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Inclusion of persons with disabilities in social protection

Policy analysis, Tanzania

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Contents

1 Introduction

Originaltext: Morning Cataract Screening, Campana Gratuita Optalmologica para Descarte de Cataratas (in a community hall)- organised by the Municipality of Villa Maria del Triumfo with the support of the Clinica Divino Nino Jesus. The screening is free of cost and the people who work there are volunteers. Here: the technical assistant (left hand) of nurse Christina and the waiting patients. **Vorschlag:** Technical assisstant at a free morning cataract screening talking to patients.

Tanzania is a unitary republic consisting of the Union Government for mainland Tanzania and the Zanzibar Revolutionary Government. Though it is socially diverse, with about 125 ethnic groups, Tanzania has enjoyed general political stability for the past fifty years. The socialistic economic management of Tanzania of the 1970s and 1980s was followed by the introduction of structural adjustment policies, which promoted economic and trade liberalization. Since the 1990s, Tanzania succeeded in stabilising the macro economy and initiating a process of economic transformation (Dagne, 2010; JBIC, 2006).

With a growth rate of 7% in the past five years, the Tanzanian economy has been among the fastest growing in Africa. However, the benefits of this economic growth have not been shared equally among the population, such that the richest 20% of Tanzanians account for 42% of total consumption, whereas the poorest 20% only consume 7% (DMFA, 2013). In response to this growing inequity and persistently high levels of poverty, the government has begun to develop social protection mechanisms to address the state of 'generalized insecurity' within which the majority of the population still live (Wuyts, 2006; MoF, 2012).

According to the 2008 National Disability Survey (NBS, 2010), the prevalence of disability in Tanzania was 7.8% for people aged 7 years and above. The survey also found that persons with disabilities had worse socioeconomic outcomes than the general population across a range of areas, such as lower literacy rates, fewer opportunities for paid employment and lower rates of marriage. Following ratification of the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) by Tanzania in 2009, the government introduced the Persons with Disability Act (URT, 2010) to formally enshrine the rights of persons with disabilities in law and ensure their full and effective participation and inclusion in all aspects of society. The law also established various institutional mechanisms to ensure its implementation.

The objective of this paper is to critically analyse the Tanzanian policy framework relating to the inclusion of persons with disabilities into social protection systems and programmes. The analysis covers laws, policies and institutions related to disability (including definitions of disability and data collection), and investigates the degree to which these inform and influence the design, implementation and evaluation of social protection policies and programmes. Specific conditions of exclusion related to gender are also discussed.

2
Social Protection in the Tanzanian Context

Originaltext: Siblings: Nayrut and Fredy Huittoccollo Ccacha, 11 and 12 years old, Laurence-Moon-syndrome (symptoms: small obese body with diminished hormone production, cognitive impairment and progressive loss of vision. Here: Nayrut (left hand) learning the alphabet in braille.
Vorschlag: 11 years old child with Laurence-Moon-syndrome which causes cognitive impairment and progressive loss of vision learning the braille alphabet.

The government of independent Tanzania inherited a system of welfare schemes left behind by the colonial state such as the Master and Native Servants Ordinance of 1924 and the Pension Ordinance of 1954. It introduced its own National Provident Fund Act in 1964 and in 1997, the National Social Security Fund Act transformed this into a broader fund covering pensions and other benefits. The National Social Security Fund (NSSF) operates alongside five other major institutions that provide social security for people working in the formal employment sector.[1] However, given the dominance of the informal sector within Tanzania's economy, these contributory schemes currently cover only a tiny portion of the total population and 6.5% of the country's workforce (ILO, 2008). As a result, in recent years a broader conception of social protection has emerged as a key area of concern in Tanzania's macro-economic policy frameworks, poverty reduction strategies, sector policies and programmes as well as in different micro- and community-based interventions (MoF, 2010; UNICEF, 2013; World Bank, 2012).

According to the current National Strategy for Growth and Reduction of Poverty – 'MKUKUTA II' – the main objective of social protection in Tanzania is 'to prevent unacceptable levels of socioeconomic insecurity and deprivation' (MoF, 2010:81).' The strategy underscores the developmental role that social protection can play in preventing poverty traps, reducing household insecurity and encouraging investments in poverty-reducing assets that can strengthen people's resilience and capacity for self-sufficiency. Under the strategy, social protection interventions are specifically intended for 'vulnerable and needy groups', defined as 'orphans and vulnerable children; people with disabilities; the elderly; people living with HIV and long term illnesses; vulnerable women and youth; former inmates and people disabled by accidents, wars and conflicts' (ibid.).

The increasing focus on social protection also reflects a shift in the policy priorities of multilateral and bilateral development agencies that operate in Tanzania from a focus on supporting systems of social security that cover the formal workforce towards the establishment of a universal 'social protection floor' for all citizens. This shift is visible in the United Nations Development Assistance Plan for Tanzania 2011-2015, which promotes the notion of a 'social protection floor' and commits the UN to supporting a 'multi-sector coordinated approach to economic deprivation and insecurity' through investment in social protection and safety nets (UN, 2010:37). However, progress in developing such an approach has been slow and the government's planned National Social Protection Framework has been in draft form since 2008. Indeed, the failure to finalize the Framework raises serious questions about the degree to which social protection remains a primarily donor-driven agenda and, as such, to what extent the Tanzanian government is truly committed to playing a leadership role on this issue.

Nonetheless, while strategic coordination may have stalled, developments have continued at programme level:

- The World Bank-supported Tanzania Social Action Fund (TASAF) is now in its third phase and is scaling up its Conditional Cash Transfer (CCT) component alongside its existing Productive Social Safety Net programmes (PSSN);
- Community Health Funds have been brought under the management of the National Health Insurance Fund (NHIF) and coverage continues to increase, albeit at a relatively slow pace; and
- broader social security, labour market and health financing policy continues to evolve.

[1] The Public Service Pension Fund (PSPF), the Parastatal Pension Fund (PPF), the Local Authorities Provident Fund (LAPF), the Government Employees Provident Fund (GEPF) and the National Health Insurance Fund (NHIF).

The overall direction of the social protection system as a whole may remain in doubt, but the critical role social protection has to play in addressing poverty and insecurity among the poorest and most vulnerable appears to have broad acceptance. As such, it is both important and timely to investigate the inclusion of persons with disabilities in the social protection programmes that are already being implemented as well as within the emerging policy framework.[2]

[2] A major workshop in 2011, Operationalising Social Protection in Tanzania: From Commitment to Action (UNICEF & ERPI, 2011), highlighted this issue and noted that, among other things, social protection would be highly beneficial to persons with disabilities for: breaking the intergenerational transmission of poverty; increasing their capacity to become independent, productive members of society; relieving the burden of care and enabling able bodied family members to engage in economic work; and reducing shocks and stigma.

3 Persons with Disabilities and Social Protection

Originaltext: Some general information about KCMC: The Department of Ophthalmology at KCMC was one of the original departments when the centre was opened in 1971. A separate wing of the hospital houses the ophthalmic ward and theatre suite, as well as eye outpatients, optical facilities, and administrative offices. This was built with donations from Christoffel Blindenmission (CBM) in collaboration with the Good Samaritan Foundation of Tanzania (GSF). From Hedaru eye outreach, Mwanga district:.Remenziana Raphael, 95 years old, cataract. She lives in Marangu and has 5 daughters (only one of them still lives with her, Catherine Raphael Tarimo, 65 years old). Her husband already died and so, it's her daughter who helps Remenziana to handle the daily life. She is a very small woman but though tough, clever and cheeky (she wants to be called 'Bibi'- her nickname). The CCBRT fieldworker Francis Manyanga discovered the cataract one year ago and enabled (with the help of CBM) the cataract operation for free (Remenziana lives a simple life and is very poor). Her vision is very bad and she can only see dimly. She is very hopeful to see again soon and already knows what she is going to do first after having vision again: go to church, thank god and visit the neigbours and children in her village. Here: Remenziana (right hand) back home again, after her operation. Her family is already waiting for her and Remenziana is very happy. Next to her: CCBRT fieldworker Francis Manyanga. .for further information see: TZA-11-0001.pdf **Vorschlag:** 95 year old widow back home after a successful cataract operation being visited by the field worker who enabled the operation after discovering the cataract a year earlier.

3.1 Definitions of Disability

In Tanzania, the formal definition of disability has changed considerably over the past three decades and this is clearly reflected in the key policies and legal texts related to disability. Broadly speaking, the definition has shifted in-line with global developments on defining disability and there has been a transition from a medically-based focus on the perceived deficiencies of individuals to acknowledging that disability is a socially constructed phenomenon resulting from the interaction of a physical, mental, intellectual or sensory impairments with various barriers in a person's environment.

As such, while the **Disabled Persons (Employment) Act of 1982** and the **1982 Disabled Persons (Care and Maintenance) Act** adopted a narrow 'medicalised' definition, the **National Policy on Disability of 2004** redefined disability as, 'the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical, mental or social factors' (MoLYDS, 2004:vi). This emphasis on the 'social model' of disability reflects Tanzania's engagement with international debates on disability rights and the policy is seen by disabled people's organisations (DPOs) and others working in the field as a major step forward in shifting attitudes to disability away from the medical approach.

The **Persons with Disability Act of 2010** formalised the earlier definition of 'disability' in the National Policy, but also contains a separate definition of a 'person with disability', which is essentially in-line with the approach of the UNCRPD:

> *'a [person with a] physical, intellectual, sensory or mental impairment and whose functional capacity is limited by encountering attitudinal, environmental and institutional barriers'.*

Disabled people's organisations, pro-disability organisations, donors and staff within the Department of Social Welfare [3] all express support for the approach adopted within the Act. However, as will be discussed below, it is less clear how far this approach has succeeded in influencing the understanding of disability within other Ministries and government agencies at national level, or among government staff, civil society and the community as a whole at regional, district and village levels.

3.2 Data on Disability

Data on disability in Tanzania has been gathered through a number of surveys and censuses over the last three decades. Early efforts were based on a narrow 'category-based' definition of disability which required respondents to self-identify as 'disabled' and this resulted in very low prevelance figures. For example, in 1981 the Ministry of Labour and Social Welfare conducted the 'Census of Disabled Persons' in mainland Tanzania and found that only 1% of the population were persons with disabilities; [4] while the fourth national census on population and housing in 2002 estimated that 2.0% of the country's population lived with same forme of disability (NBS, 2006:42).

In 2008, a more comprehensive survey on disability was carried out by the National Bureau of Statistics (NBS) to determine the prevalence of disability and the living conditions of persons with disabilities across the country. The survey used a set of questions developed by the Washington Group on Disability Statistics based on activity limitation rather than physical condition, and with this modified methodology found the prevalence of disability to be 7.8% for people aged 7 years and above. The 2012 census, which used the same methodology, found a slightly lower figure of 5.93% of the total population, but this

[3] The department in the Ministry of Health and Social Welfare assigned responsibility for issues related to persons with disabilities, discussed further below.

[4] This information is from ILO, 2004. Unfortunately it was not possible to locate a copy of the census in the context of this study.

still represents a significant increase in comparison with earlier surveys (NBS, 2014)[5].

3.3 Policies and Legislation on Disability

The Disabled Persons Employment Act No. 2 and the Disabled Persons Care and Maintenance Act No. 3 were the first major pieces of legislation on disability in Tanzania. In combination they were intended to secure employment for persons with disabilities through a quota system and reservation of posts, while designating specific responsibilities for care needs to government, families and civil society. However, not only were the two acts quite narrow in focus – with a particular emphasis on employment – but in practice they were neither effectively publicized nor enforced by the Tanzanian government (Aldersey, 2012:5).

To address these shortcomings, the government introduced a National Policy on Disability in 2004. The policy sought to empower persons with disabilities and their families, provide a conducive environment for them to engage in productive work, improve services for persons with disabilities and ensure their participation in all aspects of society including decision making. However, as Aldersey and Turnbull note, the policy has a number of major weaknesses including 'the unclear elaboration of administrative core principles, the lack of explicit concrete steps or solutions to advancing the policy statements, and the absence of judicially enforceable remedies for violation of [the policy]' (2011:10). Following ratification of the UNCRPD in 2009, the Tanzanian government therefore decided to enact the Persons with Disabilities Act (2010) in order to give legal effect to both the National Policy on Disability and the UNCRPD. The Act covers many areas in which the rights of persons with disabilities may be compromised – including equal access to education, health and employment – and provides legal and social accountability mechanisms for practical implementation. Examples of this include the establishment of a National Advisory Council, the creation of the office of the Commissioner for persons with disabilities, a more rigorous implementation of a workplace quota system, and the establishment of a National Fund for Persons with Disabilities (Aldersey, 2012:4).

However, despite progress in the enactment of legislation and policies related to disability, Tanzania faces very significant challenges in the implementation of the law and the policy, as well as in honouring Tanzania's commitments related to the UNCRPD[6]. For example, in 2010, the Ministry of Health and Social Welfare launched a National Mainstreaming Strategy intended to mainstream disability into all government policies, programmes and budgeting. Despite a high profile launch and a foreword from the Minister of Health and Social Welfare, most government staff are unaware of the document and there are no concrete examples of its implementation among any of the various ministries identified in the strategy. Similarly, MKUKUTA II contains several references to the needs of persons with disabilities but there are only two specific indicators in the Monitoring Master Plan developed by the Ministry of Finance (2011)[7].

3.4 Institutional framework

The Persons with Disabilities Act specifies a range of responsibilities for key ministries[8] that sit alongside civil society representatives on the National Advisory Council for Persons with Disabilities (NAC). The NAC is supposed to act as forum for advising the Minister

[5] The summary below is based on the 2008 survey as detailed findings from the 2012 census were not available at the time of publication.

[6] Despite the requirement to submit a report on implementation of the Convention within two years of ratification, Tanzania has yet to do so.

[7] The distribution of population by occupation disaggregated by sex, age, and disability; and the proportion of children (5 years +) with disabilities attending school.

[8] These are health, local government authorities, public service management, community development, labour and education. See also Table 1.

on all matters related to the Act and to persons with disabilities in general, including the formation of relevant policies and programmes. The members of the NAC were appointed in May 2014 but, as of December 2014, the Council had met only once and had no budget allocation to support its activities.

The Ministry of Health and Social Welfare has been assigned overall responsibility for persons with disabilities through the Department of Social Welfare. The Department is supposed to ensure the provision of effective welfare services for 'vulnerable groups' in society. However, it continues to face a range of challenges in relation to the provision of services for persons with disabilities. The Department has been moved four times since its establishment, most recently in 2006 from the Ministry of Labour and Youth to the Ministry of Health. It is still physically located away from the Ministry of Health headquarters and is widely perceived as marginalised within the Ministry structure. Staffing levels are low within the Department and it receives a very limited budget allocation. A capacity assessment by Ernst & Young (2009) found that the Department's management was competent but not efficiently performing its role and that the leadership was not sufficiently aware of the challenges facing the Department nor how to tackle them. Many stakeholders, both from government and civil society, express the view that moving the Department to the Prime Minister's Office or the President's Office would be necessary to give it sufficient visibility and political influence, a view also expressed recently by the Parliamentary Committee on Social Welfare.[9]

In addition to the responsibilities of the Ministry of Health and Social Welfare, the Persons with Disability Act requires a variety of other ministries to develop 'sectoral plans' outlining measures to be taken relating to persons with disabilities. However,

Table 1: Key Line Ministries

Ministry	Responsibility
MoLE	Implementing National Employment Policy (2008) and Employment and Labour Relations Act (2004), responsibilities include the enforcement of minimum quotas for employment of persons with disabilities
MoEVT	In charge of providing educational services for persons with disabilities at the primary, secondary and tertiary levels. The Ministry is tasked with providing education in special schools, integrated units and in inclusive educational settings. Also oversees vocational education through the Vocational Education and Training Authority (VETA) which includes the training needs of persons with disabilities.
MoW	Responsible for overseeing the construction industry and ensuring that buildings and transportation infrastructure are accessible to persons with disabilities.
RALG	In charge of Local Government Authorities, which have been given a crucial role with respect to service delivery for persons with disablities at regional, district and ward level.
President's Office, Public Service Management	In charge of ensuring that persons with disabilities occupy the allocated vacancies in the public service and that there are adequate public facilities for persons with disabilities
MCDGC	Responsible for issues related to women and children with disabilities.

MoLE=Ministry of Labour and Employment
MoEVT=Ministry of Education and Vocational training
MoW=Ministry of Works (formerly Ministry of Infrastructural Development)
RALG=Regional Administration and Local Government (Kiswahili TAMISEMI), in Prime Minister's Office
MCDGC=Ministry of Community Development, Gender and Children

[9] Interview

with the exception of the Ministry of Health and Vocational Training which has developed a 'National Strategy on Inclusive Education' (2009), none of the Ministries has yet developed a sectoral plan or similar policy document and awareness of this responsibility among government officials is very low.

Other responsibilities are specified in relevant sectoral policies and legislation, as summarised in Table 1. However, despite these provisions, there is very little awareness of existing laws and policies on disability among government officials and a perception that this is the responsibility of the Ministry of Health and Social Welfare. Rather than implement specific activities, ministries such as the Ministry of Community Development, Gender and Children and the Ministry of Labour and Employment argue that persons with disabilities will be included within their general programmes. However, as disaggregated data is not collected on beneficiaries with disabilities, no evidence is available to support these claims.

In addition to government departments, disabled people's organisations (DPOs)[10] are also represented on the NAC and have been active in advocating for the rights of persons with disabilities alongside national and international pro-disability organisations. Many of the pro-disability organisations directly provide services for persons with disabilities in addition to their role in advocacy, but even the larger organisations are unable to provide national coverage for their services (the exception being the national referral network the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) has developed for obstetric fistula). As such, there is broad acceptance within the disability movement of the importance of improving the government's implementation of its owns policies and laws, and disappointment at the absence of concrete actions in this regard.

The other key element within both the 2004 policy and the 2010 act is the role for Local Government Authorities (LGAs). The Act requires LGAs to perform a number of roles, including safeguarding and promoting the rights and welfare of persons with disabilities, providing assistance to persons with disabilities to enable them develop their potential, and keeping and maintaining a register of persons with disabilities. However, in practice, LGAs receive little or no training on disability, and the Department of Social Welfare is unable to measure and monitor Council spending on this issue.[11]

3.5 Social Protection and Disability

3.5.1 Formal Social Security

The National Provident Fund Act of 1964 was amended in 1975 and transformed in 1997 into a broader social security fund covering pensions and other benefits: the National Social Security Fund (NSSF). NSSF, together with a number of other formal schemes,[12] forms the core of mandatory and contributory schemes providing social security in Tanzania. All these schemes are regulated and supervised by the Social Security Regulatory Authority (SSRA), which was established in 2008 and became operational in 2010.

NSSF is the only programme with formal entitlements for disability known as an 'invalidity pension'. The pension provides 30% of the average monthly earnings of the insured person supplemented by 1% of the average monthly earnings for every 12 months of members' contributions. It is payable permanently, commencing with the month following the

[10] DPOs are coordinated through the Tanzania Federation of Disabled People's Organizations, SHIVYAWATA, which altogether has ten affiliated organisations: Tanzania Albino Society (TAS); Tanzania League of the Blind (TLB); Tanzanai Society for the Deaf (TSD); Tanzania Association of the Physically Handicap (CHAWATA); Tanzania Society of the Deaf (CHAVITA); Tanzania Association of the Deaf – Blind (TASODEB); Tanzania Association for the Mentally Handicap (TAMH); Kilimanjaro Association of Spinal cord Injuries (KASI); Psoriasis Association of Tanzania (PSORATA); Tanzania Users and Survivors of Psychiatric Organization (TUSPO).

[11] LGAs operate under the oversight of Regional Administration and Local Government within the Prime Minister's Office.

[12] The Public Service Pension Fund (PSPF), the Parastatal Pension Fund (PPF), the Local Authorities Provident Fund (LAPF), the Government Employees Provident Fund (GEPF) and the National Health Insurance Fund (NHIF).

date the person has to stop working and ending either on pensionable age, if at that time the insured person is entitled to retirement pension at the same or a higher rate, or on the death of the beneficiary.

Although the National Social Security Policy of Tanzania adopted in 2003 conceives social security quite broadly as 'any kind of collective measures or activities designed to ensure that members of society meet their basic needs and are protected from the contingencies to enable them maintain a standard of living consistent with social norms' (MoLYDS, 2003:2), it recognises that there are both informal and traditional social security systems as well as formal ones, and notes that the formal social security system covers only a small section of the total working population (5.4% at that time). The policy identifies three key elements of social security: social assistance, mandatory schemes and private savings. The first of these is conceived of as non-contributory and income-tested for 'groups such as people with disabilities, elderly people and unsupported parents and children who are unable to provide for their own minimum needs.'

3.5.2. Social Protection Policies

The latest draft of the National Social Protection Framework (from June 2012) identifies persons with disabilities as an 'area of focus' amongst other vulnerable groups [13] and calls for a number of specific interventions:

1. Awareness creation on the rights of persons with disabilities at all levels and facilitation of health providers (duty-bearers) in both state institutions and non-state institutions to identify children with disabilities at an early stage and provide mechanisms to meet their needs (e.g. financial and in-kind support in the form of cash transfers to the extremely poor);
2. Development of systems and modalities to facilitate access to exemptions and waivers in basic services and related opportunities for persons with disabilities (e.g. reduce conditions for accessing microfinance credits);
3. Operationalisation of international and regional conventions for persons with disabilities as adopted and ratified by the government and reporting on the same;
4. Enforcement of regulations and bi-laws that fulfil the needs of persons with disabilities.

However, despite these provisions, organisations in the disability movement express concern about their lack of engagement in the process of developing the framework and, given the length of time it has been in draft form and the uncertainty regarding its relationship to the Social Security Policy, it is unclear to what extent the framework will play a role in actively shaping Tanzania's emerging social protection system.

In addition to the draft framework, Tanzania has been reforming its health financing regime, moving from a purely budget-financed system in the early 1990s to a mixed financing model with the hope of increasing the availability and quality of care. Key elements of the system include user-fees (introduced in 1993), Community Health Funds (from 1997 onwards) and the National Health Insurance Fund (established in 1999) which were introduced to leverage additional funds, build community ownership and create stronger accountability of service providers (Stoermer et al., 2013). According to the 2010 National Health Accounts (MoHSW, 2012), government budget accounts for only 17.6% of total health expenditure, far less than the 31.9% which households contribute through out-of-pocket expenditures, raising serious equity concerns (ibid.). Currently, the two main social health protection schemes – the Community Health Funds (CHF) and the National Health Insurance Fund (NHIF) – cover approximately 7.8% and 5.8% of the total population respectively; while around 3% of Tanzanians have private insurance and 1% are covered through the National Social Security Fund.

With the exception of the 'invalidity pension' under NSSF, none of these schemes contain any specific

[13] These are: orphans and vulnerable children, the elderly, people living with long illnesses including HIV/AIDS and extremely vulnerable women.

provisions for disability (this will be discussed in relation to CHF below). Further, at the time of publication the latest draft of the Health Financing Policy (due to be approved in 2015) contained no reference to disability at all, nor had there been any consultation with persons with disabilities during the development of the policy.

3.5.3 Tanzania Social Action Fund

The Tanzania Social Action Fund (TASAF) is a semi-autonomous government agency located in the President's Office implementing poverty reduction programmes all over Tanzania. TASAF was created in 2000, receives the majority of its funding from the World Bank and is now in its third phase. A conditional cash transfer was included as a pilot in the second phase and is being scaled-up under TASAF III (2013-2017), under the title of the 'Productive Social Safety Net' (PSSN). The PSSN focuses on poor households and is intended to provide regular cash transfers to all households identified as poor as well as additional amounts conditional upon increased use of education and health services for families with children or pregnant women (TASAF, 2013). The conditionalities are designed to ensure that children are enrolled and attending school and that pregnant women and children visit health facilities so as to foster long-term improvement of health and nutritional status. Payment to beneficiary households is every two months and all families receive a basic payment of approximately 5 USD, while those with pregnant women and children receive an additional 5 USD after verifying compliance with conditionalities. Between 2012 and 2017 TASAF as a whole is expected to reach 1 million direct beneficiaries through 275,000 targeted households (ibid.).

A key feature of TASAF's approach is its emphasis on community management of the cash transfer component. Once a village has been selected, a 'Community Cash Transfer Management Committee' is established with community representatives elected during a village assembly and this committee identifies potential beneficiaries of the programme and, subsequently, manages the basic and conditional transfers. Following the community-based targeting process, a household questionnaire is used by TASAF as a proxy means test for verification at central level to minimize exclusion and inclusion errors (ibid.).

TASAF staff maintain that there has always been a focus on households with members with disabilities within TASAF. In practice, this is reflected primarily in the inclusion of disability within the targeting tool used at central level for verification of the list provided by the community. In addition, TASAF staff explained that children with disabilities can be exempted from the education conditionality if they are unable to attend school. However, persons with disabilities were not involved in the development of the questions nor in the provision of training for the users of the tool and the data collected on disability has never been analysed. Data is also not available on the number of children exempted from conditionalities and no process is in place to address the causes of exclusion where children are not in school. Staff members of the Department of Social Welfare sit on the board of TASAF and claim to have raised the issue of disability on a number of occasions, but no specific meetings have been held on the issue.

3.5.4 Community Health Funds

Community Health Funds (CHF) in Tanzania started as a pilot scheme in 1996 in Igunga District, supported by the World Bank as part of their activities on health and nutrition. The scheme was designed to address both health financing gaps and poor quality services while maintaining the government's commitment to equity of access (Msuya et al., 2004). In 2001 through an Act of Parliament, it was extended to cover all districts. The scheme operates in partnership between districts and the national government. Households pay contributions on a regular basis to finance basic health services at a district level and for each household that joins, the national government provides a 'matching grant' to the district. The contribution paid by households is designed to compare favourably with the existing average per capita out-of-pocket expenditures for health, and for those who cannot pay the Act of Parliament describes a process for exempting individu-

als from payment and providing them with a free card (ibid.).

The Health Sector Strategic Plan III (MoHSW, 2009) set a target of reaching 30% of the national population through CHF by 2015, but as of 2013 coverage was estimated to be only 7.8% (Stoermer et al., 2013). This is a result of both low coverage within operational schemes and slow establishment of new CHF schemes in Districts yet to be covered. However, the speed of establishment has recently increased and, as of September 2014, there were 137 active local government councils involved in CHF with a target of having all 168 councils in the country active by early 2015 (Pers. Comm. NHIF, 2014).

In 2009, the NHIF took over the management of the CHF to increase insurance coverage and improve efficiency of operations and access to services. Although the supervision of the CHF has been successfully integrated within the NHIF organisational structure, a number of challenges remain in areas such as overall strategic and policy leadership, the processing of matching fundings and improvements in district level CHF management (Borghi et al. 2013).

Any household is eligible to become a member of their local CHF, but in recognition that some individuals and households will be unable to pay, the CHF Act (2001) requires District councils to provide exemptions for those who cannot afford the contributions. The provisions for exemptions within the CHF Act and related policies do not contain any specific guidance related to persons with disabilities. Some efforts have been made to pilot approaches to the inclusion of elderly people within CHF[14], but no similar initiatives related to disability have been tested.

During interviews at district level, officials confirmed that no efforts had been made to target or include persons with disabilities, noting instead that an increase in overall enrolment would be sufficient to increase enrolment of vulnerable groups, including persons with disabilities. In the context of the very limited engagement of disabled people's organisations and pro-disability organisations in policy debates at the national level about the CHF – and health financing in general – it is reasonable to conclude that to-date there have been no specific initiatives to make the CHF more inclusive of persons with disabilities.

Table 2: Comparison between CHF and TASAF

Programme	CHF	TASAF
Objectives	District-based health insurance scheme providing affordable healthcare to people living in rural areas	Enable poor households to increase incomes and opportunities while improving consumption
Target population	Informal sector with exemptions for poor households (locally defined)	Poor households (locally identified) in target villages
Coverage	130 mainland Tanzania districts (2014), covering between 5% and 15% of population	All districts in mainland Tanzania and isles in selected villages with high poverty levels
Funding	Member contributions and 'matching grants' from Government of Tanzania	World Bank, other donors and Government of Tanzania
Attention to persons with disabilities	No specific measures in place. No data on number of persons with disabilities enrolled in CHF.	Questions on disability in questionnaire used at central level for verification of community targeting. Exemptions for children with disabilities who cannot attend school (decision made at local level). No data available on number of persons with disabilities enrolled in programme or use of exemptions.

[14] Supported by HelpAge International

4
Gender Analysis

Originaltext: Grace together with CCBRT community worker Janeth (32, right). Janeth visits Grace twice a month to see her development and gives advice to her mother. Grace is sitting in her new wheelchair, given to her by CCBRT. Grace (10 years old) has Cerebral Palsy (Athetoid). She lives in a village near Moshi on the slopes of Mount Kilimanjaro/Tanzania. Since 2007 she has been a client of CCBRT Moshi. A community worker of CCBRT visits her regulary. Grace has been through a long rehabilitation process. It took years before she could sit and stand. Walking alone is not possible. CBRT provided a wheelchair to her for better mobility. Today she can attend a Pre-school (Kindergarten), is learning figures and writing. A little success story. **Vorschlag:** 10 year old girl with Cerebral Palsy (Athetoid) in her new wheelchair. A community worker of CCBRT visits her regulary.

Tanzania has a Women and Gender Development Policy (2000) and a National Strategy for Gender Development (2005) both of which aim to redress gender gaps and inequalities between men and women. Gender equality targets are also clearly stated in MKUKUTA II and the latest Five Year Development Plan (2012) emphasizes women's economic empowerment as a means of bringing about equality between men and women. The Ministry of Community Development, Gender and Children is responsible for monitoring the implementation of polices on gender equality and women's empowerment at different levels of administration.

Tanzania has made notable progress in some areas such as increasing the number of women in politics and decision making positions, and is among only 28 countries in the world with at least 30% female Parliamentarians (UN Women, 2012). At the legislative level, there is a functional Parliamentary Committee on Social Welfare and Community Development responsible for overseeing promotion of gender equality, and the current draft of the new constitution guarantees a range of rights to women including protection against discrimination, humiliation, injustice, cruelty, gender based violence and antiquated customs; the right to participate without discrimination in all levels of decision making on an equal basis; and the right to equal treatment in the workplace.

In the absence of other major studies or surveys, the primary source of data on gender and disability remains the 2008 National Disability Survey. The survey did not find significant differences in overall disability prevalence among males and females (7.7% among men compared with 7.8% among women), with rates of disability among men in rural areas slightly higher (8.5%) than that of women (8.2%), while in urban areas women were more likely to have a disability (6.7%) than men (5.8%). However, men were more likely to be involved in a relationship (62.5%) than women (47.4%), and women were also more likely to be divorced. Women were also less likely to use an assistive device than men (47.% versus 5.2%) and less likely to report that their physical environment or attitudes of others made it easier to undertake complex activities.

The National Strategy for Gender Development refers only very briefly to disability and contains just one specific objective related to the inclusion of men and women with disabilities in developing gender sensitive media programmes. However, the Persons With Disabilities Act of 2010 has a number of specific provisions with regard to disability and gender including the promotion of equality and elimination of all forms of discrimination and the recognition that persons with disabilities of all ages and gender have the same rights to education, training in inclusive settings and the benefits of research as other citizens. In addition, the Persons With Disabilities Act of 2010 states that particular attention should be paid to ensuring that women and older persons with disabilities have adequate access to social protection and poverty reduction programmes.

There are no existing government programmes with an explicit focus on issues related to gender and disability and no specific research has been undertaken in this area. Some civil society organisations provide services that target women with disabilities, such as CCBRT who piloted a day care centre for children of women with disabilities, so that they can engage in economic activities. CCBRT's whose activities around maternal and newborn healthcare – including the construction of a 200 bed referral facility for high risk and emergency deliveries – aim to reduce preventable disability arising from complications during childbirth.

There is a general perception among key informants that the disability movement as a whole is dominated by men, with few leadership positions in disabled people's organisations occupied by women and no organisations that currently focus on this issue specifically. In relation to social protection specifically, beyond the general provisions in the Persons with Disability Act, very little attention has been given to this issue. The draft National Social Protection Framework makes no mention of gender issues in the set of interventions it describes targeted at persons with disabilities and, at the implementation level, the absence of structured interventions for persons with disabilities precludes a more nuanced approach to differences in the experience of men and women with disabilities in these programmes.

5 Conclusion

Originaltext: Joel (4) and Stella (9), cataract, successful cataract surgery. Project partner: KCMC (P0393). Picture: Stella after surgery. Eye examination for getting glasses. **Vorschlag:** Girl at an eye examination after surgery. She will next be fitted with glasses.

Tanzania's formal definitions of disability have evolved to reflect the social model and are in-line with the UNCRPD, but these developments are not yet reflected in the understanding of many government staff, both at national and local levels. Progress has also been made in terms of data collection on disability, with the National Bureau of Statistics active in incorporating questions on disability into censuses and national surveys, but this data is not yet being actively used to plan and improve public programmes.

The current policy and legal framework for disability – and in particular the Persons with Disability Act 2010 – represents a major improvement on previous legislation and is widely supported by DPOs and others within the disability movement. However, implementation of the legislation is almost nonexistent. This includes both specific provisions in the Act that fall within the responsibility of the Department of Social Welfare in the Ministry of Health, and the mainstreaming of disability into the policies and strategies of key ministries identified within the law.

Against this background, there has been no systematic effort to make the social protection system within the country more inclusive of persons with disabilities. Mkukuta II refers to disability on a number of occasions, but it does not form a significant part of the monitoring framework and implementation of the strategy as a whole remains very limited. The 2012 draft National Social Protection Framework contains multiple references to disability, including a number of specific interventions in its indicators, but it remains unclear if and when the framework will be agreed by government and many organisations within the disability movement expressed concern at their lack of involvement in its development. In contrast, the draft Health Financing Policy contains no reference to disability at all.

At the programme level, the incorporation of questions on disability into TASAF's household verification questionnaire is a positive development, but to-date this data has never been analysed or used to improve the programme and, once again, the disability movement was not consulted during the design process nor involved in the training of staff. Similarly, the exemption of children from the education conditionality if they are unable to attend school prevents households from losing their benefits, but does not address the longer-term exclusion of children with disabilities from the education system.

In relation to the Community Health Funds, even less attention has been paid to the needs of persons with disabilities, both at the national and district level. The criteria for exempting and enrolling those who cannot afford to pay is decided locally and many districts do not appear to have a process in place at all. Where they do, there is no evidence to suggest that the additional costs and health needs of persons with disabilities are taken into account, nor does the design of the benefit package itself conditions their particular needs.

Thus, despite a policy and legal framework in Tanzania that asserts the rights of persons with disabilities to enjoy equal access to public services, including social protection programmes, this has yet to be translated into meaningful action either at the system or the programme level. The data being collected on disability at the national and programme level could potentially provide the basis for attempts to make existing programmes more inclusive, as well as to ensure that the system as a whole is more responsive to the needs of persons with disabilities. However, for this to take place, much greater attention needs to be paid at both the policy and political level to the need for disability inclusive social protection programmes as well as to the practical and technical challenges of making existing and future programmes more inclusive.

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