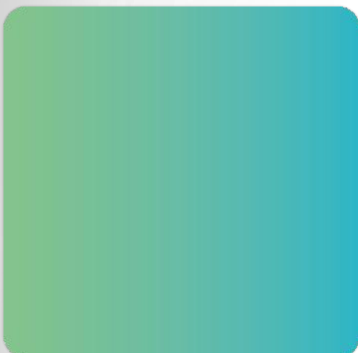
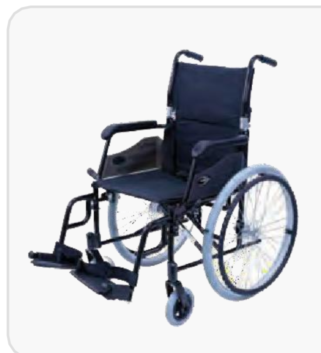
The United Republic of Tanzania

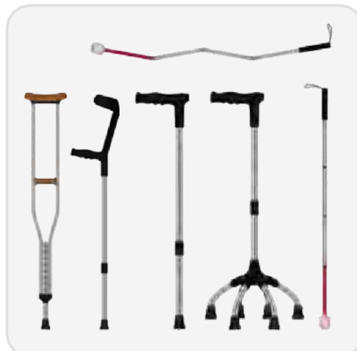
Prime Minister's Office
Labour, Youth, Employment & Persons with Disability

NATIONAL ASSISTIVE TECHNOLOGY STRATEGY

2024 - 2027







Dodoma
November, 2024

Copyright © Prime Minister’s Office, United Republic of Tanzania – November 2024

This publication was produced by the Prime Minister’s Office - Labour, Youth, Employment and Persons with Disability (PMO-LYED), United Republic of Tanzania. Its contents are the responsibility of the PMO-LYED and do not necessarily reflect the views of other Collaborators. With prior permission from the Prime Minister's Office, any part of this document may be reproduced or adapted to meet local needs.

Foreword

Assistive Technology enables and promotes inclusion and participation, especially of persons with disabilities, aging population, and people with non-communicable diseases in social, cultural, entertainment, sports and economic activities. The primary purpose of assistive products is to maintain or improve an individual's functioning and independence, thereby promoting their well-being. They enable people to live healthy, productive, independent and dignified lives, and to participate in education, the labour market and civic life.

Despite the global need and recognized benefits of assistive products, access to assistive products remains limited. Addressing this unmet need is essential to progress towards the achievement of the Sustainable Development Goals and realizing the Convention of the Rights of Persons with Disabilities. The situational analysis of Assistive Technology (AT) in Tanzania shows that the need for assistive technology is high and is increasing due to the rise in the disability and aging population, NCDs, road traffic accidents, and other emergencies. At the same time, access to safe, effective, and affordable assistive products is limited. Absence of a national strategy, cross-sector programmes for AT services and inadequate financial resources limit the country's capacity for expanding access to AT.

The development of the National Assistive Technology (AT) Strategy (NATS) is consistent with the Government's commitment to prioritize disability-inclusive development in line with the Tanzania Development Vision 2025 (TDV 2025) and the Draft National Vision 2050.

The NATS places the primary responsibilities of Policy, Leadership and Governance of AT services within the Prime Minister's Office - Labour, Youth, Employment and Persons with Disability (PMO-LYED). The Ministry of Health (MoH) will play a leading role in provision of AT products and service delivery in close collaboration with the Ministry of Education, Science and Technology and the President's Office, Regional Administration and Local Government. Other sector Ministries, Departments and Agencies; Non-Governmental Organisations (including Organisations of Persons with Disability); Private Sector (including manufacturers, importers, service providers and workshops) will also play a critical role in implementing the strategy.

It is our hope that all stakeholders will use this tool to guide them on how to fulfil their core mandates on improving access to assistive technology through sector specific operational plans and inreporting to the Prime Minister's Office-LYED on the progress being made annually.

Hon. Ridhiwani J. Kikwete (MP),

Minister of State
Prime Minister's Office,
Labour, Youth, Employment
and Persons with Disability

Hon. Jenista J. Mhagama (MP),

Minister for Health

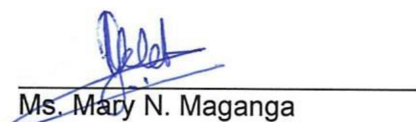
Acknowledgements

On-behalf of the Prime Minister's Office- Labour, Youth, Employment and Persons with Disability I would like to thank all internal and external stakeholders who made invaluable contributions to the development of this National Assistive Technology Strategy (2024 - 2027). In particular, I would like to recognise and appreciate the leadership and guidance of the Permanent Secretary, Ministry of Health that enabled close collaboration of our teams in this process.

I would like to acknowledge the dedicated technical support and advice of the National Assistive Technology Technical Working Group (AT-TWG) members with their respectiveorganizations, Organizations of Persons with Disabilities (OPDs), Older People's Associations (OPAs) and all contributors who made possible the timely development of this guiding document.Specifically, we would like to thank the World Health Organisation, Muhimbili National Hospital, Comprehensive Community Based Rehabilitation Tanzania (CCBRT) and representatives from Sector Ministries, Regional Administrations and Local Authorities who participated fully in the process.

Finally, my sincere gratitude goes to HelpAge Tanzania for their continued technical and financial support to ensure that the development process has culminated into this Strategy that will help improve the access to quality assistive technology products and services in Tanzania.

I look forward to continued cooperation during the implementation of the National Assistive Technology Strategy.



Ms. Mary N. Maganga

Permanent Secretary
Prime Minister's Office Labour, Youth, Employment and Persons with Disability

List of Abbreviationsand Acronyms

Abbreviation/Acronym	Definition
AT	Assistive Technology
ADL	Activities of Daily Living
CCHP	Council Comprehensive Health Plan
CHW	Community Health Workers
COVID – 19	Corona Virus Disease of 2019
CRPD	Convention nf the Rights of Persons with Disabilities
DHIS2	District Health Information System Software, version 2
DPs	Development Partners
GoT	Government of Tanzania
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IPs	Implementing Partners
LGAs	Local Government Authorities
MDAs	Ministries, Departments and Agencies
MEL	Monitoring, Evaluation and Learning
MNH	Muhimbili National Hospital
MOH	Ministry of Health
MOEST	Ministry of Education, Science and Technology
MSD	Medical Store Department
NATS	National Assistive Technology Strategy
NCD	Non-Communicable Diseases
NCPD	National Advisory Council for Persons with Disabilities
NGOs	None Government Organization
OPDs	Organizations of People with Disabilities
PD-MIS	Persons with Disability Management Information System
PMO - LYED	Prime Minister's Office - Labour, Youth, Employment & Persons with Disability
PwD	Persons with Disability
SDG	Sustainable Development Goals
SO	Strategic Outcome
TAP	Training on Assistive Products
UHC	Universal Health Coverage
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations International Children's Emergency Fund
USAID	United State Agency for International Development
WHO	World Health Organization

Glossary of Key Terms

Vocabulary & Terms	Meaning
Assistive Technologies	Assistive technology is an umbrella term covering the systems and services related to the delivery of assistive products and services. This includes innovative means and mechanisms designed to assist persons with disability and seniors people living with disability to enable independent living at home or in residential facilities, and improve quality of life by addressing related difficulties.
Assistive Products	Assistive devices are devices whose primary purpose is to maintain or improve an individual's functioning and independence to facilitate participation and to enhance overall well-being. They include items such as wheelchairs, glasses, prosthetic limbs, white canes, and hearing aids to digital solutions such as speech recognition or time management software and captioning.
Geriatric	Geriatric care refers to medical care for older adults, an age group that is not easy to define precisely. Gerontology is the study of aging, including biological, sociological, and psychological changes. Older age is associated with increasing need for some type of assistive technologies
Palliative Care	Refers to the specialized medical care for people living with a serious illness, (in most cases at their terminal stages of life) such as cancer or heart failure. Patients in palliative care may receive medical care for their symptoms, or palliative care, along with treatment intended to cure their serious illness.
Rehabilitative Care	Refers to as the care for patients who have experienced a debilitating illness (e.g: stroke, injury or major surgery) hence requiring professional services and treatment programs, including applied behavioural analysis and assistive technologies.
Community Based Rehabilitation	A community development strategy that aims at enhancing the lives of persons with disability (PwDs) within their community.
Persons with disability	Persons with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others
Strategy	Refers to a well-defined roadmap of an organization or institution that explains its overall mission, vision and direction to achieve a certain institutional goal.

Table of Contents

Foreword ii
Acknowledgements iii
List of Abbreviationsand Acronyms iv
Glossary of Key Terms v
Section 1: Introduction and Background 1
1.1 Introduction 1
1.2 Background 2
1.3 Current Situation of AT Services in Tanzania 3
1.3.1 Introduction 3
1.3.2 Policy, Leadership, Governance 4
1.3.3 People (Assistive Technology Users) 5
1.3.4 Service Provision 6
1.3.5 Personnel 7
1.3.6 AT Products 8
1.4 Rationale for preparing the National Assistive Technology Strategy 8
1.5 Approach and Methodology 9
Section 2: Strategic Direction 10
2.1 Vision 10
2.2 Mission 10
2.3 Objectives 10
2.4 Core Values 10
2.5 The Conceptual Framework (Theory of Change) 10
2.6 Strategic Focus Areas 11
Section 3: Strategic Areas for Assistive Technologies 12
3.1 Strategic Area 1: Policy, Governance and Leadership 12
3.1.1 Key Issues 12
3.1.2 Strategic Outcome (SO1) 12
3.1.3 Strategies 12
3.2 Strategic Area 2: Service Delivery 12
3.2.1 Key Issues 12
3.2.2 Strategic Outcome (SO2) 13
3.2.3 Strategies 13
3.3 Strategic Area 3: Personnel 13
3.3.1 Key Issues 13
3.3.2 Strategic Outcome (SO3) 14
3.3.3 Strategies 14
3.4 Strategic Area 4: Assistive Technology Products 14
3.4.1 Key Issues 14
3.4.2 Strategic Outcome (SO4) 15
3.4.3 Strategies 15
3.5 Strategic Area 5: Financing of Assistive Technology Services 15
3.5.1 Key Issues 15
3.5.2 Strategic Outcome (SO5) 15
3.5.3 Strategies 15
3.6 Strategic Area 6: Information and Research 16

3.6.1 Key Issues 16
3.6.2 Strategic Outcome (SO6) 16
3.6.3 Strategies 16
Section 4: Institutional Arrangements 17
4.1 National Coordination Framework 17
4.1.1 PMO - LYED 17
4.1.2 National Advisory Council for Persons with Disabilities 17
4.1.3 National Steering Committee for NATS 17
4.1.4 NATS Technical Working Group 18
4.1.5 Sectoral Ministries 18
4.1.6 Regional level 19
4.1.7 Council level 19
4.1.8 Sectoral Roles and Responsibilities 21
Section 5: Monitoring, Evaluation and Learning 29
5.1 Overview 29
5.2 Monitoring and Learning Mechanisms 29
5.3 Evaluation and Reviews 30
5.4 Reporting Plan 30
1) Sub-National Levels 30
2) Sectoral Level 30
3) National Level 31
Section 6: Risks, Assumptions and Mitigation 32
Bibliography 39
Appendices 40

Section 1: Introduction and Background

1.1 Introduction

Assistive Technology (AT) is an umbrella term covering the systems and services that deliver assistive products and services. The World Health Organisation (WHO) defines AT as “the application of organised knowledge and skills related to assistive products, including systems and services.” Assistive Technology products are products external to the human body that maintain or improve an individual’s functioning and independence, promoting their well-being. Assistive Technology services include those provided for identification, screening, assessment, provision of AT products, referral, and follow-up of persons in need of AT.

Globally, more than 2.5 billion people need one or more assistive products. The need for AT is growing rapidly alongside with the rise in non-communicable diseases (NCDs) and an ageing population, whereby, an estimated 3.5bn will need AT by 2050.

The Government of the United Republic of Tanzania (GoT), in recognising the need for AT and its critical role for its citizens in need of AT, ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2009. The CRPD and the optional protocol on the Convention of Rights of Persons with Disabilities is an internationally legally binding treaty to protect the human rights of persons with disabilities. In addition, the GoT has also ratified the UN Convention on the Rights of the Child; the African Charter on Human and People’s Rights; and the Convention on the Elimination of All Forms of Discrimination against Women. While the national policies and legislation for health, older people, persons with disabilities, and social welfare mention assistive devices, AT, or AT products, they do not include actions to improve the availability and access to AT.

The National Policy on Disability (2004) and the Persons with Disabilities Act of 2010 provide AT services' policy and legal framework. However, the policy needs to be revised to include key aspects of AT and new developments that were not present when the policy was drafted. Having the National Assistive Technology Strategy in place will facilitate improved accessibility to appropriate Assistive Technology to people of all ages who need AT services to enable them to independently carry out their daily activities and to participate actively and productively in economic and social development. The population expected to benefit directly from having the National Strategy on AT in place are the persons with disabilities, of which older people are the majority.

1.2 Background

Globally, it is estimated that more than 2.5 billion people worldwide need at least one assistive technology product[1]. With an increased overall aging population, a rise in the population with disabilities, and comorbidities related to non-communicable diseases, the number of people who need AT (Assistive Technology) products is projected to exceed 3.5 billion by 2050. People in need include persons with disabilities, older people, persons suffering from non-communicable diseases, people with mental health conditions, and those with gradual functional decline. Unfortunately, only one-tenth of people in need have access to services, translating to inadequate financing for the components needed to deliver AT services, including policies, personnel, products, and provisions. To cite a few examples, it is estimated that 70 million individuals require wheelchairs, but only 5–15% of people have access to one, and the production of hearing aids only satisfies 10% of the requirement worldwide and 3% of the need in low-income countries. Available evidence indicates that the need for assistive products is influenced by many factors, including a person's functional ability, level of awareness, socioeconomic situation, living context, and environmental interaction. (WHO 2022 Global Report on Assistive Technology)

Africa has more than 200 million people needing one or more assistive technologies. Disability is more common among women, children, older people, poor adults, and those affected by conflicts and disasters. With the region's double burden of diseases, the number of people who need assistive technology is projected to double by 2050. According to WHO and UNICEF, only 3% of the people in low-income countries have access to AT compared to those in high-income countries, where 90% of their people have access to assistive technologies. WHO highlights the key challenges hindering the effective implementation of AT services in Africa, including limited governance and inadequate domestic funding for assistive technology, weak promotion of public-private partnerships, insufficient regulatory capacity, fragmented supply of assistive products, shortage of skilled personnel, and insufficient service provision[2].

The World Health Assembly on 26 May 2018 adopted resolution WHA71.8 that requires member states to develop, implement and strengthen policies and programmes to improve access to assistive technology within universal health and social services coverage[3]. WHO supports Member States in implementing the resolution WHA71.8 and, in turn, to fulfil their related commitments to the Convention on the Rights of Persons with Disabilities and Sustainable Development. Improving access to assistive technology requires a people-centred, assistive technology ecosystem.

[1] World Health Organization. (2022). Global report on assistive technology
[2] WHO (2021). Framework for improving access to assistive technology in the WHO African region. Report of the Secretariat.
[3] World Health Assembly. (2018). World Health Assembly Resolution 71.8 Improving Access to Assistive Technology. https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_R8-en.pdf?ua=1

In order to have a sustainable system for access to AT, WHO recommends a people-centred, assistive technology ecosystem that includes inter-related action involving 4Ps -People - centered Policy, Products, Personnel and Provision as depicted in Figure 1. An overarching policy is crucial across all proposed areas supported by comprehensive data collection and effective financing mechanisms. Effective leadership and governance through national assistive technology policies ensures an adequate supply of quality, affordable products and appropriately trained personnel for effective service provision.

Figure 1: *The five interlinked areas of assistive technology (5P) people-centred: policy, products, personnel and provision (Adapted from WHO Policy Brief: Access to Assistive Technology)*

1.3 Current Situation of AT Services in Tanzania

1.3.1 Introduction

The need for Assistive technology in Tanzania is a significant and pressing issue. Overall, 8% of the population aged five and above grapple with difficulties in their day-to-day activities. According to Tanzania Population and Housing Census of 2022 there are 5.1 million persons (about 11.2%) of the total population aged 7 years and above living with some form of disability (Basic Demographic and Socio-Economic Profile, 2024). Difficulty in seeing (3.0%) and walking (1.9%) are the most common types of disabilities in the country. Prevalence of disabilities has increased from 9.3 percent in 2012 to 11.2 percent in 2022. The use of assistive devices among PWDs is very low. This is more pressing among individuals aged 60 and older (14%) than among younger individuals (4% or lower). The most prevalent challenges are related to seeing and walking, accounting for 7.1% and 3.3%, respectively, followed by hearing (2.2%), communicating (1.2%), and self-care tasks like washing or dressing (1.1%). Statistics show that more women(52.8%) than men (47.2%) are affected. Specifically, 4% percent of women and 3% of men have difficulties or cannot perform a function at all in at least one domain or cannot perform a function in at least one of the domains. Also, 11% of women and 9% of men have difficulty seeing, and 6% of women and 4% of men have at least difficulty walking or climbing steps. This data underscores the

urgent need for assistive technology in the country. Importantly, Tanzania's prevalence trend of difficulties aligns with global trends, indicating a correlation with the aging population. The government has made efforts regarding Assistive Technology services in the country in policy and governance, service provision, human resources, and assistive products. However, significant efforts are still required to improve access to AT services and products among different groups of persons with disability (PwDs) and older people (OP) who face difficulties in daily life activities.

1.3.2 Policy, Leadership, Governance

The Government has prepared policy documents which provide opportunities to safeguard persons with disabilities/loss of body functioning rights. They include the United Republic of Tanzania constitution of 1977, which recognizes the rights of PwDs; the Tanzania Vision 2025, which focuses on removing all forms of inequalities by 2025; the National aging policy designed to protect the rights of older people; the National Disability Policy of 2004 which addresses issues related to the functional ability of persons with disabilities; the Child Act of 2009 that enforces rights for children; The National Guidelines for Inclusion of Persons with Disabilities 2022 provides guidance to service and development sectors on promoting inclusion for persons with disabilities; and the inclusive education strategy of 2021-2026.The country's Health Sector Strategic Plan V (HSSP V) provides actions toward improving provisions for people with special needs, including rehabilitation. In addition, the Comprehensive Council Health Planning Guideline (2020) has a provision for strengthening Social Welfare and Social Protection Services related to early identification, care, and support to children with disabilities and reintegrating PwDs through community-based rehabilitation. The National Rehabilitation Strategic Plan 2021-2026 recognizes the provision of assistive products (e.g. those for mobility, vision, hearing, communication, and cognition) as an important component in rehabilitation.

Additionally, there are legal frameworks that highlight disability inclusion. For example, the Persons with Disabilities Act of 2010 provides protection and promotion of the rights of PwDs in health care, social support, accessibility, rehabilitation, education and vocational training, communication, and employment; the Public Health Act of 2009 contains provisions for accessible health facilities; and the National Client's Service Charter for Health Facilities of 2018 has provisions to support services for people with difficulties, including, accessible formats such as braille, large print, audio-visual materials, simple terms, and sign language interpretation services.

Also, the GoT has shown commitment by signing international treaties related to AT,such as (i) the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (ii) the United Nations Convention on the Rights of Persons with Disabilities and Optional Protocol; and (iii) the Protocol to the African Charter on Human and Peoples' rights on the Rights of Persons with Disabilities in Africa and the International Agreement on the rights of disabled people.

However, there are areas within the existing policy and legal framework that could be improved to advance towards universal access to AT for those in need. These include development of the national standards for AT products, development of the guidance on the qualifications of providers who can prescribe AT products, establishment of the national

priority list of essential AT products, and make available a national guideline on imported AT products. Furthermore, the coordination of AT provision needs to be established, this will help to avoid parallel and uncoordinated efforts among Government Ministries, Departments and Agencies (MDAs), faith-based organizations, and non-governmental partners, including organizations of persons with disabilities and associations of older people. The absence of national coordination framework has impacted the overall process of establishing a national database of individuals needing AT services and products, as well as identifying specific needs, quantifying demand, and determining the procurement and delivery modalities for AT products.

1.3.3 People (Assistive Technology Users)

Assistive technology users in the country can be categorized into two categories—the personswith disabilities (PwDs) and the older people. The latter is susceptible to difficulties (HelpAge, 2024).

According to the 2022 Population and Housing Census, Tanzania Mainland has an estimated population of 59.8 million, comprising 29.1 million males and 30.7 million females. The census results indicated that the percentage of persons with disabilities in Tanzania Mainland increased to 11.2% in 2022, up from 9.3% in 2012. Moreover, data from the 2022 Census show that the prevalence of disabilities among women is 11.3% and among men is 10.7%. The data also show that the prevalence of disability increases with age for both men and women, beginning to rise rapidly in the 40-44 age group and reaching 50.6% for women and 48.8% for men aged 80 and above.

The AT needs assessment conducted in 2024 by HelpAge indicates school-age students make up a larger proportion of PwDs in the country. For example, in 2023, students with disabilities were 0.6% of the total enrolment in schools, with the commonly used assistive equipment being braille sheets, puzzles, hand magnifiers, white cane, Perkins braille, and hearing aids. However, 0.6% is very small as compared to 15% (4,157,497) children with disabilities), as revealed in the survey conducted in 9 regions of Tanzania by Mulongo et al. (cited in HelpAge, 2024), underscoring the choice of the right research instruments.

The assessment report highlights that many AT users require devices such as white stick (particularly among men aged 60+), motorized tricycles, white cane, spectacles, and stimulation tools for individuals with Down syndrome. Hearing aids and wheelchairs are also in high demand. The Challenge is that an adequate number of AT users are not fully informed about existing programs that provide access to these devices and often rely on support from generous individuals. Those who are able to access AT devices cited occasional assistance from local councils, social workers, sponsorship donations, and direct purchases from shops or online channels. While some AT devices are locally produced and available in nearby hospitals, this is only accessible for those living in close proximity. Consequently, a significant portion of AT users (28%) were unaware of where to access these devices, and more than a third (over 32%) were unable to access AT due to insufficient awareness and availability.

Some AT Users access AT devices through some support from donors, self-funded purchases, family support, and arrangements with local artisans who make the devices. The factors that determine access to AT and related services among AT users in the country include the cost of accessing the AT devices and services, the nature of disability and the

belief by some parents that children with disability should be taken care of by the Government. (HelpAge, 2024).

1.3.4 Service Provision

The Government and the NGOs implement several programmes for AT provision in the country. The Government's programmes mainly focus on ICT-based AT, community-based outreach, Clubfoot Treatment (MDH, MNH, CCBRT, FBO & Private), orthotic and prosthetic Workshops (MoH), hearing aids, and continuous audiological assessment. The Government supports ICT-based AT for learning purposes at the Open University of Tanzania (OUT) Headquarters in Dar es Salaam whereby people with disabilities such as visual impairment and the deaf are trained to use AT products and sign languages. However, this program is currently available in a limited number of institutions, highlighting the need for additional efforts to expand its reach to more persons with disabilities (PwDs) by increasing the number of institutions offering the program. Also, about 75% of Government institutions allocate a budget for AT provision, mainly used for buying AT devices used at the institutions, paying for human resources, building infrastructure, procurement of learning resources, and capacity building for healthcare staff taking care of persons with disabilities.

Moreover, there are 80 Government and Private/Faith-based hospitals at national and regional levels (49 and 31 hospitals respectively), including Government and private/Faith-based which provide rehabilitation services, Occupational Therapy, Physiotherapy, Prosthetic & Orthotics, and Speech Therapy. The statistics show that almost all Government hospitals provide Physiotherapy, about 50% of these hospitals provide Occupational Therapy, about one-third (30.6%) of these hospitals provide Prosthetics & Orthotics, and only two hospitals (4%) provide Speech Therapy. At the district level, there are 32 Council hospitals providing rehabilitation services, whereas all of them provide Physiotherapy, only one provides Occupational Therapy, and none provides Prosthetics & Orthotics and Speech Therapy. These figures indicate the need to scale up capacity for providing Occupational Therapy, Prosthetics & Orthotics, and Speech Therapy services at the remaining Council hospitals.

The AT needs assessment report acknowledged that the Government has recently intensified its role and is emerging as a leading entity in the provision of AT services, particularly at national, zonal, and regional referral hospitals. Non-state actors and the private sector also play a significant role in providing AT services within the community; for example, NGOs such as CCBRT, Child support Tanzania, HelpAge Tanzania, Connect Autism Tanzania, Access Tech and Support, Morogoro Elderly People Organisation, Mwangaza, Boresha Macho, and Kyaro Tech provide services to PwD and elders related to assessment, diagnosis, interventions, and the AT ecosystem, including designing, production, maintenance, training, and distribution. These NGOs have programs for producing prosthetics and orthotics, including certification and Parkinsonism programs involving neurologists, physiotherapists, occupational therapists, speech therapists, dieticians, and nurses.

Regarding AT product supply, most AT products used in the country are imported and supplied by the private-sector. Moreover, these suppliers are found in urban areas, leaving the rural areas unreached. Local production of AT products is limited to efforts of local artisans producing mostly clutches and fabrication of eye glasses using imported frames and lenses.

Generally, the challenges of insufficient funds for device purchases, inadequate support systems, and limited availability of necessary inputs hinder AT service provision in Tanzania. Additionally, the absence of national standards for assistive technology contributes to challenges regarding the consistency of imported AT products, which can adversely affect users. Quality assurance guidelines are crucial to address these issues by ensuring that (a) manufactured, procured, and distributed AT devices are appropriate, (b) personnel are adequately trained and follow proper procedures in providing AT, and (c) charity organizations and other well-wishers receive management and guidance to ensure the appropriateness of provided assistive technology.

1.3.5 Personnel

The AT workforce is found across sectors, including Education, health, social workers, faith-based organizations (FBO), and other charity organizations. The AT workforce in Government institutions includes Audiologists, Audiometric technicians, hearing aid technicians, Speech and language therapists, Braille teachers, and Mobility orientation trainers. More AT workforce is found in NGO-based institutions and private institutions, including Mobility orientation trainers, opticians, occupational therapists, physiotherapists, Prosthetists, orthotics, prosthetic and orthotic technicians, community-based rehabilitation workers, Wheelchair technicians, and speech and language therapists.

In the case of human resources for children for PwDs, the Government has made good progress in training personnel for children with disabilities in schools, with Patandi TTC and teacher training universities playing a critical role. In 2023, there were 1,137 teachers with Special Needs Education (SNE) specialization, mostly for intellectual impairment, autism, deaf- blindness and deafness. In addition, the Government is proactive in implementing the SNE guidelines in recruiting teachers, whereby 1,022 teachers with disability have been employed in government schools.

The main challenge to providing assistive technology services in the country is the shortage of trained specialists and rehabilitation professionals. The Human Resources for Health (HRH) Country Profile (MoH 2023) indicates that there is a shortage of 66% health and allied human resources nationwide. The existing AT-trained specialists, such as audiologists, clinical audiologists, and speech therapist services based on the MoH staffing level, are mostlyfound at referral hospitals.

Colleges for Teachers and Allied Health Personnel cater for experts in common impairments such as blindness, deafness, and intellectual limitations while other important specializations such as cognition, communication, mobility, hearing, and self-care are seldom addressed. Consequently, the country has few specialists, particularly in cognition, communication/speech, hearing, and self-care, as some of the functional limitation categories.

1.3.6 AT Products

In 2023, the Government allocated at least TZS 8.7 billion to AT, purchased ICT facilities for PwDs, salaries for AT trainers, payments for outreach programs, purchased materials and therapeutic equipment, capacity building, and service provision. The Government is also a major consumer of AT products for students with disabilities. For instance, in 2023, the PORALG spent TZS 2.5 billion in purchasing assistive devices for primary and secondary schools; in 2020, it spent TZS 3 billion to purchase assistive devices for students with disabilities, with a bias for blind, deaf, intellectual, physical, albinism, and low vision; and in 2019, TZS 2.1 billion was spent on procuring among others, braille, speech trainers, audio meters and white canes for students who are in school.

Since the launch of the inclusive education program in 2021, the Government has regularly conducted procurement processes for assistive products, particularly for inclusive primary schools and special education schools. This initiative has resulted in significant improvements in the quantity, basic technical characteristics, and price documentation of AT products in Education Sector. However, there is a need to replicate the Education Sector's best practice across all sectors of service and development in a unified manner. To achieve this, a national costed plan for the development of requirements and the procurement process of assistive technology (AT) needs to be established, which has not yet been developed. Currently, each Ministry, Department, and Agency determines the types of AT and resources needed in isolation, which may result in over-purchasing or purchasing AT at high costs. Additionally, non-government and private organizations also make procurements of AT independently. Often, the AT products procured by the government are not different from those procured by NGOs and private actors. These products include: Crutches (axillary/elbow); Walking frames; Wheelchairs, manual for active use; Magnifiers, optical (including telescopes); White canes; Braille slate/frame writing equipment and braille paper; ICT-equipment; Canes/sticks (including tripods and Quadri pods); Lower limb orthoses; Lower limb prostheses.

1.4 Rationale for preparing the NationalAssistive Technology Strategy

The development of the National Assistive Technology (AT) Strategy is consistent with the Government's commitment to prioritize disability-inclusive development in line with the Tanzania Development Vision 2025 (TDV 2025) and the Draft National Vision 2050

The situational analysis has revealed gaps and challenges across all five domains: Policy, People, Products, Provision, and Personnel. Enhancing governance, leadership, and national coordination will be crucial in addressing the majority of these existing challenges and gaps. The NATS will provide strategic guidance for all sectors in addressing these gaps in order to realise the vision of the NATS. Each sectoral Ministry will be responsible for developing an operational plan for implementing this NATS that includes the actions of state and non-state actors

The NATS will put in place a national coordination framework under the leadership of PMO-LYED and involving all sectors (public, NGO, FBO and private) and each sectoral Ministry, depending on its core mandate will be required to prepare sector specific operational plans

for implementing the objectives of NATS strategy. The PMO-LYED will establish a steering committee and a National Technical Working Group (TWG) for Assistive Technology. Sector Ministries will use the existing TWGs in their sector dialogue structures to include roles for Assistive Technology and linkage with the National TWG for AT in the PMO-LYED.

1.5 Approach and Methodology

A participatory approach was adopted whereby the PMO-LYED, Key Sector Ministries, Regional Administrations, Local Councils, Organizations of Persons with Disabilities, Older People Organization and other key stakeholders were involved in the process of preparing the National Assistive Technology Strategy (NATS) through participation in the consultations, situation analysis workshop, and key informant interviews and a workshop for validation of the draft NATS. The process also included hearing the community's voices through the involvement of key beneficiaries' representatives in key informant interviews and the situation analysis workshop. The first draft of the NATS was subjected to a review meeting with key regional and district-level stakeholders, including users of Assistive Technology. Inputs from the review meeting informed the development of the second draft which was subjected to. A National Validation Workshop organised and led by the PMO-LYED.

The preparation of the NATS was also informed by the Assistive Technology Country Capacity Assessment conducted simultaneously as the strategy was being developed. The Assistive Technology (AT) capacity assessment report provided additional information for understanding and scoping the extent of access and utilization of AT while looking at the contributing and/or impeding factors for such access and utilization. The assessment further includes data on the country's capacity to finance, regulate, procure, and provide assistive technology. Just before finalizing NATS, the Government launched the 2022 Population and Housing Census: Basic Demographic and Socio-Economic Profile for Tanzania Mainland in April 2024. This report has made a significant contribution by providing data on the country's disability population, the prevalence and trends of disability, and the status of accessing AT products.

Section 2: Strategic Direction

2.1 Vision

Tanzania where any person with a disability is able to access Assistive Technology to restore functionality, well-being and quality of life.

2.2 Mission

To create strong and sustainable systems, mechanisms and structures for delivery of services for provision of universally accessible, equitable, safe, effective and affordable assistive products and services for persons in need of Assistive Technology.

2.3 Objectives

The objectives of this strategy are:

i. To create an enabling environment that brings together multi-sectoral collaborative efforts to improve the accessibility, affordability, and availability of AT for persons with disabilities and others in need of AT.

ii. To improve the availability of qualified and competent human resources for the provision of AT services at all levels.

iii. To increase the supply of safe, effective and affordable assistive products that meet national and international quality standards.

iv. To expand the coverage of services for the provision of assistive products.

2.4 Core Values

The core values that will guide all persons and organisations in the provision of AT services are:

(a) Equity
(b) Inclusion
(c) Integrity
(d) Accountability

2.5 The Conceptual Framework (Theory of Change)

In line with the goal of universal health coverage, leaving no one behind, the National Assistive Technology Strategy is geared towards universal assistive technology coverage, which means that everyone everywhere receives the assistive technology they need. To achieve this, efforts are required in four areas: leadership, governance, financing, information and research (policy); assistive products (products); service delivery (provision); and workforce involved in these areas (personnel). Figure 1 shows the WHO conceptual framework where "people" needing assistive technology are at the centre surrounded by products, personnel and provision. The policy environment provides the space where these are delivered.

The National Assistive Technology Strategy vision and mission with the core values and strategic areas for provision of AT services depicted in Figure 2.

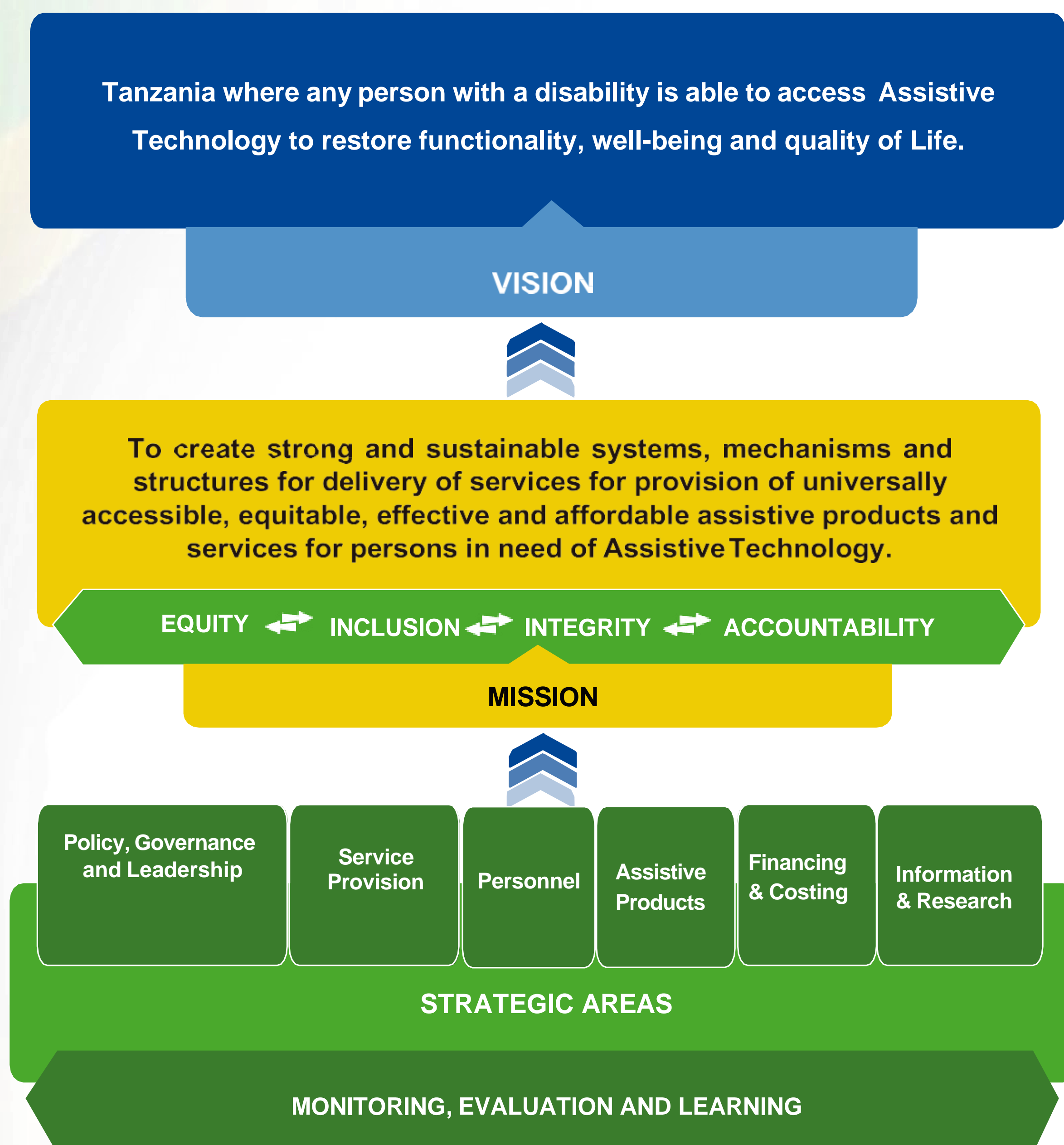


Figure 2: *The NATS Conceptual Framework*

2.6 Strategic Focus Areas

The strategic areas of the Strategy include:

(a) Policy, Governance and Leadership
(b) Service provision
(c) Personnel
(d) Assistive Products
(e) Financing and costing
(f) Information and Research

Section 3: Strategic Areas for Assistive Technologies

3.1 Strategic Area 1: Policy, Governance and Leadership

3.1.1 Key Issues:

a) The existing National Policy on Disability and the associated legal framework that need tobe updated to comprehensively cover AT issues.
b) Absence of a National Strategy to guide the implementation of the Policy includingdefining roles and responsibilities of various actors for disability and AT,
c) The leadership, Governance, and coordination mechanisms for AT are fragmented,with various actor's public, NGO and private working in silos
d) Inadequate inter-sectoral coordination due to the absence of a clear and shared vision on AT services.

3.1.2 Strategic Outcome (SO1):

Policy, Leadership, Governance, and Coordination mechanisms for AT services strengthened at all levels

3.1.3 Strategies:

a) Update national policy and legal framework on Disability to comprehensively addressissues relating to AT.
b) Establish a National Coordination Framework for AT within the PMO-LYED with linkage to existing systems, structures and mechanisms in sector ministries, Development Partners, umbrella organisations for Faith-based, NGO and private sector.
c) Provide leadership and guidance to the stakeholders implementing assistive technology services.
d) Conduct periodic review of policies, laws and regulations to understand and capture changes over time hence ensuring effective implementation of assistive technology services.

3.2 Strategic Area 2: Service Delivery

3.2.1 Key Issues

a) Most PwDs who need AT still cannot access their appropriate services due to economic constraints.
b) The majority of those who need AT but reside in rural areas where the services are not readily available face the challenge of getting referrals and specialists to serve their needs.

c) Disjointed and uncoordinated provision of AT services by different government sector ministries.
d) High cost of AT products and inadequate funding mechanisms to ensure universal access to AT without financial risk to users.
e) Inadequate availability of AT services including identification, assessment, screening, early intervention services, and ineffective and under-utilized referral pathways to rehabilitation.

3.2.2 Strategic Outcome (SO2):

Coverage of Assistive Technology services provision expanded in urban and rural areas with a well-defined service delivery package.

3.2.3 Strategies

a) Strengthen availability and access to AT services, multidisciplinary approach engaging different sectors integrating AT services at all levels of care.
b) Create awareness about availability of assistive services among stakeholders (health, social work, transport, education, media as well as users and carers).
c) Develop and strengthen referral system as a link between health practitioners and the rehabilitation centres for provision of assistive services as well as other services interlinked to assistive technology.
d) Strengthen community-based services through outreach strategies integrating community health workers, focusing on rural and remote areas.
e) Integrate high-quality need-based AT workforce in public servant scheme, ensure capacity building, professional development, incentivizing and professional regulation.
f) Establish database for AT providers.
g) Create AT users' forums linked to AT provisions and key decision makers.
h) inclusion of geriatric care including the provision of AT services as one of the priority areas for Comprehensive Council Health Plan (CCHP) and CCSWOP.

3.3 Strategic Area 3: Personnel

3.3.1 Key Issues

a) Inadequate competent and skilled human resources for the provision of AT services atall levels of care in rural and urban areas.
b) Inadequate and unequally distributed special needs experts in different departments(rehabilitation, special education teachers, social welfare officers).
c) inadequate opportunities for training and professional development for AT personnel including healthcare personnel, social workers, special education officers and others.
d) Lack of integration of disability issues as human rights in training curriculum and accredited programs.

e) Absence of Community-based programs that focus on enhancing the capacity of family members and caretakers.
f) Inaccessibility of some health facilities and schools (physically and cognitively) by people who need AT.

3.3.2 Strategic Outcome (SO3):

The availability of qualified and competent human resources for the provision of AT services improved at all levels.

3.3.3 Strategies

a) Integrate scheme of service for AT workforce in public service to ensure continuous professionals are regulated and incentivised.
b) Ensure capacity building and professional development through designing AT service training package to improve service provider skills.
c) Establish AT related courses in training institutions for different types of functioning(cognition, communication, hearing, mobility, self-care and vision).
d) Establish programs to enhance capacity of Community Health Workers, family membersand caretakers on home based AT services and products.

3.4 Strategic Area 4: Assistive Technology Products

3.4.1 Key Issues

a) Absence of a national essential list of AT products (adapted from WHO Priority Assistive Products List) according to national needs and available resources.
b) Absence of national specifications standards for AT products.
c) High cost of AT products and inadequate funding mechanisms to ensure universalaccess to AT without financial burden to users.
d) Inadequate in-country capacity for local production of AT products.
e) Absence of a system for testing and certifying AT products to ensure that they are safeand effective.
f) Absence of a national system for the registration of manufacturers and importers of ATproducts.
g) Absence of a central procurement system for AT.
h) Inadequate capacity for servicing, maintenance and repair of AT products.

3.4.2 Strategic Outcome (SO4)

Increased supply, availability and access to safe, effective and affordable assistive products that meet national and international quality standards.

3.4.3 Strategies

a) Establish national specifications standards for AT products.
b) Develop a national assistive products priority list based on the national specification and standards, needs of the users and available resources.
c) Capacitate Government and local industries to enable them produce, procure and maintain assistive devices.
d) Establish a system(s) for testing and certifying AT products and registration of manufacturers and importers of AT products.
e) Develop Government database with information on assistive devices (approved products, regulations, procurement process, intended users, prices, distribution process,manufacturers and importers).
f) Create awareness about availability of assistive devices among stakeholders (health, social work, transport, education, media as well as users and carers) and the process toaccess them.
g) Develop standards and regulatory mechanisms for ensuring quality AT products.
h) Incorporate procurement of AT products in Medical Stores Department.

3.5 Strategic Area 5: Financing of Assistive Technology Services

3.5.1 Key Issues

a) High cost of AT products and inadequate funding mechanisms to ensure universal access to AT without financial risk to users.
b) AT products and services not included in social health insurance schemes.
c) Insufficient funding for AT due to disjointed and uncoordinated provision of AT servicesby different government sector ministries.

3.5.2 Strategic Outcome (SO5)

Increased financial resources to ensure sustainable accessibility and provision of assistive services.

3.5.3 Strategies

a) Domestic resource mobilization strategy focusing on National Disability Fund under the Prime Minister's Office-LYED to highlight a coordinated plan to sustain resource provision and distribution.
b) Develop a sustainable AT financing strategy to ensure efficiency in resource mobilization and utilization.
c) Identifying priority AT services to be included in service package to ensure improvement in financial allocation.
d) Inclusion AT priority products and services in the health insurance benefit package.

3.6 Strategic Area 6: Information and Research

3.6.1 Key Issues

a) Inadequate data on human resources for the provision of AT.
b) Inadequate availability of data on PwD and need for AT services hence need for more research.
c) Absence of a communication strategy to improve access to assistive technology.
d) Absence of an AT research agenda and research fund supporting AT related

3.6.2 Strategic Outcome (SO6)

Evidence-driven decision-making system for AT supported with a robust information system, surveys and research.

3.6.3 Strategies

a) Strengthen the PD-MIS to ensure availability of up to-date (real time) information on PwDs, AT services and products.
b) Integrate the AT, rehabilitation and disability data into DHIS2 to inform planning, implementation and learning to sectors involved at all levels.
c) Establish a communication strategy for AT.
d) Develop a capacity building plan for key implementers at community, districts, regional, national, institutional levels on disability inclusion in research.
e) Develop an AT research agenda and mobilise resources support AT related research.
f) Institutionalise PwD and AT related in national surveys.

Section 4: Institutional Arrangements

4.1 National Coordination Framework

4.1.1 PMO - LYED

The Prime Minister's Office- Labour, Youth, Employment and Persons with Disability (PMO-LYED) is responsible for leading and coordinating services for Persons with Disabilities undertaken by all Government Ministries, Departments and Agencies in all sectors including those responsible for health, education, employment, social protection, social welfare and gender. The PwD Unit serves as the secretariat for the National Advisory Council for Persons with Disabilities (NCPD) and works closely with Organizations for Persons with Disabilities (OPDs).

4.1.2 National Advisory Council for Persons with Disabilities

The National Advisory Council for Persons with Disabilities (NCPD), established under the Persons with Disabilities Act No.9 2010, brings together ministries, organizations of persons with disabilities (OPDs), and others to jointly manage and coordinate affairs of persons with disability; some of the core functions of this body are providing advice on policies, monitoring and evaluating programs, creating and promoting public awareness, mobilizing resources, facilitating the registration of Organisations for Persons with Disability (OPDs) and service providers, and conducting and disseminating research information on disability issues. The composition of the National Council for Persons with Disabilities (NCPD) is defined by the Persons with Disabilities Act No. 9 of 2010, Section 11(1)(a-g). It includes:

a) A Chairperson appointed by the President;
b) A representative from the Attorney General's office;
c) Representatives from the Ministry responsible for health, local government authorities, public service management, community development, labor, and education;
d) A representative from the Association of Tanzania Employers;
e) A representative from the apex organization of persons with disabilities;
f) One member from the Commission for Human Rights and Good Governance; and
g) Five other members appointed by the Minister from organizations of persons with disabilities.

4.1.3 National Steering Committee for NATS

The PMO-LYED will establish a National Steering Committee to oversee the implementation of the NATS. The Steering Committee shall be chaired by the Permanent Secretary in the PMO-LYED and will bring together Permanent Secretaries from key Sector ministries (PORALG, Health, Education, Community Development, Gender, Women and Special. Groups, Information and Communication Technology, Culture and Sports). The Steering Committee will also involve representatives of development partners, organisations of persons with disability and older people, faith-based organisations and the private sector. The PMO-LYED will also serve as the secretariat of the Steering Committee through the Director for Persons with Disabilities Unit.

4.1.4 NATS Technical Working Group

The PMO-LYED will establish a Technical Working Group chaired by the Director of the PwD Unit to address technical issues to facilitate the implementation of the NATS. The TWG will involve technical experts representing the Government Ministries, Departments and Agencies from key sectors (as mentioned in section 4.1.3), Development Partners, Civil Society Organisations (including organisations for PwD and older people), Faith-based organisations and Private sector. The NATS will address all issues related (a) Policy (including leadership and governance, financing, information and research), (b) AT Products (for all types of needs),

(c) Personnel (Workforce of providers of AT); (d) Service Provision (to address issues from identification, screening, provision and referral); and (e) People (to address issues related to users of AT).

The TWG will have five sub-groups or sub-committees responsible for Policy (led by PMO-LYED, MOF and Planning and Investment); AT Products (led by MoH, MSD, Industries and Trade, Private Sector), Personnel (PORALG, POPSM, MOH, MoEST), Service Provision (led by MoH, MoEST, PORALG, FBO, Private sector) and People (led by Organisation for PwD and Older People, FBOs).

The NATS TWG and its sub-committees will relate to existing Sectoral TWGs related to specific issues in the NATS depending on the comparative advantage of the sector.

4.1.5 Sectoral Ministries

The PMO-LYED will work closely with all sectoral Ministries, Departments and Agencies based on the multisectoral nature of AT services. The priority sectors will include Health, Education, Community Development, Gender, Women and Special Groups, Information and Communication Technology and Sports. The President's Office, Regional Administration and Local Government is responsible for service provision through local government authorities and this is where all sector Ministries converge.

The Ministry of Health is of special importance as most of the AT personnel, services and products are regulated by the ministry or its agencies. These include the Directorate of Curative Services (DCS), Chief Pharmacist (CP), Medical Stores Department (MSD), Policy and Planning (DPP) and Monitoring and Evaluation (DME). The National, Zonal and Regional Referral Hospitals (under Directorate of Curatives Services) provide different types and levels of services to people in need of AT including fabrication, service and maintenance of AT devices. The Office of Chief Pharmacist if responsible for establishing and overseeing the Standard Treatment Guidelines National Essential Medicines List (STG&NEMLIT). At present the STG&NEMLIT does not include AT products. This has implication for products procured and stocked at MSD or services covered by Health Insurance Schemes (under DPP) or reported by the health management information system (HMIS) through the DHIS2 software (under DME). In addition, MoH works closely with PORALG at national, regional and council level with regard to provision of AT services at RHMT, CHMT, primary level health facilities and community level.

Other sectors that have a key role in the AT service provision are President's Office, Public Service Management and Good Governance (PO-PSMGG), Ministry of Finance, Ministry of Industry and Trade, Ministry of Agriculture, and Ministry of Planning and Investment.

4.1.6 Regional level

At the regional level, the Regional Secretariat (RS) under the leadership and guidance of the Regional Administrative Secretary (RAS), the following will be responsible for AT services:

(a) Assistant RAS of Health, Social Welfare and Nutrition;
(b) Assistant RAS of Education Administration; and
(c) Medical Officer in Charge of the Regional Referral Hospital (MOI-RRH).

The Assistant RAS reports to PO-RALG through the RAS while the MOI-RRH reports to the Permanent Secretary, Ministry of Health through the Director of Curative Services. The MOI-RRH also has a dotted line reporting responsibility to the RAS.

The Regional PwD Committee as established by Section 14 (2) of the Persons with Disability Act 2010 shall among its mandated responsibilities support the National Advisory Council on Persons with Disabilities to coordinate issues related to AT. This includes coordinating the participation of PwDs in regional planning sessions, creating awareness on AT among PwDs and reporting to the NACPD through the Regional Commissioner on a regular basis.

4.1.7 Council level

At the Council level, the Local Government Authority (LGA) under the leadership and guidance of the Council Director, the following will be responsible for AT services:

(a) Council Medical Officer who heads the Health, Social Welfare and Nutrition services at the council level;
(b) Council Education Officer responsible for Education Administration;
(c) Ward Executive Officers;
(d) Ward Education Officers;
(e) Village/Mtaa Executive Officers;
(f) Kitongoji Leaders; and
(g) Community Health Worker(s).

The above officers all report to PO-RALG through the Council Executive Director. The CHW is a volunteer's position supported by the Ministry of Health.

The Council, Ward, Village/Mtaa PwD Committee as established by Section 14 (2) of the Persons with Disability Act 2010 shall among its mandated responsibilities support the National Advisory Council on People with Disabilities to coordinate issues related to AT. This includes coordinating the participation of PwDs in council and health facility planning sessions, creating awareness on AT among PwDs and reporting to the higher-level committee before submission to NACPD through the District Commissioner on a regular basis.

The National Coordination Framework for the NATS is depicted in Figure 3.

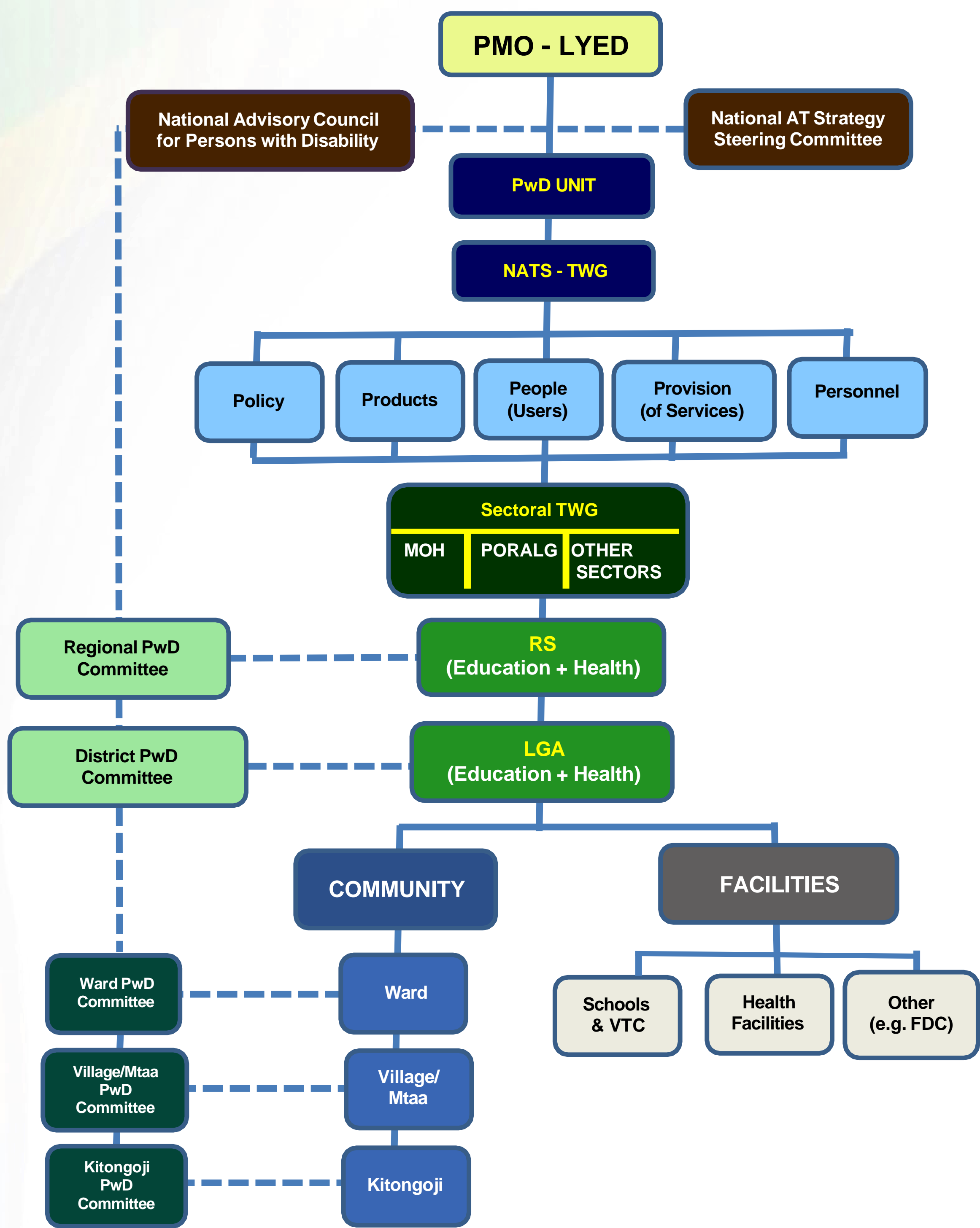


Figure 3: *National Coordination Framework for Assistive Technology*

4.1.8 Sectoral Roles and Responsibilities

The roles and responsibilities of various sectors in relation to the strategic areas of the NATS are summarized in Table 1.

Table 1: Sectoral Roles and Responsibilities in Assistive Technology

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
Policy	**PUBLIC SERVICE MANAGEMENT** • President's office Public Service Management and Good Governance is responsible in preparing and supervising the implementation of guidelines governing employee's performance. • The department also coordinates the diversity inclusion in public services including gender, PwD, HIV, NCDs. • The office recognises PwD as the part of society, public servants if employed. • There is 2008 guideline for services for public servants with disabilities that highlights employees' responsibilities in empowering PwD. • The Persons with Disabilities Act, 2010 is also used to ensure private sector employees are responsible to offer services to their employers. **PMO-LYED** • Multisectoral coordination of Assistive Technology (AT) implementation is facilitated through the National Disability Coordination framework. **SOCIAL WELFARE** • The Social Welfare Department is responsible for the identification and care for vulnerable groups including PwD, older people, children etc. • The office collaborates with the specific responsible ministry to prepare and supervise the implementation of guideline, policy and Acts. • Supportive supervision is conducted to ensure services are provided under PO-LARG. • Quarterly Technical Working Groups meeting are conducted to provide a platform for different stakeholders to meet (GLRA, HelpAge, MNH, etc). **HEALTH** • Initiation and preparation of different strategies, guidelines in collaboration with other stakeholders (other ministries, NGOs, DPs). • Supervision of provision of rehabilitation, geriatric and palliative services, this is where PwDs issues with different conditions are handled. Services are offered through health facilities and sometimes at the community level. • Dissemination of government documents and educate healthcare providers on services we offer to ensure smooth implementation process. • Private sectors are also involved in service provision, they

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
	offer service provision centres as well supplying assistive devices. The ministry registers, coordinates and supervises these organizations e.g., rehab centres, older people homes. **PO-RALG (Special Education)** • Ensure implementation of education programs in primary and secondary schools targeting those with special needs. The office does not serve those out of the system, hence those with special needs are identified from the community and registered in schools to ensure they receive services. • The office identifies and conduct initial registration for those with mental disabilities. • There are home-schooling programs for those who can't be registered in normal school system. Home visits are conducted once a week by special education teachers under the program. This helps to engage and support parents/care takers as well and to evaluate the environment they live in. Community identification process through outreach program under Council Management is done yearly around Sept-Dec. The team consists of 3 special needs teachers (mental, visual and hearing), 1 social welfare officer and 1 healthcare personnel. • Health care component is integrated in our programs by working with health facilities to ensure our students are assessed well and registered in a right school based on their specific need. Care and treatment done as well e.g., physiotherapy. • Collaboration with private sectors (organizations, special schools), instructions are given for implementation. Some schools are in partnership with the government, special needs teachers, devices and food are supplied. • Support from USAID program **"Jifunze Uelewe"** in Mtwara, Morogoro, Iringaand Ruvuma regions. They identify, assess and teach special needs students. • Sense international in Iringa have built identification and assessment centres. They also supply assistive devices and teaching materials. Emphasis is put in every education program to have implementation plan forspecific needs children. **EDUCATION** • Preparation of guidelines, strategies and any other government document to guide the provision of inclusive education. • Follow up the implementation process, conduct frequent supportivesupervision. • Collaborate with other ministries, stakeholders, disseminating government documents. • Mapping and coordinate private organisation offering special and inclusive education. This helps also in minimising duplication of efforts. • Design and monitoring training contents for inclusive and

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
	special education.
Personnel	**PUBLIC SERVICE MANAGEMENT** • Employment secretariat under the same office is responsible for all the issues concerning employees. Employers are directed by the guidelines to empower PwD to be able to perform their duties. • There is 2008 guideline for services for public servants with disabilities that highlight employees' responsibilities in empowering PwD. • Education is offered to HR departments from ministries to council management level to create awareness and implement this guideline. • PwD desks were established 2018 after instructions from PMO-LYED that supervise availability and provision of services to public servants in need. **SOCIAL WELFARE** • The shortage of personnel is a significant challenge, as 90% of the implementers are social welfare officers employed through PO-RALG (Health, Social Welfare & Nutrition Division). These officers are typically stationed at Council Headquarters, Council Hospitals, and Health Centers, with very few available at the Ward and Village/Mtaa levels. When employment opportunities arise, the Ministry allocates a specific number of positions for the recruitment of Social Welfare Officers to address the issue. • Recruit Community Health Workers (CHWs) at the Council level and capacitate them to provide Assistive Technology (AT) services and products based on the Government's available standard operating procedures. • Coordinate and implement Task sharing/Task shifting policy at Council level. **PO-RALG (Special Education and Health)** • When employment opportunities are available, the office sets aside certain percent for special needs teacher. However, due to a limited budget, few special needs teachers have been employed. To bridge the gap, other teachers are trained to be able to attend to special needs students as well. • Inadequate availability of personnel for identification/screening and assessment process, more specialties are required during the process e.g., psychologists, behavioural specialists. The Ministry implement the available guidelines on screening/identification at school of June 2023 through available Teachers. • Inadequate number of personnel who are knowledgeable to identify, assess and register students in specific schools.

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
	Inadequate number of personnel who are knowledgeable to identify, assess and register students in specific schools. The Ministry, in collaboration with implementing partners, has initiatives to train at least two teachers in each primary school. • Due to limited investment in Assistive Technology (AT), there are few available implementing partners to support Community Health Workers (CHWs) and special needs teachers or task-sharing trained teachers in conducting regular screening and identifications at schools and within the community. Therefore, the Ministry will continue to map implementing partners and allocate them to regions and councils with a greater shortage of CHWs and special needs teachers. **EDUCATION** • Inadequate personnel trained on special and inclusive education e.g., speech specialist, learning disability. Through the newly launched Education Policy 2023 Edition, the Ministry has integrated sign language and other basics of special needs teaching methodologies and techniques into the curriculum of Teachers' Training Institutions to continue bridging the shortage gap of special needs teachers.
Products, Commodities andSupply Chain	**PUBLIC SERVICE MANAGEMENT** • When it has been identified that an employee requires an assistive device,employer is responsible to provide. **SOCIAL WELFARE** • Despite coordination to ensure services are provided, there are no enough devices to be offered to every in need. Local Councils, the private sector, and implementing partners through CCSWOP are coordinated by social welfare to budget for and provide assistive devices in schools and the community. Moreover, social welfare continues to identify and register those in need of assistive devices into the PD-MIS. **PO-RALG (Special Education)** • Yearly budget is prepared under the purchase program for procuringassistive devices and teaching materials. • Devices are very expensive, so the Ministry allocates and procures devices based on the availability of funds. Moreover, through the free education program, the Ministry has set aside funds to address special needs, including the procurement of assistive devices. Therefore, each Local Council, through the Head Teacher, executes these initiatives. **EDUCATION** • Ministry is responsible for overseeing quality assurance in the implementation of the identification guidelines of 2023.

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
	Regular mentorship and coaching sessions are conducted to improve knowledge on the provision, use, and repair of assistive devices.
Planning and Financing	**PMO - LYED** • PMO-LYED (Prime Minister's Office, Labour, Youth, Employment and Disability) is the main coordinator responsible for managing the disability fund and overseeing matters related to Persons with Disabilities (PwD). • Liaison with the Ministry of Finance is crucial to incorporate directives related to Assistive Technology (AT) into planning and budgeting guidelines. **SOCIAL WELFARE** • Ensure incorporation of disability needs in planning and budgeting through CCSWOP and other Local Government programs and project related to. • Insufficient resources and personnel are the main challenge affecting theservices we provide. • Insufficient budget also affects the purchase of assistive devices required. **HEALTH** • Budget constraints affects the implementation of activities. The Ministry continues to prioritize Assistive Technology (AT) in the annual health sector budget allocation and channels the funds to MSD (Medical Stores Department) for procurement and distribution. Through the Comprehensive Council Health Plans (CCHP), Local Councils are directed to allocate funds for AT as well. **PO-RALG (Special Education)** • Resource mobilization at LGAs, including engagement of corporates such as Social Security Fund and banks to support procurement of assistive devices. • There are inadequate resources for regular screening/identify in the community. Identification is conducted in some schools, but those identified often have limited access to devices due to inadequate availability. Head Teachers continue to allocate funds for devices through the free education program where possible. • Coordinate data sharing with private organizations who offer these services. • Continued to procure centrally to reduce cost and maintain standards. **EDUCATION** • Mobilizing resources from the government and other external sources toimplement activities.

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
Service Delivery	**PUBLIC SERVICE MANAGEMENT** • The office is responsible to ensure public servants with disability access services when needed. • There is good implementation and some areas have reported best practices especially at high management level. • Implementation of the guideline has been a challenge at council levels, awareness raising meeting are conducted to Council Director to prioritise AT. • There is low awareness among employers and employees regarding the existence of guidelines and proper channels to access services. • Services are provided, but they do not adequately meet the required standards or the specific needs of the individuals. **SOCIAL WELFARE** • The office ensure services are provided to special groups in different areas such as screening, identification and registration of PwD, mental health and counselling, old people's home, early child development program, juvenile detention. • Despite technical working groups there is inadequate coordination of service provided hence inadequate implementation data affecting decision making. Despite CCSWOP, the coordination of provided services remains inadequate, impacting the availability and use of data for decision-making purposes. The ministry continues to advocate for the use of CCSWOP for multi-sectoral planning and reporting on service provision. • Supervision of community-based rehabilitation, this is where early identification in the community is checked, registering into PD-MIS, referral & linkage is conducted by Social Welfare Officers. **HEALTH** • Supervision of provision of rehabilitation, geriatric and palliative services, this is where PwDs issues with different conditions are handled. Services are offered through health facilities and sometimes at the community level. • The Ministry develops and oversees the implementation of AT standards on procurement, distribution, and provision at health facilities and in the community. **PO-RALG (Special Education)** • In provision of services, we focus on specific needs of the students. The focus is on infrastructure, assistive devices, special needs teachers, food and accommodation. • Ensure the new buildings accommodates the needs for students with special needs and the old ones are modified accordingly including the stairs, special washrooms, etc. • In accommodation, boarding school programs are currently implemented after the needs were identified due to distance

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
	from homes, the construction is stillgoing on in some areas.
Perception and Needs of Beneficiaries	**PUBLIC SERVICE MANAGEMENT** • Low awareness of the existence of the guideline and proper channels to access the services for employers and employees. • There are different platforms bringing together public servant with disabilities and we use that as an opportunity to create awareness of the guideline. • Those who had opportunity to access services are used as best practices to inform others. **SOCIAL WELFARE COMMUNITY DEVELOPMENT AND EDUCATION** • Raising awareness on existence of the program through stakeholders' meetings, conferences, and other social platforms. • Address negative attitude in accessing services.
Way Forward	**PUBLIC SERVICE MANAGEMENT** • The guideline is current being reviewed to ensure it is relevant to the current situation. • Focusing on proper coordination and creating awareness of the strategy and the implementation process. • Resource mobilization process to be directed towards the main disability fund under PMO-LYED. • Accessibility guideline (under PMO-LYED) to ensure that the devices and working environment meets the standard requirements. • Review of the Persons with Disability Act 2010, to emphasize on accessibility of assistive devices to both government and private sector. • Clear process on provision of assistive devices (proper channels, specific office, assessment of recipient's needs and education on proper use of devices. • Different ministries and departments to design the required service schemes that our office will review and approve employment permits to ensure availability of different professionals to assist with the service provision (speech therapist, physiotherapist). **SOCIAL WELFARE COMMUNITY DEVELOPMENT AND EDUCATION** • Emphasis on technical working group meetings. • Information system that will provide mapping of all service providers and collect data. • Emphasis on budget that will simplify coordination process by having enough funds to provide services. • Create awareness about existence of challenges for

THEMATIC AREAS	ROLES AND RESPONSIBILITIES
	different vulnerable groups through 'PwD day' that will attract support from other stakeholders. • Channel stakeholders handling other groups to pay attention to PwD as well. • Conduct monthly identification exercises in the community to update the Disability Register in the PD-MIS and link individuals with health facilities for the provision of assistive devices. **HEALTH** • Resource mobilization, collaborating with stakeholders to raise funds. Raise awareness for stakeholders to continue supporting government activities. • Conduct monthly identification exercises in the community to update the Disability Register in the PD-MIS and link individuals with health facilities for the provision of assistive devices. **PO-RALG (Special Education)** • Clear link to health services ensuring proper assessment and management. Early identification hence early management that can improve some of the conditions. • Direct most of the efforts to the younger generation during the early stages to reduce older age dependents. • The strategy to take into the consideration that it will be expensive to implement this program. • Capacitate teachers in primary school to screen/identify students in need of assistive technology. • Conduct screening/identification exercise at school. **EDUCATION** • Setting clear standards for teaching content, required devices, personnel. • Utilizing systems (information system0 in supervising, monitoring and providing feedback. **COMMUNITY DEVELEPOMENT** • Eliminate negative perception in the community towards Persons with Disability.

Section 5: Monitoring, Evaluation and Learning

5.1 Overview

The Monitoring, Evaluation and Learning (MEL) framework is an important tool for assessing the effectiveness of the strategic interventions and actions detailed in the National AT Strategy. The MEL framework (Table 2) details for each strategic area, the strategic outcomes and indicators with baseline, target and data sources. The indicators for each strategic area will be derived from the respective sectoral roles and responsibilities outlined in their operational plans. The National NATS Technical Working Group (NATS TWG) will use these indicators to monitor and track the progress, outcome and impact of the National AT strategy over time. Additionally, the MEF framework will provide the PMO-LYED coordinated and effective mechanisms to monitor and assess progress in the implementation of the Strategy across all sectors at national and subnational levels.

The objectives of the MEL framework are to:

1) Provide comprehensive monitoring and Learning framework for measuring the output, outcome and impact indicators resulting from implementation sector specific activities in implementing the National AT strategy;
2) Establish an evaluation and review framework for assessing the implementation of the strategy; and,
3) Define a reporting plan for sharing information, accountability and learning through periodic reports, analyses and feedback loop.

5.2 Monitoring and Learning Mechanisms

The monitoring and learning mechanisms of the NATS has three interrelated components, namely: performance monitoring, outcome monitoring, and learning as described below:

1) **Performance monitoring –** This fulfils the AT basic accountability requirement to demonstrate that the AT interventions are implemented according to the agreed work plan. Performance reporting describes the activities, processes and outputs realized during the reporting period based on the planned activities and agreed outputs by the various key stakeholders mandated with such activities. It includes providing periodic progress updates in sector review meeting and the PMO-LYED monitoring framework.
2) **Outcome monitoring –** This will be reported bi-annually and annually (where relevant) and will provide important information regarding the extent to which delivered outputs are contributing to expected outcomes of the AT strategies. Outcome monitoring will include the use of essential approaches including but not limited to contribution analysis, most significant change, and process mapping to identify how AT related initiatives have contributed to the attainment of specific outcomes, including unexpected outcomes. Findings from monitoring of outcomes feed into performance reporting and inform learning.
3) **Learning -** The NATS Technical Working Group under the PMO-LYED will

coordinate sectoral data collection systems to ensure that they contribute to various learning platforms. The team will bring together various sectoral M&E systems and platforms to produce learning through various learning opportunities including, Joint Annual Health Sector Review (joint field visits, Technical Review Meeting and Policy Meeting) among others. Considering that learning is an evolving process, it requires that the AT learning approach evolves if it is to be effective in contributing to the realization of the set health system-strengthening outcomes. This means, other adaptive monitoring techniques and methods can be brought aboard anytime as needed.

5.3 Evaluation and Reviews

Evaluation is a rigorous, systematic and objective process for assessing the implementation of the strategy including its design, implementation actions and results achieved. This involves collecting data about organizations, processes, programs, services, and/or resources to enhance knowledge and decision-making that leads to practical applications (Powell, 2013). Results Framework. On the other hand, a review is a form of evaluation that is undertaken on a regular basis such as an annual meeting involving key stakeholders to determine the progress of the strategy implementation and check if all key stakeholders are still aligned with the roadmap of the strategy.

There shall be an annual review as part of the MEL plan. The annual review will be conducted jointly in collaboration with all stakeholders at the end of each year of implementation. Since the most of the indicators in the MEL framework lack baseline information, the annual review for the first year will provide the baseline indicators for the NATS.

A mid-term review shall be conducted after two years of implementing the Strategy to check on the progress of implementation and inform adjustments if the progress is deemed not to be on course to meet the set targets.

Finally, an end-term evaluation can be conducted six to twelve months after the final month of the Strategy's implementation.

5.4 Reporting Plan

The reporting plan will be aligned with the National Coordination Framework for the NATS as depicted in Figure 3.

1) Sub-National Levels

Implementers at the Community, Local Government Authority and Regional levels (public, private and FBOs) will provide monthly, quarterly and annual reports to the supervising level which will in turn analyse and compile reports for submission to the next level above (community to LGA, LGA to Region and Region to National). The PO-RALG will be responsible to ensure that reports from the decentralized structures are compiled and submitted to the respective sectors and PMO-LYED quarterly.

2) Sectoral Level

The Sectoral TWGs will receive reports from subnational levels on a quarterly basis, analyse them and compile a sectoral report that will be submitted to PMO-LYED. Each sector will prepare an annual sectoral report on AT that shall be presented at the annual joint sector review meeting before submission to the PMO-LYED.

3) National Level

The PMO-LYED will receive and analyse quarterly and annual reports present these to the National NATS-TWG for review before submission to the Permanent Secretary and the National AT Strategy Steering Committee.

At all levels, there will be a feedback loop to lower reporting levels.

Section 6: Risks, Assumptions and Mitigation

SN	RISK	MITIGATION	RESPONSIBLE
1	AT is expensive and those who are not able to afford may be excluded from accessing the service.	• Establish an advocacy mechanism for Local Authorities, Communities, NGOs, FBOs and CBOs to secure funding for the provision of AT services and products. • Provide Tax Exemptions for AT, both imported or locally produced.	PMO-LYED, MoH, PO-RALG and MoEST. MoF and MOIT.
2	Some of the beneficiaries may not be able to afford even subsidized AT products due to poverty.	• Expand the list of AT products in the MSD catalogue • Include priority AT services and products in Universal Health Insurance scheme.	MoH, MoEST and MoF. MoH, MoEST and MoF.
3	Inadequate Family support to be able to use AT in schools or at home.	• Include school teachers, family members and caretakers in trainingfor AT provided to CHWs.	MoH, MoEST and PORALG.
4	Absence of appropriate guidelines for AT.	• Put in place guidelines for user, the producer,the suppliers and even the prescribers.	MoH.

5	Who should prescribe AT for users including those covered by NHIF and other health insurances.	• Identify required qualifications and competence for medical professionals to prescribe specific AT.	MoH, Tanganyika Medical Council, Tanzania Nurses and Midwives Council and Professional associations.

Table 2: Monitoring Framework for NATS

SN #	Strategic Area and Strategic Outcome		Indicator(s) (Related to sectors)	Baseline(2023)	Target(2027)	Data Sources	Remarks (Data availability, Strengthsand Limitations
1.0	**POLICY GOVERNANCE AND LEADERSHIP** **SO1:** Policy, Leadership, Governance, and Coordination mechanisms for AT services strengthened at all levels.	1.1	Existence of an operational, national assistive technology strategy.	None	Present, with MTR results.	PMO-LYED	None
		1.2	Existence of an operational, multisectoral national coordination mechanism for AT.	None	Present and functional.	PMO-LYED	None
		1.3	Existence of an updated policy and legal framework that includes comprehensive ATservices and products.	National Policy on Disability 2004. The Personswith Disabilities Act, 2010.	Revised and updated Policy and Act.	PMO-LYED	None
		1.4	Existence of a regulatory body forassistive technology products and services (including standards, surveillance, manufacturing and marketing of assistive products).	None	National TWG ToR in place and operationalized.	PMO-LYED	Absence of regulatory body at national and sub-national.
		1.5	Existence of TWG ToR for smooth coordination.	None	Present and functional.	PMO-LYED	Absence of ToR for TWG both sectoral and steering.

SN #	Strategic Area and Strategic Outcome	Indicator(s) (Related to sectors)		Baseline(2023)	Target(2027)	Data Sources	Remarks (Data availability, Strengthsand Limitations
2.0	**SERVICE DELIVERY** **SO2:** Coverage of Assistive Technology services provisionexpanded in urban and rural areas with a well-defined service deliverypackage.	2.1	Proportion of the population in need of assistive products that report having the products they need, towards reaching 50% coverage of such products for all people in need.	None	Incorporation of AT services and products in Health & Demographic survey.	PMO-LYED	Not included in health and demographic survey.
		2.2	Proportion of facilities (schools and health facilities) that provide assistive products	None	BEST, PIP-MIS, and GoTHOMIS capture and provide disaggregated data on PwD in need of and provided with AT.	PO-RALG (Education & Heath)	Disaggregated by type and level of school, health facility(public or private, primary, secondary or tertiary).
		2.3	Proportion of CHWs trained in Assistive Technology.	None	At least one CHW on each Village/Mtaa trained.	PO-RALG (Health)	A module on AT should designed and included in the CHW training.
		2.4	Number of AT Distributed to users over total number of AT secure by GoT.	0	At least half of the individuals screened and eligible for AT products at health facilities secured the product	MoH	None
		2.5	Proportion of council level facilities that provide a full range of assistive technology.	Present at RRH but not at Council Hospitals and Health centers.	Established and equipped relevant AT service points at Council Hospitals.	PO-RALG (Health)	Availability of guidelines on basic standard for the provision of health services.
3.0	**PERSONNEL** **SO3:** The availability of	3.1	Per capita AT personnel (by cadre) involved in providing assistive technology services to	None	Guidelines issued for budget allocation on AT.	MoF	None

SN #	Strategic Area and Strategic Outcome		Indicator(s) (Related to sectors)	Baseline(2023)	Target(2027)	Data Sources	Remarks (Data availability, Strengthsand Limitations
	qualified and competent human resources for the provision of AT services improvedat all levels.		users.				
		3.2	Proportion of training institutions(by level and by cadre) providing training for AT personnel.	None	"Fifty percent of primary schools in the country should have at least two teachers in each school trained in Assistive Technology	MoEST	None
		3.2	Proportion of CHW trained on AT.	None	Database for trained CHW in present and functioning.	PO-RALG (Health)	None
		3.3	Number of Health care providers and Technicians trained on AT over total number Rehabilitation/Health provider and technician available in the country.	0	At least 300 Health care providers and Technicians , and 100 Social Welfare Officers trained on AT	MoH	None
4.0	**ASSISTIVE TECHNOLOGY PRODUCTS** **SO4:** Increased supply, availability and access to safe, effective and affordable assistive productsthat meet nationaland international quality standards.	4.1	Existence of a national assistive products priority list.	None	Present and in operation national assistive products priority list.	MoH	None
		4.2	Existence of a list of assistive products covered by financing mechanisms of government or others, including insurance agencies.	None	Present and in operation.	MoH	None
		4.3	Existence of national guidelines for specification and standards of AT	None	Guidelines present & in operation.	MoH	To develop and disseminate AT specification &

SN #	Strategic Area and Strategic Outcome		Indicator(s) (Related to sectors)	Baseline(2023)	Target(2027)	Data Sources	Remarks (Data availability, Strengthsand Limitations
			products.				standards guidelines.
		4.4	Existence of a database with information on suppliers of assistive productsand the assistive products they supply.	None	Present and operational database.	MoH	None
		4.5	Funds allocated to MSD for AT purchase.	0	To allocate sum of TSH 2 billion for AT to MSD by June 2027.	MoH	None
		4.6	Health care providers involved.	0	To train a total of 300 Healthcare provider on AT by June 2027.	MoH	Present of some training module on AT product provision.
5.0	**FINANCING OF ASSISTIVE TECHNOLOGY SERVICES** **SO5:** Increased financial resources to ensure sustainable accessibility and provision of assistive services.	5.1	Per capital spending on assistive technology by government, development partners and other sources, including insurance agencies.	None	Universal Health Insurance (UHI) included basic and secondary AT products.	MoH	UHI package not clearly captured basic AT products.
		5.2	Existence of National Disability Fund under the Prime Minister's Office.	National Fund is functioning.	An advocacy mechanism is in place to raise awareness among the private sector and encourage them to contribute to the National Disability Fund (NDF)	PMO-LYED	Currently, the private sector is not contributing due to a lack of awareness about the National Disability Fund (NDF)
		5.3	Proportion of total cost for the provisioning of assistive products covered by	Lack of costed need for AT.	Present and operational list/package of costed AT needs at all levels.	PMO-LYED	includes at national, regional and council

SN #	Strategic Area and Strategic Outcome		Indicator(s) (Related to sectors)	Baseline(2023)	Target(2027)	Data Sources	Remarks (Data availability, Strengthsand Limitations
			government.				levels.
6.0	**INFORMATION AND RESEARCH** **SO6:** Evidence-driven decision-making system for AT supported witha robust information system, surveys and research.	6.1	Functional PwD-MIS with up to-date (real time) information on PwDs, AT services and products.	Developed but not rollout.	The PD-MIS has been rolled out in all 26 regions and 184 councils	PO-RALG (Health)	The PD-MIS has been developed and launched.
		6.2	Proportion of service points for assistive technology services relative to service points for health service.	None	Mapping of the established service points at Regional Referral Hospitals and Council Hospitals, along with an evaluation of the quality of Assistive Technology services and products offered	MoH	None
		6.3	Existence of AT research agenda and resources to support AT related research.	None	At least once annually AT stakeholders meeting conducted.	PMO-LYED	Present of ATs three-year project to support.
		6.7	PwD and AT related national surveys institutionalises with TDHS or standalone periodic surveys.	None	TDHS incorporated AT.	MoH	Census has incorporated AT good practice for learning.

Bibliography

1. URT (2010) The Persons with Disabilities Act, 2010.
2. AU (Protocol to the African Charter on Human and Peoples' Rights on the RightsOf Persons with Disabilities ni Africa.
3. URT (2004) National Policy on Disability.
4. URT (2003) National Aging Policy 20035. URT (2015) HSSP IV 2015-2020.
5. URT (2021) HSSP V 2021-2026.
6. URT (2021). National Strategic Plan for Prevention and Control of Non-Communicable Diseases 2021-2026. Leaving No One Behind.
7. United Nations Convention on the Rights of Persons with Disabilities and OptionalProtocol on the convention of Rights of Peoples with disabilities.
8. Global Report on Assistive Technology.
9. Sierra Leone Assistive Technology Policy and Strategic Plan 2021-2025.
10. Kenya Rehabilitative-Services-Strategic-Framework 2022-2026.
11. WHO Strategic action framework to improve access to assistive technology in theEastern Mediterranean Region, October 2020.
12. WHO 2020 Policy brief: Access to assistive technology.
13. Final Report ELDERLY SOCIAL CARE - Agosti,10 2017.
14. NDIA Australia Assistive Technology Strategy 2015.
15. Health status and quality of life among older adults in rural Tanzania.
16. The Social Health Insurance Bill, 2023.
17. The National Strategy for the provision of Health Services to Older People.
18. World Health Assembly (2018). World Health Assembly Resolution 71.8 ImprovingAccess to Assistive Technology. https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_R8-en.pdf?ua=1

Appendices

List of AT Products mostly purchased

1. Crutches (Axillary/Elbow).
2. Walking Frames.
3. Wheelchairs.
4. Magnifiers.
5. Optical Devices (Telescope).
6. White Canes.
7. Braille Slates.
8. Frame Writing Equipment.
9. Braille Papers.
10. Hearing Aids.
11. Sunscreen Lotion.
12. Albino Sunrays Protection Spectacles.
13. Audiometers.
14. Otoscope.
15. Desktop Video Magnifiers (CCTV).
16. Albino Hat.
17. Puzzles.
18. Rubber Mats.
19. Braille Thermoform Machine.
20. Speech Training Mirrors.
21. Picture Wall Chart.
22. Building Blocks.
23. ICT-Equipment (Smartphones, Computers, Tablets, Printers).
24. Canes/Sticks (including Tripods and Quadripods).
25. Orthoses.
26. Lumbar Belt.
27. Neck Collar.
28. Therapeutic Footwear.
29. Neuropathic.
30. Pressure Relief Cushions.
31. Spectacles (Near/Far Vision) and reading Glasses.

Prime Minister's Office, Labour, Youth, Employment & Persons with Disability

Kazi Street, Government City, Mtumba.

P.O. Box 2890 Dodoma, Tanzania.

www.kazi.go.tz