

**PROJECT TITLE:** Empowering marginalised 40,265 people affected by disability to improve their economic status in Dar es salaam city, Coast region, Lindi, Morogoro and Mtwara regions of Tanzania.

**PROJECT SUMMARY:**

The project will reduce poverty and increase social inclusion for 22,200 poor and marginalised people in disability affected households in Coast Region, Dar es salaam, Lindi, Morogoro and Mtwara regions of Tanzania districts of Coast region, Tanzania. The project will empower this target group to increase household income and demand rights to employment, health services and other social and welfare services. The project will improve basic disability care and leprosy services for an additional 18,000 people in the general population.

**PROJECT DETAILS**

***List of Acronyms***

**CBR** -Community Based Rehabilitation;

**EQA** -External Quality Assessment;

**GFATM** - Global Fund for AIDS TB and Malaria;

**HSWA** - Health and Social welfare Assistant;

**HSWS** - Health and Social Welfare Supervisor;

**JUMAWAM** - Jumuiya ya Uchumi na Maendeleo ya Walemavu

**LF** - Lymphatic Filariasis;

**LTCC** - Leprosy and Tuberculosis Coordinating Committee;

**MDG** - Millennium Development Goal;

**MoU** - Memorandum of understanding;

**M&E** - Monitoring and evaluation;

**NFOWD** - National Forum of Organizations Working with the Disabled;

**NTD** - Neglected Tropical Disease;

**PLA** – Participatory Learning Appraisal;

**PWDMG** – People with Disability Microfinance Group;

**TB** - Tuberculosis;

**UN** - United Nations;

**UNDP** - United Nations Development Programme;

**WHO** - World Health Organisation

**TZS**- Tanzania Shillings

## **PROJECT DESIGN PROCESS**

The target beneficiaries and their communities were consulted to identify the key issues faced by people with disabilities. In group discussion with beneficiaries of People with Disabilities in our similar PWDMGs programme and informal discussions with service users of basic leprosy services, beneficiaries identified **lack of earning power as the main issue negatively affecting their lives**. Target beneficiaries also identified disability care services, and in particular, the provision of disability aids and appliances as another priority area for improvement. The key issues were also identified through day to day interactions between JUMAWAM field staff and beneficiaries over a number of years during the implementation of our health programmes, giving us an in depth knowledge of the local context, the beneficiary communities, and the issues which contribute to extreme poverty and social exclusion. Through this participatory approach community ownership of the project we will increased. We involve beneficiaries in every step of the project planning and we will engage them as volunteers in project implementation. JUMAWAM Members will works in partnership with Government health services providers in implementation of health programmes and through regular formal meetings we will be able to identify gaps and weaknesses in the service delivery package for disabled people and identify best project strategies and practice.

## **PROJECT RATIONALE (PROBLEM STATEMENT)**

Disability prevalence in Tanzania is amongst the highest in the world, estimated at 31.9%, with 10 years of health lost due to disability per 100%. Given that disability affects whole households through increased expenditure on care and loss of household income, the proportion of the population in Tanzania negatively affected by disability is extremely high.

High disability rate has a double negative effect on regions where a high proportion of the population are already living in extreme poverty, such as Coast Region, Dar es salaam, Lindi, Morogoro and Mtwara regions (section 3.3 – MDG 1). Poverty and disability reinforce each other, contributing to increased vulnerability and social exclusion. People with disabilities are amongst the most marginalised of minority groups; often excluded from mainstream development initiatives. This project will address social exclusion and poverty of people living with disabilities and their household members. **By targeting people affected by disability we will directly impact upon MDG 1 because they are disproportionately affected by poverty and are thus one of the groups most off-track to achieve MDG 1.** This project responds to 6 interlinked social and economic barriers for people with disabilities in Tanzania, identified in the planning process:

i. **Social stigma and discrimination (linked to MDG 1, 3 & 6)** the root cause of many issues faced by people with disabilities, stemming from a widespread lack of understanding of disability. Social stigma leads to social marginalisation, lack of equal access to education, employment and social welfare that results in profound poverty for millions of people living with disabilities. Prejudice means that families and communities do not value disabled members, employers discriminate against the disabled, and health workers are reluctant to provide them with care. The impact of stigma is two-fold for people with visible leprosy and LF disabilities, many being excluded from family activity or forced to live away from the family home and the security and care that the home environment provides. Stigma associated with leprosy and LF means that those affected are amongst the most marginalised of disabled people, in turn affecting psychological well-being, further limiting ability to work and perpetuating poverty.

ii. **Gaps in health service provision (linked to MDG 1 & 6)**

**Lack of access to disability care services** - People with physical disabilities often have rehabilitation and disability support needs which are absent at the district level in Tanzania. Those affected have no access to appropriate disability services or assistive devices from local health facilities; there are no physiotherapists in district hospitals. People with disabilities in Coast region incur high costs if they travel to the capital to

access these services; in many cases quality care and assistive devices are simply not available or too expensive. Lack of services results in reduced ability to perform simple tasks and maintain employment. The high cost of accessing disability care, added to loss of economic productivity, result in increased poverty.

**Lack of services to control and treat disabling disease and provide disability prevention** – Leprosy is endemic to the project area, and can cause severe permanent disability (section 3.3 – MDG 6). Data from an East Africa especially Tanzanian study suggests that households with a leprosy affected member have double the rates of household poverty than households with a member who is disabled from any other cause. It is essential to include people with leprosy disability into poverty reduction programmes for general disabled if progress is to be made in reducing extreme poverty. Services to treat leprosy exist at sub-district health facilities however staff lack capacity and management is poor with no referral system, resulting in poor quality of care and a high rate of preventable permanent disability. In Coast region 12% of cases are physically disabled on diagnosis indicating late diagnosis and poor treatment services.

### **iii. Lack of access to employment and wage inequality (linked to MDG 1)**

In Tanzania the cost of disability due to lost income from a lack of schooling and employment, both of people with disabilities and caregivers, is estimated at US\$ 1.2 billion annually, or 1.7% of gross domestic product **Error! Bookmark not defined.** In Africa unemployment rate amongst people with disabilities is usually double that of the general population, as high as 85% or more<sup>1</sup>. Yet the exclusion of disabled people from labour markets not only increases poverty for those with disabilities but also has a negative impact on the wider economy due to low level of local economic productivity, resulting in a lack of growth. Employment opportunities are limited in the project area; a mainly rural area with an economy based on agriculture. There are few

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industries or tertiary service employers, therefore the project will mainly focus on increasing self-employment opportunities.

- iv. Burden of care on family members (linked to MDG 1)** Disability affects the whole family. High cost of disability care and provision of financial support is borne by household members who spend relatively more on health care than households without disabled members. The financial and social burden associated with living in a household with a disabled member contributes to increasing negative attitudes towards people with disabilities. The project will target both people living with disabilities and their household members to bring about maximum impact on poverty reduction.
- v. Lack of participation and 'voice' (linked to MDG 1, 3 & 6)** People with disabilities are often excluded from decision making processes, even those which affect their own lives. Policy design does not always take into account their needs, or policies to protect their rights are not enforced. People with disabilities are often unaware of and lack access to basic civil rights such as health care, education and welfare support. They also lack a 'voice' with which to demand their civil rights and influence decision makers on disability policy.
- vi. Gender inequality (linked to MDG 3)** Women have a low social status in Tanzania, and as a result are often excluded from decision making about their own welfare, making them more vulnerable to poverty (see section 3.3 MDG 3). Women and girls from a poor economic background living with disability live with multiple burdens and as a result are poorer, more marginalised, disempowered and unable to access their rights and entitlements.

There are gaps in provision of social care services and disability rights initiatives. There are NGOs working in the project districts for socio-economic development but none of them includes people with disabilities; JUMAWAM is one in a few NGO in the project area focusing on disability inclusive development through a holistic approach. Microfinance groups as well as institutions provide credit for people in mainstream development programmes, however these often exclude people with disabilities who are viewed as a high credit risk; most are illiterate and unskilled.

The project location has been chosen due to persistent rates of poverty in the project area (see section 3.3 MDG 1) and the high rate of disability in the country, with a focus on disabling diseases which are endemic in the area (see section 3.3 MDG 6), making this project and its comprehensive holistic approach a relevant and timely intervention that will address all three priority MDGs highlighted in section 3.

## **TARGET GROUP (DIRECT AND INDIRECT BENEFICIARIES)**

### **i. Direct Beneficiary**

#### **a. Descriptions:**

People with disabilities affected by poverty and social exclusion; Family members in disability affected households; Children born with clubfoot; General population accessing improved services at 24 sub-district health centres.

#### **b. Numbers**

3,700 people with disabilities, 18,500 family members, 65 children with clubfoot, 18,000 people accessing basic leprosy services, **total 40,265**

### **ii. Indirect Beneficiary**

#### **a. Descriptions:**

Local communities with increased disability awareness; health staff

#### **b. Numbers**

100,000 general community 2,800 government health staff.

## **POTENTIAL PROJECT IMPACT**

The project will empower people affected by disability to access their rights to employment, health services and other welfare services. The anticipated impact will be reduced poverty and improved quality of life of people affected by disability. The project

will create an environment of personal and economic independence for people living with disabilities and a 'voice'. The project will **directly benefit a total of 40,265 people in Coast region. The core target group are 22,200 people affected by disability and living in poverty in the project area** (2,000 with loco-motor disability, 1,200 leprosy disability, 500 LF disability, plus 18,500 family members in disability affected poor households). The project will also directly benefit an expected **65 children born with clubfoot and 18,000** of the general population expected to utilize improved basic disability prevention and leprosy services. The project will benefit 100,000 of the general public, including community groups and local business owners, who will receive communication messages on disability awareness, and 2,800 health workers and Local Government staff with improved skills. The project will bring about the following changes in the lives of these beneficiaries within the timeframe of the project:

- Increase in income of target beneficiaries living with disability from <\$1 per day (80%, lower national poverty line) to >\$2 per day (\$1.25, upper national poverty line) (MDG 1).
- Increase in the number of disabled people able to fully participate in family and community life from <15% to >65%.
- Increased proportion of disabled people, with equal opportunities for men and women, employed or self-employed from below 10% to 65% (MDG 1 and MDG 3).
- Reduced burden of disability and increased mobility through disability referral services expected to achieve utilization of 50% of people with general disabilities and 90% of leprosy disabled, resulting in improved functional mobility and reduced disability rate in new leprosy cases from 12% to less than 6% by providing timely treatment to prevent disability (MDG 6).
- Increase in knowledge of health staff in providing appropriate quality disability care, bringing long-term benefits and added value to the programme (MDG 6).
- People with disabilities will have increased knowledge on their rights to basic services and the confidence to advocate with service providers for improved social services.
- Equal participation of men and women in group leadership and advocacy initiatives will empower women and challenge the male dominated environment (MDG 3).

These changes will enable the target group to reconstruct their lives which have been ravaged by disability, rejection and extreme poverty in order to establish meaningful participation in society and improve their own lives by demanding their rights to employment and welfare services.

## **PROJECT APPROACH / METHODOLOGY**

It is estimated that the rehabilitation needs of 80% of people with disabilities could be satisfied at District level with at least rehabilitation centers 3; The remaining 20% are likely to require referral to some kind of specialist facility. This project will meet the needs of the target group through a comprehensive Community Based Rehabilitation (CBR) approach combining delivery of disability services at district level with community empowerment, to address the six barriers listed in the problem statement.

**Output 1 - Specialized integrated general disability care provided at three referral centers.** Three district disability referral centers will be established; integration into government facilities will enable on-the-job capacity building of government staff and advocacy with management staff. The centers will each be staffed by a physiotherapist working alongside government staff for skills transfer. The centers will be supplied with equipment and consumables to provide comprehensive secondary level services appropriate for loco-motor disability; physiotherapy, correction of child club-foot, treatment of complicated ulcers, and provision of disability appliances and protective footwear. Delivery of disability referral services will contribute to improved health and reduced negative impact of disability, increasing economic productivity (*relates to barriers 1, 2, 3 & 4 identified in section 4.4*).

**Output 2 – Increased capacity of 24 sub-district primary health centers to refer disability cases for secondary level care and provide quality basic leprosy services.** The project will introduce procedures for managing referrals from sub-district health centers to district referral services is. Referral register held at sub-centers and referral forms. Government health staff training will be conducted through formal trainings, technical support, supervision and skill transfer during weekly HSWAs visits, and monthly monitoring meetings with health department. In addition, basic leprosy services will be supported at 24 government sub-district health centers to build capacity to provide quality

diagnostic and treatment services. The project will provide basic disability care consumables and essential non-leprosy drugs; leprosy drugs are provided by WHO. Capacity building will contribute to sustainability and change negative attitudes of health workers towards people with disabilities. A focus on basic leprosy services will reduce the burden of this disabling disease, reducing the rate of permanent disability (*relates to barrier 2 in section 4.4*).

**Output 3 - People living with disabilities are empowered and aware of and able to demand their rights.** The project will facilitate the formation of 150 PWDMGs at the community level and support monthly meetings. Community Volunteers (150) will be identified from the target group and will receive formal training. Training will be provided to group members in group management and human rights issues (one per year). Trainings will be facilitated by JUMAWAM staff with participation from relevant government programme staff. The project will facilitate cross-visits between PWDMGs for learning exposure and self-advocacy initiatives by supporting participation at sub-district level meetings with government officers and local leaders. The project will facilitate the formation of a district level federation of people with disabilities and support representatives to attend national level advocacy meetings with PWD, LTCC and government decision makers. This approach will empower people with disabilities to advocate for themselves for improved access to services and increased participation (*relates to barriers 1, 5 & 6 in section 4.4*).

**Output 4 - Improved self-employment opportunities for people living with disabilities.** Training will be provided for over 2000 PWDMGs members on topics such as animal husbandry and cultivation of food crops by JUMAWAM staff and government livestock and agricultural officers. Vocational training will be provided to around 210 family members from households with limited opportunities for income generation. PWDMGs will open group bank accounts and establish a group fund with member contributions (around TZS 10,000 monthly), promoting financial independence. HSWAs will support PWDMGs to develop business plans. The project will issue groups with a one-off seed fund from which loans can be taken to finance income generation, having undergone group management training and once functioning effectively. This approach will increase

livelihood opportunities, contribute to reduced poverty and improve social status (*relates to barriers 3, 4 & 6 section 4.4*).

**Output 5 - Reduced stigma and discrimination towards people with disabilities.**

Community awareness raising activities will be carried out in the localities of PWDMGs. The project will publish materials on disability rights for general distribution and in community meetings and school programs. Project staff will conduct group awareness sessions on disability rights and advocacy with community leaders and local business owners to decrease discrimination against people with disabilities. These activities are expected to reach 100,000 people. Project staff and volunteers will conduct home visits to people with disabilities to provide family counselling, self-care training and encourage PWDMG participation. This approach will contribute to reduced discrimination towards people with disabilities, increased opportunity for community participation and increased opportunities for business interactions and employment (*relates to barriers 1, 3, 5 & 6 section 4.4*).

The approach is guided by Microfinance Act 2018 and its Microfinance regulations of 2019 as well as special Guidelines to implement a comprehensive program contributing to decreased poverty and social exclusion for adults living with disability and family members. This holistic approach across 15 districts of 5 regions ( Coast Region, Dar es salaam, Lindi, Morogoro and Mtwara regions will bring about greater demonstrable impact from which successful models can be developed for replication. The full 36 month timeframe is required to demonstrate the approach and ensure sufficient time to build capacities to a sustainable level.

**SUSTAINABILITY AND SCALING-UP**

The project will be implemented in collaboration with government departments to build their capacity to respond to the needs of people with disabilities, and to create a link between government departments and beneficiaries. The target groups will be engaged in identifying their rights and entitlements to services which will contribute to increased demand for quality services and sustainable improvement in quality of life. Empowerment has the potential to contribute to long term positive impact through policy change. This approach has the ultimate aim of building the capacity of the district apex of PEDMGs to

register as CBOs. Engaging community volunteers in project implementation to work closely with project staff will build skills required to continue their actions into the future. By playing a facilitative role in the project and empowering PWDMGs to operate their own group activities, monitor their own progress and contribute to their own financial sustainability through generation of a group fund, the project will create a sense of ownership over the project and control over their own outcomes, contributing to sustainability. The direct service delivery within this project will create a model of best practice for providing disability referral services and integrating disability services into mainstream development through skill transfer and gradual hand-over of management responsibility. These evidence based models will be used as an advocacy tool for sustainable improvements in the government health system. The ultimate aim is absorption of services into the government system, with Department of Health taking over administrative and financial management responsibility. The operational costs of Disability Referral Centers are kept relatively low by establishing them in existing health facilities, PWDMGs will be established in existing Local government facilities, thus reducing set up and overhead costs. Community awareness activities will contribute to decreased prejudice towards people with disabilities and increase community acceptance of the project which will facilitate the continuation of activities beyond the project.

### **CAPACITY BUILDING, EMPOWERMENT & ADVOCACY**

All four elements are key to the project approach and are essential for sustainable development.

Capacity building is a key approach contributes to the achievement of several project outputs; Output 1) Formal and on-the-job training provided to health staff, management training to disability referral service centers, self-care training for people with disabilities; Output 2) Formal and on-the-job staff training and supervision on disability prevention and basic leprosy service provision; Output 3 & 4) Training to PWDMGs on group management and livelihoods skills, training on disability rights awareness. Empowerment is central to this project, the core target group will be facilitated to reach their own development goals and take on a decision making role. Core target group will be provided with the skills to manage and participate in a PWDMG, undertake advocacy initiatives and generate an income. The core target group will be empowered to form a district

federation that will generate confidence and self-esteem for both individuals and communities affected. A key approach in achieving outputs 3 and 4. Advocacy; rather than advocate on behalf of beneficiaries, the project will empower and enable the target group to carry out their own advocacy initiatives, based on the issues they have identified and their own demands. These initiatives will be facilitated through providing access to forums with government and policy makers and community leaders. This will lead to increased participation at various forums and is key to achieving the project outcome.

### **GENDER AND SOCIAL INCLUSION**

Women have a low social status in Tanzania, making them one of the groups most excluded from decision making about their own welfare and more vulnerable to poverty, they become more vulnerable with extreme poverty when they are disabled. Access to employment for women is unequal in Tanzania; total labour force participation rate for women is just 36% compared with 83% for men. Women and girls from a poor economic background who live with disability experience multiple burdens and as a result are poorer, more marginalized and unable to access their rights. Women in Tanzania are disproportionately affected by disability. This project will empower women to engage in decision-making processes about the nature and quality of their lives. The project will prioritize full inclusion of women in all aspects of the project activities. We expect to achieve an equal gender balance in PWDMG membership and leadership.

The project will also promote gender equality by endeavoring to ensure an equal gender balance in staff recruitment. All positions will be open to both men and women and we will attempt to employ 50% female staff into key positions such as HSWAs and physiotherapists, and ensure a gender balance in management staff.

### **VALUE FOR MONEY (VFM)**

JUMAWAM's approach is to strengthen existing systems and build capacity of service providers such as government health workers, contributing to sustainability but also reducing program costs; strengthening existing institutions is more cost effective than establishing and growing new ones, and avoids unnecessary duplication. Our project adds value beyond the life of the project through capacity building to benefit disabled

people into the future. Evidence from our referral centres in India demonstrates the cost-effectiveness of providing disability services at on average just \$3.80 per beneficiary per year. Our self-care training approach employed in this project costs just \$52.80 to train a person disabled by LF. Under this project training for government health staff will cost just \$200 per beneficiary but will bring lasting improvements in quality of care. The cost of livelihoods training is around \$20.35 per beneficiary, in comparison with the target to increase income from well below \$1.25 per day (TZS.2,900) to above \$2 per day, this will bring about rapid improvements in economic status for a small investment. Establishing a community managed group fund to which beneficiaries contribute is a cost-effective and sustainable approach to provide financing for small businesses in the future. Community awareness activities will reach an estimated 100,000 people for a cost of around just \$ 20 For an average cost of just \$102.7 per beneficiary this project will lift 40,265 people in Five of regions of Tanzania out of extreme poverty and provide them with disability care services, improving their quality of life and ability to participate in society; and provide 18,000 people with essential disability prevention and leprosy services. JUMAWAM would be the only organization providing a comprehensive CBR approach for disabled people in the 3 districts of each region, therefore without this intervention the economic condition of the target group will remain unchanged. The cost under this project will be restricted to 7% with all funds spent directly on the costs of supporting the project through monitoring and reporting.

The total three year project is **\$4,130,000** annually equivalent to **\$12,390,000** to complete the project,

## **1. Project title**

The Organization capacity building and administration costs is **\$416,000** annually