Disability Prevention and Rehabilitation Services

Karagwe District, Kagera Region, Tanzania

“A pilot project to include persons with a disability into the society with all their human rights.”

Huduma ya Kuzuia Ulemavu na Utengamavu

A partnership of:
District government of Karagwe
Community leaders’ village/ward Karagwe
Benjamin Foundation Netherlands
Community Based Inclusive Development Organization

“All people have the same rights all over the world, to be loved, to be cared for, to be protected, to be educated, to get proper healthcare, to be part of an inclusive society and to be treated with dignity and respect. Why would we treat some different?”

“Each person in this world is having abilities and disabilities, why focussing for some on the abilities while for others we only look at their disabilities”?

“Let’s look at the abilities for all and strengthen them, everybody needs different help to accomplish their goals and reach their highest potential.”

“Let us all work together to have all persons with a disability be treated the same as all people and help them to become a valuable member of our society and have all possible measurements in place to prevent others to become disabled.”

“THANK YOU!”

ACRONYMS

CBIDO	=	Community Based Inclusive Development Organization
KCBRP	=	Karagwe Community Based Rehabilitation Programmes
CBR	=	Community Based Rehabilitation
CBRF	=	Community based Rehabilitation facilitator
VRW	=	Village Rehabilitation worker
CBID	=	Community Based Inclusive Development
ACT	=	Anglican Church of Tanzania
IGA	=	Income Generating Activities (IGA)
PWD	=	Persons with a Disability
CYWD	=	Children and Youngsters with a Disability<25 years
CWD	=	Children with a disability<18 years
YWD	=	Youngsters with a disability>17 and <25 years
DPRS	=	Disability Prevention Rehabilitation Services

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Summary

CBIDO, started as an organization in 2019, but already gained many years of experience under KCBRP in Kayanga Karagwe serving both Karagwe (18 villages) and Kyerwa (2 villages) Districts. CBIDO is working according the CBR approach/strategies with as much as possible the focus on CBID, to support and promote inclusion of PWD in their own communities. CBIDO is focussed on Children and youngsters with a disability (below 25 years old), and support them through different interventions. Families and the community are cost sharing to be able to reach more children.

In 2019 CBIDO developed a new Strategic Plan, to move from long term beneficiaries' aid to short term interventions, to prevent dependency and to be able to support more CYWD for programme sustainability. The focus with much emphasis on disability prevention.

As of the budget year 2021/2022 CBIDO wants to start a pilot project to work in collaboration with the local government of Karagwe district, with the aim to join forces and budgets, to improve the services and inclusion of PWD and to make their interventions durable and continuous. Currently CBIDO is running the interventions and assist the CYWD. In this proposed pilot project, the interventions will be run under the local government, at ward level. CBIDO will be the government's partner in co-funding and support the full implementation, training local staff and advising in implementing the **DISABILITY PREVENTION AND REHABILITAION SERVICES (DPRS),** CBIDO will be involved for 4 years, and will be cost sharing with local government, with the help of the community, to start up this program. The cost sharing will gradually decrease from 80% to 0% within the 4 years towards the District basket budget. After CBIDO exits from a ward after these 4 years, the ward and District will continue under the government's supervision, with offering the services and continuing the program. After CBIDO will move to the next wards, to start the same. With e.g. 8wards, this will mean that each year 2wards enter and 2 others exit from CBIDO's involvement. That is around 5 to 6 villages. There will be also close cooperation with other organizations like Non-Governmental Organizations, local businesses, churches and governmental organizations for referrals and possible co-funding. The pilot will start with 3 wards, to be able to have an agreeable size to pilot.

The main objectives are:

- To strengthen the existing healthcare service delivery in 5 dispensaries of Chonyonyo, Rugera and Kihanga wards particularly maternal and child care to prevent birth defects and (childhood) disabilities by 2024.

- To increase community awareness on disability-inclusive societies, in order to improve access to healthcare, education, livelihood opportunities and participation in social life for people with a disability by strengthening local systems in 3 wards of Chonyonyo, Rugera and Kihanga by 2024.

After consultation with the central government, the pilot will be focussing on one ministry at the same time, to enhance supervision, while covering 4 ministries, due to the holistic approach of PWD inclusion.

The first focus is on prevention, many disabilities are developed during the first 1000 days from conception (pregnancy), delivery up to their 2nd birthday). To prevent this the current ward health facilities (local Dispensaries) are strengthened to be birth centres, with an Ultrasound machine, monthly antenatal visits(clinics), delivery in the health facility, and monthly postnatal visits (0-5 years) and all vaccinations according to National immunization schedule. Also due to improved antenatal services more risk pregnancies referred to hospitals to prevent complications.

The second focus is to create an inclusive society where PWD can participate in the same way as their age mates, using the 5 pillars of CBR. In Health to improve their physical conditions, through operations, therapies and assistive devices.

In the 3rd year the focus will change to access to education through special Units in the program wards/villages and in the second 4-year cycle a special boarding school covering the district, to be able to offer education on the level of the child.

During all 4 years projects will be initiated which will be implemented by CBIDO with support of the local communities, like in education making public schools being accessible to CYWD and start home schooling, in livelihood, creating places where youngsters can learn skills to become self-reliant, in empowerment to assist

in business training and starting IGA's for both parents and PWD and in social to create awareness, self-acceptance, acceptance by the community and inclusion in the daily life like visiting social events and religious houses.

Scope of the Work

Currently CBIDO operates in Karagwe and Kyerwa Districts of "**Kagera"** Region in Tanzania. The pilot Project will start in Karagwe and later when successful be rolled out to other districts in Kagera. If also embraced by other partners like KCBRP, it can be rolled out to the whole lake zone via their Partner Organizations and their government leaders in different regions of Lake Zone Geita and Mwanza and their districts.

But the first scope via CBIDO is to introduce this program in Karagwe and later to surrounding districts, and make it successful together with the different levels of the Government and CBIDO's local and international funding partners, and their patron (strategic Partner), Benjamin Foundation Netherlands.

Kagera region and especially Karagwe district is a remote part of Tanzania close to the border with Uganda and Rwanda in the furthest corner of Tanzania far away from the Business and political cities of Dar Es Salaam and Dodoma respectively

Karagwe residents mostly depend on small scale farming, animal keeping and small trading (entrepreneurships). Many families in the rural areas are very poor, especially the ones with CYWD, many are not going to school which means parent(s) need to take care for them 24/24,which means they are partly not able to get work or work in their farm, which increases their poverty even more.

There is also much stigma around, fathers leave their family and blame the mother, children are locked up, children are not shown to others or included in social activities because parents haven't accepted their children and are ashamed of having them. Also there are still strong believes in witchdoctors/ herbal doctors who are saying children are having the devil in them who need to be chased out, or think the condition is curable or can be reversed.

CBIDO currently works in 20 villages. The aim is to continue working with 20 villages (5-8 wards) in 4 zones (Rwambaizi, Nkwenda, Bushangaro and Rugu), and according to funding and positive evaluation in the DPRS program, to scale this number up. In 2022 with the start of the pilot in 3 wards, it means the current 20 villages will be exited and the program to return to them when their wards will be included in the new approach DISABILITY PREVENTION AND REHABILITATION SERVICES in partnering with the government. That means in the coming year CBIDO want to phase out from the current way of working and to change completely to this new approach.

We aim to support each 4 years around 1200-1500 children with disabilities. With around 200-250 children per ward. With a focus of lobbying relevant Tanzanian Government authorities for integration of the program Districts development plans or beyond by 2024.

Some key figures[1]

- Karagwe has a population of 439,500 inhabitants of which 57% below 21 years old
- There are 4 townships and 23 wards with 77 villages, including the sub villages of townships 90 villages.
- Each year there are around 18,740 new-borns of which around 6% are born with birth defect.
- The growth rate of the population is currently around 3 to 4 % yearly
- 2% of all children have a disability, which is an average of around 60 CYWD per village.
- Around 5500 CYWD (<25Yrs) live in Karagwe, total PWD is estimated to be 8,800.
- Of school going age only around 8% is enrolled in school.
- 43/1000 child mortality within 28 days and (54/1000 mortality <5 Years). That means yearly over 1000 children die within their first 5 years.
- 556/100,0000 maternal mortality.(National Level Tanzania 2015/2016)
- Only 40% of mothers go for antenatal, and 56% for postnatal checkups and 67% takes folic acid.
- There are only 2 health centres/hospitals with ultrasound in the district and only 2 with a full lab and where Caesarean Section can be done.
- 38.9% of the children have stunted growth and 8% is malnourished.

Map Kagera Region: Karagwe District

Looking at these figures the need is clearly seen to work on all areas, prevention to reduce mortality, birth defects, disabilities, etc. By use of CBR strategies it is possible to improve the situation of the existing and newly born CYWD. In This concept the different interventions and goals are given how to improve the lives of many PWD within Karagwe District and hopefully to a wider extent in the future.

[1]Figures for 2018 from various Karagwe District offices

Background of the Organization and Activities

The Community Based Inclusive Development Organization (CBIDO) is a not-for-profit Non-Governmental Organization (NGO) based in Karagwe District of Kagera Region, Tanzania. CBIDO-Kagera is registered in 2019 with a registration number 00NGO/R/0659 with a legal mandate to operate nationally. The organization works under the Trusteeship of the Anglican Church of Tanzania, Diocese of Kagera.

CBIDO- main preoccupation is enhancing the quality of life, dignity and inclusion of Persons with Disabilities – particularly, Children and Youngsters with Disabilities (CYWD). Since it became operational in January 2019, CBIDO- has been implementing programmes in the areas of healthcare, inclusive education, socio-economic empowerment, social inclusion and livelihood of PWD and their caregivers/families.

The major strategies explored by CBIDO-Kagera to arrive at its mission include offering rehabilitation and care services, advocacy for inclusion and improved conditions for CYWD and capacity development of CYWD and their caregivers. Two other equally important strategies are networking with other service providers/referral systems as well as documentation/evidence building.

CBIDO- pursues participatory programme approaches that entail working closely with PWD, their families and complementary multi-level stakeholders, both State and Non-State-Actors (NSA). At community level, CBIDO-Kagera works with Village Rehabilitation Workers (VRW), who makes weekly home visits to supported CYWD. These are besides regular mobile village health clinics, often attended by doctors from local hospitals. Further, CBIDO-Kagera has full access to a central KCBRP rehabilitation Centre where CYWD receive intensive physiotherapy. The rehabilitation Centre is also used to train parents/caregivers of the CYWD and volunteers.

Our History

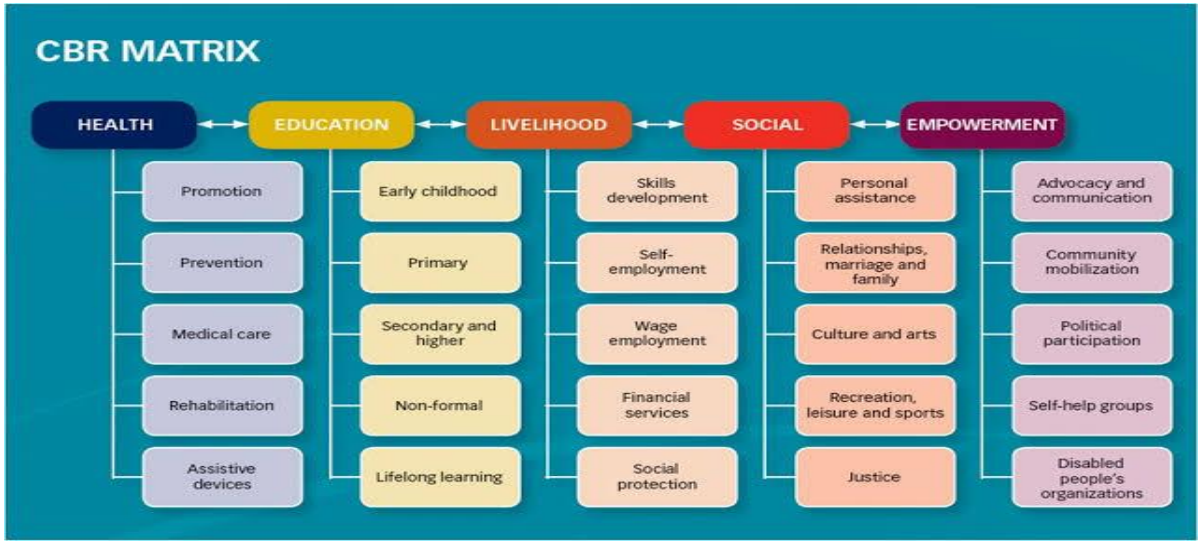
Although having started operating as an independent legal entity only in 2019, it is noteworthy that CBIDO-Kagera was crafted out of the KCBRP that has been working in Karagwe since 2004. Thus, although legally young, CBIDO-Kagera inherits 15 years of experience of CBR/CBID programming in Karagwe and Kyerwa. This includes a legacy of community structures, relationships and human resources.

Our Approach

CBIDO is using, Community Based Inclusive Development approach (CBID). This is an approach which is person centred and community focussed. Our work is based on the CBR, Community based Rehabilitation model shown down here, using the 5 pillars. This model is looking holistically at the Child and the fields to work on to reach a full inclusive life.

CBIDO is doing an assessment for each child looking at these 5 pillars. These assessments are done by the CBR facilitators. During the assessment the situation of the parents is taken into account, like living conditions and economic status. For the child, their guardians/parents and the whole community an action plan is being made, how to help that individual child in the best way. Guardians are always requested to contribute according to their capability, to cost share and being involved. After the assessment the different interventions referred to, will start in a logical order according to the highest priority.

We work with 20 different program villages, each having around 60 children within the program, which means around 1200 children.



Health & Rehabilitation

Children are being visited during **HOME VISISTS** for assessments and for follow up. Every month **OUTREACH CLINICS** are being done to reach many children with the same medical problem, in one village. In case children have operable physical conditions, they can be supported partly for an **OPERATION** in one of the district, provincial or Lake Zone hospitals. In case after an operation or the physical condition is not operable **ASSISTIVE DEVICES** can assist to improve the mobility of the PWD.

After an operation or if not operable **PHYSIO THERAPY** can be the solution to rehabilitate or improve their condition. For children who are not able to do daily house activities, like washing, toileting etc. **OCCUPATIONAL THERAPY** is an option to learn these skills. Many children, are malnourished due to shortage of food, but also often due to a lack of knowledge of their parents, through **NUTRITIONAL ADVISE/TRAINING** we make sure parents are knowledgeable in what to plant and what and how to cook. Many CYWD and their parents have many psychosocial problems, due to poverty, but often due to their conditions and the way they are treated. They learn to accept their condition or the one of their children and how to live with their problem through **COUNSELING.** The last is prevention or health insurance to be able when something happens; the hospital is financially accessible through **CHF/ NHIF registration.**

Education

Many CYWD are staying at home because the local schools are not accessible for them, due to their impairments. Just a few schools are accessible currently, but many more are needed. Some children with e.g. hearing and seeing impairments are being referred to **SPECIAL SCHOOLS,** which are focussed on education with assisting aids to serve them the best. Many children, especially those with mental disability, have never gone to school.

Livelihood

Many CYWD don't make it up to Form 4, to be able to learn skills to become self-reliant, some trainees having **TRAINING IN THE VILLAGES** in different vocational skills. For the ones being able to finish Form 4, they are referred to existing (VETA) **VOCATIONAL TRAINING CENTRES (VTC'S),** which are encouraged to have accessible facilities for the YWD. For the YWD who can't make it to local on the job training, due to their conditions, physical or mental, are enrolled to **POLITECHNIC (INTERNAL),** which is run by CBIDO to get vocational skills.

Social

During the year there are different **INCLUSIVE EVENTS** like African Child Day, World disability day, where also CYWD are registered to participate and create awareness. Also local schools and communities are encouraged to include CYWD in their events, like in the Church, sports& games etc.

To create awareness different actions are done like 2 weekly **RADIO programmes/sessions** in different local stations, to talk about Disability related topics and have callers to ask live questions. Also village meetings, school parents meetings, churches and other gatherings are visited to talk about the topic.

Empowerment

The Government gives out loans to DPA's to start small businesses to be self-reliant. CBIDO assist in here to give **ENTREPRENEURSHIPTRAINING FOR DPA TO START IGA's** or to increase their current business**,** on how to run their business successfully.

Why This Program: "Disability Prevention and Rehabilitation Services"

Tanzania- Karagwe district

The program is very important, looking at the available data showing in the scope chapter earlier in this document.

- **General:**
  Currently CBIDO and other NGO's are working in their field, but they won't be there forever and their capacity to reach many is very limited. That is why it is very important to share their knowledge to the community, to be able to reach many more CYWD and above all to prevent many to get disabled or being born with a disability. The government will be always there, so the best reliable and stable partner to do this.

- **Prevention:**
  As seen in the scope still many children are born with a birth defect, a disability or die within the first 5 years or develop a disability due to malnutrition or not attending healthcare. Also many mothers die during delivery. Some are a lack due to available equipment like ultrasound; others are due to a lack of knowledge or stigma or wrong believe among the community members. Through prevention program which is mostly based on capacity building in the community by training health workers and them doing home visits. A major impact could be generated.

- **Rehabilitation:**
  Many CYWD are not able to join Education, Healthcare or are included in the society. They depend on their family or well-wishers, because they are not learning skills to be self-reliant. Via the Rehabilitation program, they can join education, get the needed healthcare, get self-reliant and much more which enables them to become active participants and inclusive member of their communities.

- **Conclusion:**
  All program components together will first of all reduce the number children being born with a disability, reduce child and maternal mortality, improve the health of many children and secondly will have a major impact on the quality of life for all CYWD, being able to join education, learn skills and being included in social events.

References of Comparable Projects:

A comparable program was implemented by a Dutch NGO KARUNA Foundation, in Nepal under the name **Inspire2Care.** It started small but now after 12 years; the program is covering a full province (1 out of 8) in the country and being fully taken over as a government program with high success. Karuna foundation will fully hand over in the coming 5 years, by among starting a training centre to educate different health workers, CBR facilitators, etc. in this approach to finally roll the program out nationwide in Nepal.

In 2019/2020 a comparable program was started in Congo in Uvira at the border to Burundi, under guidance of TUNAFASI foundation from the Netherlands, which was started by the former director of Karuna Foundation. Also in Congo it looks very promising.

CBIDO intend to introduce a tailor made program for Tanzania, starting in Karagwe in Kagera, under guidance and support of Benjamin Foundation from the Netherlands, which is in close contact, and receiving support from both Karuna and TUNAFASI Foundation.

From the experience from Nepal and for the short period from Congo, their program is very successful and durable. Many NGO's start something, but when they stop or move on, everything which was started goes slowly back to the old situation. In this approach the program is run and supported by the local government and community, which means after the training and support are stopped after 4 years, the services and program just continue, while they are part of the local/district/national budget, and way of working. This is because from the beginning it is run by them and not by CBIDO. Also the trained staffs remains in the wards and villages, while being employed by the ward and district and not when working for NGO's disappear together with them.

When the pilot in Karagwe works out well, and after the needed adjustments from experiences, the program could be rolled out to other districts in Kagera and eventually to other provinces in Tanzania. KCBRP rehabilitation and Training centre, working with over 20 Partner organizations could be having a roll in this.

The Local, District and finally National government are key partners in this approach to make it successful, which eventually can benefit many PWD in their daily life and change the mind set of many people. Next to the government also other stakeholders like the donors of CBIDO, are crucial to give their funding and support to this approach.

How Will We Work

First of all. Many birth defects, disabilities with young children, child and maternal mortality can be prevented and or reduced with relatively simple interventions: education on hygiene and healthy food, family planning, use of folic acid to newly married (pregnant) women, regular medical check-ups during pregnancies and after delivery, and professional guidance during delivery in a birthing centre. These interventions are evidence based and, when implemented carefully, very effective. CBIDO will adopt these interventions in their prevention program and will work closely together with local health workers and volunteers to strengthen the current healthcare service delivery.

We will work with the local health centres, Dispensaries and the government to increase knowledge, have in each ward, if not yet available, one health centre/dispensary which can be added/changed to a birth centre with a Ultrasound machine (which could be portable and shared by different wards according to no of scans needed), blood pressure meter, heartbeat meter , a lab for blood and urine tests (this could also be a central lab, where samples are send to for the more complicated tests), to be able to know different conditions (anaemia, malaria, HIV, Reus factor etc.) which lead to birth of children with different disabilities. Also to make sure all pregnant women get at least monthly antenatal consults (incl. nutritional advise and free folic acid), 1 ultrasound or more with complications, birth in the facility, timely referral to district hospital in case of an CS, and monthly postnatal check-ups for both mother and baby. Also the availability of the national vaccination scheme for all new-borns. These services are already for free in Tanzania, but not all women can access or know about them. For now only the ultrasound needs to be paid for. Also all PWD we would recommend to receive free healthcare and/or free medical cover for CHF/NHIF.

Secondly, there is much stigma towards CYWD. It is very important to change the attitude of many persons around the CYWD, not only their parents, siblings, family and neighbours, but the community as a whole, including schools (children, teachers and education officers), church leaders and followers, police, Local, District government leaders, healthcare practitioners, etc. All of them are needed to embrace and include PWD into the society and to treat them equally as full members of the society and also to be shown their Potentials to contribute to this society. This will be done with the help of self-help groups, DPA's being trained, and after creating awareness in their communities/families, etc. Also via stakeholders meetings to various members. In schools a program about disability will be implemented to make children aware and accept CYWD. Also radio will be used to discuss about it and increase acceptance and inclusion.

Thirdly, the **quality of life** of people with a disability can improve significantly with 'community-based rehabilitation', the integral approach of the World Health Organization (WHO). CBIDO uses the five components of this approach in the DISABILITY PREVENTION AND REHABILITATION SERVICES: access to health care; education, income, development of skills and social participation. This will be done through to various interventions.

The work of CBIDO will be based on the following premises and success factors:

- Strong local leadership with clear responsibilities (through a readiness- and leadership assessment in wards)
- Involvement of target group in local organisations and local accountability (commitment) in villages
- Readiness to stop earlier (in case of underperformances by local leaders) and exit CBIDO after 4 years in a village
- Good care (treat them (PWD) as if they are your own, never give up, leave no one behind)
- Focus on two targets: prevention and rehabilitation of persons with disability
- Cost effectivity: tangible results, value for money, local governments adopt the program at own costs. CBR is low cost and high impact.

Additional Factors after Data Collection Exercise: CBIDO has chosen 3 wards based on the following criteria's

a. Leadership preparedness

In the 8 wards, 3 gave exemplary and outstanding cooperation in terms of time, information gatherings, and attendance.

b. Availability of health facilities

c. Accessibility in terms of roads and distance

d. Availability of technical staff

e. Number of CwDs

f. Zone Location

As shared, CBIDO has a total of 5 zones, the 3 wards only 2 are not in the direction of zones operation.

g. Chonyonyo and Kihanga ward, CBIDO supported the construction of special need class, it then build the process of ensuring CwDs have continuing support in accessing education as well strengthening rehabilitation services

The Implementing Partners and Implementation

DISABILITY PREVENTION AND REHABILITATION SERVICES, as mentioned before will take place as follows;

1. 3 wards will be selected which comply with the set criteria (readiness of local leaders to implement and cooperate).
2. In each village a CBR facilitator will be hired by CBIDO. This is often a midwife/nurse being a women or social worker if a man. Women are given priority, living in that ward for at least 3 years, married,. The ward committee will be formed after advise of the District (possible members: ward councillor, ward executive officer, ward health officer, ward education officer, CBIDO representative, 1 of the village leaders representing the others and stakeholders of church, school, DPA). One CBRF is hired per around 150 CYWD, if the area is bigger, 2 or 3 will be needed, also could be chosen for only 1 CBRF per ward, but more Village Rehabilitation Workers Volunteers (VRW). The CBRF will join a 3 month training at CBIDO, partly training on the job, partly in class, to learn all aspects in CBR(physio/occupational therapy, nutrition, basic counselling, disability assessment (physical and mental), assistive devices, inclusive education, awareness creation, empowerment, social inclusion, etc)
3. VHW (Village Health worker), preferably who are a member of women group in the ward or a member of a DPA/DPO, the most important is that they can read and write, good in communication, hard worker, committed to work on volunteer basis. Like the CBRF, they will join a part of the trainings to learn more on CBR, and also if they don't know yet on pregnancy, antenatal, postnatal check-ups, immunizations, risks and indicators during pregnancy, nutrition, family planning, therapies, counselling etc. to be able to refer and assist women to remind them going for all necessary check-ups, or to see a doctor etc. Each Village will have at least 1 VRW or 2 depending if they work full time or 2 days a week and depending on the number of inhabitants of that village. The ratio being used is 1 VRW to 50 CYWD plus the pregnant and young mothers in their village. Next to visiting the CYWD where they assist the CBRF to do follow up visits, they mostly focus on young ladies (just married) and pregnant women to oversee the whole prevention process.
4. After the staffs are trained during 3 months, the next step is to identify the CYWD in each village. The CBRF together with the VRW will pass all houses to identify all CYWD living in that village and register their details and of their guardians in a pre-assessment form (or APP). They will need to pass all houses in the village to find all.
5. The next step is a medical camp(outreach clinic) of 1 or more days in each village/ward with the specialists of CBIDO, the counsellor, nutritionist, Physio therapist, Occupational therapist, specialist in disabilities, Educational specialist and a paediatrician from (district) hospital. They will assess all children selected by the CBRF and VRW, per specialism, and fill their information in the assessment (APP). At the end for each child an holistic assessment has been filled. The group of specialist added

with the CBRF and VRW's, will sit together to establish a personal care and development plan for each individual child, what interventions are needed for that child and the family and in which order, and what are the goals for that child.

6. In the meantime the Health facility is upgraded (if not yet available), with a (portable) ultrasound, heartbeat meter baby (foetal scope), blood pressure meter, and the lab is able to do the needed test for blood, stool and urine. Also the pharmacies have availability of the basic medicines. **Note:** according to the need one ultrasound with an operator could also move daily to max 5 wards, and have a fixed day in each ward to do the ultrasound. Also for more complicated lab test samples could be send in bulk to the lab (instead of sending all individuals to go there, test are being taken in the Dispensary and transported at once to the lab, e.g. once a week/day de[ending on preservation/quality/regulations/etc.)
7. These will be preliminary activities which will take at least 6 months preparation (July-December2021). After the individual care plans are made, the interventions will start in the 5 CBR domains, but with the focus the first 2 years on Health and second two years on education, to be able to run the programs of the two ministries separately. Other CBR domains and activities with more community involvement will run during the full 4 years simultaneously.**(see down here in interventions)**

What Are the Interventions

The prevention with the health component of CBR will start in the first year in cooperation with ministry of Health, running for 2 years to implement. The Education component of starting special units/special school will run in the 3rd year for 2 years to implement. All other components will run for the full 4 years simultaneously with the education and health programs in cooperation with the communities.

Prevention

1st 1000 GOLDEN DAYS

As stated before many disabilities are caused during pregnancy or within the 2 two years of the life of the child, this period from conception is called the 1st 1000 golden days, where with good care much can be reached and or prevented. Factors influencing child development are e.g. nutrition, time between pregnancies, smoking and alcohol, health conditions, etc.

- The VRW will be reaching for young married couples and women of reproductive age, with information on reproductive health (among family planning) and the impact if not towards disabilities. The counsellor of CBIDO will be involved in these trainings.
- Information on nutrition during conception, pregnancy and during breastfeeding (1st 6 months only mother milk)
- Make sure they start taking folic acid daily when they start planning to get a baby, or latest when they skip a monthly period.
- Getting pregnancy test.
- Going for monthly antenatal check-ups receiving a booklet with all information, being filled by health practitioner.
- At least one ultrasound scanat 36 weeks (for baby position), and to know if mother will require a CS or other supervised delivery in district hospital or other hospital/health centre. Next to that an ultrasound in case of any worries.
- A delivery under professional support in the birth centre/Dispensary or in case of risks in a hospital.
- To ensure monthly post-natal check-up.
- Information on milestones, and nutrition for the mother and baby.
- All vaccinations according to national immunization schedule (see appendix 5)
- General information on all risk during the 1st2 years and when to go to the hospital. Malaria, meningitis, and others prevention, or early discovery and treatment.
- Also children are examined by the VRW and if needed referred to hospitals. VRW will also help the families to remind for their upcoming appointments and needed check-ups in person or via sms service. They will also follow up if the check-up has been actually done.

*Each ward at least and sometimes each village has a dispensary, for medication small tests for e.g. HIV, Malaria, worms etc, and for antenatal check-ups. Postnatal and vaccinations are often done in health centres

or via outreach clinics in the villages. Deliveries are also done in these dispensaries, which have around 5 staff members, there is a ward of 3-5 beds for recovery after birth (max 24 hours). In case of complications women are referred to hospitals or health centres.

Rehabilitation Services

In all interventions the family of the CYWD is requested to cost share according their capability, and for major things like operations to fundraise. Next to that the community is requested to contribute and the government has their participation fee, or giving services free of charge or at reduced rate in government facilities. CBIDO is adding for the 3 years the last part of the needed funding. For most interventions the earlier the better, so babies within their 1st 1000 golden days, will have priority in case of shortage of funds, and after in order of increasing age. For some services CBRF will refer to other NGO's partners who can assist in that area.

Health & Rehabilitation

- Needed operations to improve the mobility and functionalities or for lifesaving/saving body parts. There can be a 2nd or 3rd operation before the expected result is obtained.
- Assistive devices, to improve mobility, functionalities and positioning and or to do exercises/muscle strengthening. Many assistive devices can be made locally by CBRF or VRW's. In case the CYWD doesn't need them anymore they can be repaired and given to others in need within the same ward, or returned to CBIDO.
- All PWD to receive a Disability ID card, with mention of their disability, which entitles them to receive free healthcare (like 60+).
- The CBRF will be trained on counselling to be able to help PWD and their families with the social problems the disability has given. During the 1st year the CBIDO counsellor will assist, and difficult cases can be referred.
- The CBRF and VRW's will give info on nutrition to parents and women during and after pregnancy, with assistance of the CBIDO nutritionist, to train them and to do group trainings in the different villages during the year.
- The CBRF and VRW's are trained on physio and occupational therapy to be able to guide the parents and do therapy with the children and to oversee the progress and parents continuing daily. The CBIDO physio and occupational therapists will guide them and difficult/complicated cases are referred to them or to KCBRP rehabilitation centre. Each health centre in each ward to also to get a physio room, where physio and occupational therapy will be given to CYWD by the CBIDO staff, while local staff in the different health centres and hospitals are being trained to take over after 1 year on the job training. For post operation rehabilitation or where intensive therapy could help an intensive therapy week is scheduled at the KCBRP facility or in a health centre or in the ward Dispensary or a place given for that purpose by the local government, if it can be combined for many in the same ward.

Education

- For children who never went to school, the CBRF will arrange for home schooling by a volunteer from the village, to be able to get to a certain level to enter school. This could be by retired teachers or other volunteers with higher education like students during their holidays as community work. It should fit within the scope of the special education strategy in Tanzania.
- For children who are not mobile at all and can't reach school, also home schooling will be introduced.
- For both primary and secondary schools in each village a disability inclusive program will be started. For each school 1 teacher will be trained in charge of implementing that program in the school. It is to create awareness and acceptance for the other children in the village schools, to prepare them for inclusive education. This will be done in all schools in the ward.
- After each school will start a child inclusive club, with representation of one student per class, who will be in charge to report and take action together with the club to protect the rights of the CYWD. This club will also learn and look at child rights.
- All primary and secondary schools in each village will make the necessary changes in infrastructure (disability friendly class rooms, ramps, toilets, doors), to be accessible for CYWD. But at least one per village if more than one.
- For some CYWD a special school in Bukoba could be more beneficial, like for the ones with hearing and seeing problems. For them transport will be arranged with help of the community.

- In each ward minimum one primary school is chosen where a "special unit" is constructed for Children with mental disability, who are not able to join the normal classes and study the normal syllabus. They

will get a special needs trained teacher and special materials, and study in small groups of max 10 persons. If the need is higher more than 1 school could be adding the special unit. They will learn basics, partly also some occupational skills and finally some vocational skills.

- To have in the district a minimum of one Boarding special school, for CYWD with mental disability who are not able to travel daily to the local schools (special units). This special boarding school can grow out of one of the special units and is planned for in the second 4 year program, having 4 years of experience and evaluation with the special units. For that reason it is not yet part of this 4 years budget later in this document.

Livelihood

- Learning life skills and practical/vocational skills is very important to be an inclusive member and productive member in the society.
- VTC (VETA) to be accessible for YWD, the government should make it obligatory to have all disability friendly infrastructures in all learning centres. This is only for the ones finished Form 4.
- For the ones that can't access VTC in formal settings due to their disability conditions in a centre and the slow learners, they will be referred on the job training in different community businesses like welding, carpentry, mechanic, cooking, sewing, farming, masonry, etc. The community is requested to have at least 10% of their learners with a disability and to sponsor them. Materials are paid by the parents.
- For the youngsters with intellectual impairments on the job training for the mild disabled can work, but for the more severe ones skills training in smaller groups in an informal setting will be done by volunteers, like beadwork, basket/maths making, broidery, farming, simple woodwork/making assistive devices locally, assist in construction, simple cooking and bakery etc. which is done in the sub villages and arranged by the CBRF and VRW.
- Polytechnic at CBIDO, a vocational training for PWD with low mobility and mental challenges who can't join in the other activities. Parents are requested to contribute for food and materials.

Empowerment

- Empower PWD and their parents in starting business via seed capital, and/or increase their business via microloans via the DPA's. They receive training in entrepreneurship or in farming/nutrition gardening. The community will allocate some community land for them to start farms, if they don't have sufficient own land.

Social Inclusion

- CBIDO will have weekly radio programs to talk about disability prevention, awareness, inclusion, and get questions from listeners via the phone.
- All community social groups are given seminars on inclusion and requested to include PWD into their activities. E.g. schools with sports, drama, music, etc. Churches within their choir, meetings/gatherings, etc, councils in meetings, etc. This is done by CBRF and VRW's.
- Implement a pilot to a monthly social security via cash transfer for 20,000 Tshs per month for all PWD who are in need of constant care of their family and are not able to produce any income for the family, to support them financially for their basic needs. This can be started in 1 ward as a pilot program, to be able to compare after 1 year what difference it makes compared to another ward, where they don't get. This will count for the severe cases of Cerebral Palsy and Epilepsy (around 14% of the number of CYWD).

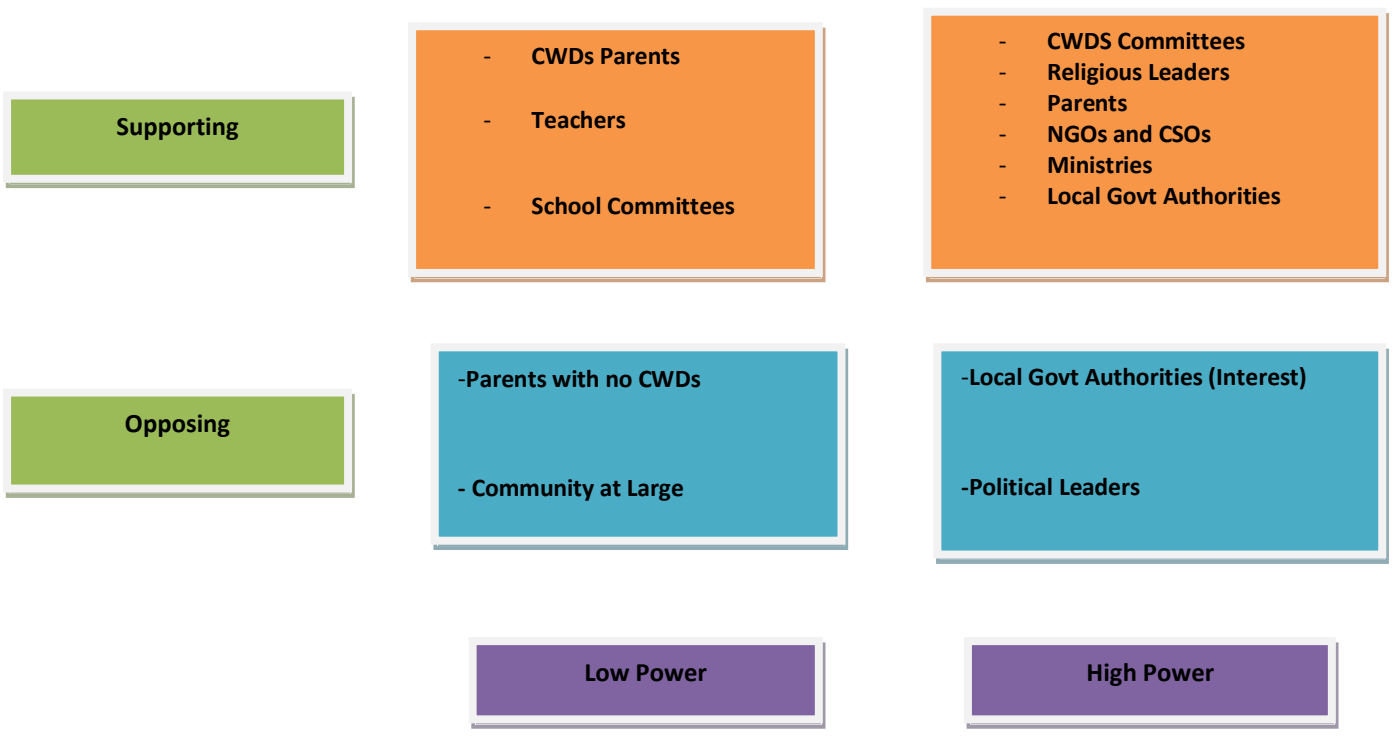
Risks and Opportunities

CBIDO categorises risks into delivery, financing, governance, fiduciary, management and reputational. Based on the analysis and experience by POs, the key projected risks have been identified and categorized, with overall risk rating of high, moderate and low. The projected delivery risks will be continuously monitored and mitigated through improved planning, budget allocations and careful oversight around data and implementation quality. Similarly, governance and management risks will be monitored and mitigated by careful planning and adjustments. Funding and spending risks highlighted based on the unforeseen experience of the uncertainty and instability, will also will be closely monitored with a view of scaling, replication and sustaining interventions. Overarching mitigating measures include working across the zonal network to establish clear rules and procedures for performance-based allocations, ensuring transparency in financial

projections for funding, and working closely with funding and field partners. Reputational risks will be covered where delivery and fiduciary issues are addressed.

Risk	Predetermined Level of Risk	Risk Mitigation Measures
Local Government Authorities Budget allocation and flexibility to contribute and sustain future interventions	High-Centralization of revenue collection by central government may limit Local Government budget flexibility	Early lobbying and advocacy through executives and elected leaders
Low commitment among parents without children with disabilities	Moderate	Active sensitization of local communities through their community structures and influential people Rigorous sensitization using children and school committees
Preparedness and Readiness of schools to integrate and support children with disabilities	High	Collaborative monitoring with Local Government Authorities to ensure children with disabilities are supported
New wave of COVID-19 spread during implementation	High	Consistent community sensitization and advocacy on prevention measures on COVID -19 Close monitoring of COVID -19 plan and timely adjustment of implementation plans

Stakeholders with who will collaborate throughout this programme / project.



Roles of Stakeholders

Stakeholders	Role(s)
CwDs Parents	• Ensure the functional roles are well applied within families • Engage in social economic activities through ISHG
Teachers	• Support dissemination of functional approaches practices on rehabilitation services in schools special units
School Committees	• Engage in planning, identification of CwDs needs in schools • Monitoring of functional approaches practices in schools • Lobbying and advocacy of CwDs needs
Political Leaders	• Lobbying and advocacy of CwDs needs, Resources needed, Policy reforms and integration in government plans and education curriculums
LGAs	• Lobbying and advocacy of CwDs needs, Resources needed, Policy reforms and integration in government plans and education curriculums
Traditional Leaders	• Support in dissemination of information on attitude and behaviour change
NGOs/CSOs	• Synergy of efforts, technical support and resources
Ministries	• Lobbying and advocacy of CwDs needs, Resources needed, Policy reforms and integration in government plans and education curriculums
Benjamin Foundation	• Strategic partner of CBIDO in whole implementation process, App development and funding partner via CBIDO towards the program.

Sustainability

A simple check list will be developed to help in assessing the project sustainability during implementation and at the end of the project:

National

- Best practices are mainstreamed in development processes, and government budgets are allocated.
- Information and knowledge generated by the project is available
- Practices and approaches are mainstreamed in national resources action plans

District

- Action plans are mainstreamed in district development plans, and district funds are allocated.
- Partnership and collaboration continue at district level between different stakeholders

Communities

- Interventions are maintained by local communities and land owners
- Technologies/tools promoted are up scaled by communities
- Strengthening DPA to be able to undertake some roles in ensuring CwDs gets appropriate services

Monitoring and Evaluation

PURPOSE: The monitoring and evaluation plan will serve two functions:

- First, periodic assessment of project implementation and performance of activities (M&E of Project Performance), and;

- Second, evaluation of their results in terms of relevance, effectiveness and impact in promoting the adoption of sustainable functional approaches (M&E of Project Impact). The M&E system of the project will provide answers on the progress and impact made by partners in achieving the project's outputs and outcomes.

Project Performance: Performance evaluation will assess the project's success in achieving the outputs with the inputs provided and activities conducted. The project will be monitored closely by CBIDO.

- Through bi-annual reports, annual reports, and technical reports.
- Regular technical supervision field visits
- Back to Office Reports will be provided as required to enhance success, and well as guidance notes and feedbacks on reports.

Project Impact: Evaluation of the project's success in achieving its outcomes will be monitored continuously throughout the project CBIDO will have to ensure;

- The key indicators found in the logical framework, and developed M&E matrix will guide the evaluation of the project results and impacts.
- To do so, reliable baseline data will be collected at start of the project activities, and implementation.

Both project performance and impact M&E will contribute to improve decision making and management, by keeping the project on track towards achieving the outcomes of the project and development objectives and by integrating lessons learnt into planning. Project achievements will be evaluated after two and a half years of project execution during the midterm evaluation (planned in 2024) through an independent final evaluation.

Communication Plan

Project Communication Matrix

Communication	Frequency	Goal	Responsible
Project Level			
Project Implementation Report	Quarterly	Review status of implementation and discuss potential emerging issues/ delays	Executive Secretary/ DPRS Coordinator
Activity (ies) Progress (Both narrative and finance)	Monthly	Share status of progress on implemented activities	Executive Secretary/ DPRS Coordinator
Project Review	At All Milestones	Present project deliverables Gather feedback Discuss on next steps/plans	Executive Secretary/ DPRS Coordinator
Donor Level			
Project Report	Quarterly	Review status of implementation and discuss potential emerging issues/ delays	Executive Secretary/ DPRS Coordinator
Project Review	At All Milestones	Present project deliverables	Executive Secretary/ DPRS

		Gather feedback Discuss on next steps/plans	Coordinator
Project Budget	Quarterly	Review status of implementation and discuss potential emerging issues/ delays	Executive Secretary/ DPRS Coordinator
Project Evaluation	Before End of the Project		Executive Secretary/ DPRS Coordinator

Staffing

Item	CBIDO	Ward	District	Remarks
Committees	-	1 at ward level with all ward officers + head teachers+ religion leaders +CBIDO representative	1 on district level with district officers +CBIDO representative	Getting allowance per meeting
Focal person	1 director for supervision 1 DPRS program Coordinator	1 person responsible for the ward.	1 person responsible from district	Getting extra incentive per month in ward and district when extra duties are involved
Administration	1 accountant at CBIDO for NGO's bookkeeping and monthly reporting	For daily administration	For monthly bookkeeping and budget keeping, reporting	Getting extra incentive per month in ward and district when extra duties are involved.
CBRF	1 Education specialist 1 Disability assessor 1 livelihood specialist 1 health specialist 1 or more per ward for each 150 CYWD			Employed and paid by CBIDO, but transition to the local government with time.
VRW/ Community health worker	Min. 1 per village, so 2-5 per ward (1/50 CYWD)			Getting monthly allowance by CBIDO, but transition to local government with time
Therapists/medical	1 physio therapist + rehab. specialist 1 Occupational therapist 1 Counsellor 1 Nutritionist		1 Paediatrician for medical camps - Specialists for other outreach clinics	CBRF and VRW's are trained in this area Getting allowance per day for doctors.
Health staff		Normal staff in ward health facility/birthing centre/ Dispensary, 1 extra person if needed to operate ultrasound in 1 or more wards.	Normal staff in district hospital.	Training in ultrasound and physiotherapy via CBIDO.

Reviews of the Program

Midterm review (after 2 years), The program shall be reviewed by multi-stakeholders after second of implementation these stakeholders will include, policy makers at mistrial level, local government authorities and development partners, to share learn learnt, challenges, successes and possible scale ups and rollout to possible other districts. This will be a more day meeting.

IT USE

To be able to make the whole M&E easier to oversee, and to get daily actual data, what is happening, an IT solution is very important to do so. Not only CBIDO and the different government levels want to see what happens, but also donors can see what is the impact of their donation and how is it spend.

We are working on the development of an app. currently we look at partner organizations who are also interested to assist in developing the APP, so it can be easily used by many. If the project works out successfully, also other NGO's and Governmental Organization's in different districts in Tanzania could be using the same APP.

The most important features are:

- Registration of clients (beneficiaries) with all necessary details and GPS function for house location.
- Assessments and rating
- Reporting and management information
- Impact measurement compared to targets (quality of life, period, cost, etc)
- Referrals internal and external interventions
- Information on disabilities and diseases for early discovery.
- Prevention program for 1st 1000 golden days babies.
- Chat function to professionals for healthcare & CBRF staff
- A function to enter financial information linked to the interventions.

Expected Impact and Changes

The first expected change is to have the government in charge instead of an NGO, which means that the programs will continue in the wards and villages also after CBIDO has exited. The output and improvements will be measured per ward at the end of the 4-year period of the cooperation between CBIDO and the local government. After 4 years another assessment will be done to measure once more to see the long term results and impact.

General:

- We expect that 80% of the wards/villages will continue with the DPRS program after exit of CBIDO.

Prevention:[2]

- 60% reduction in birth defects in program wards from 60/1000 to 24/1000.
- 60 % increase of birth deliveries in a health facility in case of expected complications (98% delivers in mostly a dispensary, but complications are not known before)
- 60% increase of antenatal visits (min. 4 times) from 40% to 76%.
- 60% increase in postnatal visits (min 2 times) from 56% to 82%.
- 76% of all pregnancies get a ultrasound at week 36, and 80% get an ultrasound in case of complications. Currently hardly nobody gets an ultrasound (no data)
- 60% increase in use of folic acid, from 67% to 87%.
- 6% point increase for vaccinations from 89% to 95%.
- 60% less maternal mortality from 76/1000to 30/1000.
- 60% less child mortality at birth and first 28 days from 43/1000 to 17/1000.
- 60% less child mortality below 5 years from 54/1000 to 22/1000
- 50% decrease in cases of stunted growth from 38.9% to 19.5%
- 20% reduction in cases for malnourished children under 5 from 8% to 6.4%

[2] These data are gotten from the Karagwe district offices for the year 2018.

Health

- 70% of CYWD (<25Yrs) with health issues, to give a positive mayor impact concerning their health situation (mobility, functionalities, muscle strengthening)

Education & livelihood

- Primary schools accessibility for CWD with an increase from 3% to 75%
- Primary schools having a special unit from 0% to 28% of all primary schools (minimum 1 per ward)
- Enrolment for CWD in primary schools, special schools, special units or home-schooling increase from 10% to 80%
- Secondary schools accessible for CYWD increase from 3% to 77% (1 per ward)
- Enrolment for CYWD in secondary schools increase from 5% to 30%
- Vocational, on the job or skills training for YWD (currently no data, but expected to be <5%), to increase to 60% for youngsters <25 years.

Social

- 70% of CYWD indicate a moderate to significant improvement in the **quality of life**. (based on increased mobility/physical health, access to education, acceptance by family and community, psychosocial wellbeing, self-reliance/freedom, religion)
- 20% of adult PWD experience an increase in their quality of life as positive impact of improved awareness creation and community sensitization, etc).
- Introduction of Disability ID cards to at least 75% of PWD in program wards.
- Visibility, acceptance and care for PWD has been increased

Empowerment

- 50% of the families with CYWD experience an increase in household income.

Option to be discussed with district and central government

- Free CHF health insurance to at least 80% of the CYWD in the program wards. Currently no free cover.
- Cash transfer to 70% of the most vulnerable CYWD (who need livelong care of their guardians), on a monthly basis.

Note: These goals are for now an indication. The final % will be entered in the final stage, in the contract (MoU) with the District and wards, which can be obtained with combined efforts and both agreeing on that.

Budget and Funding

Budget

BUDGET DISABILITY PREVENTION AND REHABILITATION SERVICES					
*	2021/2022	2022/2023	2023/2024	2024/2025	
EXPENSES	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Staff and overhead costs	290,067,975	290,067,975	294,067,975	290,067,975	**1,164,271,900**
Health	263,954,000	45,006,000	45,006,000	45,006,000	**398,972,000**
Education	97,401,160	2,201,160	98,201,160	2,201,160	**200,004,640**
Social	55,603,600	11,050,000	11,050,000	2,210,000	**79,913,600**
Empowerment	18,895,500	18,895,500	3,000,000	3,300,000	**44,091,000**
Livelihood	39,945,750	39,945,750	39,945,750	39,945,750	**159,783,000**
Total	**765,867,985**	**407,166,385**	**491,270,885**	**382,730,885**	**2,047,036,140**
Total in USD	**332,986**	**177,029**	**213,596**	**166,405**	**890,016**
INCOMES					
Community	41,754,310	41,754,310	41,754,310	41,754,310	**167,017,240**
CBIDO**	765,867,985	407,166,385	491,270,885	382,730,885	**2,047,036,140**
External NGO's	9,447,750	9,447,750	9,447,750	9,447,750	**37,791,000**
This budget is based on 3 ***ward*** with a ***population of 100,000*** (CYWD 1326)					

Planning

A planning has been made with the first general overview what needs to happen to be able to start serving the first CYWD as of January 1st 2022. This planning can still be added needed activities.

1st step June 2020

This will be presenting this concept document to the head of the Disability department at central government. Also the involved permanent secretaries will get a copy and finally the minister of Disability.

After a meeting with the different stakeholders from the 3 involved ministries (1. Labour, youth, employment and the disabled, 2. health & SW, 3. Education, Science, Technology and vocational training.) with a presentation of the concept, and changes to respond to questions.

And finally to get endorsement letters and the concept document to be stamped and signed by the 3 ministries.

This part need to be done in June 2020, to be able to find all needed persons in their offices due to closure of Parliament and the elections.

2nd Step November 2020-January 2021

After the elections the letters and concept document will be taken in November to the District Karagwe to the council Chairperson, the District commissioner and District Executive Director.

After a meeting will be organized with all involved head of department to know: Community Development officer, Social Welfare officer, District Planning Officer, District Medical Officer, District midwifes coordinator, District Education officer, District Executive director, District commissioner and District council chairperson.

This meeting might be repeated.

3rd stepFebruary2021

A meeting for the ward councillor, involved ward officers and head health facility, village executive officer, village chairperson and village and ward committees. For e.g. 3 selected wards, where one will be chosen to start the pilot. (if not yet concluded with the district)

4th Step March 2021

Meetings with village and ward DPA's and DPO's and with head teachers. And other stakeholders meetings. By end April this process should be ready and all MoU for district and ward signed.

5th Step July-September 2021

Training for CBRF and health volunteers (VRW) and trainings to other stakeholders to prepare. CBRF are trained first and will be involved in selecting VRW and in their training.

6th step October-December 2021

Selection and assessments for beneficiaries October/November and medic camps for specialist assessments. So the interventions can start as of January 1st 2022.

CBIDO-Kagera

P.O.BOX 389

Karagwe

Director: Mr Flourian Protase

Mobile: **+255 622027628**

www.cbido.org

info@cbido.org

PROJECT STRATEGIC PARTNER (patron)

Stitching Benjamin Netherlands

Adviser: Stijn Kneppers

www.stichtingbenjamin.nl/en/

stijn@stichtingbenjamin.nl

Signing Page

Document for the implementation of DISABILITY PREVENTION AND REHABILITATION SERVICES in partnership with CBIDO NGO.

Function:……..

Name:……..

Signature: ……..

Date and stamp:

Benjamin Foundation

Function:……..

Name: ……..

Signature: ……..

Date and stamp:

Appendix

Appendix 1: Developed Action Plans after Preliminary Data Collection

(Additional to the Actions to be taken on General Data Findings)

1. Conduct a five (5) days workshop/ training/ seminar/ meeting to the leaders of all the 23 wards (VEOs, Village Chairman, WEOs, Ward Counselors, Wards Departments (Education, Health, Social Welfare) and Districts head of departments (Education, Health and Social Welfare)
    a. This will be a joint training to about 120 participants (90 village leaders, 23 ward leaders and 7 Districts officers from Health, Education and Social welfare)
2. Conduct awareness training in 3 selected wards (Train leaders on each wards – WEO, VEOs, Village Chairman and Leaders from each sub village and members from Education, Health and Social welfare committees)
3. Design, Print and Distribute IECs materials on disability, particularly that which describes the types of disabilities in all the 23 wards in offices, health centres/dispensaries/hospitals, and schools.
4. Conduct training to teachers in the 3 selected wards (At least 30 teachers)
5. Conduct screening of CwDs in each village/sub village for proper CBR support
6. Develop training modules on different types of disability
7. Establish new DPAs in villages that do not have DPAs and identify areas of strengthening/capacity building in identified areas for social and economic empowerment
        i. DPAs strengthening can play a vital role in exit plan particularly if they are economically empowered
            1. CBIDO and Government can work together in identifying viable economic opportunities that can be implemented by DPA
            2. CBIDO and Government can ensure skills training are tailor made based on the assessed capacities of DPAs – Design skills training based on competences/experiences/nature ad type of business found in particular communities
            3. Provide capacity building on Parental Responsibilities and Care for CwDs (as a building skill on exit plan – will enable parents of CwDs who are members of DPAs take over the tasks that CBIDO and District Government were handling)

Actions to be taken for health Findings

1. Capacity building to health personnel on disability (types, care and treatment)
2. Strengthening laboratories with sufficient technical personnel and equipments
3. Conduct clinical training to pregnant women during clinic days on nutrition, sexual reproductive health, consumption and use of recommended doses during pregnancy
4. Conduct sexual reproductive health education/awareness to young girls in schools
5. Education and counselling session that promote physical activity, improve nutrition or reduce the use of tobacco, alcohol or drugs during pregnancy
6. Blood pressure and cholesterol assessment during antenatal visits, and screening for illnesses such as cancer, diabetes, and heart disease.
7. Work across public health systems to encourage including accessibility features for all people with disabilities;
    a. Focus on specific functional populations (for example, those with vision or hearing loss, or mobility limitation) as a whole, with accommodations as necessary; and
    b. Support in developing and implement public health programs for people with specific conditions
        i. Serve as a resource for increasing knowledge and changing attitudes and practices as it relates to people with disabilities;
        ii. Educate policymakers about differences in health among people with disabilities;
        iii. Build collaborations with consumers, local health organizations, and other relevant partners;
        iv. Share information about programs, methods, materials and lessons learned;
8. Identify the health needs of people with disabilities. (part of screening and DPAs strengthening)

Actions to be taken

1. Capacity building to district education officials on types of disabilities, needs assessment for proper educational placement
2. Conduct a screening exercise on the nature, type and education support needed for CwDs in 3 wards
3. Develop CwDs rehabilitation plan
4. Identify rehabilitation services needed by CwDs identified for better learning
5. Cost sharing with district government on the provision of education materials needed
6. Collaborate with other stakeholders in the district/region for provision of service and rehabilitation
7. Participate in establishing district education basket fund (DEBF) for construction of classroom where different stakeholders can contribute.
8. Participate in Develop a District Inclusive Education Roadmap (Integral of the National Education Policy, Laws etc)

Appendix 2: Demographic Data Karagwe

Table 1.1 Karagwe district wards and villages

Karagwe

ward number	Ward names	Villages names	Population per ward 2012 Census	Population per ward Expected 2021	No. DPA's	No Villages /ward	Average population village	Health facilities
1	Bugene	1. Bugene; 2.Bujuruga; 3. Kishao	15.867	20.600	1	3	6.867	D
2	Bweranyange	1. Muguruka; 2.Chamchuzi; 3. Kijumbura; 4. Bweranyange.	18.629	24.186	1	4	6.046	D
3	Chanika	1.Omurulama; 2.Kaundwe; 3. Ruhanya; 4. Ruzinga; 5. Runyaga; 6. Chanika.	17.632	22.891	1	6	3.815	D
4	Chonyonyo	1. Omukimeya; 2. Rukole; 3.Rularo; 4. Chonyonyo.	7.918	10.280	-	4	2.570	D
5	Igurwa	1. Bwera; 2. Igurwa; 3. Kigarama	10.525	13.664	-	3	4.555	D
6	Ihanda	1. Rwenjojo; 2. Kyerunga; 3. Ihanda.	14.583	18.933	1	3	6.311	D
7	Ihembe	1. Ihembe i; 2.Ihembeli; 3. Rubale; 4. Kibogoizi.	8.846	11.485	1	4	2.871	D
8	Kamagambo	1. Ahamlama; 2.Kafunjo; 3. Kamagambo	6.590	8.556	1	3	2.852	D
9	Kanoni	1. Rwambaizi; 2.Kibona; 3. Kanoni; 4. Nyakaita.	17.126	22.234	1	4	5.559	D
10	Kayanga	1. Rwambare; 2. Kagururu; 3. Katoma Ruzinga; 4. Bomani ; 5.Omugakorongo; 6. Miti.	18.968	24.626	-	6	4.104	HC+H,U,L ,SC *
11	Kibondo	1. Kibondo; 2. Kakuraijo; 3. Nyakaiga.	12.621	16.386	-	3	5.462	HC,CS,L
12	Kihanga	1. Kishoju; 2. Kihanga; 3. Katanda; 4. Kibwera; 5. Mulamba; 6. Rutunguru.	18.202	23.631	-	6	3.939	D
13	Kiruruma	1. Nyakagoyegoye; 2. Biyungu; 3.Kiruruma; 4. Nyamieli	34.945	45.369	-	4	11.342	D
14	Kituntu	1. Katwe; 2. Katembe; 3.Kituntu.	12.970	16.839	1	3	5.613	D
15	Ndama	1. Ndama; 2.Kagutu; 3. Nyabwegira.	11.887	15.433	-	3	5.144	D
16	Nyabiyonza	1. Ahakikshaka; 2.Bukangara; 3.Chabalisa; 4.Nyabiyonza; 5. Nyakashenyi	10.748	13.954	-	5	2.791	D
17	Nyaishozi	1. Nyaishozi; 2.Nyakayanja; 3. Rukale	12.782	16.595	1	3	5.532	HC,L
18	Nyakabanga	1. Chabuhora; 2.Kanogo; 3.Kayungu; 4. Nyabweziga.	16.531	21.462	1	4	5.365	D
19	Nyakahanga	1. Rwandalo; 2.Bisheshe; 3.Omurusimbi; 4. Omurusimbi	20.284	26.334	-	4	6.584	H,U,L,CS **
20	Nyakakika	1. Kandegesho; 2. Kaiho; 3. Nyakakika; 4.Kanywamagana.	16.531	21.462	-	4	5.365	D
21	Nyakasimbi	1. Kahanga; 2.Bujara; 3.Nyakasimbi; 4. Muungano	12.803	16.622	-	4	4.155	D
22	Rugera	1. Nyarugando; 2. Omukakajinja; 3. Kikkurula.	7.388	9.592	-	3	3.197	D
23	Rugu	1. Kasheshe; 2.Misha; 3. Ruhita; 4. Rugu.	14.160	18.384	1	4	4.596	D
23	**wards**		**338.536**	**439.516**	**11**	**90**	**4.984**	
No of Households			**71.931**	**90.673**	* District Hospital			
Average household			**4,7**	**4,8**	** Hospital under ELCT (private)			

Thes are townships devided in villages. Total villages 77, 4 townships. HC= Health centre U= Ultrasound CS= ceasarean section
Households are an estimation using the 2015 number of 76425 households. H= Hopsital L= Laboratorium D= dispencary/birth centre

Table 1.2 Demographic below 21 Years old

Category	Population %	Population	Growth rate	Expected CYWD
< 1 Year	4,30%	18.899	4,3%	379
1-4 Yrs	12,90%	56.698	3,2%	1.138
5-14 Yrs	27,70%	121.746	2,8%	2.444
15-17 Yrs	5,20%	22.855	1,7%	459
18-24 Yrs	16,22%	71.275	2,3%	1.431
Total	**66,32%**	**291.472**	**2,9%**	**5.850**

Table 1.3 Expected number per education type

Education	Total		Per Ward average		Enrolement Others
	CYWD	Others	CYWD	Others	
Kindergarten (4-5yrs)	525	25.824	23	1.123	
Primary 1-7	1.699	83.523	74	3.631	100%
Secondary 1-4	789	12.415	34	540	32%
Vocational 50% 17-20 Yrs	609	29.923	26	1.301	
Total	**3.623**	**151.684**	**158**	**6.595**	

Table 1.4 Numbers of Churches in Karagwe

Religion	No churches	%
Catholics	195	29%
ELCT	120	18%
Muslim	82	12%
ACT	34	5%
Other *	250	37%
Total	**681**	**100%**

Estimation

Table 1.5 numbers of children per age

Age	No. CYWD *	No total
<1	379	18.899
1	284	14.174
2	284	14.174
3	284	14.174
4	284	14.174
5	244	12.175
6	244	12.175
7	244	12.175
8	244	12.175
9	244	12.175
10	244	12.175
11	244	12.175
12	244	12.175
13	244	12.175
14	244	12.175
15	153	7.618
16	153	7.618
17	153	7.618
18	204	10.182
19	204	10.182
20	204	10.182
21	204	10.182
22	204	10.182
23	204	10.182
24	204	10.182
	5.850	**291.472**

* Estimation using 2% statistics

Table 1.6 types of disability

Handicap CYWD		Total current program villages	Expected for Karagwe <25	%
Blind fully		10	56	1%
Eye problems		40	225	4%
Deaf fully		41	230	4%
Hearing problems		16	90	2%
Celebral palsy-light		77	0	
Celebral palsy-medium		85	1.432	24%
Celebral palsy-strong		93	0	
Ostreomyelits		28	156	3%
Hand/arm		18	100	2%
leg/foot		61	341	6%
club foot		34	190	3%
cleft lip		16	89	2%
Autism		13	73	1%
Contractures		15	84	1%
Epilepsy		190	1.061	18%
Down syndrome		33	184	3%
Bowlegs		20	112	2%
Knocking knees		14	78	1%
Hydrocephulus		29	162	3%
Microcephulus		16	89	2%
Burns (skin)		14	78	1%
Conduct disorder		16	89	2%
Albinism		14	78	1%
other.....		64	357	6%
Dwarfism		3	17	0%
Sickle cell		14	78	1%
Spinal Bifida		4	22	0%
Muscular Dystrophy		4	22	0%
Elephantiasis		5	28	0%
Autism		13	73	1%
Intellectual problems		11	61	1%
children with no disability		13	73	1%
Hernia		6	33	1%
Neck deformity		6	33	1%
Nasal polyps		2	11	0%
Goitre		2	11	0%
Amputation		3	17	0%
Malnutrition		3	17	0%
TOTAL		**1046**	**5.850**	**100%**

*This is an estimation.

Appendix 2 App Development

To be able to monitor the program, to make the work easier, and to improve the knowledge and services and to measure the impact, we are developing an app which can do all that. We have seen different apps, who all have a part of what we are looking for. We want to make an app combining all this different functionalities.

1. Medic mobile, with the prevention of disabilities and child deaths part with follow up, referring to health facilities, being able to assess a child to get the medication and disease. Getting and /or sending sms to health workers and or direct to beneficiaries for appointment reminders etc.
2. Macheo Children's Organization having a system of assessments for CSI (child status index), and KPI for each intervention, after entree and exit are measured which gives an average period (efficiency), cost and impact for that client or in general. Also they can refer internally or externally to service providers.
3. SOMESHA, having a chat function to get assistance of professionals/specialists like doctors, CBR etc. who are volunteering in e.g. USA, etc.
4. Like REHAPP, having info on many disabilities for learning.
5. Like REHAB MY PATIENT, an app giving all types of exercises for physio according to the problem.

The following functionalities should be included:

App functionalities

The app will have different functionalities, like assessments, which are linked to a database for further analysis, reporting, management information and for approvals of individual cases/villages. They will give the base info (entree) and info at exit to measure the impact/improvements/change.

1. For all assessments needed.

a. Village infrastructural/facilities assessment (start and end), to measure if basic facilities are there according to minimum entree conditions. And to measure if required infrastructures are there at exit.
b. Village leaders/organizations assessment (to measure if it complies with conditions and expected cooperation) (before start, yearly to decide to continue/stop and at end)
c. Beneficiary (child and family) assessment (for entree , follow up and exit for impact measurement on beneficiary basis)
d. Intervention KPI assessments (entree, middle and exit, to measure success of the intervention)
e. Disability assessment to determine the type of disability and suggestions for interventions/referrals to other organizations (hospitals, governmental and NGO's)(using algorithms)
f. Diseases assessment to determine the disease, referral and possible treatment (using algorithms)
g. And others (to be added)

Flow of information via app and back end online>

- General (e.g. CBR) assessment being done with referrals for interventions/activities needed (made to a care plan with all needed interventions and goals at end intervention KPI's looking holistically at the child/family)>**via app in the field**
- gets to (service provider) manager to approve/deny/waiting/external referral according to capacity, budget, likeliness of success>**via back end in the office**
- if approved gets to service provider (1 for each CBR pillar), who does assessment using KPI's and after they can approve/deny (depending if they think they can have a positive/successful impact in that family with their intervention)>**via app in the field**
- **OR** it goes to external service providers who get a message the client has been referred and or they are part of the system and get a list online with the clients details and can also give feedback for the CBRF/VRW (Health volunteers)
- if approved they start intervention.>**via app in the field**
- they do middle assessment on KPI (time to decide to continue or stop if no progress)>**via app in the field**
- If continues does end assessment on KPI (after the period stated or number of sessions needed has been reached)>**via app in the field**
- after a follow up CBR assessment to measure if there is progress and cooperation from family/community>**via app in the field**

- other interventions continue) >
- At end 4 year program the general (e.g. CBR) assessment to measure total impact/change since start. (for individual that could be earlier when all interventions have been finished by CBR organization, and the individual beneficiary is exited from the program (or continues without the CBR organization support)> **via app in the field**
- Info can be gotten via reporting or downloaded>**via back end in the office**

*this can also be used in the same form for other assessments.

- **Individual development/care plan for each beneficiary.**
  This will be a result of the assessment and the needed activities/interventions for that child to accomplish short term and long term goals.

2. Documents which can be downloaded

- A standard contracts for villages, health facilities, schools, etc
- A contract for beneficiaries/parents
- Manuals for all activities and approaches
- New updates and info on CBR/CBID
  *So standard documents are there and updated by admin and also organizations can share and upload documents for others (published after admin has agreed)

3. Chat function

- To be able to chat to professionals linked to the network worldwide, (health practitioners, specialists, counsellors, etc.) to be able to use for staff to get advice, also open forums to discuss about different topics. Also for village volunteers to get from the CBR organization.

4. Calendar

- A calendar with trainings, events, which can be added by partner organizations, so others could join. To be selected per area, country, continent, world wide (filter possibility, and to enter when adding event)
- Also a personal calendar with appointments for the health workers/CBRF/ and service providers (external and internal), where and who to visit and when and for the clients (to receive a reminder sms when to go for appointments and where). Also the responsible health worker/service provider to get the same reminder in their agenda to check on their clients if they go for all their appointments.

5. Beneficiaries portal:

- To be able to get info on different handicaps, to find support groups in their area, to talk to specialists within the CBR organization only. (this might be more for village leaders, etc. most beneficiaries will not have a smart phone). But can also be used by staff members to get info on all handicaps, like description, how to recognize, how to treat, how to prevent etc. (like the CP app of REHAPP), but then for all disabilities both physical and Intellectual.

6. HRM function

- Staff member can check in when starting work and check out when stopping work, it can be with a picture and GPS location for management to know where they are starting and finishing work and the time worked. (in the office, or in the field)

7. SMS function

- Sms can be send automatically from the system on determined dates to remind them for appointments to both Health worker and client.

8. GPS function

- Used for the previous point, but especially also to locate the exact locality of the beneficiary, so if others have to find the house, they can easily find it on google maps.

9. Report function

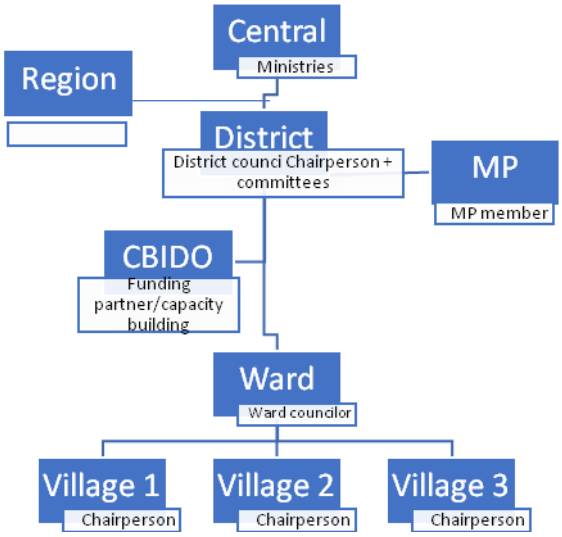
- The data can be accessed via reports and can be downloaded.
- Also there are many filters possible and possibility to compare to last year, other villages/areas/countries, compare between gender, age, dates/periods, etc. with graphs for visibility. Or to zoom in to details.
- Be able to download in PDF, excel, word, etc.
- Possibility to select certain part of database and to download and upload to eg SPSS for more analysis.

Appendix 3 Budget Local and District Government after Exit

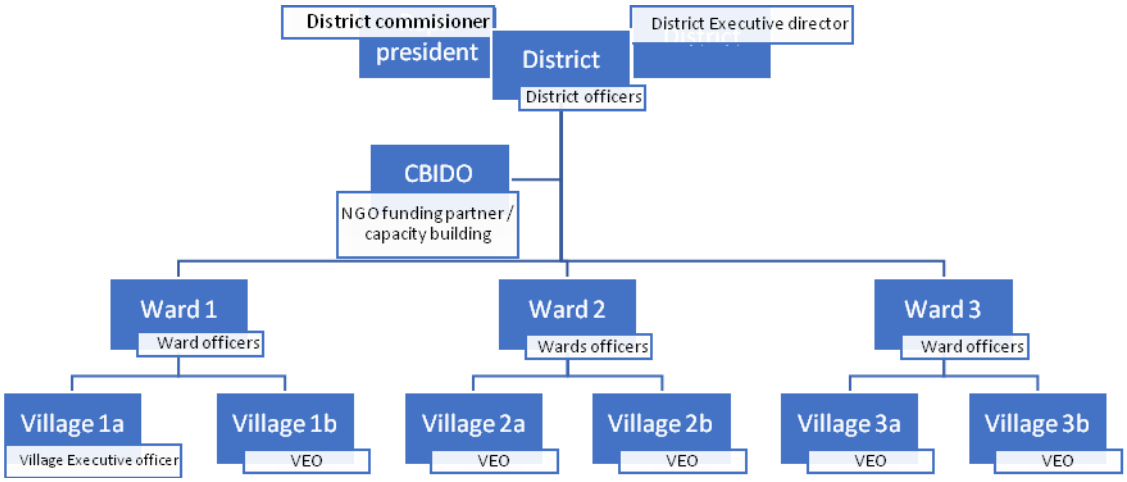
This budget will be made after consultation with the Central, district and ward government, after the final budget has been agreed on. In the chapter Budget and Funding a rough estimation is already given for district and national additional budget per year.

APPENDIX 4 Organizational Chart Of Program

Political Central to Village



Appointed District to Village



Appendix 5 Vaccination Schedule

NATIONAL IMMUNIZATION SCHEDULE

United Republic of Tanzania

Recommended routine immunization

Vaccine	Description	Schedule	Comments
Primary and Adolescent Infant Vaccination Schedule			
BCG	Bacille Calmette-Guérin vaccine	Birth	
OPV	Oral polio vaccine	Birth; 6, 10, 14 weeks	
Rotavirus	Rotavirus vaccine	6, 10 weeks	
DTwPHibHepB	Diphtheria and Tetanus and Pertussis and Haemophilus influenzae and Hepatitis B vaccine	6, 10, 14 weeks	
Pneumo_conj	Pneumococcal conjugate vaccine	6, 10, 14 weeks	
MR	Measles and rubella vaccine	9, 18 months	
HPV	Human Papillomavirus vaccine	9 years (2 doses)	From January 2018
Adult Vaccination Schedule			
TT	Tetanus toxoid vaccine	1st contact; +1, +6 months; +1, +1 year	Women of child-bearing age and pregnant women

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