THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

HEALTH EQUITY FOR PERSONS WITH DISABILITIES ACTION PLAN 2026-2031

Leaving No One Behind

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Health Equity
For Persons with Disabilities
Action Plan 2026 - 2031

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Foreword

Advancing health equity for persons with disabilities is essential to building a healthy society where all Tanzanians have equal opportunity to participate and contribute to national development. The United Republic of Tanzania has made significant strides in improving the health of its population, which has resulted in an increase in the average life expectancy for both men and women. However, these improvements do not benefit everyone equally, including 16% of the global population that the World Health Organization estimates have significant disability. Many persons with disabilities die younger; have increased risk of health conditions; and face greater limitations in functioning than persons without disabilities. These health inequities are due to unfair, unjust, and avoidable conditions which disproportionately affect persons with disabilities, and must be addressed as part of health systems strengthening.

Efforts to improve the health and well-being of persons with disabilities have been progressively expanding in Tanzania, with government and non-government stakeholders designing and delivering a range of services, such as community-based rehabilitation and specialized interventions for children with disabilities. In 2021, the Ministry of Health developed a National Rehabilitation Strategic Plan which seeks to expand both the access and quality of these services to all Tanzanians. Nevertheless, persons with disabilities continue to have unmet health needs and face a range of barriers when accessing the same health services as others.

In April 2023, the Ministry of Health convened a two-day consultative meeting with over 50 participants from government departments, health service providers, United Nations Agencies, development partners and organizations of persons with disabilities. In this meeting, the Ministry of Health and stakeholders agreed to develop a plan to ensure persons with disabilities are systematically included in health system strengthening efforts. With support from the World Health Organization, Tanzania Mainland is now implementing the ***Disability Guide for Action*** – a national planning tool to advance health equity for persons with disabilities.

The actions developed in this Disability Guide for Action are aligned with and support the implementation of the ***Health Sector Strategic Plan July 2021 – June 2026 (HSSP V)***, ensuring that efforts to advance universal health coverage; to build healthier populations through the control of communicable and non-communicable diseases; and to improve responses to epidemics and disasters, thus leaving no one behind. The Ministry of Health is committed to providing leadership in this process and welcomes renewed efforts and collective action from stakeholders across the country moving forward.

Dr. Seif A. Shekalaghe
Permanent Secretary

Acknowledgements

The development of the Health Equity for Persons with Disabilities Action Plan 2026–2031 was a collaborative and participatory process, guided by the World Health Organization's Disability Inclusion Guide for Action. It reflects the Government of Tanzania's continued commitment to advancing inclusive health services that leave no one behind. The Ministry of Health extend their sincere appreciation to the members of the Disability Inclusion Guide for Action Working Group, who provided strategic leadership and technical direction throughout the process.

This initiative was led by the Ministry of Health through the Rehabilitation and Geriatrics Services Section, with coordination and technical support from the Non-Communicable Diseases Section, the Policy and Planning Department, and other key units across the Ministry. The active involvement of senior management helped ensure strong alignment with national health priorities and frameworks.

We gratefully acknowledge the contributions of government ministries, departments, and agencies whose policy guidance and technical input were instrumental in shaping the content of this Action Plan. The engagement of regional and council health management teams, as well as service providers, helped ground the Plan in the realities of implementation at all levels.

Special thanks are extended to development partners and United Nations agencies for their technical and financial support, which strengthened the overall quality and relevance of this document.

We are especially thankful to networks and organizations of persons with disabilities, alongside national and international civil society organizations, for sharing their lived experiences and expertise. Their meaningful engagement ensured that the Action Plan responds to the rights and aspirations of persons with disabilities in Tanzania.

The Ministry also recognizes the valuable inputs from academic and research institutions, regulatory bodies, and all stakeholders who participated in consultations and the validation process.

Finally, we extend heartfelt appreciation to persons with disabilities, their family members, and health professionals who shared their time and perspectives - contributions that were vital in shaping both the Disability Inclusion Guide for Action and the resulting Health Equity Action Plan.

Dr. Grace E. Magembe

Chief Medical Officer

Acronyms

APHFTA	Association of Private Health Facilities in Tanzania
CCBRT	Comprehensive Community Based Rehabilitation Tanzania
CRPD	Convention on the Rights of Persons with Disabilities
DHIS2	District Health Information System
HFGC	Health Facility Governing Committee
HI	Humanity and Inclusion
HMIS	Health Management Information System
HSSP V	Health Sector Strategic Plan V July 2021 – June 2026
M&E	Monitoring and evaluation
MCDWSG	Ministry of Community Development, Gender, Women and Special Groups
MoH	Ministry of Health
NACP	National AIDS Control Programme (NACP)
NACTVET	National Council for Technical and Vocational Education and Training
NatHREC	National Health Research Ethics Committee
NEHCIP-TZ	National Essential Health Care Interventions Package Tanzania
NIMR	National Institute for Medical Research
OPD	Organization of persons with disabilities
PMO-PPCD	Prime Minister's Office – Policy, Parliament, Coordination and Persons with Disability

PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
SHIVYAWATA	Shirikisho la Vyama vya Watu Wenye Ulemavu Tanzania (Tanzania Federation of Disabled People's Organizations)
SRA	Star Rating Assessment
SWAp	Sector-wide approach
NBS	National Bureau of Statistics
TDHS	Tanzania Demographic Health Survey
TWG	Technical Working Group
WHO	World Health Organization

Executive Summary

The Ministry of Health (MOH), with the support of the World Health Organization (WHO), have developed a five-year action plan (2026-2031) with priority actions to advance health equity for persons with disabilities in mainland Tanzania (herein referred to as the Action Plan). This Action Plan was developed using the WHO Disability Inclusion Guide for Action process,[1] and is aligned with the priorities of the Health Sector Strategic Plan V July 2021 – June 2026 (HSSP V), which has a:

- **Vision** of a healthy and prosperous society that contributes fully to the development of individuals and the nation.
- **Mission** to provide sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical, disability and gender equity.

The Action Plan is built upon the findings of a situation assessment conducted in August 2023. A series of workshops and meetings were undertaken to prioritize and develop more detailed actions for disability inclusion in the health sector and to validate the final Action Plan. Central to this process has the active participation of a wide range of health and disability stakeholders, including MOH departments, other ministries and government bodies, development partners, and organizations persons with disabilities.

Health equity is a driving force for achieving Tanzania's development goals. This Action Plan reinforces the stewardship role of the health sector for intersectoral coordination and action in advancing health equity for persons with disabilities. In this role, the health sector will leverage knowledge, expertise, reach, and resources of other sectors and partners, including the Prime Minister's Office, the National Advisory Council for Persons with

[1] The Disability Inclusion Guide for Action a strategic planning tool developed by WHO to support ministries of health to advance health equity for persons with disabilities by identifying entry points and planning appropriate actions to strengthen disability inclusion1 across the health sector.

Disabilities, and development and civil society partners, strengthening coordination and collaborative action.

The Action Plan has ten strategic health system entry points, with 1-2 action areas under each. The following table summarizes these action areas, including those that have been identified as a “priority action areas” for implementation by the Disability Gide for Action Working Group. Appropriate mechanisms will be established to ensure that disability-inclusive actions are integrated into other health sector processes, including in the development, review and evaluation of health sector policies, strategies, and plans, and in the implementation of quality assurance tools and assessments. A permanent Disability Inclusion Technical Working Group will be established to oversee the implementation and monitoring of the Action Plan and provide ongoing inputs to wider health sector processes.

Strategic Entry Point	Action Areas
1. Political commitment, leadership, and governance.	Action Area 1.1: Governance mechanism for disability inclusion in the health sector.
	Action Area 1.2: Participation in health governance at community levels.
2. Health financing.	Action Area 2.1: Strengthening advocacy on UHI Schemes among OPD
	Action Area 2.2: Disability inclusion in the implementation of the Universal Health Insurance Act (2023).
3. Engaging stakeholders and private sector providers.	Action Area 3.1: Strengthening the capacity of disability committees and organizations of persons with disabilities.
	Action Area 3.2: Disability inclusion in private and public health service regulation.
4. Models of care.	Action Area 4.1: Disability inclusion in the National Essential Health Care Interventions Package Tanzania (NEHCIP-TZ).
	Action Area 4.2: Documenting practices on disability inclusive essential health care packages.
5. Health and care workforce.	PRIORITY Action Area 5.1: Mandatory training on disability inclusion for the health workforce.
6. Physical infrastructure and communication.	Action Area 6.1: Improving accessibility of health facilities and infrastructure.
	Action Area 6.2: Improving accessibility of health information and communication.
7. Digital technologies for health.	Action Area 7.1: Adopting standards on accessibility of digital health technologies.
8. Quality of care.	PRIORITY Action Area 8.1: Disability inclusion in referral systems, processes, and guidelines.
	Action Area 8.2: Disability inclusion in quality improvement systems.

9. Data collection for monitoring and evaluation.	PRIORITY Action Area 9.1: Disability-disaggregated data in District Health Information System (DHIS2) tools.
	Action Area 9.2: Disability-disaggregated data in population-based health surveys.
10. Health systems and policy research.	Action Area 10.1: Disability inclusive health research agendas.
	Action Area 10.2: Disability inclusive health research processes.

1: Introduction

Persons with disabilities have the right to the highest attainable standard of health, as enshrined in international law, such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD), as well as in domestic legal frameworks. However, the ***Global Report on Health Equity for Persons with Disabilities*** launched in December 2022, demonstrates that persons with disabilities still experience health inequities, due to avoidable, unjust and unfair conditions [1].

Over the last decade, the United Republic of Tanzania has made significant strides in improving the health of its population, which has resulted in an increase in average life expectancy for both men and women. However, there are persistent gaps in health indicators between urban and rural populations, the poorest and richest households, and between regions, across the country. Sub-populations, such as women, children, the elderly, and persons with disabilities, also continue to face a range of barriers to accessing health services [2]. As efforts continue to reach health-related Sustainable Development Goals and targets set forth in the Tanzania Development Vision 2025 [3], identifying and addressing health inequities experienced by persons with disabilities is critical.

The current Health Sector Strategic Plan 2016 – 2026 (HSSP V) recognizes that universal health coverage, protection in emergencies and disasters, and healthier populations will only be achieved by tackling health inequities experienced by "vulnerable groups", including persons with disabilities [2]. To contribute to these wider health sector goals and priorities, the Ministry of Health (MOH), with the support of the World Health Organization (WHO), has developed the ***Health Equity for Persons with Disabilities Action Plan 2026-2031*** with priority actions for disability inclusion to be undertaken in the health sector in mainland Tanzania.

The Action Plan on Health Equity for Persons with Disabilities 2026 – 2031 (herein referred to as the Action Plan) contributes to the vision and mission of the HSSP V:

- The **vision** is to have a healthy and prosperous society that contributes fully to the development of individuals and the nation.

- The **mission** is to provide sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical, disability and gender equity.

The overall goal being to reduce health inequities experienced by persons with disabilities in Tanzania.

Action Plan development process

The Action Plan was developed using the Disability Inclusion Guide for Action tool. The Disability Inclusion Guide for Action is a planning tool, developed by WHO, to support ministries of health to advance health equity for persons with disabilities by identifying entry points and planning appropriate actions to strengthen disability inclusion across the health sector. Entry points for disability inclusion are aligned with the primary health care approach to health systems strengthening as outlined in Figure 1.

Following a consultative meeting conducted April 2023, the MOH established the Disability Inclusion Guide for Action Working Group with representatives from relevant government ministries and departments, UN agencies, and country partners, including organizations of persons with disabilities (OPDs), to contribute to this process. A situation assessment was conducted, including desk-based research and document review, key informant interviews, group discussions with persons with disabilities, and a workshop with Working Group members to conduct the Disability Inclusive Health System Assessment [4]. Gaps and opportunities to strengthen disability inclusion health sector priorities were documented in the Situation Assessment Report. The gaps and opportunities were then prioritized, and the actions outlined in this plan were developed. The Action Plan has been developed in consultation with diverse stakeholders through the Working Group and validated with a range of health and disability stakeholders, including organizations of persons with disabilities.

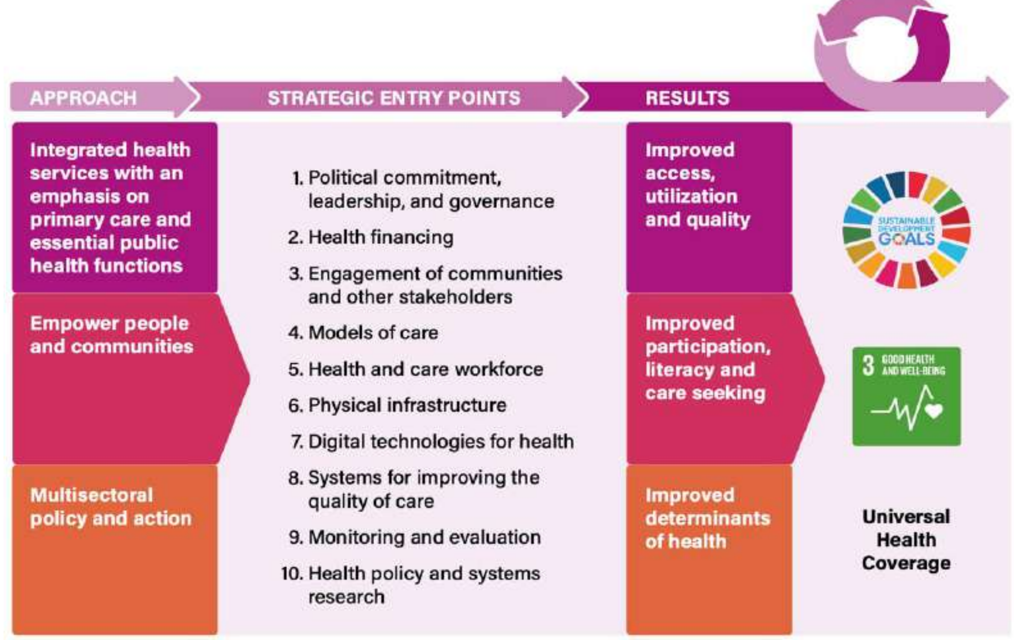
Figure 1: Strategic Entry Points for Disability Inclusion in the Health Sector (extracted from the WHO Global Report on Health Equity for Persons with Disabilities, 2022 [1, p. 160]

2. Core concepts informing the Action Plan

The Action Plan contributes to health equity. Health inequities are differences in health outcomes that are avoidable and unjust. In general, health equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically, or by other dimensions of inequality (e.g. age, sex, gender, ethnicity, disability,). With health equity, every individual has a fair opportunity to realize their full health potential without being disadvantaged in achieving it [1].

A primary health care approach to health systems strengthening can address the contributing factors to health inequities. Taking this approach, the Action Plan seeks to address the contributing factors to health inequities faced by persons with disabilities. These factors include a lack of inclusion in governance and decision-making processes in the health sector; gaps in knowledge, negative attitudes, and discriminatory practices among healthcare workers; inaccessible health facilities and information; and lack of information or data collection and analysis on disability.

Health equity for persons with disabilities will only be achieved if disability-inclusive strategies are implemented in mainstream health



actions. Persons with disabilities need the same health services as others in the population. For example, women with disabilities need access to the full range of women's health interventions, such as cervical and breast cancer screening; the barriers faced by children with disabilities need to be considered in childhood vaccination programmes; and HIV information, education and communication needs to reach persons with intellectual disabilities in a way that they can understand.

The Action Plan is focused on disability inclusion in the sector. Disability inclusion refers to the meaningful participation of persons with disabilities in all their diversity and the promotion and mainstreaming of their rights into the work of the health sector, in compliance with the CRPD. However, disability inclusion in the health sector cannot be meaningfully achieved without the collaboration and participation of other ministries and government departments, disability NGOs and service providers, development partners and OPDs.

The Action Plan is aligned with and contributes to health sector priorities as outlined in the HSSP V. Most notably actions are proposed to increase the participation of persons with disabilities health sector governance and decision-making, for example in the implementation of the Universal Health Insurance Act (2022) and the new National Essential Health Care Interventions Package Tanzania (NEHCIP-TZ). Actions can also be integrated into efforts to strengthen quality assurance, health information management and health workforce capacity development. Lastly, the Action Plan provides disability-inclusive strategies for integration into the revisions of the National Research Agenda and Digital Health Strategy.

Achieving health equity for persons with disabilities will be a process, not a one-time event. The current Action Plan seeks to strengthen the health sector structures and processes for ongoing inclusion of persons with disabilities in the development, implementation and monitoring of national health policies, strategies, and plans. Lessons learned over the next three years of implementation will inform and be reflected the development of the next Health Sector Strategic Plan for Tanzania – the HSSP VI and strengthen disability inclusion in regular health sector planning processes.

3. Situation of disability inclusion in the health sector in Tanzania

The following section provides an overview of the findings of the Situation Assessment which served as the evidence base for the Action Plan. For more information, please see the Health Equity for Persons with Disabilities: Situation Assessment Report [4].

Persons with disabilities

The 2022 Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) reports that approximately 8% of the population (age 5 and older) have some level of difficulty in at least one functioning, and 3% have a lot of difficulty functioning or cannot function at all in at least one domain at all. This prevalence increases to 14% among the older population (age 60 and older). There is also a higher prevalence of difficulties in at least one domain for women (16.1%) compared to men (13.7%). However, the prevalence in men decreases with level of education, highlighting potential linkages between disability and the social determinants of health [5].[2]

Persons with disabilities in Tanzania are less likely to attend school and have lower literacy rates and poorer living conditions than those without disabilities which can affect their health outcomes. For example, the 2012 Census found that a higher proportion of 24.2% of persons with disabilities (ages 5 – 24 years) reported having never attended school, compared with 21.8% of persons without disabilities [6]. Literacy rates are also lower among persons with disabilities (64.1% versus 70.1%). In line with wider literacy trends, men with disabilities have higher literacy rates than women with disabilities (69.9% of men with disabilities compared with 60.1% of women with disabilities). There are also higher literacy rates among those living in urban areas (81.3%) compared to rural areas (58.7%). Two-thirds (70.2%) of persons with disabilities were employed at the time of the census, 27.1% were considered “inactive” and 2.7% were unemployed. In terms of living conditions, a lower proportion of households headed by persons with

[2] The 2022 TDHS-MIS Disability Module included a series of questions based on the Washington Group on Disability Statistics (WG) questions, which are based on the framework of the World Health Organization’s International Classification of Functioning, Disability, and Health. The questions relate to difficulties in six functional domains—seeing, hearing, communication, cognition, walking, and self-care [5].

disabilities compared to those without disabilities use electricity (14.7% compared to 20.1%); and have flush toilets (11% compared to 14.5%) [6]. Such conditions in which people are born, grow, live, work, and age are called social determinants of health. These can contribute to health inequities for persons with disabilities and a multi-sectoral approach beyond the health system alone is required to improve health outcomes for persons with disabilities.

Health leadership and governance

Inclusion of persons with disabilities in the health sector is supported through current legislative and policy frameworks in Tanzania. Tanzania has committed to ensuring health equity for persons with disabilities through ratification of the CRPD in 2009. The ***Persons with Disabilities Act 2010*** establishes the wider legislative framework for protection and promotion of the rights of persons with disabilities in Tanzania. It makes explicit references to ensuring that persons with disabilities receive the same level and standard of health and rehabilitation services as provided to other citizens [7]. The ***National Health Policy 2007*** also commits to the provision of health services which meets the needs of persons with disabilities [8]. The ***National Client's Service Charter for Health Facilities (2018)*** provides more detail. It makes specific references to persons with disabilities having priority access to medical treatment; information being readily available in the health facility, with explicit references to accessible formats such as braille, large print, audio visual materials, simple terms, and sign language interpretation services; clients receiving information about payment and medical insurance schemes; and that client, families, and carers are treated with dignity, respect, and compassion [9].

These commitments are translated into national health strategies and plans, with concrete actions relating to ensure persons with disabilities have access to rehabilitation, community health, nutrition, and reproductive health programmes (among others). For example, the current ***Health Sector Strategic Plan July 2021 – June 2026 (HSSP V)*** highlights the needs of persons with disabilities under strategic outcomes relating to rehabilitative care, community health; nutrition; reproductive, maternal, neonatal, child and

adolescent health; and availability of quality, essential primary health care services with acceptable quality standards throughout the country [2].

While Tanzania has established legislative and policy frameworks and concrete actions for disability inclusion in national level health strategies and plans, there is limited evidence available to demonstrate implementation. This may in part be due to gaps in governance mechanisms. There is no formal mechanism to oversee and monitor disability inclusion in the health sector, and no systematic approaches at national levels to engaging and coordinating with disability stakeholders, including persons with disabilities, their families, and representative organizations, in wider health sector actions. For example, no disability organizations were included in the list of "technical experts" engaged in the design of the ***HSSP V (2021-2026)*** [2].

Responsibility for "providing expertise and services to persons with disabilities" lies with the Prime Minister's Office under the Persons with Disability Unit in the ***Prime Minister's Office-Policy, Parliament, Coordination and Persons with Disability*** [10]. There is a ***National Advisory Council for Persons with Disabilities***, which monitors the implementation of the disability law, among actions. The composition includes the Prime Minister's Office, the Attorney General, and representatives from the Ministries for Health, Local Government Authorities, public service management, community development, labour, and education [7], and Shirikisho la Vyama vya Watu Wenye Ulemavu Tanzania (SHIVYAWATA) – the Tanzania Federation of Disabled People's Organizations.

At local levels, the ***Prime Minister's Office – Regional Administration and Local Government (PMO-RALG)*** coordinates social welfare officers who identify persons with disabilities and establish disability committees. However, key informants report that committees do not yet exist in all villages due to a lack of human resources. There are also health committees at village levels, which bring health concerns to the District Council. The ***Comprehensive Council Health Planning Guidelines (2020)*** [11] and ***Guidelines for the Design and Operation of Council Health Service Board (CHSB) and Health Facility Governing Committees (HFGCs) (2013)*** [12] do not explicitly reference representation from persons with

disabilities and their organizations. As such, their participation in health decision-making at local levels is not yet systematic.

Health financing

Many persons with disabilities cannot afford health services. One study reports that 94% of persons with disabilities interviewed could not afford the cost of medical services [13], and 72% reportedly missed routine health services and 62% were unable to access specialized services due to financial constraints [14]. The ***National Health Policy (2007)*** [8] and the ***PO-RALG directive to regional administrative secretaries (2012)*** [15] provide for free services for persons with disabilities. However, persons with disabilities lack awareness of these provisions or don't have appropriate documentation to prove an exemption [13, 14].

In 2012, only 10% of households headed by persons with disabilities were a member of one of Tanzania's social security schemes, most commonly the National Health Insurance Fund and Community Health Fund [6]. There are now moves to reshape Tanzania's health insurance schemes through the recently passed ***Universal Health Insurance Act (2023)***. This act references the right of persons with disabilities to be included under the health insurance scheme and stipulates that specific sources of financing for health insurance services for persons with disabilities will be identified [16].

Engagement of stakeholders and private sector providers

There are a range of actors implementing health projects with persons with disabilities. However, many of these NGOs usually report to the Ministry of Community Development, and as such may not be connected to health system even when delivering health services. There are also gaps in the regulation of disability inclusion among wider health service providers; and that those auditing the health service providers are not well equipped or supported to know how to assess quality of services for persons with disabilities.

Models of care

The National Essential Health Care Interventions Package Tanzania (NEHCIP-TZ) (2000) is currently being revised with the development of universal health insurance and will serve as the basis for providing care at various levels. It will have three explicit packages with standards of care defined for: primary health care (dispensary, health centre and council hospital) level; secondary level (regional referral hospital); and tertiary level (zonal, specialized, and national referral hospitals) [2]. It is encouraging to see the involvement of OPDs during the development phase of the Essential Health Care Intervention Package. Formalizing such consultations ensures that the perspectives of persons with disability contribute to capture disease trends appropriately and to address the health needs of persons with disabilities.

Health and care workforce

Persons with disabilities continue to face barriers in accessing health services due to the knowledge, attitudes, and practices of health workers. While there are some promising examples of disability being integrated into health worker training,[3] it is still not systematic or comprehensive, nor is this content required for accreditation of institutions delivering training.

Physical infrastructure and communication

Legislation supports making all health infrastructure accessible to persons with disabilities, and PMO-PPCD have developed additional guidelines on accessibility and inclusion in all programmes and services. Despite these guidelines, there are still widespread physical accessibility barriers to health facilities across the country. However, the designs used by MOH for new facilities (at all levels) require ramps and accessible toilets.

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[3] These include integrating topics on communication through sign and tactile sign language in the recently revised National Nursing & Midwifery Curriculum and Dentistry Curriculum; training for doctors on specific conditions, such as albinism and mental health; and in-service training through the Medical Council of Tanzania. There are also reports of disability being integrated into social worker training.

There are no overarching standards on accessible health information and communication. However, there are isolated / ad hoc efforts to improve the accessibility of communication on specific topics and / or for specific groups. For example, UNFPA projects have developed sexual and reproductive health rights information in Easy-Read formats [17], in line with organization's global guidelines [18].

Digital technologies for health

While digital health is a relatively new in Tanzania, there are a range of telemedicine facilities / services being provided across the country. The ***Digital Health Strategy (2019 – 2024)*** establishes a governance structure including the National Digital Health Steering Committee (NDHSC), a National Digital Health Secretariat (NDHS), Institutional Digital Health Committees, and Health Facility Digital Health Committees [19]. Accessibility for persons with disabilities or universal design is not referenced in either the Strategy. Digital health partners report that they are not aware of international standards on digital accessibility which would need to be adopted and contextualized by the government.

Quality of care

In the ***HSSP V (2021-2026),*** quality of care is measured through the percentage of primary health facilities with 3 stars in the ***Star Rating Assessment (SRA)*** [2]. It is promising to see that the SRA tools ask explicit questions about whether "buildings have ramps for easy access of physically challenged patients" and whether there are at least two "disability friendly toilets" in each facility [20]. However, there are opportunities to also integrate questions on disability under other sections, particularly those focused on client satisfaction.

Persons with disabilities are aware of the feedback and complaint mechanisms at facility level, including online portals, phone numbers and suggestion boxes. However, they note that some mechanisms may not be accessible for everyone, and they don't perceive these as effective mechanisms.

The ***HSSP V (2021-2026)*** recognizes wider gaps in referral mechanisms [2]. These gaps may disproportionately affect persons with disabilities. Persons with disabilities report that those living in rural areas may not get appropriate referrals and specialist support for their health conditions.

Health system monitoring and evaluation

There is no standardized approach to disability-disaggregated data collection and analysis across the health management information system (HMIS), with OPDs calling for this to be addressed [21]. However, there are isolated examples of disaggregation at facility levels and data is collected by NGOs and other delivering health services to persons with disabilities. The most recent TDHS-MIS collected information about disability but has not yet undertaken disaggregated data analysis for health outcomes. Finally, PMO-PPCD is developing an electronic system for the registration of persons with disabilities, which could possibly be linked to the HMIS/DHIS2 in the future.

Health policy and systems research

The National Institute for Medical Research (NIMR) oversees and coordinates that national health policy and systems research agenda, which sits within the wider National Research Priorities 2021-2026 coordinated by Commission of Science and Technology (COSTECH). While persons with disabilities and disability issues are not explicitly mentioned, there is a focus on research on social determinants of health and delivery of health services to disadvantaged groups to reduce health inequities [22]. To date, disability has not been included in health research policy and guidelines, including institutional review board / ethics approval processes.

4. Implementation of the Action Plan

The Action Plan has 10 strategic entry points, with 1-2 action areas under each. The following list summarizes these. Chapter 5: Actions on disability inclusion in the health sector expands on each action areas with more detail. Among these action areas, three have been identified as a “priority action areas” for implementation.

Strategic Entry Point	Action Areas
1. Political commitment, leadership, and governance.	Action Area 1.1: Governance mechanism for disability inclusion in the health sector.
	Action Area 1.2: Participation in health governance at community levels.
2. Health financing.	Action Area 2.1 Strengthening advocacy of UHI schemes among OPD
	Action Area 2.2: Disability inclusion in the implementation of the Universal Health Insurance Act (2023).
3. Engaging stakeholders and private sector providers.	Action Area 3.1: Strengthening the capacity of disability committees and OPDs.
	Action Area 3.2: Disability inclusion in private and public health service regulation.
4. Models of care.	Action Area 4.1: Disability inclusion in the National Essential Health Care Interventions Package Tanzania (NEHCIP-TZ).
	Action Area 4.2: Documenting practices on disability inclusive essential health care packages.
5. Health and care workforce.	PRIORITY Action Area 5.1: Mandatory training on disability inclusion for the health workforce.

6. Physical infrastructure and communication.	Action Area 6.1: Improving accessibility of health facilities and infrastructure.
	Action Area 6.2: Improving accessibility of health information and communication.
7. Digital technologies for health.	Action Area 7.1: Adopting standards on accessibility of digital health technologies.
8. Quality of care.	PRIORITY Action Area 8.1: Disability inclusion in referral systems, processes, and guidelines.
	Action Area 8.2: Disability inclusion in quality improvement systems.
9. Data collection for monitoring and evaluation.	PRIORITY Action Area 9.1: Disability-disaggregated data in DHIS2 tools.
	Action Area 9.2: Disability-disaggregated data in population-based health surveys.
10. Health systems and policy research.	Action Area 10.1: Disability inclusive health research agendas.
	Action Area 10.2: Disability inclusive health research processes.

Appropriate mechanisms will be established to ensure the implementation of the Action Plan, and that actions are integrated into, and implemented as a cross-cutting issue, in other health sector / programme plans.

<u>Sub Committee on Disabilities, Rehabilitation and Geriatrics</u>

MOH has established a permanent Sub-Committee on Disabilities, Rehabilitation and Geriatrics (herein after referred to as Sub-Committee on disability) under the Technical Working Group on Service Delivery 2 to address disability inclusion in the health system and to oversee the implementation and monitoring of the Action Plan. The Sub-Committee is coordinated by MOH and have representatives from MOH departments

responsible for the implementation of actions, PMO-RALG, PMO-PPCD, selected health and disability NGOs, development partners and OPDs.

The Sub-Committee will meet at least four times a year to assess progress, identify and address challenges, and adapt to emerging priorities in the health sector. The first meeting convened by MOH will revise and agree on the draft Terms of Reference (Annex 1). This first meeting will also clarify roles and reporting processes for each of the actions.

Individual members may also be appointed to represent the Sub-Committee in other Health Sector-Wide Approach (SWAp) TWGs, coordination bodies and health-related forums, for collaboration and information sharing. The Sub-Committee will also become a formal body to be engaged in the development of national health policies, strategies, and plans, providing technical inputs relating to disability inclusion.

Integrating disability inclusion actions into health sector processes

Operationalizing the Action Plan will be largely done through the integration of the actions into a wide range of health sector processes, including strategic and operational planning, and through the adaptation of guidelines and tools already being used. The table below describes the health sector processes in which disability inclusive actions will be integrated, with links to the Action Plan for more information and easy reference. Disability-inclusive actions outlined in the action plan should be embedded in the work plans of respective MOH departments, programmes, and Health SWAp TWGs. This table may be expanded and updated by the Sub-Committee on disability as new opportunities emerge in the health sector.

IF YOU ARE WORKING ON:		GO TO:
HSSP V Mid-term Review or Evaluation (and HSSP VI development)	➡	Action Area 1.1: Governance mechanism for disability inclusion in the health sector.
Health Facility Governance Guidelines	➡	Action Area 1.2: Participation in health governance at community levels.
"Cost of Service" Guidelines	➡	Action Area 2.1: Strengthening advocacy of UHI schemes among OPD
Implementation of the Universal Health Insurance Act (2022)	➡	Action Area 2.2: Disability inclusion in the implementation of the Universal Health Insurance Act (2023)
Accreditation of private and public health facilities	➡	Action Area 3.2: Disability inclusion in private and public health service regulation.
National Essential Health Care Interventions Package Tanzania (NEHCIP-TZ)	➡	Action Area 4.1: Disability inclusion in the National Essential Health Care Interventions Package Tanzania (NEHCIP-TZ). Action Area 4.2: Documenting practices on disability inclusive essential health care packages.
Health worker curriculum accreditation	➡	Action Area 5.1: Mandatory training on disability inclusion for the health workforce.
		Action Area 1.2: Participation in health governance at community levels.
Star Rating Assessment		Action Area 6.1: Improving accessibility of health facilities and infrastructure. Action Area 6.2: Improving accessibility of health information and communication.

	→	Action Area 8.2: Disability inclusion in quality improvement systems.
Digital Health Strategy 2019-2024 Evaluation (and development of the next Digital Health Strategy)	→	Action Area 7.1: Standards for accessibility of digital health technologies.
Tanzania Health Management Information System	→	Action Area 9.1: Disability-disaggregation in DHIS2 tools.
Population-based health surveys	→	Action Area 9.2: Disability-disaggregated data in population-based health surveys.
National Research Priorities / Health Research Agenda (2021-2026)	→	Action Area 10.1: Disability inclusive health research agendas.

Health sector reporting processes

Disability inclusion and the implementation of this Action Plan can be included into wider health sector reporting processes. Most notably, the Sub-Committee on disability, rehabilitation and geriatrics through Service delivery 2 present a report as part of the mid-term review and end-term evaluation of the HSSP V, drawing on information gathered through the situation assessment and monitoring and evaluation framework. This analysis will inform future health sector strategic planning processes and facilitate further integration of disability inclusion across the health sector.

5. Actions on disability inclusion in the health sector

The following section outlines the actions that should be taken by stakeholders under each strategic entry point from 2025 – 2031, along with information about potential resources to support implementation.

Strategic Entry Point 1: Political Commitment, Leadership and Governance

Action Area 1.1: Governance mechanism for disability inclusion in the health sector.					
	Actions	**Key stakeholders and their roles in each activity**	**Outputs**	**Timeline**	**Resources available / needed**
1.1.1	Establish a Sub-Committee on disability as part of Rehabilitation, and Geriatrics subcommittee under the Service delivery 2 TWG to input into health sector policy development and strategic planning processes.	MOH – Coordinate the Disability Inclusion subcommittee as part of Service delivery II TWG, and make sure it is referenced in concept notes relating to health sector strategic planning. Other Sub-Committee members – Raise issues of health equity for persons with disabilities in other TWGs, policy and planning consultation processes, and in multi-sectoral coordination forums or bodies (e.g., National Advisory Council on Disability)	Sub-Committee on disability is established and meeting at least twice per year.	Year 1 and ongoing.	Resources available: *MOH and Sub-Committee member human resources. *Meeting venues provided by Sub-Committee member and partners. Resources needed: *Transportation, sign

					interpretation and assistants for OPD members.
Action Area 1.2: Participation in health governance at community levels.					
	Actions	**Key stakeholders and their roles in each activity**	**Outputs**	**Timeline**	**Resources available / needed**
1.2.1.	Review guidelines for Health Facility Governance Committees (HFGC) to include persons with disabilities as a member.	MOH & PMO-RALG – Revise guidelines (in consultation with the Sub-Committee on disability) and disseminate to facilities. PMO-PPCD – Link disability committees to HFGC. Civil society organizations – Provide sensitization to HFGCs and disability committees on health equity and addressing barriers.	HFGC guidelines reference inclusion of persons with disabilities.	Years 1 & 2 for guideline revision. Year 3-5 for dissemination and capacity development.	Resources available: *Technical expertise through the Sub-Committee on disability. Resources needed: *One consultative meeting (Year 1 or 2). *Launch & dissemination event (Year 3).

Strategic Entry Point 2: Health Financing

Action Area 2.1: Strengthening advocacy of UHI schemes among OPD					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
2.1.1	Raise awareness with persons with disabilities on the universal health insurance schemes.	PMO-PPCD, MOH, PMORALG and MCDWSG (Social Welfare) – Develop information and communication on UHI schemes. SHIVYAWATA and Humanity & Inclusion – Share information with persons with disabilities.	Number of persons with disabilities receiving information on UHI schemes	Year 2-5	Resources available: *PMO-PPCD and MCDWSG staff time. Resources needed: *Transportation, sign interpretation and assistants for OPD members. *Communication materials – Posters and Easy-to-Read formats.

Action Area 2.2: Disability inclusion in the implementation of the Universal Health Insurance Act (2023)					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
2.2.1.	Develop guidelines on how persons with disabilities should be considered in the implementation of universal health insurance scheme regulations and guidelines.	Sub-Committee on disability	Policy brief or guidelines endorsed by MOH.	Year 2	Resources available: *Technical expertise through the Sub-committee on disability. Resources needed: *None
2.2.2.	Present guidelines to the MOH Technical Working Group on Health Financing and Social Protection.				
2.2.3.	Sub-Committee on disability participates in meetings and provides feedback on the development regulations and guidelines relating to	Sub-Committee on disability	Number of health insurance regulations and guidelines which include	Ongoing	Resources available: *Technical expertise through the Sub-Committee on disability. Resources needed:

	the universal health insurance scheme.		persons with disabilities.		*None

Strategic Entry Point 3: Engagement of Stakeholders and Private Sector Providers

Action Area 3.1: Strengthening the capacity of disability committees and OPDs.					
	Action	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
3.1.1.	Train national level OPDs on disability inclusion in the health system.	PMO-PPCD & MOH – Coordinate the training with OPDs. CBM, Sightsavers, CCBRT, HI, MKUTA – Contribute existing training materials and resources on disability inclusive health. SHIVYAWATA – Identify members to be trained and integrate health training into other capacity development projects.	Two trainings conducted with at least 30 representatives from national level OPDs, including organizations representing women and marginalized groups of persons with disabilities.	Years 1 & 2	Resources available: *Technical and training expertise through NGOs. Resources needed: *Two trainings, 30 participants for three days each training. *Transportation, sign interpretation and assistants for OPD members to attend training.

3.1.2.	Integrate messages on health system planning processes into existing training and awareness raising packages for disability committees at council and village levels.	PMO-PPCD & PMO-RALG – Coordinates training of disability committees. CBM, Sightsavers, CCBRT, SHIVYAWATA – Delivers health messages in existing training and awareness raising with persons with persons with disabilities at council and village levels.	Number of disability committees at council and village levels receiving information on health system planning processes.	Years 2-5	Resources available: *NGO projects already working with persons with disabilities at council and village levels. Resources needed: *None Note: This activity assumes that NGOs and OPDs will integrate health messages into existing programmes.
Action Area 3.2: Disability inclusion in private and public health service regulation.					
	Action	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
3.2.1.	Identify and review existing audit and accreditation tools for health service providers.	MOH (Quality Assurance), PMO-RALG, Pharm Access & APHFTA – Provide information about audit and accreditation tools and resources. PMO-PPCD & Sightsavers – Review audit and accreditation	Number of audit and accreditation tools revised to integrate disability.	Year 1& 2	Resources available: *Standards on accessibility and inclusion developed by PMO-PPCD and Sightsavers. Resources needed: *None.

		tools for health service providers.			
3.2.2.	Deliver training on disability-related criteria to people conducting audits and accreditation assessments. Note: This training activity could also be integrated into any trainings already planned by Pharm Access (e.g., on Safe Care) or APHFTA.	MOH (Quality Assurance), PMO-RALG, Pharm Access & APHFTA – Identify people to be trained. PMO-PPCD & Sightsavers – Deliver training.	Number of staff involved in auditing and accrediting health service providers who are trained on disability inclusion.	Year 2-5	Resources available: *Technical expertise through PMO-PPCD and Sightsavers. Resources needed: *Two trainings, 30 participants for one day each training.

Strategic Entry Point 4: Models of Care

Action Area 4.1: Disability inclusion in the National Essential Health Care Interventions Package Tanzania (NEHCIP-TZ).					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
4.1.1.	Develop and cost guidelines / standards on disability inclusion to accompany the implementation plan for the NEHCIP-TZ.	MOH (Policy & Planning) & WHO – Drafting and costing guidelines and standards. Sub-Committee on disability – Review and feedback. SHIVYAWATA – Sharing and validating guidelines / standards with members.	Guidelines / standards on disability inclusion in the essential health care package are adopted.	Year 1&2	Resources available: *Technical support from WHO and the Sub-Committee on disability. *Standards on accessibility and inclusion developed by PMO-PPCD and Sightsavers. Resources needed: *Validation meeting – One day, 40 people.
4.1.2.	Integrate guidelines / standards on disability inclusion into the standards and norms revised as part of the NEHCIP-TZ implementation plan (e.g., for	Sub-Committee on disability – Members to participate in the NEHCIP-TZ implementation plan process. Expert groups developing	Guidelines / standards on disability inclusion are referenced in the NEHCIP-TZ implementation	Year 1& 2	Resources available: *Technical support from WHO and the Sub-Committee on disability. Resources needed: *None.

	infrastructure, human resources, etc.).	implementation plan – To ensure alignment with disability inclusion standards and guidelines.	plan and accompanying norms / standards.		

Action Area 4.2: Documenting practices on disability inclusive essential health care packages.					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
4.2.1.	Identify three (3) health facilities to model practices in implementation of the guidelines / standards on disability inclusion in essential health care interventions.	MOH, PMO-RALG and Shivyawata – Identify and health facilities. Sub-Committee on disability – Provide information and feedback on the facilities being selected.	Memorandum of understanding or a term of reference with selected facilities.	Year 2 -5	Resources available: *Technical expertise through the Sub-Committee on disability. Resources needed: *None
4.2.2.	Design and implement a participatory process to identify and document practices for disability inclusion in	MOH, PMO-RALG, WHO & SHIVYAWATA – Develop and	Case studies / publication documenting practices for disability inclusion in	Year 2-5	Resources available: *Technical support from WHO and the Sub-Committee on disability. Resources needed:

	essential health care interventions.	implement project. Sub-Committee on disability – Provides feedback on the methodology for the project and reviews case studies / publications developed.	essential health care interventions.		*Will depend on project design, but suggest the following: - Consultant to design and oversee process. - Transportation, sign interpretation and assistants for OPD members to conduct pre- and post-assessment. - Training and action planning workshops with five facilities. - Communication materials – Posters and Easy-to-Read formats.

Strategic Entry Point 5: Health and Care Workforce

PRIORITY Action Area 5.1: Mandatory training on disability inclusion for the health workforce.					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
5.1.1.	Develop core competencies and training materials on disability inclusion for the health workforce (pre-service and in-service).	MOH (Human Resources Development) – Establish expert group and integrate core competencies into annual training needs assessment. Sub-Committee on disability – Link to existing training initiatives, tools, and resources on disability inclusion for the health sector. National Council for Technical and Vocational Education and Training (NACTVET) – Ensuring that competencies are included in all health	Core competencies and training materials on disability inclusion are approved by MOH.	Years 1 & 2	Resources available: *Technical support from WHO. * Training tools and resources through the Sub-Committee on disability. Resources needed: *Expert group workshop to develop core competencies – One workshop, 30 participants for three days. *Consultant to develop and test training materials.

		care workforce curriculums. Academic institutions – Deliver health care workforce curriculum. WHO – Can advise on global norms and standards relating to core competencies on disability inclusion.			*Validation meeting – 30 participants for one day. *Vendor to put training package online (ensuring accessibility standards).
5.1.2.	Train a pool of resource people with disabilities and caregivers to provide sensitization of health professional on selected topics (e.g., women with disabilities to sensitize CHWs on their SRH needs). Note: This action could intersect with 3.1.1.	PMO-PPCD & MOH – Coordinate the training with OPDs. UNFPA, CBM, Sightsavers, CCBRT, HI, MKUTA – Contribute existing training materials and resources on disability inclusive health. SHIVYAWATA – Identify members to be trained. World Bank – Project on capacity building CHWs on disability inclusion.	Two trainings conducted with at least 30 persons with disabilities and caregivers, including those representing women and marginalized groups of persons with disabilities.	Years 1 -3	Resources available: *Technical and training expertise through NGOs. Resources needed: *Two trainings, 30 participants for three days each training. *Transportation, sign interpretation and assistants for OPD members to attend training.

5.1.3.	Integrate core competencies on disability inclusion into mandatory continuing professional development.	MOH (Human Resources Development) – Advocacy to professional councils. Professional councils – Make disability training a requirement of registration and licensing of health professionals.	Number of health councils with mandatory requirements for continuing professional development relating to disability inclusion.	Year 3-5	Resources available: *Online training package will have been developed in previous years. Resources needed: *None.

Strategic Entry Point 6: Physical Infrastructure and Communication

Action Area 6.1: Improving accessibility of health facilities and infrastructure.					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
6.1.1.	Review existing health infrastructure standards and guidelines to consider the needs of all persons with disabilities.	MOH (Building & Infrastructure Unit) – Identify and review relevant infrastructure standards. PMO-RALG – Prepares structural and architectural drawings (which are approved by MOH) [23]. Ministry of Infrastructure Development – Interpret national policies and strategies relating to accessible infrastructure development. Tanzania Building Authority – Participate in the review of standards and guidelines.	Number of health infrastructure standards and guidelines reviewed.	Year 1& 2	Resources available: * Technical expertise through the Sub-Committee on disability. *Global standards and guidelines on accessible infrastructure. Resources needed: *None

		PMO-PPCD – Share guidelines on accessibility of infrastructure.			
6.1.2.	Implement accessibility standards and guidelines for health infrastructure.	Ministry of Infrastructure Development – Capacity building and technical support on accessibility standards and guidelines for infrastructure development and maintenance at LGA level [23]. PMO-RALG – Disseminate accessibility standards and guidelines to LGAs and HFGCs. Tanzania Building Authority – Ensure that buildings are constructed / upgraded according to standards. SHIVYAWATA – Accessibility audits of facilities constructed / upgraded.	Number of health facilities constructed / upgraded in line with accessibility standards and guidelines.	Ongoing	Resources available: *Technical expertise through the Sub-Committee on disability. Resources needed: *Training for health infrastructure partners on accessibility standards and guidelines. Note: This training activity could also be integrated into any trainings already planned. *Transportation, sign

					interpretation and assistants for OPD members conducting audits.
Action Area 6.2: Improving accessibility of health information and communication.					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
6.2.1.	Develop guidelines on accessible health information and communication, including provision of sign language interpreter services and information in accessible formats, such as Braille, Easy-Read and captioning.	MOH (Health Promotion & Government Communication Unit) – Develop and adopt the guidelines and standards. PMO-PPCD – Share existing guidelines and standards on accessibility of information and communication.	Guidelines on accessible health information and communication are adopted.	Year 1& 2	Resources available: * Technical expertise through the Sub-Committee on disability. *Global standards and guidelines on accessible information and communication. Resources needed:
6.2.2.	Implementation of guidelines on accessible health information and communication.	PMO-RALG – Disseminate accessibility standards and guidelines to LGAs and HFGCs.	Number of LGAs receiving information and / or training on the guidelines on accessible	Years 2-5	

		UNFPA, CBM, Sightsavers, CCBRT, HI, MKUTA – Contribute existing training materials and resources on disability inclusive health. SHIVYAWATA – Accessibility audits of health information and communication.	health information and communication.		* Expert group workshop to develop guidelines. * Transportation, sign interpretation and assistants for OPD members conducting audits.

Strategic Entry Point 7: Digital Technologies for Health

Action Area 7.1: Adopting standards on accessibility of digital health technologies.					
	Action	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
7.1.1.	Adopt and contextualize the WHO-ITU Global Standard for Accessibility of Telehealth Services.	MOH (Information Communication Technology) – Coordinating this activity and integrating standards into the implementation of the Information and Communications Technology and E-Health strategy. National Digital Health Steering Committee (NDHSC) / National Digital Health Secretariat (NDHS) / Monitoring and Evaluation & Information Technology and Communication Technical Working Group (M&E/ICT TWG) – To integrate standards into the implementation of the Digital Health Strategy (2019 – 2024) [19]. e-Government Authority and Ministry of Information,	Standards on accessibility of telehealth services in Tanzania exist.	Year 1	Resources available: *Digital health governance mechanisms already exist. *Availability of global standards. Resources needed: *Workshop with stakeholders to contextualize standards. One workshop, 30 participants for one day.

		Communication and Technology – Adopt standards and support implementation.			
7.1.2.	Disseminate adopted standards with stakeholders.	Development Partners Group on Disability (DPG-Disability) – To make implementation of the standards a donor requirement for any telemedicine and technology-based projects. National Digital Health Steering Committee (NDHSC) / National Digital Health Secretariat (NDHS) / Monitoring and Evaluation & Information Technology and Communication Technical Working Group (M&E/ICT TWG) – To integrate standards into the implementation of the Digital Health Strategy (2019 – 2024) [19]. Health technology partners (e.g., PATH) – To implement the standards in health technology projects.	Implementation of standards on accessibility is reflected in the revision of the Digital Health Strategy (in 2024/2025).	Years 2-5	Resources available: *Digital Health Centre – Can advise provide expertise and technological services in the design, development, and implementation of the standards. Resources needed: *Workshop with stakeholders to disseminate standards. One workshop, 30 participants for one day.

		Mobile telecommunication companies – To make telehealth services toll free. Digital Health Centre – To provide expertise and technological services for the implementation of the standards. PO-RALG & Health Facility Digital Health Committees – To disseminate standards to LGAs and councils.			

Strategic Entry Point 8: Quality of Care

PRIORITY Action Area 8.1: Disability inclusion in referral systems, processes, and guidelines.					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
8.1.1.	Assess current referral systems, processes, and guidelines, identifying the barriers faced by persons with disabilities in care pathways.	MOH and PMO-RALG – Develop TOR and recruit consultant to conduct research on referral processes. NIMR & Disability Inclusion TWG – Provide feedback to consultant on methodology and share procedures and documents. SHIVYAWATA – Coordinate consultations with their members.	Report with recommendations on strengthening referral processes for persons with disabilities.	Years 1 & 2	Resources available: *Technical expertise through the Sub-Committee on disability. Resources needed: *Consultant to collate and synthesize referral procedures and documents. *Consultations with health service providers and persons with disabilities.
8.1.2.	Integrate recommendations on inclusion of persons with	MOH (programmes) – Identify care pathways and referral mechanisms	Number of care pathways and referral mechanisms	Years 2-5	Resources available:

	disabilities into care pathways and referral mechanisms being revised.	being reviewed and consult with the Sub-Committee on disability. The Sub-Committee on disability – Participate in consultation processes for any health care pathways and referral mechanisms being reviewed.	integrating disability recommendations.		*Technical expertise through the Sub-Committee on disability. Resources needed: *None.
Action Area 8.2: Disability inclusion in quality improvement systems.					
	Actions	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
8.2.1.	Revise the Star Rating Assessment tool, including adding disability to the demographic section of the Client Exit Interview, so that satisfaction can be disaggregated	MOH (Health Quality Assurance) – Coordinate this activity. Sub-Committee on disability – Can be part of the expert group. PMO-RALG and SHIVYAWATA –	Star Rating Assessment tool is published.	Year 2-3	Resources available: *Technical expertise through the Sub-Committee on disability. *Technical support from WHO. Resources needed: *Expert group workshop to adapt SRA tool – One

	for persons with disabilities.[4]	Oversee pilot in a selected region and gather feedback from Quality Improvement Teams (QIT) using the tool.			workshop, 30 participants for two days. *Transportation, sign interpretation and assistants for OPD members supporting the pilot.
8.2.2.	Review feedback systems at national and facility levels for accessibility, in line with standards developed under action area 6.2.	MOH (Health Quality Assurance) – Coordinate this activity. PMO-RALG and SHIVYAWATA – Share accessibility standards when undertaking the SRA pilot (activity 8.2.1).	Accessibility standards are shared with Quality Improvement Teams.	Year 2	*This activity intersects with actions 6.2.2. and 8.2.1. No additional resources required.

[4] Please see the Star Rating Assessment Tool: https://figshare.com/s/cb90b0c9c30dae9587ac. Recommended adaptations include:

- Area 7: Client Focus / 7.1.3: Client Feedback Mechanisms and Complaint Handling – Add a question about the accessibility of the mechanism.
- Area 7: Client Focus / 7.2.1: Clients Satisfied with Services Provided – Add a question about differences in satisfaction for persons with and without disabilities. To answer this, disability should be added to the demographic sections of the Client Exit Interview.
- Area 8: Social Accountability / 8.2.2: HFGC/HFB voices community concerns – Add a question about whether women and men with disabilities are represented on the HFGC/HFB (as referenced in action 1.2.1).
- Area 9: Facility Infrastructure / 9.2.7: Disability-friendly facilities – This question should reference infrastructure standards and communication guidelines developed under action areas 6.1. and 6.2.

Strategic Entry Point 9: Data Collection for Monitoring and Evaluation

PRIORITY Action Area 9.1: Disability-disaggregated data in DHIS2 tools.					
	Action	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
9.1.1.	Develop / identify appropriate indicators on health equity for persons with disabilities to be included in DHIS2 tools.	MOH (Health Information System Programme) – Coordinates activity. Sub-Committee on disability – Participate in workshops with HISP and advise on pilot locations. Selian Hospital & Sightsavers & CCBRT – Share lessons learned in disaggregating health information by disability.	"Book" (manual) on data collection on health equity for persons with disabilities in the DHIS2. Case studies and examples of disability data disaggregation at facility level.	Year 1	Resources available: *DHIS2 tools and technical resources. *WHO technical support and guidelines on disability data collection. *PMO-PPCD – Can contribute lessons learned from the development of the "disability database". *SHIVYAWATA – has already undertaken from preliminary research on the gaps. *Selian Hospital & Sightsavers & CCBRT – All have expertise in disaggregating health information by disability.
9.1.2.	Review the health sector M&E framework and tools to measure indicators on health equity for persons with disabilities.			Year 1 & 2	

9.1.3.	Disseminate disability-disaggregated health indicators and tools, pilot and evaluate implementation.	PMO-RALG & health facilities – Piloting data disaggregation and providing feedback. University of Dar es Salaam – Make adaptations to the DHIS2 tools and platforms.		Year 2-5	Resources needed: *Workshop with HISP and Sub-Committee on disability TWG – One workshop, 30 participants for two days.
Action Area 9.2: Disability-disaggregated data in population-based health surveys.					
	Action	**Key stakeholders and their roles in each action**	**Outputs**	**Timeline**	**Resources available / needed**
9.2.1.	Conduct disability-disaggregated analysis of available population-based survey data (e.g., 2022 Census and TDHS).	MOH (Policy and Planning) – Coordinates with relevant departments and programmes, such as the National Bureau	M&E framework has baseline measures where data is available.	Year 1	Resources available: *Disability data should be available through the 2022 census and TDHS. *WHO and Sightsavers – Technical support in disability disaggregated

9.2.2	Identify priority population-based health surveys and programmes for disability-disaggregation and add questions on disability.	of Statistics (NBS) and the National AIDS, STIs and Hepatitis Control Programme (**NASHCoP**)	M&E framework is revised with appropriate data sources for selected indicators.	Year 1	data collection and analysis. Resources needed: *Workshop with health partners undertaking health surveys (e.g., NBS and NACP) on disability disaggregated data collection and analysis.

Strategic Entry Point 10: Health Systems and Policy Research

Action Area 10.1: Disability inclusive health research agendas.					
	Action	**Key stakeholders and their roles in each action**	**Output**	**Timeline**	**Resources available / needed**
10.1.1.	Inclusion of persons with disabilities in the review (2021-2026) and development (2027) of the National Research Priorities.	National Institute of Medical Research (Committee on Research Agenda) – Coordinating activity. Sub-Committee on disability – Can contribute expertise on research gaps on health equity for persons with disabilities. SHIVYAWATA – Can share the priorities of persons with disabilities for health research based on their experiences as health service users.	Disability inclusion is referenced in National Research Priorities (2027) relating to health.	Year 2	Resources available: *Evaluation of current national research priorities already has indicators on inclusion of persons with disabilities. Resources needed: *Transportation, sign interpretation and assistants for OPD members to participate in meetings.

Action Area 10.2: Disability inclusive health research processes.					
	Action	**Key stakeholders and their roles in each action**	**Output**	**Timeline**	**Resources available / needed**
10.2.1.	Ensure that the National Health Research Ethics Committee (NatHREC) includes a member with disabilities.	National Institute of Medical Research – Coordinating activity and drafting TOR. Sub-Committee on disability – Feedback on TOR and selection process. SHIVYAWATA – Will share TOR / call for applications with members and persons with disabilities.	NatHREC has a process established for representation from persons with disabilities, considering age, gender, and type of impairments.	Year 1	Resources available: *Technical expertise through the Sub-Committee on disability. Resources needed: *Reasonable accommodation for NatHREC member with disabilities to attend monthly meetings. *Orientation and training on ethics processes for
10.2.2.	Develop and disseminate guidelines on inclusion of persons with disabilities in health research, including topics such as criteria for inclusion, ethics and	National Institute of Medical Research – Coordinating activity. Sub-Committee on disability – Review and provide	Guidelines on disability inclusion in health research are published.	Year 3-5	Resources available: *Technical expertise through the Sub-Committee on disability. Resources needed: *Regional sharing and learning workshop to

	safeguarding, informed consent, participatory approaches, and ownership over findings.	feedback on guidelines, and possible case studies.			inform guidelines development. *Launch and dissemination event with health research partners. * Communication materials – Posters and Easy-to-Read formats.

6. Monitoring, evaluation, and review of the Action Plan

Monitoring and evaluation of health outcomes for persons with disabilities and disability inclusion in the health system helps to identify gaps, determine priorities, set baselines and targets, and track progress towards health equity. The Monitoring and Evaluation (M&E) Framework for the Action Plan is aligned with the wider health sector M&E system. It describes disability indicators across different levels of the results chain from the HSSP V M&E Framework, including health system inputs, structures, and processes; health system outputs relating to access and quality; outcomes relating to health service coverage and risk factors; and impact relating to morbidity and mortality measures.

A baseline and target for each indicator will be set, and data sources are proposed with reporting intervals. There is limited quantitative data relating to the health of persons with disabilities available. As such, strategic Entry Point 9 of the Action Plan seeks to expand the collection and analysis of data on persons with disabilities through routine health information systems and population-based health surveys. Once available, such data can fill gaps in baselines and targets.

The M&E framework should provide information on disability inclusion in the health to inform policy discussions and the revisions to the national strategic and operational plans. The monitoring process will include an annual evaluation meeting of the Sub-Committee on disability to reflect on the activities undertaken in the previous year; analyse available data demonstrating progress towards outputs and outcomes; and feed into annual health sector operational planning for the next year.

Action Plan Monitoring and Evaluation Framework

Objective: Preventative and curative services improved.	Impact									
	#	**Outcome**	**Output**	**Indicator Name**	**Indicator Definition**	**Baseline 2026**	**Target 2031**	**Data Source**	**Responsibility**	**Reporting Frequency**
	1	Number of living days per individual improved	Diseases prevalence controlled against individual person	Life expectancy at birth	Life expectancy at birth in years for women and men with disabilities in years.	TBD	TBD	Needs changes to census or TDHS questionnaire or DHIS2.	Tanzania Bureau of Statistics MOH Health Information System Programme	TBD
	2	% of women giving birth safely	Death among women during delivery reduced	Maternal mortality ratio	Number of maternal deaths during a given time period per 100,000 live births during the same time period among	TBD	TBD	Needs changes to census or TDHS questionnaires or Maternal Death Surveillance and Reporting system.	Tanzania Bureau of Statistics MOH Health Information System Programme	TBD

	#	Outcome	Output	Indicator Name	Indicator Definition	Baseline 2026	Target 2031	Data Source	Responsibility	Reporting Frequency
					women with disabilities.					
	3	% of population living free from NCD incidence	NCD incidence among community controlled	Mortality due to NCDs	Percent of deaths among women and men with disabilities ages 30-70 years which are due to NCDs (cardiovascular, cancer, chronic respiratory disease, and diabetes).	TBD	TBD	Adapted DHIS2 data on causes of death.	MOH Health Information System Programme	Every four years with HSSP monitoring and evaluation.
	Coverage									
	#	**Outcome**	**Output**	**Indicator Name**	**Indicator Definition**	**Baseline 2026**	**Target 2031**	**Data Source**	**Responsibility**	**Reporting Frequency**

	4	% of pregnant women attending clinics	Default clinic attendance of pregnant women reduced	Timing and number of antenatal care visits	(a) Percentage of women with disabilities aged 15-49 who had a live birth and / or still in the 2 years preceding the survey who received first antenatal care visit in the first 3 months of pregnancy.	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.
		% of pregnant women with disabilities protected against death risk	Delivery complications among pregnant women with disabilities reduced		(b) Percentage of women with disabilities aged 15-49 who had a live birth and / or still	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.

					in the 2 years preceding the survey who received antenatal care four or more times.					
	5	% of married women with disabilities protected against unintended pregnancies	Death risk among married women with disabilities controlled	Modern family planning methods	(a) Percentage of married women with disabilities aged 15-29 years demand for family planning that is satisfied by modern methods.	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.
		% of women with disabilities access to health	Death risk among women with disabilities controlled		(b) Percentage of all women with disabilities aged 15–49 years who	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.

		services increased			have their demand for family planning that is satisfied by modern methods.				
	6	% of women with disabilities attended by skilled birth personnel increased	Barriers that prevent women with disabilities from accessing skilled birth attendants reduced	Skilled birth attendants	Percent of women with disabilities who had live births and/or stillbirths in the 2 years preceding the survey and delivered by a skilled provider.	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.
	7	% of children protected against infectious disease	Disease prevalence among children controlled	Childhood vaccination	Percentage of children with disabilities aged 24–35 months who were fully	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.

					vaccinated (according to national schedule).					
	8	% of women with disabilities tested for HIV increased	HIV prevalence among women with disabilities reduced	HIV testing	Percentage of women and men with disabilities ages 15–49 years who report having ever been tested for HIV and received the test results.	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.
	9	% of women with disabilities living with HIV on	HIV prevalence among women with disabilities reduced	ART coverage	ART coverage among people with disabilities living with HIV, with viral load	TBD	TBD	Need to find out what data is collected through the National	National AIDS Control Programme (NACP).	Every four years with HSSP monitoring and

		ART increased			suppression.			AIDS Control Programme (NACP).		evaluation.
	10	% of women with disabilities screening for cervical cancer increased	Cervical cancer prevalence among women with disabilities controlled	Cervical cancer screening	Percentage of women with disabilities aged 30-50 years ever tested by a doctor or health care worker for cervical cancer.	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	HSSP V Indicator 9: Cervical cancer screening coverage among women 30-50 years in last 3 years.	
	11	% of women and men with disabilities screened for eye conditions increased	Avoidable blindness controlled among persons with disabilities	Eye conditions screening	Percentage of women and men with disabilities aged 5 and above years ever screened for eye conditions.	TBD	TBD	Health Management Information System (HMIS)	MOH - National Eye care programme and DCS	

	12	% of women and men with disabilities screened and treated for hypertension increased	Deaths due to hypertension among women and men with disabilities reduced	Hypertension screening and treatment	(a)Percentage women and men with disabilities aged 15–49 who have ever had their blood pressure measured by a doctor or other health care worker.	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.
		% of women and men with disabilities given medication prescriptions improved	Barriers to access essential medications for women and men with disabilities removed		(b) Percentage of women and men with disabilities aged 15–49 who have been told by a doctor or other health worker that they have high blood	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.

					pressure or hypertension that are prescribed medication to control their blood pressure.					

Have not seen anything on disease outbreaks/emergencies

Risk Factors									
#	**Outcome**	**Output**	**Indicator Name**	**Indicator Definition**	**Baseline 2026**	**Target 2031**	**Data Source**	**Responsibility**	**Reporting Frequency**
13	% of stunting among female and male children with disabilities reduced	Death incidence among female and male children with disabilities controlled	Child stunting	Percentage of female and male children with disabilities under age 5 classified as having stunting (height for age <-2 standard deviation from the median of the WHO	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.

				Child Growth Standards).					
14	% of nutrition status among female and male children with disabilities improved	Death incidence among female and male children with disabilities controlled	Child malnutrition	Percentage of female and male children with disabilities under age 5 classified as being malnourished (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards WHO Child Growth Standards).	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.
15	% habit smoking among women and men with	Lung cancer incidence among women and men with	Tobacco use	Percentage of women and men with disabilities aged 15–49 years who	TBD	TBD	Tanzania Demographic and Health	Tanzania Bureau of Statistics	Every four years with the TDHS.

#	Outcome	Output	Indicator Name	Indicator Definition	Baseline 2026	Target 2031	Data Source	Responsibility	Reporting Frequency
	disabilities reduced	disabilities controlled		currently smoke any tobacco products.			Survey (TDHS)		
Health System Outputs – Access and Quality									
#	**Outcome**	**Output**	**Indicator Name**	**Indicator Definition**	**Baseline 2026**	**Target 2031**	**Data Source**	**Responsibility**	**Reporting Frequency**
16	% of persons with disabilities' satisfactory care reporting increased	Barriers to persons with disabilities accessing satisfactory care removed	Experience of care.	Percentage of persons with disabilities reporting satisfactory care.	TBD	TBD	Adapted Star Rating Assessment Tool.[5]	MOH Quality Assurance	Annual
17	% of men and women with disabilities aged 15–49 who	Difficulties to men and women with disabilities aged 15–49 who reported that	Barriers to accessing facilities	Percentage of men and women with disabilities aged 15–49 who reported that they have	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.

[5] Area 7: Client Focus / 7.2.1: Clients Satisfied with Services Provided – Add a question about differences in satisfaction for persons with and without disabilities. To answer this, disability should be added to the demographic sections of the Client Exit Interview.

#	Outcome	Output	Indicator Name	Indicator Definition	Baseline 2026	Target 2031	Data Source	Responsibility	Reporting Frequency
	reported that they have serious problems in accessing health care increased	they have serious problems in accessing health care decreased		serious problems in accessing health care for themselves when they are sick, by type of problem.					
18	% of facilities with disability inclusion in the essential service package increased	Facilities with limited disability inclusion in the essential service package decreased	Inclusive essential service package implementation	Number of health facilities implementing guidelines / standards on disability inclusion in essential services.	No guidelines / standards adopted.	At least two facilities meeting guidelines/ standards.	Assessment reports and case studies.	Sub-Committee on disability or equivalent	Annual

Health System Structures, Processes, and Inputs

#	Outcome	Output	Indicator Name	Indicator Definition	Baseline 2026	Target 2031	Data Source	Responsibility	Reporting Frequency
19	% of persons with disabilities	Limitation of persons with disabilities involvement	Inclusive governance mechani	(a) Number of Sub-Committee on disability or	0	6 (at least 2 per year)	MOH meeting minutes	MOH Focal Point	Annual

	involved in TWG increased	in TWG removed	sm on disability inclusion in the health sector	equivalent coordination meetings on disability inclusion in health.					
	% of persons with disabilities involved in TWG increased	Limitation of persons with disabilities involvement in TWG removed		(b) Percentage of Sb-Committee on disability or equivalent coordination meetings on disability inclusion in health with representation from OPDs.	N/A	80%	MOH meeting minutes	MOH Focal Point	Annual
	% of persons with disabilities involved in Health Facility Governan	Limitation of persons with disabilities involvement in in Health Facility Governance		(c) Percentage of Health Facility Governance Committees with representation from women	TBD	TBD	Adapted Star Rating Assessment Tool.[6]	MOH Quality Assurance	Annual

[6] Area 8: Social Accountability / 8.2.2: HFGC/HFB voices community concerns – Add a question about whether women and men with disabilities are represented on the HFGC/HFB (as referenced in action 1.2.1).

	ce Committees increased	Committees removed		and men with disabilities.					
20	Number of NHPSP developed with disability inclusion increased	Action plan for NHPSPs are disability inclusive during development	Disability inclusion in national health policies, strategies, and plans (NHPSP).	(a) Percentage of NHPSPs developed during the action plan period with concrete actions on disability inclusion.	N/A	30%	Review of NHPSPs	Sub-Committee on disability or equivalent	Annual
	Proportion of disability stakeholders participating in development of action plan for NHPSPs increased.	Limitation to participation of disability stakeholders in development of action plan for NHPSPs are removed		(b) Percentage of NHPSPs developed during the action plan period with participation by disability stakeholders. Disaggregated by government, UN,	N/A	50%	Review of stakeholder lists in NHPSPs. Survey / feedback from working group, committee, or other governing body members.	Sub-Committee on disability or equivalent	Annual

				NGOs/service providers and OPDs.					
21	% of persons with disabilities with any type of health insurance increased	Barrier to access of insurance scheme among persons with disabilities reduced	Health insurance coverage	Percentage of women, men, and children with disabilities with any type of health insurance.	TBD	TBD	Tanzania Demographic and Health Survey (TDHS)	Tanzania Bureau of Statistics	Every four years with the TDHS.
22	Health plans, regulations, tools, policies, guidelines are disability inclusive	OPD and disabilities committee capacity on health systems planning improved.	Training of OPDs and disability committees.	Number of trainings conducted with OPDs and disability committees on health system planning during the action plan period.	N/A	27	Survey / feedback from working group, committee, or other governing body members.	Sub-Committee on disability or equivalent	Annual
23	Number of audit and accreditation tools revised to	Disability accessibility audit report in public and private	Disability inclusion in private and public	Disability inclusion is integrated into existing audit and	No mechanism exists.	Disability criteria is included in auditing	Review of audit and accreditation tools.	MOH Quality Assurance	Annual

	integrate disability.	health facilities.	health service regulation.	accreditation processes for health service providers.		and accreditation tools.			
24	% of persons with disabilities utilizing essential health package increased	Barriers to access essential health services for persons with disabilities reduced.	Inclusive essential service package planning.	Guidelines / standards on disability inclusion in the essential health care package are adopted.	No guidelines / standards adopted.	Guidelines / standards on disability inclusion are adopted.	NEHCIP-TZ implementation plan.	Sub-Committee on disability or equivalent	Annual
25	Number of health courses with integrated disability modules.	Training materials on disability inclusion are approved by relevant authority.	Health workers training on disability inclusion.	(a) Percentage of accredited health training courses with an appropriate disability inclusion module.	0	50%	Survey / feedback from NACTVET and professional councils.	NACTVET and professional councils.	Annual
	% of persons with disabilities attended by skilled health	Trained health workers with basic skills on disability		(b) Number of health workers who receive appropriate training on	TBD	TBD	NACTVET and professional councils training	NACTVET and professional councils.	Annual

	care provider	inclusion increased		disability inclusion.			databases .		
26	Number of health facilities that meet minimum accessibility criteria for persons with disabilities	Accessibility barriers at health facilities for persons with disabilities are reduced	Health facilities are physically accessible.	Percentage of health facilities that meet accessibility standards and guidelines.	TBD	TBD	Adapted Star Rating Assessment Tool.[7]	MOH Quality Assurance	Annual
27	Number of health facilities with accessible health information and communication materials	Health information and communication accessibility barriers at health facilities for persons with disabilities are reduced	Health information and communication are accessible.	Percentage of health facilities which have health information and communication available in accessible formats, e.g. Braille, Easy-Read,	TBD	TBD	Adapted Star Rating Assessment Tool.[12]	MOH Quality Assurance	Annual

[7] Area 9: Facility Infrastructure / 9.2.7: Disability-friendly facilities – This question should reference infrastructure and communication standards and guidelines developed under action areas 6.1 and 6.2.

				captioning, sign language.					
28	Revised digital health strategy to include disability accessibility standards	Implementation of standards on accessibility is reflected in the Digital Health Strategy	Standards for digital accessibility adopted.	International digital accessibility standards are at a national level.	No standards adopted.	Standards are adopted.	Digital health strategy.	MOH Information Communication Technology	Annual
29	Number of health facilities with accessible feedback mechanism systems for persons with disabilities	Disability friendly feedback mechanisms are accessible at health facilities	Client feedback and complaint mechanisms are accessible.	Percentage of health facilities which have accessible feedback and complaint mechanisms.	TBD	TBD	Adapted Star Rating Assessment Tool.[8]	MOH Quality Improvement	Annual

[8] Area 7: Client Focus / 7.1.3: Client Feedback Mechanisms and Complaint Handling – Add a question about the accessibility of the mechanism.

30	% of councils reporting disaggregated data for disability in health information system increased.	Availability of data collection and reporting tools that collect disaggregated data for disability.	Disability disaggregation in health information.	Percentage of districts collecting disability-disaggregated health data.	0	10%	Adapted DHIS2	MOH Health Information System Programme	Annual (starting in 2025)
31	% of people living with disability	Lives of individuals with disability improved	Prevalence of Disability.	Proportion of individuals within the population who have a disability. Disabilities can be physical, sensory, intellectual, or mental health-related	11.2% (2022 Census)[9]	Not appropriate	Tanzania Demographic and Health Survey (TDHS) National Population and Housing Census	Tanzania Bureau of Statistics	Every four years with the TDHS.

[9] As presented by UN Women Tanzania on 19th October 2023. https://www.unwomen.org/sites/default/files/2023-10/2_unw_tanzania_promoting_disability_inclusion_2023-10-19.pdf

32	Number of research guidelines developed that promote disability inclusion.	Research guideline revised to promote disability inclusion	Established mechanisms to promote disability inclusion in health systems and policy research.	Number of health research guidelines and committees which reflect disability inclusion.	0	At least, one committee (e.g., NatHREC) and one guideline.	NatHREC meeting minutes. NIMR publications.	National Institute of Medical Research	Annual

Annex 1: Sub-Committee on disability Terms of Reference

The Terms of Reference for the Sub-Committee will be revised and agreed upon during the first meeting.

Purpose

The purpose of the Sub-Committee on disability matters is to oversee and monitor the implementation of the ***Health Equity for Persons with Disabilities Action Plan 2026-2031*** (herein referred to as the Action Plan). The Action Plan is aligned with and contributes to health sector priorities as outlined in the HSSP V and is organized around the health systems strengthening building blocks.

Scope

The Sub-Committee on disability will ensure that disability and the actions outlined in the plan are integrated into national health strategies, policies, and plans, and in the health sector processes. The cross-cutting nature of the Action Plan means that the Sub-Committee on disability should be contributing to health systems and programmes, not establishing new systems and processes.

Role and responsibilities

Leadership

The Sub-Committee on disability is expected to lead the implementation of the Action Plan. This will include designating focal points to represent disability inclusive actions in other health related TWGs; official monitoring, evaluation and reporting on disability inclusion in the health sector; and making recommendations and progress reports to senior management in MOH. The Sub-Committee on disability will also become an official body to be engaged in the development of national health policies, strategies, and plans, providing technical inputs relating to disability inclusion.

Information sharing

The Sub-Committee on disability will build a collaborative, cooperative, supportive environment for sharing knowledge, information, and experience. It provides structure for information-sharing on disability inclusion in the health sector among stakeholders and sectors. Ideally, this information sharing will help to identify strategic opportunities to advance the Action Plan.

Coordination

The Sub-Committee on disability will assign roles to different members in the implementation of the Action Plan, based on their respective organization's priorities, expertise, and capacities. This will include coordination with relevant MOH departments, units and programmes who must adopt disability inclusive actions; National Advisory Council on Disability; local government authorities (LGAs) at council, ward, village, and community levels; and civil society organizations and groups, including NGOs and organizations of persons with disabilities (OPDs).

Monitoring & Reporting

The Sub-Committee on disability will collate information and write an annual report about the progress of implementation of the Action Plan, in line with the Action Plan monitoring and evaluation framework.

Membership

The Sub-Committee on disability will be coordinated by MOH and have representatives from MOH departments responsible for the implementation of actions, PMO-RALG, PMO-PPCD, selected health and disability NGOs, development partners and OPDs. More specifically:

- MOH – Secretariat for the Disability Inclusion Subcommittee invite members, coordinate meetings twice a year, and ensure appropriate documentation.
- PMO-RALG – Coordinate implementation of action plan, through local government authorities (LGAs) at council, ward, village, and community levels.

- PMO-PPCD – Coordinate between the MOH TWG and the National Advisory Council on Disability on Action Plan implementation.
- SHIVYAWATA – Nominate two representatives (one female and one male) to participate in TWG initiatives and share information and collect feedback from persons with disabilities.
- Other TWG members – Contribute technical expertise to the activities outlined in the Action Plan. Raise issues of health equity for persons with disabilities in other TWGs, policy and planning consultation processes, and in multi-sectoral coordination forums or bodies (e.g., National Advisory Council on Disability)

Members should be selected to ensure that all relevant stakeholders are equitably represented. The gender balance should also be considered in the group, with spaces created to receive inputs from organizations working with women and girls, and persons with different types of disabilities.

Members should be given sufficient authority by their organizations to make decisions. While it is important to have sufficient representation of these key stakeholders, the Sub-Committee on disability will need to strike a balance between full representation and the functionality of the group.

Meeting format and rules

The meeting format and rules should conform to national norms. Standard operating procedures may be elaborated, transparently and according to the principles of best practice, to guide the activities of the Sub-Committee on disability.

Permanent Secretary, Ministry of Health should appoint a staff member to oversee and support the activities of the Sub-Committee – this may be the Disability Inclusion desk officer / focal point from within the ministry (to be formalized).

The Sub-Committee on disability will meet at least four times a year to assess progress in the implementation of the Action Plan, identify and address challenges, and adapt to emerging priorities in the health sector. Members can rotate their representatives; however, it is recommended that this is only done annually to ensure continuity.

If the Sub-Committee on disability becomes too large or is given tasks that require specific expertise or input, it may establish ad hoc subgroups or invite new members with appropriate expertise. Any subgroup should have a clearly defined mandate and a focal person.

All members of the Sub-Committee on disability will be invited to share any accommodations required for their participation in meetings. Where needed, reasonable accommodation will be provided for persons with disabilities, including transportation for support people, wheelchair accessible meeting venues, access sign language interpretation, and documents in accessible formats.

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Participants

S/NO	Name	Organization
1.	Dr. Hamad J. Nyembea	Ministry of Health
2.	Dr. Mwinyikondo J. Amir	Ministry of Health
3.	Dr. Msafiri N. Kabulwa	Ministry of Health
4.	Mr. Christopher Mariba	Ministry of Health
5.	Mintanga M. Milulu	Ministry of Health
6.	Edwin Oliver	Ministry of Health
7.	Cornelio S. Bayo	Ministry of Health
8.	Edith Masenga	Ministry of Health
9.	Dr. Omary Nassoro	Ministry of Health
10.	Dr, Asteria Mpoto	Ministry of Health
11.	Amina Mfaki	PO-RALG
12.	Wambura Kizito	Prime Minister's Office-Labour, Youth, Employment and Persons with Disability

13.	Yohana T. Mcharo	Commission of Human Rights and Good Governance
14.	Emanuel Makundi	National Institute of Medical Research
15.	Albert Chaki	Community Based Rehabilitation Network Tanzania
16.	Jonas Lubago	SHIVYAWATA
17.	Tungi Mwanjala	SHIVYAWATA
18.	Happiness Kosianga	SHIVYAWATA
19.	Edwin Maleko	Sight savers
20.	Nesia Mahenge	Christian Blind Mission
21.	Brooke Winterburn	Humanity & Inclusion (HI) (also known as Handicap International Federation)
22.	Daryl Barret	WHO
23.	Mary Kessy	WHO
24.	Dr. Isihaka Mwandalima	UNICEF
25.	Stella Manda	UN WOMEN
26.	Matilda Kivelege	World Bank

27.	Ramadhani Hangwa	UNFPA
28.	Dr. Remy Mnzava	Selian Hospital
29.	Dr. Mgolegrace Mabusi	Help Age Tanzania

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