilities in social protection. Policy analysis, Tanzania (2015)			
Zanzibar Disability Acts and the Persons with Disability Act, 2010(mainland		x	X

Annex 4: Literature Search Inclusion/Exclusion Criteria

Key inclusion criteria	Excluded	Reason
- Recommended reference list on disability in the ToRs is mandatory - The literature outlined in the concept note by UNICEF is mandatory - Impact studies: i.e., studies that discuss impacts of programmes for children with disabilities and disability on children and their families - Studies that highlight functional limitation of children against different factors - Evidence of common New patterns and trends of key deprivations affecting children with disabilities - Legislation and policy papers on children with disabilities from government agencies/OPDs/NGOs - Legal and policy frameworks that exist in Tanzania on children with disabilities - Studies that quantify prevalence of disability in general and, disability among children in particular - Addresses best practices in the region on supporting children with disabilities/programs for children with disabilities??? (Tanzania belongs both to SADC and East African Community)	- Disability but not focused on children with disabilities - Not disability focused - Without a focus on Tanzania mainland and Zanzibar, or East African/SADC region. - Nothing before 2013	Irrelevant to research questions
Gray literature (policy documents, strategic plans, reports, best practices, etc.)	Non disability/country focused	Focused on practical /applied research
Disability – Cognitive/hearing/sight/learning/mobility/albinism/other Gender - male/female/other	All other	Areas of Inquiry

Annex 5: Literature Review Coding Guide

RQ 1: How is disability defined and measured in Tanzania, and are these parameters compliant with international standards? (i.e., CRPD, CRC, & CEDAW)

RQ 2: What are the major barriers (structural, social, etc.) facing children with disability in Tanzania and how do these lead to different outcomes for children and young people with disabilities and their families?

RQ 3: How have different stakeholders acted to create an enabling environment in support of the rights of children and young people with disabilities? What challenges do they face and what opportunities do they have?

RQ 4: To what extent are existing programmes and services (e.g., social services) inclusive of children with disabilities and their families?

RQ 5: To what extent are domestic laws and policies compliant with the CRPD, including domesticating the precepts of the social model of disability in local laws and practices?

RQ 6: To what extent is disability-disaggregated data collected in the country (at the national, subnational and community level), such as in administrative data systems, and to what extent is this data incorporated in decision-making?

RQ 7: Is there relevant research and evidence or best practices programme approaches available in the region, and how can this help address the challenges in Tanzania?

Reading and Coding Guide			
Section	Theme Code	Research Question Mapping (Based of TORs)	Theme for coding for Literature Review
Definitions_ measurements_ Disabilities	A.1	RQ 1	How have disabilities been defined and measured in Tanzania (laws, policies, programmes, surveys and census)?
	A.2	RQ 1	To what extent are these definitions and measurements aligned to international standards?
	A.3	RQ 1	What are the major or most prominent disabilities in Tanzania?
Barrier_children_ disability	B.1	RQ 2	To what extent are children and young people with disabilities and their caregivers excluded from participation in society based on social and cultural practices, and beliefs?
	B.2	RQ 2	To what extent do children and young people with disabilities have the same level of participation as children and young people without disabilities?
	B.3	RQ 2	What are the immediate, underlying and structural barriers and bottlenecks to the well-being of children and young people with disabilities and to accessing and utilising basic social services and other critical resources?
	B.4	RQ 2	How do outcomes and barriers differ when comparing children and young people with disabilities and children and young people without disabilities?

Reading and Coding Guide			
Section	Theme Code	Research Question Mapping (Based of TORs)	Theme for coding for Literature Review
	B.5	RQ 2	How do outcomes and barriers differ across subgroups of children and young people with disabilities (e.g., girls, indigenous, or adolescents) by geographical areas, during humanitarian situations and in development contexts?
	B.6	RQ 2	Which are the most deprived groups of children, young people and parents with disabilities in terms of access and facing negative attitudes? a. What forms of deprivation and exclusion do they face? b. What are the determining factors that give rise to and perpetuate their exclusion?
Stakeholders_ Enabling Environment	C.1	RQ 3	What capacities (financial, technical and institutional) exist at national, subnational and community levels to address inclusion of children and young people with disabilities?
	C.2	RQ 3	What existing social, institutional and political factors (e.g., social norms, institutional capacities at all levels of government, accountability and coordination mechanisms, policy, and legal frameworks) could potentially support the creation of an enabling environment for the realisation of the rights of children and young people with disabilities?
Programmes_ Services	D.1	RQ 4	To what extent is the physical, communication and information environment accessible for people with disabilities?
	D.2	RQ 4	To what extent are mainstream services and programmes inclusive of and accessible to children and young people with disabilities? Have health; water, sanitation and hygiene (WASH); nutrition; education services; and programmes taken measures to be more inclusive?
	D.3	RQ 4	To what extent do social protection measures exist and are inclusive of and reach children and young people with disabilities and their families? a. To what extent are families of children and young people with disabilities aware of these social protection measures?
	D.4	RQ 4	Are specialised services for children and young people with disabilities available in the country (such as rehabilitation and provision of assistive devices)?
	D.5	RQ 4	How are the voices of children and young people with disabilities and their families or their representative organisations incorporated into the design and planning of national/local strategies and programmes?
	D.6	RQ 4	How satisfied are children and young people and their families with the current services and programmes?

Reading and Coding Guide			
Section	Theme Code	Research Question Mapping (Based of TORs)	Theme for coding for Literature Review
Existing_Policy_legislation	E.1	RQ 5	To what extent are national legislations and policies compliant with and aligned to the Convention on the Rights of Persons with Disabilities (CRPD), and to what extent is the government taking steps to realise the rights of children, young people and women with disabilities. Refer to CRPD Concluding Observations as a reference for compliance.
	E.2	RQ 5	To what extent are the rights of children and young people with disabilities and their families articulated in national policies?
	E.3	RQ 5	What is the government's approach to the education of children and young people with disabilities in policy and practice, i.e., inclusive education, integrated education or special schools?
Data_Evidence_disability		RQ 6	To what extent is disability-disaggregated data collected in the country (at the national, subnational and community level), such as in administrative data systems?
		RQ 6	To what extent is the data used for decision-making?
		RQ 7	Is there relevant research and evidence or best practices programme approaches available in the region?
		RQ 7	How can the country programme draw upon and align to these?

Annex 6: Data Collection Tools

Key Informant Interview Guide

Client: United Nations Children's Fund (UNICEF)

Consulting firm: Includovate

Lead investigator: Dr. Kristie Druza kristie@includovate.com

Note: This guide will be used after the interviewer has obtained consent from the participants. Consent will be granted either by participants signing the consent form (sent in advance) or by oral authorisation to the researcher to sign the consent form. This guide shall not be used in the event that the participant declines to provide or withdraws consent.

Interviewer: Thank you for taking time to speak with me. My name is X, from Includovate where I work as a researcher. The purpose of this interview is to get your views about the context and situation of children and young people with disabilities in Tanzania/Zanzibar. This information is for purposes of updating UNICEF's 2013 Situational Analysis of Children living with Disabilities. Before we start, I would like you to be aware of the ethical requirements guiding my research and to re-confirm your consent to taking part in this interview.

Background and Demographic Questions

Name of interviewer: _____

Name of interviewee: _____

Organisation interviewee works for: _____

Geographical location of organisation: _____

Questions

1. Let's start with basics. Could you please tell me your roles and responsibilities and how they relate to children with disabilities? Also, please tell me if you will be speaking to the Mainland or Zanzibar (or both).
2. Let's talk about conceptualisation of disability. How does society in Tanzania/Zanzibar treat disability? What are the social/cultural/religious assumptions about disability?
3. Could you please tell me, from your work and/or experience, what you understand as the major barriers facing children (0-17) and young people (10-24) with disability in Tanzania/Zanzibar?
 - (a) How do these barriers affect the life outcomes of children with disabilities and their families?
 - (b) What improvements have you observed in the last five to 10 years in violence against and killings of albino children and sexual abuse against girls with disabilities? Would you characterise such improvements as overarching the spectrum of children with disabilities?

4. Speaking of stakeholder interventions, could you please tell me what you see as the government's actions to create an enabling environment for children with disabilities?
 - (a) Do you think the government is making sufficient effort to address the challenges facing children with disabilities? Describe the efforts, if any.
 - (b) In terms of legislation, would you say that the government has sufficiently aligned its laws and policies with international standards, particularly with the provisions of the United Nations Convention on the Rights of Persons with Disabilities? Describe.
 - (c) How accessible are assistive devices for children with disabilities in Tanzania? What barriers do children with disabilities and their families face in accessing assistive devices/technology?
5. On a scale of 1-5, how satisfied are you with the current services and programmes available for your child with a disability. *(They can vote with zoom or Mentimeter, or with a rock on a Likert scale depending on literacy)*
 - a) Support from government for raising your child with disabilities (e.g. cash transfers)
 - b) Health services for your child with disabilities
 - c) Therapy (speech, physio) services for your child with disabilities
 - d) Parent support/education groups for your child with disabilities
 - e) Education services for your child with disabilities
56. Still speaking about stakeholders, how have non-state actors (e.g., bilateral and multilateral partners, NGOs, and Organisations of Persons with Disabilities) helped in creating an enabling environment for children with disabilities in Tanzania/Zanzibar?
 - (a) Are there specific programs/interventions you could point at that you think have yielded impactful results?
 - (b) What challenges do they face?
 - (c) What opportunities do they have?
67. From your work and/or experience, how inclusive is Tanzania/Zanzibar in its existing programs and services of children with disabilities and their families?
8. How accessible are assistive devices for children with disabilities in Tanzania? What barriers do children with disabilities and their families face in accessing assistive devices/technology?
96. To what extent is disability-disaggregated data collected in the country (at the national, subnational and community level), such as in administrative data systems?
7. Is there relevant research and evidence or best practices programme approaches available in the region? If so, how can the country programme draw upon and align to best practices in the region?
8. What do you see as the priority advocacy issues for Tanzania Mainland and Zanzibar respectively that are currently not receiving as much attention?
9. In the new Country Programme to strategically maximise impact on disability inclusion, for Tanzania Mainland and Zanzibar, where would you suggest that UNICEF Tanzania focus technical assistance respectively?
10. What do you see as the potential or existing key partnerships to leverage UNICEF's work on disability inclusion?
11. Is there anything else I have not touched on that you would like to say about children with disabilities and their families?

Thank you for taking time to talk to me. If you have any organisational documents about the topics we just covered that you would like to share, please email them to me at _____. At a later date, we would be holding a validation workshop to share our findings and get feedback from you. In the meantime, if you have any questions, please feel free to contact me at the email address above.

Focus Group Guide for UN Agencies

Client: United Nations Children's Fund (UNICEF)

Consulting firm: Includovate

Lead evaluator: Dr. Kristie Druzca kristie@includovate.com

Name of moderator:

Thank you for taking time to speak with me. My name is _____, from Includovate where I work as a researcher. The purpose of this focus group discussion is to get your views about the context and situation of children and young people with disabilities in Tanzania/Zanzibar. This information is for purposes of updating UNICEF's 2013 Situational Analysis of Children living with Disabilities. Before we start, I would like you to be aware of the ethical requirements guiding my research and to re-confirm your consent to taking part in this discussion. Please confirm you have all signed the consent form.

Questions

1. Let's start with the basic conceptualisation of disability. How does society in Tanzania/Zanzibar treat disability? What are the social/cultural/religious assumptions about disability?
2. Could you please tell me, from your work and/or experience, what you understand as the major barriers facing children (0-17) and young people (10-24) with disability in Tanzania/Zanzibar?
 - (a) How do these barriers affect the life outcomes of children with disabilities and their families?
 - (b) Have you, in the last five to 10 years, observed any improvements in violence and killings against albino children and sexual abuse against girls with disabilities? Describe. Would you characterise such improvements as overarching the spectrum of children with disabilities?
3. Speaking of stakeholder interventions, could you please tell me what you see as the government's actions to create an enabling environment for children with disabilities?
 - (a) Do you think the government is making sufficient effort to address the challenges facing children with disabilities? Describe the efforts, if any.
 - (b) In terms of legislation, would you say that the government has sufficiently aligned its laws and policies with international standards, particularly with the provisions of the United Nations Convention on the Rights of Persons with Disabilities? Describe.
 - (c) How accessible are assistive devices for children with disabilities in Tanzania? What barriers do children with disabilities and their families face in accessing assistive devices/technology?
4. On a scale of 1-5, how satisfied are you with the current services and programmes available for children with disabilities.
 - a) Support from government for raising children with disabilities (e.g. cash transfers)
 - b) Health services for children child with disabilities
 - c) Rehabilitation (speech, physio) services for children with disabilities
 - d) Parent support/education groups for children with disabilities
 - e) Education services for children with disabilities
5. Still speaking about stakeholders, how have non-state actors (e.g., bilateral and multilateral partners, NGOs, and Organisations of Persons with Disabilities) helped in creating an enabling environment for children with disabilities in Tanzania/Zanzibar?
 - (a) Are there specific programs/interventions you could point at that you think have yielded impactful results?
 - (b) What challenges do they face?
 - (c) What opportunities do they have?

6. What do you see as the priority advocacy issues for Tanzania Mainland and Zanzibar respectively that are currently not receiving as much attention?
7. In the new Country Programme to strategically maximise impact on disability inclusion, for Tanzania Mainland and Zanzibar, where would you suggest that UNICEF Tanzania focus technical assistance respectively?
8. What do you see as the potential or existing key partnerships to leverage UNICEF's work on disability inclusion?
9. From your work and/or experience, how inclusive is Tanzania/Zanzibar in its existing programs and services of children with disabilities and their families?
10. How accessible are assistive devices for children with disabilities in Tanzania? What barriers do children with disabilities and their families face in accessing assistive devices/technology?
11. Is there relevant research and evidence or best practices programme approaches available in the region? If so, how can the country programme draw upon and align to best practices in the region?
12. Is there anything else I have not touched on that you would like to say about children with disabilities and their families?

Thank you for taking time to talk to me. If you have any organisational documents about the topics we just covered that you would like to share, please email them to me at _____. At a later date, Includovate would be holding a validation workshop to share our findings and get feedback from you. In the meantime, if you have any questions, please feel free to contact me (or Dr. Kristie Druzca) at the email address above.

Focus Group Guide for Parents and Carers

Client: United Nations Children's Fund (UNICEF)

Consulting firm: Includovate

Lead investigator: Dr. Kristie Druzca kristie@includovate.com

Name of moderator:

Background and Demographic Questions:

Geographical location:

Number of participants in the FGD:

Number of participants: **Gender:**

1) Welcome and introduction

Good morning/afternoon and welcome to our session. Thank you for accepting the invitation to speak with me. My name is, from Includovate where I work as a researcher. The purpose of this discussion is to learn about your experiences as parents of children with disabilities in accessing services for your children. I would like to hear what challenges you experience at the household and community levels. Also, I would like to hear of the good practices or processes that could be re-enforced. This information is for purposes of updating UNICEF's 2013 Situational Analysis of Children living with Disabilities to enhance disability policy interventions.

2) Focus Group logistics and ground rules

a. Logistics

- » Focus group will last 45-60 minutes.
- » Feel free to leave for the bathroom when you need to.

b. Ground Rules

- » Everyone will try to say something.
- » We will let each participant express their views without judging or interrupting them.
- » No view is wrong or more accurate than the other. We all experience life differently.
- » Enjoy the discussion.

Does anyone have any questions before we get started?

Discussion Questions:

1. On a scale of 1-5, how satisfied are you with the current services and programmes available for your child with a disability. *(They can vote with zoom or Mentimeter, or with a rock on a Likert scale depending on literacy)*
 - a. Support from government for raising your child with disabilities (e.g. cash transfers)
 - b. Health services for your child with disabilities
 - c. Therapy (speech, physio) services for your child with disabilities
 - d. Parent support/education groups for your child with disabilities
 - e. Education services for your child with disabilities

2. What other types of services would you like to be able to access locally for your child? Go around one by one and write a list on a zoom whiteboard and then get all parents to pick the top 3 they agree with. Ask the parents to describe what their ideal service would be like
3. What is the best program/assistance that your child with a disability has experienced? Probe: what made it so good? What did they or their child learn from the experience? Did anyone else participate in this experience?
4. What is one thing you would like to change (improve) at your home to better support your child with disabilities? Probe: why? How would it help them/their child?
 - a. How do you think your child would answer this question?
5. What is one thing you would like to change (improve) at your child's school to better support your child with disabilities? Probe: why? How would it help them/their child?
 - a. How do you think your child would answer this question?
6. What do you like/dislike about society's perception of disability?
 - a. What is one thing you would like to change (improve) in your community to better support your child with disabilities? Probe: why? How would it help them/their child?
 - b. How do you think your child would answer this question?

Is there anything you would like policymakers to know about your reality as a parent of a child with a disability? (probe: what makes your life harder/easier? What makes your child's life harder/easier)

Thank you for taking time to talk to me. At a later date, we would be holding a validation workshop to share our findings and get feedback from you. In the meantime, if you have any questions, please feel free to contact me at the email address above.

Focus Group Guide for Children¹⁷

Client: United Nations Children's Fund (UNICEF)

Consulting firm: Includovate

Lead Investigator: Dr. Kristie Druza kristie@includovate.com

Name of moderator:

Demographics of participants:

- » Number of children:
- » Types of disabilities represented in the room:
- » Age:
- » Gender:

Thank you for taking time to speak with me. I am very excited to meet you all and I look forward to learning a lot from you today. My name is X, from Includovate where I work as a researcher. Includovate is a social enterprise that conducts research for inclusion. At Includovate, we have a great commitment and deep passion to work with all children to amplify their voices in social and economic development. Ideally, we wanted to meet you and have this discussion face to face. But we cannot visit you because of the Coronavirus. However, your views and opinions are still very important for us, hence we are having this discussion over the internet. We hope that things will go back to normal very soon, and that one day we will get to meet you in person.

The purpose of this discussion is to hear your voices about your experiences every day. We are going to have a very interactive and fun time together. The reason we want to hear your voices and your stories is so that your experiences can help us to inform UNICEF about the needs of children whom you represent. At the end of these discussions, Includovate will be writing a report called the Situational Analysis of Children with Disabilities. It is a report that UNICEF uses to make decisions regarding strengthening policies towards children in general and children with disabilities in particular. You have all been chosen to take part in this discussion because your experiences and voices matter.

Although your parents are aware of this discussion with you, we would like you to know that your participation in this discussion is voluntary and entirely up to you. Also, even if you are happy to speak with me, you can also change your mind midway. It is ok to stop your participation at any time you feel like. In addition, everything we discuss here is completely confidential. That means neither me nor your teacher will talk about our discussion outside this classroom. During the interview, we will be taking notes, and with your permission, we would like to audio record the discussion for purposes of note taking and anonymised use in the report. These materials will be kept completely confidential and any personal identifying information (e.g., your name, parents' names, or your school) will not be used in any reports, publications, or presentations from this discussion. Also, there is no wrong or right answer. All your voices and experiences matter. This discussion will take between 45 – 60 minutes. Do you all agree to go ahead with the discussion? Do you have any questions for me?

Enabling/constraining BARRIERS/OPPORTUNITIES

Purpose: is to understand the opportunities to increase happiness and excitement and remove constraints that cause frustration, sadness, etc., in their day-to-day reality. We really want to capture the children's voices/stories. So let them use their own words but do actively listen so they know you care.

1. Ask the group of children with disabilities to pick one of the cards that are placed on the floor representing the following emotions:
 - » Happy
 - » Love
 - » Hope

¹⁷ This guide is developed with younger children in mind. The guide will be adapted for a discussion with adolescents and young people.

- » Disappointment
 - » Sad
 - » Fear
 - » Angry
2. Go around one by one and ask 'Tell me what feeling is represented on your card'
 3. Do you like having this feeling? Why/why not?
 4. Who can share a story where they had that feeling today?
 - a. probe to understand who was there and the situation that brought about the feeling
If no one answers then introduce your teddy bear (prop) and explain how teddy had that feeling today. Then (after teddy has finished speaking) ask
 - b. Does anyone else want to share their story about that feeling?

Then continue to move around the cards one by one asking the same questions. Don't force anyone to speak.

Programmes & Services / Stakeholders & Enabling Environment

Purpose: to find out what improvements could be made to existing services

Give all participants a love heart shape and a black cross

Have the following in pictures placed on the floor

- » Doctor/hospital
 - » Church
 - » School
 - » Home
 - » Friend's house
 - » Grandparents house
 - » River/creek/pond
 - » Beach
 - » Parents place of work
 - » Shops
 - » Other
1. Out of the following, I want you to put your love heart on your favourite place to visit
 - a. Ask why it is their favourite place to visit (probe as necessary)
 2. Now I want you to put your x shape on the place you least like visiting
 - b. Ask why it is their least favourite place to visit (probe as necessary)

Definitions and measurements of disabilities.

Purpose: to understand how these children identify with their disability.

Teddy has asked if you can do a drawing of yourself. He has done one of himself for you to keep. He wants you to know how he feels different and how he feels similar to you. Show the drawing and explain it to the children

1. Can everyone take a piece of paper and coloured pencils and do a drawing of yourself for teddy to keep?
 - a. Can you describe your drawing to me?
 - b. If they do not explain the following then probe: What do you have in common with other children in your family?
What is different about you compared to other children in your family?
2. Is there anything else you would like to share with me or anything else to ask me?

Annex 7: Approval Letter from Includovate's Internal Review Board



Includovate Research Center P.L.C
<http://www.includovate.com>
P.O.B 1213 code 1250
Addis Ababa, Ethiopia

16th December 2020

Includovate Research Center PLC
P.O. Box 1213 code 1250
Addis Ababa, Ethiopia.

Ethical clearance letter: IRB member's decision on the Includovate's 'Situational Analysis of Children living with Disabilities in Tanzania and Zanzibar'.

Dear Elizabeth,

On 12th December 2020, the IRB received the case for clearance. Situational Analysis of Children living with Disabilities in Tanzania and Zanzibar, was discussed by the IRB members. The board members also scrutinized the attached documents for ethical assessments in depth.

The reviewed documents include,

1. IRB application form
2. KIs tools and accompanying consent form
3. FGD guide for children with an inbuilt consent request
4. FGD consent form for parental consent
5. FGD guide for parents and accompanying consent form
6. FGD guide for UN agencies and accompanying consent form

There are some minor comments. However, the board is happy to approve the study.

Please contact sujata.ganguly@includovate.com should you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sujata', is placed above the printed name.

Sujata Ganguly, Chair, Includovate IRB
Peter Nash, Vice Chair of Includovate IRB
Jan Edwards, IRB Member
Srilakshmi Subramanyam, IRB member

Annex 8: Data tables from Analysis of 2017/18 Tanzania HBS and 2019/20 Zanzibar HBS

Appendix Table 9.1: Prevalence of Disability (any type of impairment) Disaggregated by Age and Gender, Mainland Tanzania

Age group	Disability and Gender							
	No				Yes			
	Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,044	97.88	3,139	97.45	66	2.12	82	2.55
10-14 years	3,102	97.92	3,121	98.24	66	2.08	56	1.76
15-19 years	2,329	97.53	2,226	97.55	59	2.47	56	2.45
20-24 years	1,447	97.31	1,731	97.30	40	2.69	48	2.70
25-34 years	2,455	97.19	2,899	96.22	71	2.81	114	3.78
35-54 years	3,458	93.48	3,683	89.92	241	6.52	413	10.08
≥55 years	1,480	74.37	1,474	65.63	510	25.63	772	34.37
Total	17,315	94.27	18,273	92.22	1,053	5.73	1,541	7.78

Appendix Table 9.2: Prevalence of Difficulty Seeing, Disaggregated by Age and Gender, Mainland Tanzania

Age group	Difficulty seeing and Gender							
	No				Yes			
	Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,084	99.16	3,198	99.29	26	0.84	23	0.71
10-14 years	3,118	98.42	3,130	98.52	50	1.58	47	1.48
15-19 years	2,349	98.37	2,242	98.25	39	1.63	40	1.75
20-24 years	1,456	97.92	1,721	96.74	31	2.08	58	3.26
25-34 years	2,448	96.91	2,893	96.02	78	3.09	120	3.98
35-54 years	3,316	89.65	3,498	85.40	383	10.35	598	14.60
≥55 years	1,407	70.70	1,477	65.76	583	29.30	769	34.24
Total	17,178	93.52	18,159	91.65	1,190	6.48	1,655	8.35

Appendix Table 9.3: Prevalence of Difficulty Hearing, Disaggregated by Age and Gender, Mainland Tanzania

Age group	Difficulty hearing and Gender							
	No				Yes			
	Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,076	98.91	3,192	99.10	34	1.09	29	0.90
10-14 years	3,128	98.74	3,141	98.87	40	1.26	36	1.13
15-19 years	2,344	98.16	2,249	98.55	44	1.84	33	1.45
20-24 years	1,462	98.32	1,753	98.54	25	1.68	26	1.46
25-34 years	2,490	98.57	2,951	97.94	36	1.43	62	2.06
35-54 years	3,606	97.49	3,967	96.85	93	2.51	129	3.15
≥55 years	1,790	89.95	1,978	88.07	200	10.05	268	11.93
Total	17,896	97.43	19,231	97.06	472	2.57	583	2.94

Appendix Table 9.4: Prevalence of Difficulty Walking, Disaggregated by Age and Gender, Mainland Tanzania

Age group	Difficulty walking and Gender							
	No				Yes			
	Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,072	98.78	3,192	99.10	38	1.22	29	0.90
10-14 years	3,135	98.96	3,148	99.09	33	1.04	29	0.91
15-19 years	2,363	98.95	2,249	98.55	25	1.05	33	1.45
20-24 years	1,460	98.18	1,747	98.20	27	1.82	32	1.80
25-34 years	2,464	97.55	2,907	96.48	62	2.45	106	3.52
35-54 years	3,496	94.51	3,697	90.26	203	5.49	399	9.74
≥55 years	1,542	77.49	1,454	64.74	448	22.51	792	35.26
Total	17,532	95.45	18,394	92.83	836	4.55	1,420	7.17

Appendix Table 9.5: Prevalence of Difficulty Remembering, Disaggregated by Age and Gender, Mainland Tanzania

Age group	Difficulty remembering and Gender							
	No				Yes			
	Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,071	98.75	3,171	98.45	39	1.25	50	1.55
10-14 years	3,114	98.30	3,142	98.90	54	1.70	35	1.10
15-19 years	2,342	98.07	2,225	97.50	46	1.93	57	2.50
20-24 years	1,450	97.51	1,745	98.09	37	2.49	34	1.91
25-34 years	2,465	97.59	2,911	96.61	61	2.41	102	3.39
35-54 years	3,498	94.57	3,841	93.77	201	5.43	255	6.23
≥55 years	1,712	86.03	1,827	81.34	278	13.97	419	18.66
Total	17,652	96.10	18,862	95.20	716	3.90	952	4.80

Appendix Table 9.6: Prevalence of Difficulty Communicating, Disaggregated by Age and Gender, Mainland Tanzania

Age group	Difficulty communicating and Gender							
	No				Yes			
	Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,082	99.10	3,181	98.76	28	0.90	40	1.24
10-14 years	3,127	98.71	3,153	99.24	41	1.29	24	0.76
15-19 years	2,359	98.79	2,250	98.60	29	1.21	32	1.40
20-24 years	1,462	98.32	1,761	98.99	25	1.68	18	1.01
25-34 years	2,492	98.65	2,980	98.90	34	1.35	33	1.10
35-54 years	3,645	98.54	4,042	98.68	54	1.46	54	1.32
≥55 years	1,899	95.43	2,120	94.39	91	4.57	126	5.61
Total	18,066	98.36	19,487	98.35	302	1.64	327	1.65

Appendix Table 9.7: Prevalence of Difficulty Self-Care, Disaggregated by Age and Gender, Mainland Tanzania

Age group	Difficulty self-care and Gender							
	No				Yes			
	Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,038	97.68	3,140	97.49	72	2.32	81	2.51
10-14 years	3,142	99.18	3,157	99.37	26	0.82	20	0.63
15-19 years	2,373	99.37	2,265	99.26	15	0.63	17	0.74
20-24 years	1,476	99.26	1,775	99.78	11	0.74	4	0.22
25-34 years	2,506	99.21	2,990	99.24	20	0.79	23	0.76
35-54 years	3,658	98.89	4,044	98.73	41	1.11	52	1.27
≥55 years	1,811	91.01	1,973	87.85	179	8.99	273	12.15
Total	18,004	98.02	19,344	97.63	364	1.98	470	2.37

Appendix Table 9.8: Proportion of Persons with Disabilities Aged 5-24 Years by Type of Disability and Level of Difficulty, Mainland Tanzania

Level of difficulty	Seeing	Hearing	Walking	Remembering	Communicating	Self-Care
Some	11.84%	16.70%	11.84%	21.78%	20.72%	14.80%
A lot	8.46%	8.88%	13.53%	20.51%	13.95%	12.05%
Cannot perform	0%	1.27%	2.54%	5.50%	6.13%	8.03%

Appendix Table 9.9: Prevalence of Albinism, Disaggregated by Age and Gender, Mainland Tanzania

Age group	Albino and Gender											
	No				Yes				Don't know			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
5-9 years	3,086	99.23	3,201	99.38	22	0.71	18	0.56	2.00	0.06	2.00	0.06
10-14 years	3,150	99.43	3,154	99.28	17	0.54	20	0.63	1.00	0.03	3.00	0.09
15-19 years	2,375	99.46	2,265	99.26	12	0.50	15	0.66	1.00	0.04	2.00	0.09
20-24 years	1,484	99.80	1,766	99.27	3	0.20	12	0.67	0.00	0.00	1.00	0.06
25-34 years	2,504	99.13	2,992	99.30	17	0.67	21	0.70	5.00	0.20	0.00	0.00
35-54 years	3,670	99.22	4,057	99.05	27	0.73	34	0.83	2.00	0.05	5.00	0.12
≥55 years	1,971	99.05	2,235	99.51	13	0.65	9	0.40	6.00	0.30	2.00	0.09
Total	18,240	99.30	19,670	99.27	111	0.60	129	0.65	17.00	0.09	15.00	0.08

Appendix Table 9.10: Prevalence of Disability (Any Type of Impairment) Disaggregated by Age and Gender, Zanzibar

Age group	Disability and Gender											
	No				Yes				NA			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<5 years	512	45.55	518	46.67	63	5.60	62	5.59	549	48.84	530	47.75
5-9 years	997	94.95	1,025	94.73	30	2.86	29	2.68	23	2.19	28	2.59
10-14 years	924	98.61	918	98.71	11	1.17	10	1.08	2	0.21	2	0.22
15-19 years	813	97.72	754	98.05	14	1.68	12	1.56	5	0.60	3	0.39
20-24 years	571	97.61	632	98.14	11	1.88	8	1.24	3	0.51	4	0.62
25-34 years	797	97.79	1,063	97.97	16	1.96	18	1.66	2	0.25	4	0.37
35-54 years	1,212	98.62	1,311	95.83	12	0.98	52	3.80	5	0.41	5	0.37
≥55 years	614	89.90	477	80.17	63	9.22	117	19.66	6	0.88	1	0.17
Total	6,440	88.77	6,698	88.33	220	3.03	308	4.06	595	8.20	577	7.61

Appendix Table 9.11: Prevalence of Difficulty Seeing, Disaggregated by Age and Gender, Zanzibar

Age group	Difficulty seeing and Gender											
	No				Yes				NA			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<5 years	1,051	93.51	1,058	95.32	6	0.53	0	0.00	67	5.96	52	4.68
5-9 years	1,043	99.33	1,073	99.17	5	0.48	5	0.46	2	0.19	4	0.37
10-14 years	932	99.47	919	98.82	4	0.43	9	0.97	1	0.11	2	0.22
15-19 years	822	98.80	758	98.57	7	0.84	8	1.04	3	0.36	3	0.39
20-24 years	579	98.97	633	98.29	4	0.68	7	1.09	2	0.34	4	0.62
25-34 years	803	98.53	1,070	98.62	10	1.23	11	1.01	2	0.25	4	0.37
35-54 years	1,200	97.64	1,298	94.88	26	2.12	66	4.82	3	0.24	4	0.29
≥55 years	612	89.60	513	86.22	65	9.52	81	13.61	6	0.88	1	0.17
Total	7042	97.06	7322	96.56	127	1.75	187	2.47	86	1.19	74	0.98

Appendix Table 9.12: Prevalence of Difficulty Hearing, Disaggregated by Age and Gender, Zanzibar

Age group	Difficulty hearing and Gender											
	No				Yes				NA			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<5 years	1,034	91.99	1,025	92.34	5	0.44	6	0.54	85	7.56	79	7.12
5-9 years	1,039	98.95	1,070	98.89	8	0.76	10	0.92	3	0.29	2	0.18
10-14 years	934	99.68	921	99.03	2	0.21	7	0.75	1	0.11	2	0.22
15-19 years	822	98.80	757	98.44	6	0.72	11	1.43	4	0.48	1	0.13
20-24 years	577	98.63	635	98.60	7	1.20	6	0.93	1	0.17	3	0.47
25-34 years	807	99.02	1,067	98.34	8	0.98	15	1.38	0	0.00	3	0.28
35-54 years	1,221	99.35	1,341	98.03	7	0.57	24	1.75	1	0.08	3	0.22
≥55 years	664	97.22	559	93.95	15	2.20	35	5.88	4	0.59	1	0.17
Total	7098	97.84	7375	97.26	58	0.80	114	1.50	99	1.36	94	1.24

Appendix Table 9.13: Prevalence of Difficulty Walking, Disaggregated by Age and Gender, Zanzibar

Age group	Difficulty walking and Gender											
	No				Yes				NA			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<5 years	839	74.64	834	75.14	23	2.05	17	1.53	262	23.31	259	23.33
5-9 years	1,042	99.24	1,072	99.08	6	0.57	7	0.65	2	0.19	3	0.28
10-14 years	934	99.68	928	99.78	3	0.32	0	0.00	0	0.00	2	0.22
15-19 years	824	99.04	760	98.83	5	0.60	8	1.04	3	0.36	1	0.13
20-24 years	578	98.80	636	98.76	6	1.03	5	0.78	1	0.17	3	0.47
25-34 years	808	99.14	1,071	98.71	7	0.86	11	1.01	0	0.00	3	0.28
35-54 years	1,215	98.86	1,316	96.20	12	0.98	49	3.58	2	0.16	3	0.22
≥55 years	593	86.82	465	78.15	86	12.59	129	21.68	4	0.59	1	0.17
Total	6,833	94.18	7,082	93.39	148	2.04	226	2.98	274	3.78	275	3.63

Appendix Table 9.14: Prevalence of Remembering, Disaggregated by Age and Gender, Zanzibar

Age group	Difficulty remembering and Gender											
	No				Yes				NA			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<5 years	679	60.41	668	60.18	22	1.96	25	2.25	423	37.63	417	37.57
5-9 years	1,035	98.57	1,061	98.06	9	0.86	13	1.20	6	0.57	8	0.74
10-14 years	926	98.83	924	99.35	11	1.17	4	0.43	0	0.00	2	0.22
15-19 years	818	98.32	759	98.70	10	1.20	9	1.17	4	0.48	1	0.13
20-24 years	580	99.15	634	98.45	4	0.68	7	1.09	1	0.17	3	0.47
25-34 years	804	98.65	1,064	98.06	11	1.35	18	1.66	0	0.00	3	0.28
35-54 years	1,214	98.78	1,322	96.64	13	1.06	44	3.22	2	0.16	2	0.15
≥55 years	650	95.17	523	87.90	29	4.25	71	11.93	4	0.59	1	0.17
Total	6,706	92.43	6,955	91.72	109	1.50	191	2.52	440	6.06	437	5.76

Appendix Table 9.15: Prevalence of Difficulty Communicating, Disaggregated by Age and Gender, Zanzibar

Age group	Difficulty communicating and Gender											
	No				Yes				NA			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<5 years	703	62.54	705	63.51	36	3.20	33	2.97	385	34.25	372	33.51
5-9 years	1,036	98.67	1,062	98.15	12	1.14	13	1.20	2	0.19	7	0.65
10-14 years	927	98.93	922	99.14	10	1.07	6	0.65	0	0.00	2	0.22
15-19 years	818	98.32	758	98.57	10	1.20	10	1.30	4	0.48	1	0.13
20-24 years	579	98.97	636	98.76	4	0.68	5	0.78	2	0.34	3	0.47
25-34 years	803	98.53	1,076	99.17	12	1.47	6	0.55	0	0.00	3	0.28
35-54 years	1,224	99.59	1,355	99.05	4	0.33	9	0.66	1	0.08	4	0.29
≥55 years	674	98.68	580	97.48	5	0.73	12	2.02	4	0.59	3	0.50
Total	6764	93.23	7094	93.55	93	1.28	94	1.24	398	5.49	395	5.21

Appendix Table 9.16: Prevalence of Difficulty Self-care, Disaggregated by Age and Gender, Zanzibar

Age group	Difficulty self-care and Gender											
	No				Yes				NA			
	Male		Female		Male		Female		Male		Female	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<5 years	536	47.69	533	48.02	55	4.89	67	6.04	533	47.42	510	45.95
5-9 years	992	94.48	1,025	94.73	39	3.71	31	2.87	19	1.81	26	2.40
10-14 years	923	98.51	924	99.35	14	1.49	4	0.43	0	0.00	2	0.22
15-19 years	821	98.68	763	99.22	8	0.96	4	0.52	3	0.36	2	0.26
20-24 years	581	99.32	637	98.91	3	0.51	4	0.62	1	0.17	3	0.47
25-34 years	809	99.26	1,080	99.54	6	0.74	2	0.18	0	0.00	3	0.28
35-54 years	1,226	99.76	1,353	98.90	2	0.16	12	0.88	1	0.08	3	0.22
≥55 years	649	95.02	544	91.43	30	4.39	49	8.24	4	0.59	2	0.34
Total	6537	90.10	6859	90.45	157	2.16	173	2.28	561	7.73	551	7.27

Appendix Table 9.17: Proportion of Persons with Disabilities Aged 5-24 Years by Type of Disability and Level of Difficulty, Zanzibar

Level of difficulty	Seeing	Hearing	Walking	Remembering	Communicating	Self-Care
Some	5.60%	12.00%	6.40%	13.60%	24.00%	16.00%
A lot	4.00%	8.00%	4.80%	18.40%	15.20%	16.80%
Cannot perform	0.80%	1.60%	7.20%	8.00%	6.40%	28.00%

Annex 9: Stakeholder Mapping

Most of the information provided in the below is from the organisation website except for Sense International and Department of Disability Affairs.

* We are still waiting to get information from the Ministry of Health and Social Welfare-Zanzibar, Organization of People with Disabilities in Zanzibar (UWZ), Tanzania Federation of Disabled People's Organizations (SHIVYAWATA) and the President's Office. Most of the OPDs never responded to the calls thus the information we got on the website could not allow us to fill the table as required. Lastly, some of the contacts were all but the calls were not answered and some contacts were off and some never went through. Follow-up contacts were made for 3 days (4th, 6th and 7th/May/20121) but despite the efforts made, little information was obtained.

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees
Government	Ministry of education, science, technology and vocational training	Both	National strategy for inclusive education 2018-2020	This strategy aims at promoting an inclusive education system that removes the barriers limiting the participation and achievement of all learners, that respects diverse needs, abilities and characteristics and that eliminates all forms of discrimination in the learning environment	Key funding sources: World Bank, Global Partnership for Education, SIDA, United Nations Education Scientific and Cultural Organisation and United Nations Children's Fund Grants received: 2020-2021 \$ 15.16million (Mainland)) and \$ 1.5million (Zanzibar)	
Government	President's Office— Regional Administration and Local Government (PO-RALG) (Mainland) and President's Office – Regional Administration and Local Government and Special Departments (PORALGSD) (Zanzibar)	Both	USAID Tusome Pamoja program	The goal of Hesabu na Elimu Jumuisi is to improve lifelong learning skills and increase the inclusivity of primary education for children with disabilities in Standards 1 and 2, as well as teachers and administrators in government primary schools in Iringa, Morogoro, Mtwara, and Ruvuma regions, and all Zanzibar regions	Key funding sources: United Nations Capital Development Fund, United Nation Children's Fund, World Bank and Japan International Cooperation Agency	-

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
Government	Special Need Unit of Ministry of Education, Science and Technology	Mainland	Education Sector Development Plan (2016/17 – 2020/21)	The Government's strategy is to include as many as possible of the children living with disabilities into the mainstream education system. Only those whose disabilities are too severe for regular schools will be enrolled in special schools. The Government has initiated a screening programme to check children's hearing and sight. Simple steps can be taken to support those with minor sight and hearing impairment, such as seating them at the front of the class and working with health services to ensure that they can be provided with spectacles or hearing aids if possible. Fellow students can also be encouraged to provide support for children with disabilities.	Key funding sources: SIDA, UNICEF and Global Partnership for Education	100 employees

Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees
Government	Department of Social Welfare - Ministry of Health and Social Welfare	Mainland National Social Protection Framework (NSPF) 2015-2015 Community Health and Social Welfare System Strengthening Program(CHSSP)	CHSSP supported the Department of Social Welfare(DSW) and the Social Protection and Social Welfare Technical Working Group (SPSW-TWG) to update/ revise three key social welfare documents that affect the health and well-being of most vulnerable children (MVC): the Social Welfare Policy; the National Guidelines for Early Identification and Intervention for Children with Disabilities; and the new National Plan of Action (NPA) for the Elimination of Violence against Women and Children	Key funding sources: Centre for Disease Control and Prevention, USAID, Helen Keller International Grants received: \$2.5million (2019-2023)	

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
Government	PWDs Unit - Office of the Prime Minister	Mainland	Regulation of disability act 2010, National development of persons with disabilities, Persons with disability Act 2010	The Persons with Disability Unit, is a unit under the Prime Minister's Office Labour, Youth, Employment and Persons with Disability, responsible for providing expertise and services to persons with disability. The department argues that persons with disabilities have a significant contribution in socio economic development, and their contributions can be even greater when accessibility to basic services such as health, education, transportation, emergency and disaster response, resilience building, sanitation and water and access to information and communications.	Key funding sources: UKAid, BRAC, USAID, ILO and United Nations High Commissioner for Human Rights	–
Government	Zanzibar Department of Elders and Social Welfare	Zanzibar	Zanzibar Universal Pension Scheme (ZUPS)	Older person's pension with a disability allowance with the objective of eradicating absolute poverty in the society	Key funding sources: Revolutionary Government of Zanzibar	–

Name		Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees
Government	Department of disability affairs	Zanzibar	Establishment of disability database (Jumuishi database)	The database was developed to increase the government's capacity to generate more reliable and comparable disability statistics and to mainstream disability data collection into national statistics systems, harmonizing efforts with international disability measurement standards	Key funding sources: United Nations Population Fund, GlobalGiving, United Nations Voluntary Fund on Disability, United Nations Children's Fund and Revolutionary Government of Zanzibar	8 employees with disabilities
Government	Zanzibar Inclusive Education Unit	Zanzibar	The Zanzibar Education Development Plan I 2008/09 – 2015/ 16 (ZEDP I), the Zanzibar Education Development Plan II 2017/18– 2021/22 (ZEDP II).	Increased Net-enrolment rate in Standard 1 for children having received 2 years of quality PPE, schools and teachers in schools meeting inclusive education standards and high quality timely and evidence based annual monitoring and review	Key funding sources: Sweden Government, UNICEF, USAID, GPE, World Bank and Revolutionary Government of Zanzibar Ministry of Education and Human Right Council Grants received: \$8.23 million (2014)	
Government	Ministry of Health	Zanzibar	Knowledge and healthy practices on SRHR for adolescents and youth improved by 2023	Support implementation of innovative information, education, and services for adolescent and youth SRH and HIV, including those with disabilities.	Key funding sources: UNICEF, D-tree International and Revolutionary Government of Zanzibar Grants received: \$6million (2018)	

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
Government	President's Office	Zanzibar	Coordinates the Productive Social Safety Net programme which was implemented since 2014 under the Zanzibar Social Protection Policy (ZSPP) and also manages the Department of Disability Affairs which handles the Disability Fund, which provides loans and grants for assistive devices for people with disabilities	The overall objective of the ZSPP is, to establish a comprehensive social protection system that meets the needs for income security, risk management and access to basic services for all Zanzibaris, thereby contributing to a more equitable society	Key funding sources: UNDP, UNICEF, Africa Climate Change Fund and African Development Bank	90 employees
Government	Second Vice president office	Zanzibar	The (Mkakati wa Kukuza uchumi na Kuondoa Umaskini Zanzibar) / Strategy for Growth and Reduction of Poverty) program targets vulnerable households living below the food and income poverty lines, including vulnerable households caring for vulnerable children under five years old, children eligible for school living in vulnerable households, and households with elders (people older than 60 years of age) who are sick, have a disability, and who are caregivers of vulnerable children	The overall objective of the ZCPA is to reduce incidence of most vulnerable children in both rural and urban areas in the short-run, and put in place requisite economic, social, policy and institutional foundations for elimination of all forms of child vulnerability to various risks in the long term	Key funding sources: United Nations Population Fund and the URT and Revolutionary Government of Zanzibar	11-50 employees

Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees	
OPD	Organization of People with Disabilities in Zanzibar (UWZ)	Zanzibar	The Community Based Rehabilitation Programme (CBR) was established in 1988 as a core programme. Economic Empowerment for Youth Programme and Community Based Legal Empowerment in North and Urban West Regions	Through this programme UWZ has registered over 5,000 children with different disabilities under 17 years. These children, later on, become members of the organization when they are 18 years old The organization is economically empowering youths especially youths with disabilities in entrepreneurship skills In 2015, UWZ received a grant from the Legal Services Facility (LSF) for conducting a magnitude of domestic gender-based violence in north and mcheweni districts in unguja and pemba respectively. however, the organization received another grant from LSF for implementing the north and urban west regions community based legal empowerment and economic development project from 2017 to 2020	Key funding sources: foundation for civil society, Legal Services Facility, ABSA Bank Tanzania-Zanzibar Branch, - GlobalGiving and women fund Grant funding received: 59,957,000 Tanzania Shillings (2020) Largest single grant: 400 Million Tanzania Shillings	21 employees

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
OPD	Zanzibar Association for People with Developmental Disability (ZAPDD)	Zanzibar	ZAPDD development programme includes (i) Strengthening association through increasing membership (ii) empowering leaders with appropriate knowledge and skills, (iii) awareness raising in the community on the right of people with developmental disabilities (iii) empowerment of local branches and (iv) enhancing networking Inclusive education	Advocate for the rights of People with Developmental Disabilities, improving the lives for people with intellectual disabilities and their families. and also focuses on inclusive education focusing on increased enrolment and proper teaching techniques for children and youth with disabilities	Key funding sources: Norwegian Association for persons with Developmental Disabilities), the Ministry of Education and Vocational Training (MoEVT) , with funding from the Norwegian youth organization, Kehitysvammaliitto, Land Foreningen LEV, Norsk Forbund for Utviklingshemmede, The Open Society Initiative for Eastern Africa and Revolutionary Government of Zanzibar	10 employees
OPD	Zanzibar Association of the deaf (CHIVIZA)	Zanzibar	Zero projects on the website	Their mission is to ensure full effective and equal enjoyment of human rights for deaf people including good and quality of social, economic, cultural as well as civil and political rights and to ensure deaf people are free from poverty, diseases, acts of injustice, segregation and all types of discrimination.	Key funding sources: GlobalGiving (crowd funding)	–

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees
OPD	Zanzibar National Association for the Blind (ZANAB)	Zanzibar	Advocate for blind and albino children to be mainstreamed in normal school	To strengthen and empower the blind and visually impaired people in understanding their needs, rights, responsibilities and other privileges in their development through awareness-raising training, capacity building and advocacy.	Key funding sources: GlobalGiving (crowd funding)	–
OPD	Association of People with Albinism in Zanzibar	Zanzibar	–	–	–	–
OPD	Zanzibar Psychiatric Association	Zanzibar	Their programs include mental health services, education, treatment and medication	The aim of ZPA is to improve the quality of life for those with mental illness and those affected by epilepsy.	Key funding sources: Zanzibar Ministry of Health and Social Welfare	–
OPD	SHUUWAZA (Shirikisho la Jumuiya za Watu wenye Ulemavu Zanzibar) Zanzibar Federation of Disabled People Organizations	Zanzibar		Advocacy organization acting as an advocate for the rights of People with Disabilities	Key funding sources: Department of Disability Affairs, GlobalGiving (crowdfunding) and Norwegian Association of Disabled.	–

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
OPD (Federation) Non-governmental federation	Tanzania Federation of Disabled People's Organization (SHIVYAWATA).	Mainland	SHIVYAWATA aims to unite all Disabled Peoples' Organizations (PWDs) and the Pro-Disability Organizations (OPDs) for effective lobbying and advocacy work, coordinates with the Government, Political Parties and the Public so as to provide required and appropriate services to persons with disabilities on time, Motivating, encourage and assist the formation and registration of DPOs and PDOs as well as ensuring the existence of the already registered DPOs and PDOs, provides advisory role to members (PWDs) of SHIVYAWATA and advocate for mainstreaming the Disability in Public and Private sector plans and programs. From rights to Inclusion project" in collaboration with the Handicap International. The Project aims at moving forward the protection of rights for Persons With Disabilities (PWDs) as outlined in the Convention on the Rights of Persons With Disabilities (CRPD) in Kenya and Tanzania national legislations.	Empower persons with disabilities to realize their human rights so they can live in the society which is free and inclusive. Collaborates with twelve OPDs from Mainland Tanzania and Zanzibar promote the implementation of the CRPD through strengthening grassroots, national and regional capacities and linkages with other organizations. It also focuses on strengthening capacities of DPOs to advocate for the implementation of the CRPD and to institutionalize civil participation for the implementation of the CRPD.	Key funding sources: African Disability Forum (ADF), the National Lottery Community Fund, Norwegian Association of the Disabled, Sightsavers and the Big Lottery Fund.	–

Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees	
OPD	The Kilimanjaro Association of Spinal cord Injuries (KASI)	Both Mainland	KASI implements the following activities: Members' training meetings to increase their knowledge about related health and social issues, assisting members to access appropriate wheelchairs and other essential assistive devices, support initiatives of Spinal Cord Injured people especially women to raise their status in society, providing individual and group counseling, conduct regular home visits to KASI members who are already at home, support the establishment of income generating activities for its members, promoting local production of appropriate assistive devices and availability of proper medical and rehabilitative care for Spinal Cord Injured people, promote recreational activities for people with disabilities and collaborate with other Disabled People's Organizations (DPOs) to influence government and development agencies to adopt disability inclusive policies	Aims to mobile and provide rehabilitation services to persons with spinal cord injuries and promote long lasting changes that can improve their social lives.	Key funding sources: GlobalGiving (crowdfunding)	–

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
OPD	The Tanzania Albino Society (TAS)	Mainland	TAS supports people with albinism through learning aids in schools to help with their low vision problem; education and aids for skin and eye care; conduct periodic skin cancer clinics and; continuously lobby and advocate for the rights of children, men, women and old persons with albinism.	Promote people with albinism rights at every level of the society and fight against discrimination through advocacy, awareness, education and support.	–	–
OPD	Tanzania Association for Sign Language Interpreters (TASLI)	Mainland	Provide sign language interpretation services	Train both teachers and deaf children in sign language	Key funding sources: Institution for Inclusive Development (I4ID) funded by UKAid and IrishAid Embassy of Ireland and Government	–
Disabled People's Organisation (OPDs)	The Tanzania League of the Blind (TLB)	Mainland	TLB is committed to improve the quality of life of people with visual impairment in Tanzania through lobbying and advocacy; awareness raising; information sharing; facilitating access to education and vocational training; and economic empowerment.	Tanzania League of the Blind (TLB) is the only national Non-governmental Organisation operated by the blinds and visually impaired themselves in Tanzania. It has around 35,245 members with 104 district branches countrywide. TLB also network with other like minded organizations and take cognizance of the cross cutting issues of gender, HIV/AIDS, environment and good governance. TLB is also in partnership with Tanzania Albino Society and Zanzibar National Association of the Blind of the Blind	Key funding sources: SRF Sweden, Myright Tanzania, Finish Library and Foundation for Civil Society	–

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees
OPD	The Tanzania Association of the Physically Handicapped (CHAWATA)	Mainland	–	–	–	–
OPD	The Tanzania Society of the Deaf (CHAVITA)	Mainland	Sign Language Development: This programme aims to increase awareness and usage of Tanzanian Sign Language (TSL) amongst Deaf and hearing people. This is achieved through provision of sign language training, coordination of an interpretation service, undertaking TSL research and production of the TSL Dictionary and other related materials.	Intends to improve the living standard of people with hearing difficulty through mobilization, participation and education. The organization emphasizes the use of sign language for inclusive communication.	Key funding sources: Disabled People International, International Committee of the Red Cross, Foundation for Civil Society, United Nations Development Plan, CCBRT, ADD Tanzania, United Nations Women, Disability Fund Organization and Global Disability Rights Library	11-50 employees
OPDs	The Tanzania Association for the Mentally Handicapped (TAMH)	Mainland	TAMH has programs like Inclusive home learning to develop some basic home learning guidance for families with children with disabilities, inclusive early childhood education training videos and participatory development of teacher training among others.	This association works towards addressing the needs of people with mental challenges through advocacy and empowerment	Key funding sources: Norwegian Youth Organisation and Agricultural Development Project -Isongati Trust Fund Tanzania	TAMH has 144 basic branches, 66 district branches and 20 regional/ provincial branches, with a total number of about 4,200 members countrywide
OPDs	The Psoriasis Association of Tanzania (PSORATA)	Mainland	–	–	–	–

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
OPDs	The Tanzania Users and Survivors of Psychiatric Organization (TUSPO)	Mainland	Community/public awareness about the rights and needs of persons with Mental illness by conducting and sensitize the religious leaders and civil society leaders on the community responsibility towards the right of persons with mental illness	This project's concern is to address the issue of mental health law and policy. It targets raising awareness of the general community and policy makers at Kisarawe on the need of adjusting their policies / by laws to suit the needs of persons with psychiatric problems.	Key funding sources: National Lottery Community Fund, SightSavers, Norwegian Association of the Disabled, International Development Association and My Right Sweden	–
OPDs	The Association of Spinal Bifida And Hydrocephalus of Tanzania (ASBAHT)	Mainland	Hospital discontinued offering surgery for children with spina bifida and hydrocephalus, Child-Help started a surgical project, research into the causes of spina bifida Community awareness of SBH on primary prevention, early intervention and care, advocacy and lobby for the right to social inclusion, Education ,vocational training and economic empowerment	Aims to improve the quality of life for people with Spinal Bifida and Hydrocephalus.	Key funding sources: SightSavers, International Federation for Spina Bifida and Hydrocephalus, National Association for Disabled Children and Adolescents-Sweden, Norwegian association for Spina Bifida and Hydrocephalus, Comprehensive Community Based Rehabilitation in Tanzania, Arusha Lutheran Medical Centre, Child-Help Tanzania and the Bo Hjelt Foundation	–

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
OPDs	The Tanzania Association of the Deaf – Blind (TASODEB)	Mainland	Poverty Reduction Project aims to enhance self reliance of the Tanzanian Deaf, especially women and youths, Sign Language Training & Advocacy Project; to strengthen sign language development in Tanzania at district levels through training sign language to trainers, deaf people, parents of deaf and service providers. Sexual Reproductive Health Rights to Youths Project aims at sensitizing deaf youths girls to boys aged 10 to 24 years on sexual health rights and equipping them with life skills for combating HIV/AIDS and poverty.	Aims to increase sensitization and awareness about the use of sign language among the people with hearing difficulty and the deaf. This is done through training and interpretation of services through the use of TSL materials.	Key funding sources: SightSavers	–
OPDs	Disabled Organisation for Legal Affairs and Social Economic Development	Mainland	Increasing access of education for persons with disabilities	Advocates for education for people with disabilities through school enrolment or training.	Key funding sources: United Nations Voluntary Fund, UKAid, Swedish International Development Agency	–

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
NGO	Amani Early Childhood Care and Development (Amani ECCD) Amani Trust Foundation	Tanzania	The Foundations of Development Programme that aims to improve the commitment to holistic Early Childhood Development support, Msichana Shule	Advocates for and facilitates integrated, multi-sectoral approaches for supporting women, families, care-givers, educators, and communities, in their roles of nurturing Tanzania's socially and economically disadvantaged young children 0 - 8 years. The goal is to ensure that all children have the opportunity to enter school healthy, happy, ready and able to develop to their full potential - and that schools are ready and able to support them	Key funding sources: GIZ & African Union, the Foundation for Civil Society, JM MEDIA Key funding sources: NDANDA, Machinga Transport Service and Government of Tanzania	-
NGO	Tanzania Empowerment for Persons with Disability and Gender Health Organization (TEPDGHO)	Mainland	TEPDGHO is offering a variety of programs that serve deaf community members of every age and background like ICT, education and economic opportunities	TEPDGHO partners with various CSOs in Tanzania to provide computer classes to children with disabilities and their teachers (deaf, blind, physical and children with albinism) like DeafNET,	Key funding sources: UKAid, Tanzania Social Action Fund	-

Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees
NGO	Walio Katika Mapambano na AIDS Tanzania (WAMATA)	Mainland	Provision of essential services to the most vulnerable children (MVC) and participate in mitigating the impacts of HIV/AIDS and poverty to the affected children and their families. The WAMATA also aims at reducing discrimination, stigma and suppression experienced by children affected by social and economic hardships, HIV/ AIDS and any kind of children rights violation in their own families and surrounding communities	Provides social services like shelter and care, education and health support, psychosocial and food and nutrition, protection and care and economic strengthening to the MVC and their families	Key funding sources: President's Office, USAID
NGO	Kilimanjaro CBR - Comprehensive Community Based Rehabilitation Tanzania (CCBRT)/ Comprehensive Community Based Rehabilitation Moshoro Tanzania (CCBRT)	Mainland	Provides rehabilitation and disability services/ rights like advocacy, physiotherapy, speech, occupational therapy, community development, training, community-based rehabilitation and health education	CCBRT is a national reach organisation which focuses on any type of disability through rehabilitation, prevention and operates a community-based rehabilitation programme in a remote rural area. CCBRT has a private-public partnership with the government of Tanzania, CCBRT opened the 200-bed CCBRT Disability Hospital. The hospital provides free surgical procedures and treatment for obstetric fistula and cleft lip/ palate patients, as well as free care for all patients under the age of five through heavily subsidizing other treatments	Key funding sources: The Agha Khan University, MSSl, Attigo, momconnect, Management Development Institute, Amref Health Africa, Croix-Rouge Suisse, Schweizerisches Rotes Kreuz, Croce Rossa Svizzera, Wiser, Save the Children, One Young World, Spark Health Africa, Mental Health UK, Mothers2mothers, Government of Tanzania, CBM, EU, Irish Aid and Standard Chartered Bank Largest grant received: \$79 million (revenue)

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
NGO	Madrasa Early Childhood Programme - Zanzibar (MECP-Z)	Zanzibar	Identification, intervention and referral	A teacher-training programme on early childhood development designed for children with disabilities, with a focus on play-based teaching in partnership with Department of Disability Affairs and Global Partnership Education	Key funding sources: Norwegian Association for Disabled and Agha Khan Foundation Grant funding received: \$1.5 million between 2016-2019	
INGO	ADD International Tanzania	Both	Support the education of out of school children and tackle the exclusion of disabled children from all aspects of education. Disability Inclusive Covid Response and Recovery Coordination in partnership with SHIVYAWATA and other local OPDs.	ADD-Tanzania works with disability activists to empower disabled children and their families to access education, work with teachers and schools to deliver inclusive education in inclusive environments	Key funding sources: ADD International is member of African Disability Forum, Arab Organization of Persons with Disabilities, ASEAN Disability Forum, Down Syndrome International, European Disability Forum, Inclusion International, International Federation of Hard of Hear People, International Federation for Spina Bifida NS Hydrocephalus, Pacific Disability Forum, RIADIS, World Blind Union, World Federation of the Deaf, World Network of Users and Survivors Psychiatry	—

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/or what programs does the organisation fund or implement	Notes	Funding information: grants receive, key funding sources	No. employees
INGO	UNICEF Tanzania	Both	Education, eternal and children, nutrition, social policy especially for the most marginalised children, water sanitation and hygiene, providing adequate WASH services to improve health and development of children and children in emergencies in partnership with the URT and all other UN partners, Private sector,	The programme's aim is that Tanzanian children, especially the most disadvantaged children and families, have access to and benefit from quality social services, knowledge and opportunities, and thereby have a fair chance in life.	Key funding sources: All UN agencies and other bilateral agencies among others	–
INGO	Sense International Tanzania	Mainland	Deaf blind children's learning. Education, health and livelihoods programmes and through awareness raising and campaigning	Supports people with deafblindness and complex sensory impairments by working in partnership with local organisations and governments	Key funding sources: No specific funding source but they write proposal and win grants from various donors like Sense International Global, UkAid, AustraliaAid, USAID and IrishAid Grant funding received: GBP 366,549 (2020)	10 staff and 2 interns. Of the 10 staff, one employee is deafblind
NGO	Sightsavers	Both	Children with visual disability. National Trachoma Elimination Program Tanzania	Restoring sight through specialist treatment and eye care. They also support people who are irreversibly blind by providing education, counselling and training.	Key funding sources: Conrad N Hilton Foundation, UKaid, European Union, Bill and Melinda Gates Foundations, Standard Chartered, Helen Keller International, The Fred Hollows Foundation, USAID, The End Fund, Irish Aid Grant funding received: Various \$5million, \$1.4million,	

	Name	Geographic reach (Mainland, Zanzibar, Both)	Disability-related programming/ operations advocacy and/ or what programs does the organisation fund or implement	Notes	Funding information: grants received, key funding sources	No. employees
INGO	Salvation Army school-Tanzania	Mainland	Children with disabilities and albinos (primary school and vocation centre).	Is a boarding school that provides education, physical therapy and we operate a workshop for the manufacturing and repair of walking appliances and chairs.	Key funding sources: MG Marketing and Dole New Zealand Ltd.	118 employees
Institute	Zanzibar Center for Disability and Inclusive Development	Zanzibar	Provide loan specially for people with disabilities	Centre promoting equal rights and full inclusion of persons with disabilities in all spheres of society and development in Zanzibar	Key funding sources: Institute of Development Studies, United Nations Population Fund	—

Annex 10: Preliminary Action Plan

Recommendation Category	Recommendation	Primary Responsibility	Key Stakeholders
A. What are potential priority advocacy issues for Tanzania Mainland and Zanzibar?			
Harmonise Domestic Legislation with the CRPD and other International Conventions	Although URT is a signatory to the CRPD and has domestication legislation, the Situation Analysis shows that there are still gaps with domestic legislation. The URT's National Policy on Disability of 2004 predates the CRPD. The URT needs to import the rights of persons with disabilities from the directive principles of state policy to the Bill of rights as fundamental rights in both Mainland Tanzania and Zanzibar that can be enforced in the court of law. While policy instruments are crucial for the success of individual plans, they are rendered weak if not anchored in constitutional provisions.	Prime Minister's Office	
Make changes to children and disability laws to reflect rights of children with disabilities	Although the URT has made some progress in domesticating the CRPD and other international protocols, <i>it still needs to adapt its local laws to reflect the rights of children with disabilities.</i> Guaranteeing these rights for children with disabilities would create obligations, for example, for health insurance schemes and for infrastructure accessibility in schools (e.g., toilets) and public spaces. Implementing such reforms requires multisectoral efforts, including the involvement of the ministries in charge of health, education, gender, youth, elderly, and legal issues.	Prime Minister's Office	Cross cutting issue- can't remain confined to the Ministry of health; other ministries of gender and children and elderly, constitution and legal affairs. (UNICEF and WHO country office) department dealing with labour, employment, youth with disabilities
Implement disability inclusive policy and legal reviews	Both the Mainland and Zanzibar have made commendable efforts in advancing the welfare of children with disabilities, especially through progressive legislation and policies. There is a need to understand what is working and where success is limited. In some cases, implementation of legislation and policy may be the problem, or it may be the way the policy is drafted, or a combination (e.g., Mainland Tanzania has a legal 3% employment quota for persons with disabilities, but it does not enforce the requirement in the public sector and it is not enforceable in the private sector). In other cases, URT has made good effort but with little captured result. <i>Ensuring disability inclusive reviews and evaluations of policies would help to capture lessons learnt and areas for improvement.</i>	Who monitors the 3%? They should lead. OPDs should advocate for this information to be shared and to be in place.	Need to start from the village level. Would like to explore laws more to see how participation of people with disabilities are encouraged - especially in the rural areas.

Recommendation Category	Recommendation	Primary Responsibility	Key Stakeholders
Leave no one behind by adopting an intersectional approach	The 2010 and 2006 Person with Disabilities Acts of both the Mainland and Zanzibar fail to adopt an intersectional lens and to provide specific rights to girls and women with disabilities, contrary to their international obligations under the CEDAW. For example, there is need for research on the intersectional links between violence against women and SRHR. Currently, the Mainland is reviewing the National Plan of Action to prevent violence against women and girls while Zanzibar is reviewing the National Plan of Action to End Violence Against Women and Children (NPA-VACW), presenting good opportunities to advocate for linking these policies with disability. At the same time, there is a need for legislative guidelines on rights to SRHR particularly for young women with disabilities. Further, there are differences in age, location and disability types that all require corresponding interventions. All policies - especially those relating to disability - should adopt an intersectional approach that understands the specific barriers affecting identity categories by: gender, disability type, age, location and how different combinations of these categories can lead to more extreme forms of exclusion that are harder to overcome.	Mainland: Ministry of health, community development, gender, elderly & children Similar in Zanzibar - Ministry of Health, social welfare, elders, women, children	UN is active with these plans; CSOs; Zanzibar - Save the Children is active
The importance of disability-poverty intersection	There is a correlation between incidence of disability and poverty. Social policy experts have shown that social protection can be a powerful tool for social inclusion, especially for lower income groups of society. In URT, as evidenced from repeated observations from parents of children with disabilities, material poverty weighs heavily on many families of children with disabilities. <i>The URT should explore the affordability of a Disability Grant, which could offset material barriers of children with disabilities from active social and economic participation.</i>		
Improve survey data	Discrepancies in methodologies and definitions across and between data sets lead to inaccurate data and make the data incomparable with global standards. the lack of globally comparable data. The URT could draw lessons for collecting such statistics from its regional peers such as Uganda that have already advanced disability data standards. Collaborating with OPDs and using the Washington Set of questions to generate internationally comparable standards is advised. Further, national survey data should have unambiguous sex-disaggregated analysis. Such data should explore whether the lack of difference between disability prevalence rates for girls and boys varies by type of disability and explain what happens across the life cycle. It should explain reasons behind the sex difference that emerges in middle adulthood and widens by older adulthood. Looking at risk factors for disability and whether there are differences between boys and girls in terms of these risk factors, has implications for policy responses and advocacy issues. <i>The URT should improve the quality of its national census and other national level studies to include disability and gender disaggregation and the Washington Group child functioning module questions.</i>	NBS - Mainland & OCGS - Zanzibar	Ministry of Policy, Parliamentary Affairs, Labour, Employment, Youth and the Disabled (mainland) & comparable ministry for Zanzibar; DPOs. Needs range of stakeholders - government, civil society, UN partners.

Recommendation Category	Recommendation	Primary Responsibility	Key Stakeholders
Improve education and health data	The lack of data can be solved in many ways. Health and education sectors already collect a lot of data but this is not always disaggregated by disability, gender and age. <i>Any information management system improvements in health and education should integrate and disaggregate disability data.</i>		
Develop awareness raising and behaviour change campaigns	One of the most critical needs for advancing the rights of children with disabilities in URT is public education and awareness raising about disability, including albinism. Countering deep-seated negative norms, stereotypes, and stigma requires equally aggressive intersectional efforts led by the government in collaboration with OPDs and other key stakeholders. These should include more voices from women and children with disabilities to tell their own stories (UN Women, 2020). The following key awareness raising/behaviour change campaigns are needed: • <i>Early screening and diagnosis days (e.g., at designated places such as schools, paediatric hospitals, and community public health centres).</i> • <i>Developing narratives around disability inclusion and gender equality.</i> • <i>Countering sexual and gender-based violence against women and girls (and also boys) with disabilities.</i> • <i>Use role modelling for positive image creation (e.g., showcase employed people with disabilities or high-profile achievers with disabilities).</i> • <i>Involve religious and traditional leaders in advocacy/behaviour change.</i> • <i>Capacity building for influential leaders (elders and tribal leaders too) to communicate key messages and to eliminate stereotypes and misinformation and negative taboos.</i> • <i>Encourage quota systems at all levels of governance and in key decision-making areas across society, e.g., parliament, and political party electoral adoptions.</i>	General awareness raising falls to departments. UNICEF does C4D and SBCC messaging and to what extent does this include children with disabilities in visual messaging. OPDs unit in the PMO. department of community development and community level (ensures social wellbeing of the community). Link to central government (meso level)	CCBRT has a role to play. Cross cutting issue and involve all departments. Need to speak the same language re: discrimination and stigma. Plus the media.
Improve community-based rehabilitation and local assistive device development and maintenance	Rehab services are expensive and still institutionalised in many cases. Families with children with disabilities can only receive the needed services in a limited number of places which are expensive to travel to. Assistive devices are purchased overseas rather than supporting local markets and innovations. <i>Develop a localisation plan for disability services such as rehabilitation and assistive device development and maintenance that includes a decentralised approach and monitoring visits to local communities.</i>	Ministry of Health	Cross cutting across all Ministries including NGOs and private sector.
Accessibility audits to improve infrastructure	Even with assistive devices, infrastructure such as classroom, ICT, road, bank and health facilities are not always accessible to children with disabilities. Making ICT accessible to children with disabilities will increase their future employability and connection. <i>URT should mandate accessibility audits for all infrastructure projects and buildings.</i>		

Recommendation Category	Recommendation	Primary Responsibility	Key Stakeholders
Improve the early identification of disabilities and referral services	With regard to early identification, first, there is a need for specific revisions in the law and policies such as the National Policy on Disability, 2004 to provide for early identification and intervention in an actionable format. Early identification of disabilities can prevent chronic disability and enable appropriate educational support. These facilities need to be local and built into existing services (e.g., prenatal and newborn babies at health centres; early childhood learning centres; primary schools; or designated public health centres). Early identification should be integrated into regulations and guidelines of health facilities and made available locally. This should be accompanied by treatment referrals. Second, since children (e.g., under 5-year-old) rely on parents' understanding and having the ability and acceptance to report having a child with an impairment, there are opportunities to cross-check self-reported information from families with medical data (growth monitoring, medical services, etc). For Zanzibar, the community health volunteers could be empowered with some capacity to start simple referrals for young children who may be presenting evidence of an impairment. Also, the government could engage with baby clinics around early identification and referrals.		Zanzibar community health volunteers' program; well baby clinics health care facilities- through the parent ministry President's Office - Regional Administration and Local Government
Train more personnel to manage inclusive programmes across sectors.	Without adequate numbers of trained professional staff, disability inclusion could remain an ideal. The URT needs to invest in the training of professional service providers to run disability inclusive programmes across the social and economic spectrum.	URT lead. Although there is a lack of professionals in URT with an understanding of disabilities, therefore URT have to rely on OPDs and NGOs.	Collaboration with OPDs and NGOs is essential. In Zanzibar this work has started (e.g., disability focal ppl), but bring in OPDs and NGOs to complement and support these efforts.
Weak accountability mechanisms and enforcement of anti-corruption laws to prevent waste of financial resources.	The URT should make efforts to submit its obligatory CRPD reports. This would increase accountability. Shadow reports must be done too. Budgets should account for allocations to disability inclusion.	URT to report OPDs/NGOs for shadow reports	UNICEF on CRC.. UN cross sector - joint program (leave no one behind pillar)
B. Where can UNICEF Tanzania focus technical assistance in the new Country Programme to strategically maximise impact on disability inclusion, for Tanzania Mainland and Zanzibar?			
Play a convening role	UNICEF should bring people working on disability inclusion together to share and learn from each other. This will improve coordination and capacity across the sector, as well as help with networking and building alliances for change. As observed by participants during the validation workshop, convening multi sectoral actors together is key for bringing about reforms. It is through such collaboration that success stories are shared, and collective problems, goals, and objectives identified. UNICEF could play the role of the convener for these actors.	UNICEF and other donor partners	Govt of Tanzania; (specific ministry that is developing the 5-year plan- National rehab plan)

Recommendation Category	Recommendation	Primary Responsibility	Key Stakeholders
Focus on disability data for under 5 years	The Washington Group/UNICEF Child Functioning Module is an adapted question set specifically designed for identifying children with disabilities. It has two sub-modules, one for children aged 2-4 years, and one for children aged 5-17 years (Washington Group, 2020). Integration of the Child Functioning Module in key surveys in URT could strengthen data on children with disabilities and facilitate disability disaggregation of data on SDGs that apply to children. <i>Including a chapter on disability in the HBS Key Indicators Report as well as in the Child Poverty in Tanzania and Child Poverty in Zanzibar publications produced in collaboration with UNICEF are other ways to improve data on children with disabilities.</i>		
Collect advocacy data	This recommendation has two related aspects. The first is that local research and evidence can also be a powerful driver of advocacy and awareness raising. For example, Box 4 highlights research on the negative economic impacts for low- and middle-income countries. Comparable figures for URT could bring together human rights and economic development arguments and support advocacy for inclusion of children and young people with disabilities. The second is that UNICEF and other donors, in collaboration with actors such as the Ministries of Policy, Parliamentary Affairs, Labour, Employment and Youth, and OPDs could help harmonise research methodologies for more consistent data both in Mainland Tanzania and in Zanzibar. Currently, there are inconsistent data reflections of disability prevalence among children and young people in both geographical territories. Effective policy interventions require more consistency and predictability in measurement.		
Walk the talk	UNICEF Tanzania should increase the number of people with disabilities employed in their offices. Consider starting an internship program for youth with disabilities.		
UNICEF cross sectoral approach	UNICEF Tanzania has a disability working group which is commendable. Ensuring that the UNICEF office adopts a cross-sectoral approach to disability inclusion can happen through sourcing a disability resource person during the next CPD process. If UNICEF does this internally then it will have a ripple effect externally.		
C. Which partnerships are key to leverage UNICEF's work on disability inclusion?			
Develop an action learning, institutional strengthening program for OPDs	This will help OPDs be ready for grants by having the right governance in place and be stronger advocates. The Tanzanian Federation of Disabled People's Organisations in both the Mainland and Zanzibar, with the support of other OPDs and other stakeholders should lobby the government to entrench disability rights in the constitution and national policies. The capacity of OPDs for advocacy, governance and their absorptive capacity requires improvement. <i>Working closely with OPDs to understand their internal governance and institutional strengths and weaknesses could help in holding the URT to account, while also strengthening OPD capacity in advocacy and mobilisation.</i>		

Recommendation Category	Recommendation	Primary Responsibility	Key Stakeholders
Develop strategic partnerships with research institutions	Research is needed to better understand the linkages between poor nutrition and disability, and the gaps in programmes and service for children and young people with disabilities relating to nutrition. <i>By building partnerships with government statistician institutions and academic institutions and even think tanks to improve disability data, the quality and availability of disability inclusive data will improve.</i>		
Fostering OPD inclusion of children	Women and young people are significantly underrepresented by OPDs. UNICEF should undertake proactive engagement with OPDs to explore partnership models that would allow for meaningful engagement of young people with disabilities, as per the principles of the CRPD. This engagement would also explore opportunities for capacity building and advocacy on (a) alignment of national legislation with regional and international obligations relating to children and young people with disabilities, and (b) improvements in domestication of international treaties and implementation of domestic laws and policies related to children and young people and children with disabilities.		
Foster a regional approach to disability inclusion	At a regional level, UNICEF should engage the EAC to incorporate disability in regional conventions and indicators. For example, the EAHRC health indicators do not include disability. Study tours across Africa to share disability inclusion good practices and lessons learned would also help to develop a regional approach to disability inclusion. Briefing URT ministers before regional events with data on disability inclusion and advocacy figures will help make URT a leading voice on disability inclusion as well as promote regional awareness for the issue.		
Foster an early identification and disability inclusive health care alliance	Given how important early identification is to life chances, there is a need for a special committee/unit to be established on this topic. It should be government led and include private, public, non-government, and UNCT members who self-select to participate and collaborate on this important topic.	Ministry of Health	Multifaceted approach is required
Foster a CRPD-compliant inclusive education alliance	While URT has adopted important legislation to advance inclusive education such as the Zanzibar Education Policy of 2006 and Zanzibar Inclusive Education Policy of 2019, the current practices of inclusive education are incongruent with the CRPD's conception of inclusive education. Inclusive education is neither "institutionalisation" of children with disabilities in "special schools" nor a mere clustering of children in one space. Nor is it a mere distribution of assistive devices. It is a more complex process of creating an enabling environment that takes away the inherent barriers to equitable access and participation of children with different disabilities. It entails sufficient training of teachers, public sensitisation and awareness raising, participation of family members, and adaptable use of facilities tailored to the students' needs. URT needs proportionate efforts, and corresponding financing, for training teachers in inclusive and gender sensitive disability education. Both the Mainland and Zanzibar also need to address the specific needs of categories of disabilities within the education sector (e.g., learning for children with intellectual disabilities). The Ministry of Education should take the lead in these reforms as well as in documenting budgetary commitments towards inclusive education support.	Ministry of Education	CSOs, OPDs - essential for advocacy President's office, Regional administration, Local government (key implementers of policy)



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