



# strategy

2008-2012



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design by Sarah Markes

## ACRONYMS

AMO	Assistant Medical Officer
ARV	Anti-Retroviral Treatment
CBO	Community Based Organisation
CBR	Community Based Rehabilitation
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CP	Community Programmes
CRW	Community Rehabilitation Worker
DCC	Dar es Salaam City Council
DPO's	Disabled People's Organisations
HARP	Holistic HIV/Aids Related Programme
HBC	Home Based Care
INGO	International Non-Governmental Organisation
KCMC	Kilimanjaro Christian Medical Centre
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MDH	MUCHS/City of Dar es Salaam/ Harvard
MKUKUTA	Mkakati wa Kukuza na Kuondoa Umaskini Tanzania (English translation "National Strategy for Growth and Reduction of Poverty")
MUCHS	Muhimbili University College of Health and Science
NGO	Non-Governmental Organisation
OT	Occupational Therapy
PCM	Project Cycle Management
PT	Physiotherapy
SLT	Speech and Language Therapy
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing (HIV/Aids)
VVF	Vesico-Vaginal Fistula

## EXECUTIVE SUMMARY

**C**omprehensive Community Based Rehabilitation in Tanzania (CCBRT) is a locally registered non-governmental organisation first established in 1994. It is the largest indigenous provider of disability and rehabilitation services in the country. CCBRT's areas of operation are the urban and peri-urban areas of Dar es Salaam and the so far underserved regions such as Kilimanjaro, Pwani, Morogoro, Mwanza, Tanga, and the island of Zanzibar serving a total population of 10 million people.

CCBRT aims to contribute towards poverty reduction by improving the quality of life of disadvantaged people living with a disability and HIV/Aids by providing easier access to quality rehabilitative services and enabling them to play an active role in their community. It is CCBRT's mission to achieve this vision in several ways: by providing comprehensive medical and rehabilitative services; including children with disabilities and HIV/Aids orphans in mainstream education; building awareness on how to prevent disabilities and by collaborating with partners to empower people living with disabilities. CCBRT strongly believes in and advocates a 'twin-track approach' to disability. This involves supporting specific disability initiatives which empower the participation of people with disabilities in their communities while at the same time mainstreaming disability into all strategic areas of development work.

Approximately 3.5 million Tanzanians live with an impairment. Of these nearly 50% are children. In a low income country like Tanzania, having a disability not only affects the health and functional abilities of an individual, it also impacts on the life of the individual and their family members. People with disabilities are faced with exclusion from community life, education, information and work opportunities. Very few people living with a disability in this country have access to appropriate basic services or even know they exist. The few services that are available are too expensive for most people and costs of transport to them also prohibitively high. Many families, in addition, face income loss due to the

incapacity of the care giver to follow a profession. CCBRT has identified several main development challenges in the field of disability. There is a need to improve access to health (especially in mother and child health care) and HIV/Aids services and build awareness about the availability of such services. More emphasis on rehabilitation efforts involving families and communities is required, mainstream development issues should be more inclusive of people with disabilities and there is a need to create equal opportunities for all people living with disabilities and/or HIV/Aids and their care givers so they can participate fully and actively in society.

Following a review of its services CCBRT has found its strategy to be fundamentally sound. However, during the coming years (2008-2012), CCBRT will focus on improving the quality and reach of its services rather than increasing the quantities in direct service provision. The aim is to provide a more comprehensive and sustainable service. This will be achieved by putting a greater focus on its community based projects, developing the infrastructure at its Dar es Salaam site, developing CCBRT's internal organisation and human resources, and boosting its networking and advocacy efforts to make mainstream development issues more inclusive of people living with disabilities. The 2008-2012 strategy plan will concentrate on attaining its objectives in the following areas:

### 1) COMMUNITY SERVICES

CCBRT has many projects at the community level including its mobile outreach programme, its Community Based Rehabilitation Programmes in Dar es Salaam and Kilimanjaro as well as its Holistic HIV/Aids Related Programme (HARP). By working actually in and with the communities themselves, CCBRT actively seeks people who are in need of help, provides rehabilitation in the communities with the aim to empower and socially include people with disabilities in their communities, and provides home based care or, where necessary, refers them to the disability hospital for further treatment. Having an active presence on the ground can greatly

assist in rehabilitation efforts. Over the next few years, CCBRT wishes to build on experience built in these areas and will expand the geographical reach of its community programmes in order to serve more impoverished people. A core factor in its approach will be a focus on raising awareness amongst those most in need about the services that are on offer. Another key focus of the community programmes will be a drive to include people living with disabilities in mainstream HIV/Aids services and an expansion of its training services, not only for staff but also for the families and care givers who look after people with disabilities. An agreement has been signed that over the coming years CCBRT will gradually hand over the coordination of home based care services to MDH (MUCH/ City of Dar es Salaam/ Harvard) and the Dar es Salaam City Council.

## 2) DISABILITY HOSPITAL SERVICES

The next few years will see a drive to expand CCBRT's existing infrastructure. Extension of the facilities is necessary so that a more comprehensive service can be provided. CCBRT will expand the rehabilitation centre on the CCBRT compound to offer a more comprehensive rehabilitation package including speech and language therapy and the production of mobility and positioning devices to children with life long disabilities. The new facilities will include an assessment centre, therapy rooms, training facilities for professionals and family members as well as hostel facilities (detailed plans are available upon request). In addition, the Board of CCBRT and the City Council of Dar es Salaam have joined efforts to create a Mother and Child Health (MCH) hospital with an integrated HIV/ Aids aspect. Since the signing of the memorandum of understanding it acquired the status of being a Regional Designated Hospital. The Government of Tanzania has generously provided CCBRT with land near its current site on which to build the hospital. The new hospital will not only provide mother and child health and HIV/Aids services to mothers and children, thereby preventing maternal and child mortality and disability, it will also

provide training to future generations of MCH/ HIV and disability medical and nursing staff in Tanzania. CCBRT is in the process of exploring new collaborations and partnerships and drawing up detailed implementation plans.

## 3) POLICY AND CAPACITY BUILDING

CCBRT believes that in order to effectively tackle disability issues in Tanzania, greater efforts are required at a national level to help change stigmas and attitudes towards people living with disabilities. In collaboration with other organisations, CCBRT will step up its lobbying and advocacy efforts to put disability issues on the mainstream development agenda. The strategic plan 2008-2012 will also place further emphasis on capacity building both within CCBRT and externally through the provision of a variety of training programmes.

CCBRT is seeking co-funding support of EURO 28,355,111 from a number of partners in order to achieve its objectives. Further information on CCBRT's objectives during 2008-2012 is available beginning page 14.

Throughout the five year plan, CCBRT will continue to evaluate the efficiency of its services through a constant monitoring process. It will also continue to assess staff motivation and efficacy via a variety of measures such as performance related pay. Employees are encouraged to offer feedback and suggestions on day to day issues affecting the organisation so that lessons can be learned on an ongoing basis. Partners are also encouraged to be part of the monitoring process. An annual report (comprised of a comprehensive narrative report and audited financial report) will be available to partners and will provide a comprehensive overview of progress made in relation to the strategic plan and annual activity plan, outline successes and reveal challenges faced during the implementation as well as lessons learned.

# CCBRT VISION AND MISSION

## VISION

CCBRT's vision is of a Tanzania where children and adults with disabilities, people with HIV/Aids and their families and HIV/Aids orphans can access quality rehabilitative services that improve their quality of life, enable them to enjoy their basic human rights and allow them to contribute to their families' living and are respected members of their community.

## MISSION

CCBRT's mission is to prevent disabilities, improve the quality of life of people with a disability, HIV/Aids and HIV/Aids orphans and empower them to access their human rights so they can participate fully in their communities and benefit from mainstream services.

CCBRT achieves this by:

- raising awareness about the prevention of disabilities,
- providing comprehensive medical and rehabilitative services that prevent the development of disability or improve the abilities of people with disabilities,
- providing holistic HIV/Aids services (including Voluntary Counselling and Testing (VCT) home based care (HBC), counselling, legal aid) that improve the health status and legal security of people with HIV/Aids and their family members,
- including children with disabilities and HIV/Aids orphans in schools,
- economically empowering people with disabilities and HIV/Aids in collaboration with specialised partner organisations,
- networking with local communities, Disabled People's Organisations (DPO's), other disability or mainstream organisations and governmental bodies and advocate / supporting mainstream development services in making their services inclusive to people with disabilities,
- training and capacity development of specialised staff.



# SITUATION ANALYSIS - TANZANIA

## DISABILITY, HIV/AIDS AND POVERTY

In African societies, disability, HIV/Aids and poverty are strongly interlinked. A large number of disabilities are caused by poverty: poor nutrition, dangerous working conditions, limited access to vaccination programmes, poor health and maternal care, poor hygiene, bad sanitation and inadequate information about the causes and treatment of impairments are some of the causes. It is estimated that 50% of disabilities are preventable and directly linked to poverty.<sup>1</sup> In Tanzania, it is estimated that households with a member who has a disability have a mean consumption less than 60% of the average of the country.<sup>2</sup>

Disability affects not only the health condition and reduced functional abilities of an individual. Disability also has strong implications on the life of the individual and their family members. Especially in developing countries like Tanzania, people with disabilities are faced with exclusion from community life, education, information and work opportunities. As a result of missing integration and full participation in the community, people living with disabilities become segregated and deprived of virtually all rights. Women are the most involved in providing care to people living with disabilities. As 75% of a Tanzanian families' food production is supplied by women, prevention or cure of disability or aiding people living with disabilities to become independent in their daily activities can be of great benefit for the nutritional situation of a family.

Today, approximately 3.5 million Tanzanians live with an impairment (see box). Nearly half of those are children. Just a fraction of people living with a disability in Tanzania have access to comprehensive rehabilitation and appropriate basic services: services are scarce while costs of transport and existing services are prohibitively high for most people. In addition, people are often unaware of the availability of services. The vicious circle of

poverty acts as both cause and effect of disabilities and HIV/Aids in Africa. Impoverished people lack awareness, funds and access to existing facilities and this may lead to increased poverty thus resulting in a greater number of people suffering from avoidable disabilities and HIV/Aids. This, again, may lead to increased poverty.

HIV/Aids is the leading death cause in sub-Saharan Africa.<sup>3</sup> In 2006, 63% of all people living with HIV/Aids were living in Sub-Saharan Africa. With 2.1 million HIV/Aids deaths in 2006, 72% of all HIV/Aids deaths were in Sub-Saharan Africa. Tanzania belongs to those countries which an overall stagnating HIV/Aids prevalence.<sup>4</sup> Statistics show an HIV prevalence rate in adults of 6.5%. This implies that about 1.4 million adults in Tanzania are HIV positive. This makes Tanzania one of the most affected countries in the world. There are strong regional variations with Dar es Salaam having the third largest infection rate (11%) in the country. Studies indicate that HIV/Aids infection through injection of drugs with non-sterile syringes, combined with unsafe sex practiced by female drug users could become an increasing factor to the HIV/Aids epidemic in Tanzania.<sup>5</sup>

Using the WHO statistics combined with CCBRT and other research materials, it is assumed that about 3.5 million people in Tanzania (10%) face some form of impairment:

- Physically Impaired (28%) - 967,932
- Visually Impaired (27%) - 933,363
- Hearing Impaired (20%) - 691,380
- Intellectually Impaired (8%) - 276,552
- Multiple Impaired (4%) - 138,276
- Other Impairments (13%) - 449,397

1 DFID (2000)

2 Inclusion International (2005)

3 UNDP (2002)

4 UNAIDs (2006)

5 UNAIDs (2006)

HIV/Aids impacts on the individual as well as on national development. People tend to die of HIV/Aids in the prime of their lives. UNDP states: “As families lose their breadwinners and caretakers, income is lost, agricultural output declines, nutrition worsens, spending on health care increases, funeral costs soar, savings turn into debt, children drop out of school, the health status of individuals deteriorates...” It is generally found that HIV/Aids affected households often make a rapid transition into poverty. In addition, studies have shown a lower school enrolment of children of HIV/Aids affected households. Children drop out of schools as families cannot afford school fees and / or children tend to assume the domestic role of the mother.<sup>6</sup>

On the national level, human development and labour productivity is reversed and essential services eroded. Projections indicate that the per capita GDP will be 4% lower as a result of HIV/Aids.<sup>7</sup> HIV/Aids is found on all levels of society. In the past, people with higher education had a higher rate of HIV/Aids infection due to their increased mobility. In the recent years, however, the social epidemiology of HIV/Aids has changed. Better educated people have access to information and knowledge and have the opportunity to change behaviour while poor and less educated people have limited access to health related information, medical and care services. Consequently, less educated people are therefore more vulnerable to the spread of HIV/Aids. It is evident that people with disabilities who are generally excluded from basic services are among the most vulnerable groups.

There is a growing recognition that vulnerable groups need to be included in development issues. Tanzania spearheaded the initiative by making its poverty reduction strategies inclusive of disability. *The Tanzanian National Strategy for Growth and Reduction of Poverty (MKUKUTA)* seeks to ‘pay

greater attention to mainstreaming cross-cutting issues - HIV and Aids, gender, environment, employment, governance, children, youth, elderly, disabled and settlements’. Each goal has targets and strategies specifically focusing on people with disabilities. For instance ‘Increased proportion of children with disabilities enrolled, attending and completing schools from 0.1% in 2000 to 20% in 2010’. Also the *Millennium Development Goals (MDGs)* recognise the need to make poverty eradication inclusive of people with disabilities. Inclusive targets are set by the following MDGs in particular: MDG 1 Eradicate hunger and poverty, MDG 2 Achieve primary universal education and MDG 6 Combat HIV/Aids, malaria, TB and other diseases.

Tanzania is a signatory to various international human rights instruments<sup>8</sup> and is morally and legally bound to adhere to and translate them into legislations and policies. One example is the African Decade of Persons with Disabilities which aims at the full participation, equality and empowerment of disabled persons in Africa. Among the relevant national legislation<sup>9</sup> are the National Policy on Disability and the National HIV/Aids Policy. The policy on disability aims to provide ‘a conducive environment for people with disabilities to engage in productive work for their development and the utilization of available resources for improved service delivery.’ The MKUKUTA specifically states the aim to reduce the prevalence of HIV/Aids in women and men with disabilities (aged 15-35). “Continued prioritisation of policy and actions remains essential to all poverty reduction and development efforts. These include: Financing to reduce HIV/Aids transmission, and its impact on those affected, with a special focus on girls, young women, the aged, young children, orphans, and persons with disabilities who increasingly face the impact of HIV and Aids.”

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6 United Nations (2005)

7 United Republic of Tanzania (2005)

8 Universal Declaration of Human Rights and the Bill of Rights, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), The Convention on the Elimination of Violence Against Women, The Convention on the Rights of the Child (CRC), Resolutions of the World Social Summit, International Conference on Population and Development (ICPD), The African Charter on Human and Peoples Rights of 1981 (ACHPR), The UN convention on Disability, The Beijing Platform of Action, The 1999 Lome Declaration on African Decade on Disability

9 The National Legislation Constitution of Tanzania, National Policy on Disability (2004), National Policy on HIV/Aids (2001)

## MAIN CHALLENGES

Despite the supportive environment, many challenges remain.

### *1. Access to health services*

There are far too few existing health services in Tanzania, for people with and without disabilities. For example, access to basic services such as maternal health care is still a problem. The maternal mortality rate has increased from 529 (per 100,000 live births) in 1996 to 578 in 2004/5, and is well above the MDG target of 193<sup>10</sup>. With this in mind, it can be assumed that the prevalence of preventable impairments and mother-to-child HIV transmission due to poor maternal and ante-natal care has not decreased either. Lack of services is largely due to the lack of qualified personnel and equipment country-wide.

The health services that do exist are not accessible for the majority of people with disabilities. There are far too many barriers between people with disabilities and the formal medical structures. Apart from the lack of money, other barriers are the fear of treatment (due to bad experiences) and the distance from the service centre<sup>11</sup> and related costs involved. As long as families of poor people with disabilities have to get to hospital entirely on their own, the chances that they can get the services they need remain rather small. In many cases, a combination of ignorance and wrong information together with the perceived high cost of treatment and the long distances to access treatment means that many patients in Tanzania simply do not seek help. Traditional customs also contribute to these barriers. The concept of health, disease and death by Tanzanian people is based on the belief that there are several levels of causality that lead to disease and impairment. Many tribal cultures still consider that disability is a result of a curse for which nothing can or should be done. This is especially true for impairments that are congenital, such as club feet. The largest contributing condition to preventable blindness, which is cataract, is considered by many in Tanzania to not be a medical condition that can be rectified, but a disability that is purely a result of ageing eyes for which nothing can or should be done.

### *2. Rehabilitating people with disabilities*

People who do get treated often do not fully benefit from their restored or improved ability. The medical approach to disability has traditionally been that of 'curing' the obvious impairment. Thus the doctors' task was over when the cataract had been removed from the blind eye, or the club foot had been surgically straightened. Generally little has been done in Tanzania to reintegrate and rehabilitate these people living with long-term disabilities back into their family and community. Even after surgery, many continue to live in the same social role of disabled, as if they were still in the same condition as before surgery. This is due to the fact that the expectations of family members have not changed and no one has empowered them to make use of the opportunities they now have.

### *3. Empowering lives*

The empowerment of people with disabilities is an important part of in making rehabilitation successful. This includes the ability of children with disabilities to go to regular school, young adults with a disability to learn a profession and contribute to the livelihood of the family, enjoy legal security and access basic mainstream services. In addition, society also needs to change and become inclusive and barrier-free for the effective participation of people with disabilities. Children living with a disability are significantly deprived of opportunities. While the national education sector development programmes have raised enrolment rates in primary school, still children with disabilities are much less likely to be in school than other children. Data from the Ministry of Education and Vocational Training (MoEVT) show 24,003 children with disabilities attending primary schools, which represents 0.3% of the mainstream school population. Clearly, this percentage is much lower than the proportion of children with disabilities in the population which is 8,316,925. At the secondary level the enrolment of children with disabilities drops to 911 (0.09%) out of a total enrolment of 1,020,510 (MHEST 2007)<sup>11</sup>.

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10 National Bureau of Statistics Tanzania (2005)

11 Ministry of Higher Education, Science and Technology (2007)

Despite the inclusion of 'disability' in MKUKUTA, little has yet been done. The translation to practical situations and, thus, implementation is lagging behind. This is due to lack of awareness in governing bodies, civil society and development partners as well as limited funds allocated to make things happen. Making Tanzania's society and mainstream services truly inclusive remains a challenge for the future.

#### ***4. Addressing HIV/Aids comprehensively***

As HIV/Aids infections progress, effective care and social support is needed for people infected and affected by HIV/Aids. This includes treatment of opportunistic diseases, checking the adherence of patients to ARV medication, psychological counselling and other support. HBC is an effective strategy to provide quality care and treatment while enabling the family members to provide basic care and reduce stigma. Legal security for people with HIV/Aids infection and their spouse and children is another aspect required to effectively address HIV/Aids and its impact. People with HIV/Aids are entitled to all basic needs and civil, legal and human rights without any discrimination. Furthermore, women have few if any rights with respect to property ownership or tenure to inheriting wealth. Death of a partner due to HIV/Aids can lead to destitution of the rest of the family. The protection of the rights of people with HIV/Aids, the rights of their children and their spouse is therefore an important issue to ensure that people do not enter into the spiral of poverty. In cases where children are left behind, care must be taken to ensure that children are able to access schooling and live in a protected environment to become independent adults.

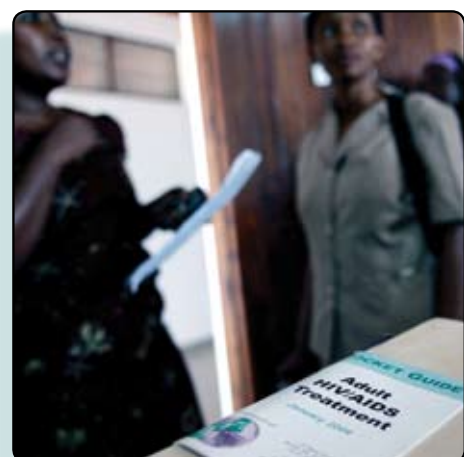
#### ***5. Making HIV/Aids programmes inclusive***

People with disabilities are hardly ever included in HIV/Aids programmes yet they are at higher risk of contracting the HIV/Aids infection and lack service access for a number of reasons. First, only 3% of adults with disabilities are literate, a rate that sinks to 1% for women.<sup>12</sup> Hence, prevention messaging and service access that requires literacy mostly bypasses people with disabilities. Second, awareness and prevention campaigns that use the

print and broadcast media miss those who are deaf, blind or mentally challenged. Third, many health professionals, unaware that individuals with disability may be sexually active, do not offer to test them or provide services, under the assumption that they are not at risk. Hence efforts to develop accessible messaging and services are given no priority. Fourth, people with disabilities lack access to legal protections to ensure that interventions reach them. Finally, women and children (who are the majority of disabled and therefore the most vulnerable) are largely neglected and even physically abandoned, with no advocates for inclusion in HIV/Aids services. *To effectively address HIV/Aids in Tanzania, particular attention needs to be given to making HIV/Aids strategies accessible to people with disabilities and their care givers.*

Thus the core challenges that require addressing are to:

- build awareness about the availability and accessibility of disability and HIV/Aids services (adequate preventive, medical, rehabilitative, consultative and integration services),
- place more emphasis on rehabilitation efforts involving families and communities,
- help create equal opportunities for all people living with disabilities and/or HIV/Aids and their care givers so they can participate fully and actively in society and
- make mainstream development efforts inclusive.



12 Nora Ellen Groce (2005)

# CCBRT: BACKGROUND AND ACHIEVEMENT

**C**CBRT, a Tanzanian Non-Governmental Organisation, was established in 1994 in response to the needs of people with disabilities in and around Dar es Salaam and the lack of accessible services available to them. From its inception, CCBRT has grown rapidly into a large disability and rehabilitation programme. Today, it comprises two Community Based Rehabilitation (CBR) programmes in Dar es Salaam and Moshi, a Disability Hospital, an International Training Programme and a Holistic HIV/Aids Related programme.<sup>13</sup>



CCBRT's vision is to prevent disabilities and HIV infection and improve the quality of life of people with disabilities, those with HIV/Aids and families and caretakers directly affected by it. CCBRT believes that people with disabilities, HIV/Aids and orphans have a right to participate in all aspects of life. Empowering them to participate fully in their communities and benefit from mainstream services is the driving force for CCBRT's work. CCBRT aims to increase the reach of quality rehabilitation services through collaboration with other organisations as well as through supporting mainstream development services in making their services inclusive to people with disabilities.

CCBRT provides services to persons with:

- a physical impairment (cerebral palsy, congenital deformities such as club feet, cleft lip and palate),
- hydrocephalus (water on the brain) and/or spina bifida,
- a visual impairment,
- an intellectual impairment,
- epilepsy,
- Vesico-Vaginal Fistula (VVF),
- or without disabilities and infected with the HIV/Aids virus
- and HIV/Aids orphans.

CCBRT is one of the few organisations in Tanzania providing quality medical and rehabilitative services for people with disabilities. Measures to restore or improve abilities (including rehabilitation) offer greater opportunities to people with disabilities themselves and those caring for them to engage in socio-economic and educational activities. CCBRT gives a voice to those that are traditionally 'invisible' enabling them to engage in self-advocacy for access to health care, education and other services.

## WORKING PRINCIPLES

CCBRT is committed to applying a twin-track approach to its work. In this approach, CCBRT provides comprehensive rehabilitative services to restore or improve the abilities of people with disabilities and empower people with disabilities to become full members of their communities (e.g through the inclusion of children with disabilities in regular or special schools, or providing mobility and orientation training for people with visual impairments to move independently etc.) while implementing and contributing towards mainstreaming initiatives that aim at making development inclusive. This means that CCBRT will continue providing comprehensive rehabilitative services for people with disabilities while positively influencing the institutional environment through networking and alliance building to making mainstream services accessible to people with disabilities. The approach focuses on inclusion and

13 Additional information on the various programme components can be found in part I of the CCBRT Vision Document

elimination of attitudinal, institutional and physical barriers. The two streams of initiatives mutually reinforce each other and result in equal rights and opportunities for participation and improved quality of life.

CCBRT adheres to the following working principles:

### ***1. Working in the communities, working with communities***

Community based rehabilitation (CBR) is the guiding principle of CCBRT's work. Locating the rehabilitative process in the communities, closely involving family and community members has many benefits: It enables people with disabilities to take care of themselves, become personally as independent as possible, improve their social relationships, take part in the activities of the communities and contribute towards their own and their family's livelihood. CBR builds on available reserves such as locally available material resources, skills, ideas, an ability to identify solutions that exist in the heart and mind of the person with an impairment, family members, care givers and community members. CBR is the most effective strategy to change prevailing attitudes towards people with disabilities and ultimately achieve inclusion.

### ***2. Applying a comprehensive approach to achieve impact***

To address disability successfully, CCBRT takes a holistic approach towards the needs of those with disabilities. Services include preventive health interventions, cure, awareness raising, community based rehabilitative services, empowerment, social inclusion into communities and mainstream education, counselling and support.

### ***3. Making services affordable to the poor***

The majority of people with disabilities and their families in Tanzania are amongst the poorest of the poor. CCBRT implements a so-called 'pay-according-to-capacity' principle in its pricing structure: wealthier clients (i.e. those who can afford to contribute) pay extra fees for additional

services such as a private room in hospital with air conditioning, while poor patients pay according to their ability to contribute. The cost for services at CCBRT includes assessment, surgery, medical treatment, food and accommodation. Social workers working at the CCBRT Social Department together with the patient determine the contribution they are able to make. CCBRT operates a poor patient fund that subsidizes services for people who cannot afford the pay for the necessary treatment. CCBRT does not compromise on the quality of services. In line with government policies, CCBRT provides free medical services for children under five years of age.

### ***4. Ensuring quality***

Quality of services is another of CCBRT's key principles; to ensure the best possible outcome in the rehabilitative process for the individual who is central to CCBRT's work. Qualification and continuous training of staff members and reliable follow up of CCBRT's clients through community rehabilitation workers (CRW's) are just some of the measures that ensure quality. Other strategies are regular assessment of surgical outcomes as well as auditing of services and internal work processes.

### ***5. Helping others to strengthen their capacities***

The occurrence of impairments can only be effectively reduced if medical, rehabilitative and inclusive services are extended in quality and number throughout Tanzania and other developing countries. CCBRT wants to contribute to sustainable development with services more widely available through training, capacity development of key stakeholders and awareness raising activities to main stakeholders and the public to make them aware of preventive measures and available services. CCBRT is committed to assisting in the development of human resources in other, same sector, organisations by offering specialised medical and rehabilitative training to national and international stakeholders.

## ***6. Working in partnership: Together we can do more***

CCBRT is dedicated to working in partnerships within the disability sector; building on each other's strengths and complementing each other rather than duplicating work. CCBRT links up with and collaborates with other NGOs. It works closely with governmental bodies and contributes to international initiatives like "Making PRSP Inclusive" or Vision 2020. In the future, CCBRT will extend its partner network even more to create national synergies, share knowledge and expertise and learn from others.



### **ACHIEVEMENTS**

- Since the foundation of CCBRT, the organisation has been able to establish a multi-component programme that provides quality rehabilitative services for people of different disabilities. Through its International Training Programme, CCBRT has contributed considerably towards human resource development within the medical and rehabilitative sector throughout Africa. The high number of services delivered has changed many lives. It has shown that often a small intervention can make a big impact on a person's life and has helped people to break through the vicious circle of poverty and disability.
- To address disability successfully, CCBRT has developed a holistic and integrated approach towards the needs of persons with disabilities and HIV/Aids. Services include: preventive health interventions, cure, awareness raising, community based rehabilitative services, economic empowerment, social inclusion into communities and mainstream education, counselling and support.
- CCBRT has a good reputation in the community, at national and even international levels for its high quality medical and rehabilitative services. It has successfully built up the expertise and experience to optimally overcome or reduce the individual impairment and restore or improve the loss of function.
- CCBRT services also greatly contribute to the achievement of (inter)national targets like Vision 2020, the National Strategy for Growth and Reduction of Poverty and the MDGs.
- The Disability Hospital is well established and equipped serving over 60,000 people and delivering about 9,000 surgeries annually.
- The Hospital finances about one-third of its budget from patient contributions. Basic fees are charged but destitute patients and all children under five years old get free services. Private patients can opt for additional luxuries like a private room and pay higher charges. This allows CCBRT to treat more poor patients and also contributes to maintaining high quality standards.
- Year on year, CCBRT has been able to increase the number of children and adults reached through its community based rehabilitation programme. Today 1,400 children with disabilities are enrolled in the programme, receiving rehabilitative services at home or at weekly support units. On a regular basis, CCBRT offers intensive training sessions for parents as well as mobility and orientation training for adults with a visual impairment.
- In integrating people with disabilities into society, CCBRT has contributed successfully to the enrolment of children with a disability into primary education (beginning 2007: 134 children with a physical impairment, 188 with a hearing impairment) in partnership with the local government authorities and other NGOs.

- Through its training activities, CCBRT has been able to contribute to the development of specialised medical staff in Tanzania and other African countries, thus supporting other medical and rehabilitation institutions in the development of quality services for people with disabilities. There remains a great need for specialist medical staff in Africa.
- In collaboration with the Dar es Salaam City Council (DCC), CCBRT has developed a comprehensive HIV/Aids programme (HARP) including awareness raising, pre-test counselling, testing, post-test counselling, ARV provision through the Dar es Salaam governmental hospitals, home based care services, legal aid support to provide legal security for spouse and children as well as orphan care. The programme has expanded steadily and now provides quality services and care to many Dar es Salaam districts.
- CCBRT has established good collaboration with government, local and international civil society organisations and funding agencies.



## THE FUTURE

CCBRT will continue to cure impairments, increase ability or limit the disabling effects of impairments in as many people as possible and improve to a maximum the lives of people living with disabilities.

**CCBRT's founding principles remain:**  
**“Cure before care,  
 young before old,  
 near before far.”**

The organisation has reached a stage in which it looks for ways to consolidate its efforts and to address a number of challenges:

- The lack of understanding about disability and negative stigma and discrimination against people with disabilities and their families is still extensive in Tanzania. Advocacy and awareness raising activities are necessary to improve positive inclusion in society.
- There is also a need to create more awareness about the services available. Most disabilities that CCBRT addresses are only served by a few other institutions in the whole of Tanzania. CCBRT aims to offer its services in much wider areas. Other service providers and stakeholders should be encouraged to take over part of the responsibilities and build up service delivery in reachable distance to people in need.
- The quality of service offered by CCBRT is of a very high standard. CCBRT wants to maintain this standard and add more rehabilitation services (e.g. occupational, speech and language, bobath therapy, mobility and positioning devices) to increase the quality of outcomes.
- The poverty situation is not automatically addressed through medical and rehabilitative interventions. CCBRT wants to concentrate its efforts on also contributing to the economic empowerment of the beneficiaries and their families.

- A lack of local qualified personnel is still a major challenge in the country. There are very few highly qualified doctors in Tanzania. Career development and training activities can address this. Therefore, CCBRT will refocus its efforts in extending its training offers for sub-speciality training. Yet also at national level; action needs to be taken.
- There is a need to upscale CCBRT's experiences of integrating people with disabilities in society and promoting inclusive development. E.g. the experiences in the education sector can also be applied to other basic public services and contribute to national level development.
- Increased networking and collaboration with stakeholders at different levels including DPOs, NGO, governmental stakeholders and INGOs will be necessary to achieve the objectives.
- People with disabilities are especially vulnerable to HIV/Aids infection as they have less access to education, information and medical services. They are also more likely to be victims of violence and abuse. CCBRT will pay specific attention to the inclusion of people with disabilities in HIV/Aids related services.
- To maintain and improve the quality of services and to increase efficiency and sustainability, CCBRT will need to look towards improving inter-organisational processes. CCBRT will explore all opportunities to work more efficiently but to achieve the same results (with higher quality).
- In order to be able to plan better, have more stability and the chance to develop and implement a more comprehensive human resource strategy there is need to secure more long-term funding based on the overall strategic plan and the overall targets.



# OBJECTIVES AND ACTIVITIES

## CORE OBJECTIVES

In order to achieve its vision of improving quality of life for people with disabilities, CCBRT has the following three core objectives:

1. **Contribute to the prevention of impairments and HIV/Aids infections.**
2. **Empower people with disabilities, HIV/Aids and HIV/Aids orphans to participate as equal members in society.**
3. **Mainstream disability into development issues to work towards an inclusive environment for people with disabilities, HIV/Aids and HIV/Aids orphans.**

Within these areas, CCBRT specifically aims to:

- A. Contribute to the prevention of impairments and HIV infections and strengthen early identification and referral pathways in collaboration with national and international partners.
- B. Expand the reach of quality medical and rehabilitative services.
- C. Strengthen the quality of medical and rehabilitative services to ensure sustainable outcomes.
- D. Empower people with disabilities, HIV/Aids and HIV/Aids orphans to participate in society through comprehensive community based rehabilitation.
- E. Strengthen the human resources capacities in specialised fields in Tanzania and other countries.
- F. Mainstream disability and HIV/Aids into the national development agenda and of other organisations and institutions.
- G. Strengthen CCBRT's capacities and organisational processes enabling it to carry out its core tasks in a sustainable way.

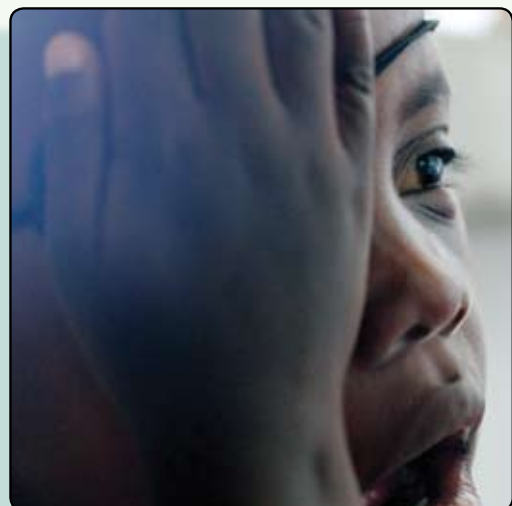
## A. PREVENTION AND IDENTIFICATION

### Objective:

To contribute to the prevention of impairments and HIV Infections and strengthen early identification and referral pathways.

### Main issues:

Major causes of disabilities are poor nutrition, poor health and maternal care, poor hygiene, bad sanitation and inadequate information about the causes and treatment of impairments. Thus, many disabilities are preventable. Early intervention is key for achieving good outcomes especially for children. If certain health problems are addressed quickly, they will not result in an impairment.



**Examples:**

Condition	Action to prevent condition
Fistula	Adequate maternal health care can prevent this impairment happening in the first place.
Cerebral Palsy (CP)	Risk of CP in a child can be reduced by women avoiding pregnancy until they are fully grown (16 or 17 years of age), avoiding unnecessary medicine during pregnancy, going through regular health checks during pregnancy, avoiding the hastening of birth by pushing forcefully against the womb and quality assistance during delivery as well as preventing malaria and/or early treatment of malaria and high fever in children.
Trachoma	An infectious eye disease which can lead to permanent blindness. Frequent face and hand washing and improved domestic sanitation prevent the transmission of the bacteria that causes trachoma.
Club Foot	Early intervention can prevent a permanent impairment occurring. It only requires a small intervention at a very early stage. With proper follow-up in 95% of cases it does not lead to a physical impairment. If a patient with club foot waits too long to seek treatment it can lead to a serious physical impairment which can be rectified to some extent but requires a long rehabilitation process and a series of operations.
HIV/Aids Transmission	a) Sexual and b) blood Strategies for the prevention of HIV/Aids transmission are practicing safer sex (use of condoms, abstinence from sex, be faithful to one partner or have fewer partners), counselling and testing – people who are aware that they have HIV/Aids are less likely to transmit the virus to others if they know they are infected and they have received counselling about safer behaviour – and provision of Antiretroviral treatment (ARV) which enables people with HIV/Aids to live longer and prevent / reduce the transmission of HIV/Aids. c) Mother to Child HIV/Aids transmission from the mother to her baby during pregnancy, labour, delivery and breast feeding can be prevented / considerably reduced through treatment with ARVs during pregnancy, prevention of the infection of the baby with mother’s fluids during labour through caesarean section, or avoidance of breastfeeding if nutritional replacements are acceptable, feasible and affordable.

*The best prevention of the development of impairments and consequently disabilities and HIV transmission is quality mother and child care.* The main issues that require addressing are accessibility to good quality primary health care (specifically mother and child health care) and lack of awareness among key stakeholders, the general public and health workers.

## **Activities:**

### ***Ai) Awareness raising:***

Access to correct and up-to-date information is vital in order for people to become fully aware of what services are available to them and what their rights are. Therefore, CCBRT will work to raise awareness on disabilities and the availability of curative treatments amongst the population in target areas through community meetings, radio announcements, church, mosques, theatre and dance.

Specifically, CCBRT will help to spread core messages about the HIV/Aids services available and make them accessible for people with disabilities. It will do this by developing inclusive HIV/Aids materials, adapted to the needs of persons with different disabilities (incl. visually, hearing and intellectually impaired). Additionally, through its community programmes and courses/training sessions run at its Dar es Salaam disability hospital, CCBRT will help to extend awareness among people with disabilities (and their care givers) about the causes of HIV/Aids, how it can be prevented and how to care for those living with HIV/Aids. Networking and collaborating with mainstream HIV/Aids organisations will form an important part in working towards making HIV/Aids strategies inclusive to people with disabilities.

### ***Aii) Training:***

CCBRT will undertake training of staff members in other health units, mother and child care health workers as well as lay key informants to enable them to detect symptoms of eye problems and other physical impairments in children at an early stage and refer children to specialised services. In order to boost capacity within Tanzania, CCBRT will play a role in developing human resources in the field of specialised disability for staff from other institutions through networking, exchange, collaboration, training and on-the-job support. In the CCBRT eye department for instance 2 paediatric fellows, 2 cataract fellows, 2 Mmed ophthalmology trainees, and 2 AMO surgeons are trained every year.

### ***Aiii) Preventive medical interventions:***

In order to prevent some impairments occurring in the first place, CCBRT will continue to provide its high quality medical services including medicines (for instance, to prevent eye conditions worsening and leading to blindness) and surgical interventions. It will also maintain its screening, consultation and follow up services.

### ***Aiv) Mother and child health:***

As outlined above, many impairments could be avoided if there was an improvement in mother and child care facilities in Tanzania. The Board of CCBRT and DCC have joined hands in a Public-Private Partnership for the development of a Mother and Child Health Hospital in the coming years. The new hospital, to be based on the current disability hospital site in Dar es Salaam, will serve many thousands of people and will provide:

- Ante, neo and post natal clinics and deliveries in a safe, sterile environment by highly trained medics and mid-wives,
- education on reproductive health, HIV/ARV, Malaria, TB, prevention of HIV/Aids transmission to babies to future mothers,
- HIV/Aids education and training to other organisations and private companies,
- training to Tanzanian mother and child care staff on reproductive health,
- world class mother/child health (MCH) facilities,
- holistic HIV/Aids services (VCT, ARV treatment, HBC, Legal Aid, orphans care).

### ***Av) Networking and advocacy:***

The occurrence of impairment can only be effectively reduced if medical, rehabilitative and disability inclusive services are developed and made accessible throughout Tanzania. More needs to be done on a national level to alter prevailing stigmas and attitudes towards people living with disabilities and to increase awareness countrywide that there are services available which could greatly improve quality of life for those living with disabilities. Therefore, CCBRT will liaise with other bodies such as religious groups, schools, NGOs and Community Based

Organisations (CBO's) to stimulate early referral pathways. It will also increase its collaboration with governmental and private health facilities on developing strategies for early identification and advocacy. CCBRT will also play an active role in general discussions on primary health care in order to raise awareness and keep disability issues firmly on the agenda.

## B. EXPANSION OF SERVICES

### Objective:

To expand the reach of quality medical and rehabilitative services.

### Main Issues:

In the 2005 *Health in Crisis Action Report for Tanzania*<sup>14</sup> the WHO identified large remote areas of Tanzania, particularly Zanzibar and rural areas on the mainland, as greatly underserved by medical services. Most of the rural areas surrounding Dar es Salaam provide no specialised services for people with disabilities. Lack of funds, high transport costs and low availability of information about the possibilities of treatment keep many people of poor background from travelling to Dar es Salaam to seek specialist advice and treatment. Therefore, through its Mobile Outreach Programme, CCBRT operates within the communities themselves to find those in need of help. CCBRT Kilimanjaro is very active in referral of eye patients to KCMC. The eye referral unit covers Arumeru and Karatu (Arusha region), Babati and Mbulu districts (Manyara region) and Lushoto district (Tanga region).

The Mobile Outreach Programme aims to make specialist services available and affordable to the underserved rural areas surrounding Dar es Salaam by raising the awareness about the availability of rehabilitative services, screening people with visual and other impairments, providing treatment on the spot or transport to CCBRT's disability hospital for those patients in need of surgery. CCBRT's vision is to increase the number of people assisted not only through its own services but also in close collaboration with local stakeholders (hospitals,

other NGO's in the area, District Medical Officers). This is an important step in bringing quality services closer to those most in need.

CCBRT intends to expand the reach of the services to so far underserved target regions such as Pwani, Morogoro, Tanga, Mwanza and the island of Zanzibar. This increases the number of those directly or indirectly serviced by CCBRT in its target area from 3.5 to 10 million people. The CCBRT Kilimanjaro branch will maintain its activities in the target area for the coming year.

### Activities:

#### *Bi) Mobile outreach:*

Following the success of CCBRT's long running Mobile Outreach Programme, the programme's geographical remit will be extended to cover more remote areas such as Mwanza, Mbeya, Morogoro, Pwani and Zanzibar. Screening teams will regularly operate in remote areas which currently have no services and conduct widescale screening sessions providing transport to CCBRT's disability hospital where specialised services are required. Furthermore, in order to offer a more comprehensive approach to disability services and avoid duplication of efforts, greater collaboration will be sought with local government and NGO services in remoter, densely populated areas (Mwanza, Mbeya).



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14 World Health Organisation (2005)

### ***Bii) Satellite units:***

In order to service a greater number of people, CCBRT will establish more permanent eye units (satellites) in various localities. CCBRT will realise this through human resource (training in awareness raising, screening and provision of services) and service development in medical institutions in the surrounding regions of Dar es Salaam (Zanzibar, Tanga, Morogoro, Rufiji, Handeni). Next to human resource development, CCBRT also provides equipment to health units. So that high quality standards can be maintained in these institutions, CCBRT will provide regular surgical outreach services (including managerial advice and surgical auditing) to these units until they run self-sufficiently (3-4 years development period). Through its outreach activities, CCBRT will also support service providers in remoter areas to provide and / or improve the accessibility of medical services.

## **C. ENSURING SUSTAINABILITY**

### **Objective:**

**To strengthen the quality of medical and rehabilitative services to ensure sustainable outcomes.**

### **Main Issues:**

Many people living with a disability and HIV/Aids could see their ability restored or improved with adequate medical and rehabilitative care. After treatment follow-up is often necessary in order to achieve good outcomes. While continuing to provide its existing comprehensive services, CCBRT is continuously looking for ways to strengthen the quality of its services and add on other services that will ensure sustainable outcomes.

### **Activities:**

#### ***Ci) Medical services:***

Every day, around 300 patients arrive at CCBRT for treatment of some form. Everybody is seen and nobody is turned away. CCBRT offers a wide range of medical services, many of which are not readily available (or affordable) elsewhere.

Within its Rehabilitation Department, CCBRT is able to provide orthopaedic, plastic/reconstructive, neurosurgical surgeries to prevent or reduce a number of impairments: (spina bifida, hydrocephalus, congenital deformities) as well as VVF surgery. The department also has a busy physiotherapy unit where mobility and function can greatly be improved through specialised exercises. The rehabilitation department is also able to provide a number of orthopaedic appliances including splints, callipers, crutches and artificial legs.

CCBRT's Eye Department provides sight restoring improving surgery for a range of conditions such as cataract, glaucoma, trauma, tumor and trachoma. Laser treatment for patients with diabetes is also available. Also within this department, therapy and devices are offered for people with low vision and low cost spectacles can be accessed here (outsourced).

#### ***Cii) Quality control and follow up:***

CCBRT wishes to improve referral pathways and post-operative follow up of patients in its CBR programme to ensure that children treated receive services until they are fully rehabilitated. It will do this in several ways: firstly a computer based database will be established and operational in February 2008. This will link up the disability hospital and the community programmes. This database allows registering of patients, keeping records of their assessment, referral, treatment, rehabilitation measures and follow up. It allows a reliable follow up as well as a comprehensive overview and audit of the rehabilitation process of clients which can be easily obtained. CCBRT will establish a toll free phone line for patients to receive information on available services and enable priority patients who miss their follow up appointment to be contacted.

Additionally, CCBRT will establish referral paths with other health institutions (such as training of their nurses in early detection) in order to improve efficiencies. Quality control will also be maintained via regular auditing of surgical outcomes. CCBRT operates to the highest standards and applies /

and or works towards international best practice standards in service provision, such as adherence to WHO standard of 90% of eye surgeries need to be 6/18 or better.

***Ciii) Comprehensive, quality rehabilitation package:***

CCBRT aims to offer a number of further services in order to reach more people in need. Post surgery many patients still need follow up care and therapy. For instance, a child with a cleft palate may never have learned how to speak properly and without additional speech and language therapy (SLT) may never be fully integrated back into their community. New therapeutic services such as SLT, new physiotherapy techniques (PT) (e.g. bobath), occupational therapy (OT) and daily living training will soon be provided at CCBRT. So that successful rehabilitative outcomes can be maximised there will be further efforts to strengthen interdisciplinary collaboration between all parties involved in a patient's treatment (Doctors, PT, OT, SLT, orthopaedic technician, CBR workers and family members). The orthopaedic workshop services will be extensively expanded to include functional, tailor made mobility and positioning aids for sitting, standing and walking. In a step forward from the current provision of callipers, splints and artificial limbs, the workshop will start to produce wheelchairs and tricycles.

Staff training opportunities will be strengthened and extended. Current staff will be trained in new physiotherapy techniques in order to upgrade their skills and capacities. New staff will be recruited to broaden the range of therapies currently on offer (such as a physiotherapist with bobath experience, a speech and language therapist and an occupational therapist.)

As well as building up staff expertise, CCBRT also aims to add to its infrastructure capacity with the construction of a rehabilitation centre which will include an assessment and administration centre, therapy room (PT, OT, SLT), workshop for orthopaedic positioning and mobility devices,

training rooms, hostel facilities and an outdoor training centre (see Objective Gii).

***Civ) Holistic HIV/Aids services:***

CCBRT's experience shows that adopting a holistic approach to HIV/Aids is much more successful than just treating the disease itself. As well as providing VCT services, CCBRT is increasing its efforts in making VCT accessible to people with disabilities and their care givers. In collaboration with Dar es Salaam City Council CCBRT provides ARV treatment and once the MCH hospital is up and running, CCBRT itself will be in a position to provide ARVs at its facilities.

HBC services to improve the health of people with HIV/Aids are already provided by CCBRT and efforts to expand this service to reach more people with disabilities living with HIV/Aids will be stepped up. As well as HBC, CCBRT's holistic HIV/Aids services include the provision of legal aid to people with disabilities and HIV/Aids and their care givers.

CCBRT will strengthen the existing capacities of staff with an additional two annual training sessions in HBC related topics.

CCBRT and the DCC have signed an agreement that CCBRT will gradually hand over the coordination of home based care services to the MDH and DCC. The long-standing collaboration however will be extended and nurtured in the accessibility of holistic HIV/Aids services for people with disability.



## D. EMPOWERING LIVES

### **Objective:**

**To empower people with disabilities, HIV/Aids and HIV/Aids orphans to participate in society through comprehensive community based rehabilitation.**

### **Main Issues:**

Community based rehabilitation is the guiding principle of CCBRT's work. Locating the rehabilitative process in the communities, closely involving family and community members has many benefits. It enables people with disabilities and HIV/Aids to take care of themselves, become personally as independent as possible, improve their social relationships, take part in the activities of the communities and contribute towards their own and their family's livelihood. CBR builds on resources such as locally available materials, skills, ideas and local solutions. CBR is the most effective strategy to change prevailing attitudes towards persons with disabilities and ultimately achieve inclusion. The empowerment of people with disabilities plays an important role in making rehabilitation successful. This includes the ability of children with disabilities to go to school, young adults with a disability to learn a profession and contribute to the livelihood of the family, enjoy legal security and access basic mainstream services. The same applies to people with HIV/Aids. Direct care (such as treatment of opportunistic diseases and ensuring access to ARVs) is crucial for a person to maintain or regain their physical strengths. Empowering them to claim their rights and supporting their reintegration in society is also very important. Society also needs to change and become inclusive and barrier-free for the effective participation of people with disabilities and people living with HIV/Aids. The latter will be elaborated on in the section on 'mainstreaming disability' (Objective F below).

### **Activities:**

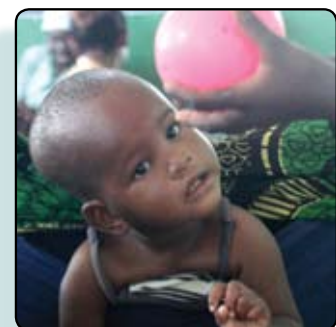
#### ***Di) Rehabilitative services:***

CCBRT currently provides a range of CBR services such as improving functions of children with

disabilities through home visits (OT, PT), epilepsy treatment, training on daily living skills), weekly support units and intensive weeks of training. The aim is to ensure full recovery so that the patient can achieve maximum benefit from the ability restoring intervention at CCBRT's disability hospital. For those with life-long disabilities the purpose of CCBRT's CBR initiatives is to provide long term rehabilitation to improve function and abilities in that person. The mobility of children with disabilities will be improved through the increased provision of mobility and positioning devices (see Ciii above). CCBRT will also offer further training to improve the skills and knowledge of parents of children with disabilities about the impairment itself along with rehabilitation techniques.

#### ***Dii) Integration services:***

CCBRT will seek to empower people with disabilities, HIV/Aids, orphans by assisting their participation in social, economic or educational activities with the end result of social inclusion. Already CCBRT has successfully supported the integration of many children with disabilities into mainstream education or special schools and will expand this aspect of its work going forward. CCBRT also plans to integrate people with disabilities and HIV/Aids in existing educational activities and economic empowerment services (e.g. business development, micro-credit schemes, job mediation etc). By making CCBRT's legal aid services increasingly accessible to people with disabilities and their families, CCBRT will make a vital contribution in securing their basic rights. Efficiencies will be improved and duplication will be avoided in the above programmes through collaboration and networking with other organisations.



## E. CAPACITY BUILDING

### Objective:

To strengthen the human resources capacities in specialised fields in Tanzania and other countries.

### Main Issues:

The occurrence of impairments can only be effectively reduced if medical, rehabilitative and inclusive services are extended in quality and number throughout Tanzania and other developing countries. CCBRT is committed to assisting in the development of human resources in other, same sector, organisations by offering specialized medical and rehabilitative training to national and international stakeholders. The high volume of patients and quality of services provide ideal training opportunities to further develop skills for specialists in Tanzania.

### Activities:

#### *Ei) National and international networking:*

CCBRT will establish close networks and formalize relationships with accredited training institutions inside and outside Tanzania such as Muhimbili University College of Health (MUCHS) Tanzania, Kilimanjaro Christian Medical College (KCMC) Tanzania, St. Thomas', UK and Gonin, Switzerland and will increase exchanges with other Dar es Salaam hospitals. Medical students at schools and training centres in Tanzania will be targeted for training opportunities as will potential CBM-co-workers, medical staff including nurses and medical doctors of other organisations and, finally, maintenance staff.

#### *Eii) Medical training sessions:*

Several training programmes are available through CCBRT. The NGO offers sub-speciality training through a Paediatric Ophthalmology Fellowship, a Vitreoretinal (VR) Fellowship, a Modern Cataract Surgery Fellowship (Small Incision Cataract Surgery (SICS) and phacoemulsification surgery). It also supplies theatre, ophthalmic, ward and general nursing training. CCBRT hopes to employ a full time nurse trainer in the future. Ultimately, CCBRT

is working towards accreditation of its training offer over the coming years.

#### *Eiii) Maintenance of hospital equipment:*

Going forward, CCBRT will develop training capacities within the organisation for equipment maintenance (x-ray, microscopes, sterilizers, laboratory equipment) and also to provide maintenance training of hospital equipment to external stakeholders. On average 2 external maintenance training sessions are planned per year.

## F. MAINSTREAMING DISABILITY

### Objective:

To mainstream disability issues into the national development agenda and of other organisations and institutions

### Main Issues:

The simple fact that 'disability' is often ignored in development matters<sup>15</sup> reflects the common tendency that people with disabilities are generally 'invisible' within most societies and they rarely participate in development matters. Also in Tanzania, the inclusion of 'disability' in development efforts is very limited. A number of supportive policies like the UN convention and the Tanzania Poverty Reduction Strategy MKUKUTA are in place, which specifically address inclusion of people with disabilities. However, the translation to practical situations and, thus, implementation is lagging behind due to lack of awareness in governing bodies, civil society and development partners as well as scarce funds. For instance, schools remain inaccessible to children with disabilities (no ramps for wheelchairs, no adjusted toilet facilities), there are not enough specialist teachers and information services on HIV/Aids are not in accessible formats (such as Braille, bigger font, basic language etc).

CCBRT has engaged in advocacy initiatives in the past and would now like to develop this component further. At the national level CCBRT will engage in dialogue with the Government on inclusion of disadvantaged people with disabilities in

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15 Handicap International & CBM (2006)

national policies and collaborate with like-minded organisations on advocacy issues. Besides CCBRT's direct involvement, it is envisaged that CCBRT can also play a more prominent role in strengthening the civil society movement in Tanzania to advocate for improved services and inclusion of disadvantaged groups who currently lack a strong and united voice. The major part of CCBRT's work takes place in the community. CCBRT intends to up-scale its efforts through networking with other organisations and lobbying for inclusive development.

#### **Activities:**

##### ***Fi) Capacity development:***

CCBRT will offer training and technical advice to mainstream service providers (including health facilities, education establishments, formal and informal employers, legal system) to make services disability inclusive. It will also provide consultative and technical advice to other stakeholders to ensure a disability inclusive environment.

##### ***Fii) Networking, lobbying and advocacy:***

Stronger link ups with DPOs, NGOs, INGOs, governmental stakeholders (health, education, labour, social welfare), church groups and legal bodies are essential in order to improve efficiencies and raise awareness about disability issues. CCBRT aims to step up collaboration between its legal aid offices and human rights organisations to promote and protect the rights of people with disabilities and persons living with HIV/Aids. CCBRT will also engage in awareness raising activities for inclusive mainstream strategies and services using best practice examples. Also planned are further lobbying activities for national policy changes (specifically lobbying for adaptation of teachers' curriculum to include a disability component in teacher training, lobbying for inclusive construction policies for schools and public buildings to make buildings accessible). CCBRT will join forces with DCC, Chavita, Cheva, Femina HIP, Pasada, Pathfinder, TACAIDS, UNAIDS, Dreams for all and disability organisations which are members of the MKUKUTA Network to work towards a disability inclusive environment.

## **G. STRENGTHENING CCBRT'S CAPACITIES**

### **Objective:**

**To strengthen CCBRT's capacities and organisational processes to carry out the implementation of core tasks in a sustainable way.**

### **Main Issues:**

Organising internal capacity is key to the long-term ability of CCBRT to carry out quality of life improving services for people with disabilities in an effective and efficient way. CCBRT has identified comprehensive strategies to strengthen its organisational capacities during the implementation period 2008-2012. Strategies specifically aim at:

- i) Strengthening the organisation of human resource management systems to carry out the work on a sustainable basis
- ii) Strengthening the professional capacities of CCBRT employees to carry out the strategic vision of CCBRT
- iii) Strengthening the internal work processes that support planning, monitoring and evaluation
- iv) Developing the infrastructure of CCBRT to facilitate the expansion of CCBRT's activities.

### **Activities:**

#### ***Gi) Human resource management systems:***

Over the past decade, CCBRT has continuously grown programmatically as well as in size. From a CBR programme based in Dar es Salaam and Moshi, CCBRT has grown into an organisation offering quality rehabilitative services at its disability hospital, through its community rehabilitation programmes as well as providing comprehensive HIV/Aids services in collaboration with the DCC. Today, CCBRT employs well over 300 staff members. Like many other organisations in Tanzania, CCBRT provides one year contracts to its employees.

CCBRT has reached a stage where a systematic, long-term organisation wide approach to Human Resource Management needs to be taken to enable and support the implementation of its strategic plan. To enable long term organisational and staff

development, CCBRT has taken the decision to provide open ended contracts to each staff member of CCBRT from 2008 onwards. This has opened the way to the development of systematic career paths for senior staff in the organisation and provided all staff members with an increased security and perspective.

In addition to open-ended contracts, CCBRT introduced a performance based payment system in October 2007. This provides additional incentives for staff members who excel and awards a bonus based on their performance at the end of each year. The system has been developed in a participatory approach by a team of CCBRT staff members from all organisational units, which consulted other organisations who work with similar systems. The system is based on a 360 degree performance appraisal against the job description of the individual staff member. In November 2007, the first round of staff appraisals were successfully implemented. By 2012, five more rounds of staff appraisals will be implemented.

During 2008, CCBRT is looking at employing a full time human resource manager to drive human resource development of CCBRT in a concerted way to ensure that the CCBRT strategy 2008-2012 is implemented by a capable and motivated staff on a sustainable basis.

#### ***Gii) Professional capacities of CCBRT staff:***

One of CCBRT's working principles is to guarantee quality. To be able to carry out the CCBRT strategic plan and maintain and further develop the quality of services, staff competencies at various levels of the organisation need to be continuously developed and new core competencies acquired based on the 2008-2012 strategic plan.

#### **Community Programmes**

In order to meet that objective, CCBRT plans 25 short term in-house training courses a year for CBR staff members in Dar es Salaam and Moshi. The training courses aim at strengthening existing skills and knowledge in several areas. For instance,

in construction and adjustment of assistive devices, HIV/Aids, refresher courses in epilepsy, OT, PT, SLT, bobath method and economic empowerment. By 2012 CCBRT will have conducted 125 in house training sessions for CBR staff.

The competencies of CCBRT HBC staff are reinforced through 2 annual one week training courses on (amongst others) nutrition, ARV medication, opportunistic diseases and treatment as well as counselling. Latter courses will also include 45 HBC nurses employed by the Dar es Salaam District City Council. By 2012, CCBRT will have implemented 10 in house training courses for HBC nurses.

#### **Disability Hospital**

To ensure long term sustainability of CCBRT's work, the management of CCBRT disability hospital aims at handing over the management of CCBRT eye department to a Tanzanian ophthalmologist by 2010. Over the coming 2 years, the CCBRT Head of the Eye Department will work on the systematic development of an existing staff member into the position of the Head of the Eye Department. Continuous further development of existing staff is an integral part of the work at CCBRT eye department. Training and re-training of staff is part of the regular activities conducted at CCBRT eye department. Further training of staff is conducted on a weekly basis. Nurses receive weekly training updates (e.g. nurse auxiliary training, theatre training) and receive additional further trainings by visiting doctors. In addition, the CCBRT eye department will employ a childhood blindness coordinator to strategically develop the extension of early intervention services to children in need of sight restoring eye services.

Between now and 2012, the rehabilitation department will extend its spectrum of rehabilitative services. To realise the development of the rehabilitation centre, CCBRT will put extra effort into internal staff development of the existing physiotherapy department. Regular further training in new PT techniques like bobath, as well as an extension of core competencies through employment of new specialist

### **CCBRT Headquarters**

Fundraising is one of CCBRT headquarter's (HQ) tasks. Currently, fundraising is strongly supported by an expatriate staff member. In the coming 2 years this task is to be fulfilled by a Tanzanian staff member. In 2008 CCBRT will employ a new staff member who will be trained to carry out fundraising on a national and international level.

Over the past decade, CCBRT has gained in depth technical expertise in rehabilitation and is a well recognized organisation in the rehabilitation sector in Dar es Salaam and neighbouring regions. In the coming years, CCBRT will use its expertise to work towards mainstreaming disability into the development agenda of governmental institutions as well as other non-governmental players. For this purpose, CCBRT will assign one staff member to take over advocacy and lobbying activities and support networking and the development of alliances in the field of inclusive education, employment policies, vocational training and lobby for disability inclusive HIV/Aids strategies. Capacity development of other organisations so they include disability issues in their work will form an important component in CCBRT's work.

In the future CCBRT will encourage job rotation and professional experience and exchanges between clinical and community services to create learning opportunities, responsiveness and coherence between the disability hospital and the community programmes

### ***Giii) Internal work processes:***

CCBRT applies PCM standards to its work. During the planning process CCBRT applies a participatory approach involving key staff in assessment and planning exercises. (For more detail please see Organisational Management and Development P?).

CCBRT implements a pricing system that allows people to pay according to their capacity. This ensures that people of poor background are able to access rehabilitative services. People who can

afford more are able to get extra "luxuries" such as a single room, choice of treatment date and doctor. Through this pricing system, CCBRT disability hospital was able to recover 40% of its costs in 2007. That was achieved mostly through the provision of eye services to private patients. In 2008-2012 CCBRT aims to improve its costs recovery system by exploring additional services to private patients without compromising services to people of poor background. Possible additional services for private patients are hip replacements, as well as SLT and PT at the new rehabilitation centre. The establishment of a "Doctors Pavilion", separate facilities for private patients on the CCBRT compound, is being explored.

### ***Giv) Developing CCBRT's infrastructure:***

To be able to provide more comprehensive rehabilitative services, CCBRT will extend the facilities of the rehabilitation department and construct a rehabilitation centre including an assessment centre, therapy rooms, orthopaedic, mobility and positioning workshop, training rooms, hostel facilities for family members and out door training facilities.

One of CCBRT's aims is to increase the cost efficiency of its services in the coming years. One of the measures taken is the construction of low cost hostel for 80 patients in 2008.

Also additional hostel space is required due to the development of CCBRT as an ophthalmic sub-speciality training centre in Sub-Saharan Africa and the increase of visiting doctors and medical trainees at CCBRT. These include Paediatric Ophthalmology Fellows, Vitreoretinal Surgery Fellows, Modern Cataract Surgery Fellows, ophthalmic and general nurse trainees, as well as the possibility for general eye surgery training. CCBRT will construct 6 more flats to host students, visiting doctors and other visitors.

As part of the plans for the development of a new MCH Hospital in collaboration with CCBRT and the Government of Tanzania, CCBRT will

construct new hospital facilities on the neighbouring plot. Hospital facilities will include delivery rooms, ante/neo and post natal wards, private patient wing, training facilities, VCT and ARV facilities, laboratory as well as a reception area and an office for MCH hospital administration. CCBRT is in the process of detailing the budget needs for the construction of the new facilities.

## CROSS CUTTING ISSUES

### *Disability and achieving gender equality*

- 70% of people living with disability are female<sup>16</sup>
- Women with disabilities are likely to be poorer, less healthy, more socially isolated and vulnerable to abuse than men with disabilities or women with no disabilities
- Women and girls with disabilities face even more discrimination and neglect than women/ girls without disabilities in developing countries
- Especially women and girls with mental disabilities face especially horrific abuse
- The literacy rate of people with disabilities worldwide is 3%, of women 1%
- Women are more likely than men to become disabled due to gender bias in the allocation of scarce resources and in the access to services
- More than 80% of women with disabilities in developing countries have no independent means of livelihood, they are twice as unlikely to get a job
- Sexual and physical abuse is alarmingly high

### **CCBRT's response:**

- CCBRT aims to achieve gender equality in the accessibility and provision of services
- Women and men / girls and boys with disabilities have equal rights to social opportunities, resources and responsibilities and goods enjoyed in the communities
- CCBRT will promote gender equality through community based rehabilitation
- In the future, CCBRT will specifically make efforts to include women with disabilities in vocational training programmes (empowerment of women)

- CCBRT ensures gender balance in recruiting and training of personnel

### *Disability and children*

- The survival of children in countries like Tanzania is threatened by HIV/Aids and poverty
- Children with disabilities are more vulnerable than children with no disability: they have less chances to receive care and, later in life, access to schooling
- The mortality of children with disabilities can be as high as 80% in countries where the mortality rate of children under 5 is 20%. In 2004 Tanzania the mortality rate of children under 5 was 10% (112 out of 1000). Figures about the mortality rate of children with disabilities are not available.<sup>17</sup>

### **CCBRT's response:**

- CCBRT focuses its activities on children as they are the most vulnerable in society
- Child protection: CCBRT maintains a child safe environment within its facilities
- To maximise impact, CCBRT applies and will strengthen in the future its twin track approach: lobbying for the inclusion of children in education where possible and vocational training programmes while focussing practical work on children in community programmes and in its rehabilitation department



16 UNDP (1995)

17 Ministry of Planning, Economy and Empowerment (2006)

## CCBRT: FUTURE TARGETS

**From 2008 till 2012 the Public Private Partnership will aim to achieve the following targets:**

### COMPREHENSIVE COMMUNITY AND HOSPITAL BASED DISABILITY SERVICES

Prevention/reduction of disability through the provision of ability restoring/impairment reducing surgeries;

● Eye surgeries	35,000
● Orthopaedic and plastic reconstructive surgeries	7,000
● Fistulae surgeries	1,200
● Neuro-surgery	800

Provision of corrective devices to fully or partially restore the ability to see, hear, to be mobile or to function;

● Low Vision devices and spectacles	100,000
● Orthopaedic and Mobility devices	10,000

Hospital/centre based provision of therapy/advice sessions to increase ability or reduce impairment;

● Eye examinations	300,000
● Physiotherapy sessions	50,000
● Other (epilepsy)	3,000

Community based therapy sessions by community health workers and professionals;

● Home based therapy sessions	10,000
● Community based group sessions	1,000

Community based functional training in daily living skills (blind adults);

250

Formal/inclusive education to increase chances of integration, employment and of self reliance;

● Physically impaired	300
● Hearing impaired	300
● Orphans	500

Disability Hospital and Community Programme Staff Trained to Achieve Clear Goals;

200

## HIV/AIDS HOLISTIC CARE COMPONENT

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Education on HIV/Aids, Reproductive Health, Malaria, TB (37,415* x 3)	112,245
People aware of HIV status (number new people (re) tested by MCH + HIV project)	80,000
HIV+ people timely on ARV, able to educate children (also referrals)	20,000
Persons not widowed and economically more viable	20,000
Young orphans prevented (20,000 x 3)	60,000
Orphans inheriting the belongings of their parents (through legal aid)	2,000
Orphans prevented from becoming street children (estimate)	1,600
HIV/Aids Staff Trained and Guided to Achieve Clear Goals	200

\* 37,415 is the number of deliveries: each lady will be required to bring at least 2 other persons for education (daughter, husband, partner, sister,...)

## MOTHER AND CHILD HEALTH HOSPITAL

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**Total Deliveries 37,415 – from 15 per day at the start, up to 35 per day later on.**

	Objective of Project	Outcome (NB: the projects will often receive late referrals)
Mortality - Lives of mothers saved	50% reduction in mothers dying	306 lives of mothers saved
Mother's morbidity/disability due to complications prevented	50% reduction	4,904 mothers not sick/disabled
Children preserved from orphan status	918 less children orphaned	918 children preserved from orphan status
Perinatal lives saved	50% reduction (MDG: reduce 2/3)	2,244 lives of children saved
Perinatal disability prevented	50% reduction	2,244 children not disabled
Perinatal HIV infection prevented (PMTCT)	65% reduction	972 children HIV prevented
MCH staff trained and guided to achieve clear goals		200

# ORGANISATIONAL MANAGEMENT AND DEVELOPMENT

## LEGAL STATUS

CCBRT is a registered non-profit making organisation registered under the Tanzanian Societies Act, No SO8261. Copies of the registration certificate and the CCBRT constitution are available upon request. The constitution provides information about the purposes for which CCBRT was established, and details the governance structure and procedures of the organisation. It also delineates the means by which it can be amended through annual or special general meeting processes.

## ORGANISATIONAL CULTURE

CCBRT realises the values of democratic governance, transparency, human rights, gender, equity and meaningful participation in decision making. CCBRT encourages a culture of openness, mutual respect, critical reflection and learning. CCBRT encourages staff members to give open feedback on a regular basis through staff meetings or feedback boxes and takes action where possible. To measure the quality of services, open feedback is also sought from patients. CCBRT clients are regularly asked to evaluate CCBRT's services and steps are taken to implement recommendations made. The management of CCBRT is committed to empowering its staff members by encouraging the taking on of responsibility in work and providing the necessary supportive framework for staff members through training and coaching. CCBRT's aim is to contribute to the creation of an inclusive society. CCBRT, therefore, implements disability inclusive policies in employment. In the future, CCBRT will put an even higher focus on offering job opportunities to people with disabilities and creating an empowering environment through its programmes. CCBRT believes in working in partnerships. CCBRT proactively works on the development of alliances and networks with DPO's, other disability organisations, and mainstream organisations to join hands in making quality of life improving services inclusive for people with disabilities and HIV/Aids.

## GOVERNANCE, MANAGEMENT AND STAFFING

CCBRT was established 1994 by a group of 10 founding members who established the CCBRT General Assembly. Five of these members formed the CCBRT Board. Today, the CCBRT Board consists of 5 board members who bring in expertise from different fields (law, education, finance, management, medical and disability and rehabilitation), including the Executive Director. The Board is responsible for the governance of CCBRT, the setting of overall policies and financial/operational guidelines, supervision of programme implementation, and appointments of the senior management team. The Board has 3-4 scheduled meetings each year, however the Chairman and Vice Chairmen are consulted and involved on a regular basis by the CCBRT management. Board directors normally serve for 3 years.

The General Assembly consists of 10 members, of which 5 are members of the Board of Directors. Members of the General Assembly represent different expertise. The CCBRT General Assembly meets once a year and is responsible for approving activity and financial reports presented by the Board of Directors and reviews and agrees on suggested plans.

The senior management of CCBRT consists of an Executive Director, one CCBRT Hospital Director and one Director for Community Programmes with 4 programme managers (CBR Dar es Salaam, HARP Dar es Salaam, Eye Department, and Rehabilitation Department). The CCBRT senior management team is responsible for organisational management, and programme planning, implementation and monitoring.

The CCBRT HQ consists of an accounts unit, an administration unit, a controlling unit and service/planning unit. The management of the CCBRT disability hospital is supported by a service coordination unit, nurses unit, accounting unit and procurement unit. In 2008, one staff member

of the accounting unit of CCBRT HQ will be assigned to support the community programmes more closely. This decision has been made to ensure sound financial management of the community programmes.



**Staffing distribution per department as of December 2007:**

Unit	Staffing levels	Total
<b>Head Quarters</b>		<b>Total: 15</b>
Chief Executive Office	Executive Director, Executive Assistant	2
Accounting Unit	1 finance manager, 1 accountant	2
Administration Unit	2 administrators, 1 cashier,	3
Controlling Unit	2 controllers	2
Service Unit	2 service workers, 1 auxiliary staff, 1 driver	4
Programme Development Unit	2 programme development staff	2
<b>Community Programmes</b>		<b>Total: 120</b>
Community Programme Office	1 director community programmes, 1 IT/ database manager	2
CBR Dar es Salaam	1 community rehabilitation manager, 1 secretary, 2 physiotherapists/ supervisors, 1 occupational therapist supervisor, 1 CBR supervisor work with blind adults, 2 community rehabilitation workers blind adults, 20 community rehabilitation workers, 3 teachers for deaf classes, 2 drivers, 1 service worker	34
HARP Programme	1 programme manager HARP, 1 assistant, 2 home based care supervisors, 5 home based care nurses, 41 DCC nurses (part time), DCC doctor (top up) 1 lawyer manager, 1 lawyer, 4 law assistants, 1 secretary , 1 counsellor manager, 1 counsellor, 5 social workers orphans, 24 orphan mediators (top ups), 3 office attendants, 1 service worker, 4 drivers	31



Unit	Staffing levels	Total
CBR Kilimanjaro	1 programme manager/ language pathologist, 1 assistant programme manager, 1 accountant, 1 administrator 1 liaison officer, 1 referral and eye work coordinator, 1 occupational therapist, 2 physiotherapists, 1 store keeper, 1 assistant speech therapist, 8 community rehabilitation workers, 7 cataract surgical rate workers, 7 watch men, 2 driver, 1 office attendant, 1 sign language teacher, 1 Montessori teacher, 3 rehabilitation assistants, 1 matron, 1 receptionist, 3 cleaner hostel, 4 gardener, 2 cooks	53
<b>CCBRT Disability Hospital</b>		<b>Total 199</b>
Office Hospital Director	1 hospital director, 1 coordinator disability hospital, 1 secretary	3
Eye Unit	1 manager, 3 doctors, 4 AMOs, 1 training manager, 1 training secretary,	10
Rehabilitation Unit	1 manager, 4 doctors, 2 AMOs, 8 anaesthetic staff, 2 staff x-ray, 2 staff laboratory, 1 paramedical coordinator, 6 physiotherapists, 7 orthopaedic workshop staff, 2 positioning and mobility staff	35
Service Coordination Unit	5 staff hospital maintenance, 7 staff maintenance workshop, 2 secretary, 1 programmer, 1 staff counselling and training, 4 administrative staff, 3 mobile work staff, 7 optical store staff, 2 coordination outsourced services	32
Nursing Unit	1 nurse matron, 10 nursing assistants, 51 nurse midwives, 26 nurse officer (incl anaesthetic nurses)	89
Accounting and Registration	1 accounting manager, 1 accountant, 2 accountant assistants, 3 accounting clerks, 9 registration clerks	16
Procurement	1 procurement manager, 2 pharmacists, 1 local procurement officer, 3 stock keeping officers, 7 drivers	14
<b>CCBRT Staff Total</b>		<b>334</b>

The management team of CCBRT meets on a weekly basis to discuss major management issues, review progress and take joint decisions.

Individually, the management of CCBRT's HQ, disability hospital and community programmes hold weekly meetings with the head of departments / units to discuss achievements of the previous week, upcoming issues and plan for the coming week.

On demand, programme directors and heads of department meet with the Executive Director to discuss individual issues and take joint decisions.

Due to the decentralised working structure of the community rehabilitation programme, all community rehabilitation workers meet on a monthly basis for a joint information sharing, planning and monitoring meeting. Nonetheless, CRWs are supported by their supervisors on an ongoing basis during the month.

Additionally, the CCBRT management team organises a monthly CCBRT staff meeting where departments report their achievements and plans for the coming months. The Executive Director presents updates of CCBRT's financial status, new developments and important events within the organisation.

As already outlined in Gi above, CCBRT has taken active measures to increase staff motivation and performance. These measures include performance based payment and a change from the traditional one year contract to permanent contracts. Salaries within the programmes have been adjusted so that staff members with the same qualification receive the same salary as their fellow colleagues. This has resulted in considerable salary increases for some of CCBRT staff. In addition, CCBRT has undertaken extra efforts in adjusting the salary level to the governmental salary scheme, and additionally raised salaries by 15% to cover the increase of living costs due to inflation (this increase is planned to be undertaken every year provided funding is available).

These steps will ensure that CCBRT remains a competitive employer in the coming years. As an effect, CCBRT has, on average, increased salaries by 20%. From 2008 onwards all CCBRT staff members will have a permanent contract with the organisation. The permanent contracts enable management to systematically develop staff capacities in line with the CCBRT Strategy Plan 2008-2012. Part of this process will be the development of medium and long term career plans for its mid-level and senior staff members starting in 2008.

### ***Planning, monitoring and evaluation***

CCBRT applies PCM standards to its work. CCBRT applies a participatory approach involving key staff in assessment and planning exercises. In the design of new programme components, CCBRT conducts participatory planning in consultation with the concerned target groups. Lessons learned are an integral part of the organisational development of CCBRT. To be able to facilitate the lessons learned, the organisation puts a high emphasis on measurable quantitative and qualitative output and outcomes. This includes the setting of measurable quantitative and qualitative targets. To be able to improve the monitoring of CCBRT's activities in the future, CCBRT will introduce a database, allowing a quantitative and qualitative assessment of CCBRT's community and hospital outputs and outcomes as well as the measurability of the quality of life indicator. The database will be fully operational in 2008. Besides the database, CCBRT conducts an external evaluation of its programmes every 3-4 years. The next evaluation is planned during 2011, at the end of the EU funding period of CCBRT's activities. In addition, CCBRT implements small scale external programme assessments to guide programme development and strategic decision making (for instance, during 2008 the HIV/Aids programme will be assessed).

### ***Accountability and sustainability***

CCBRT operates a transparent financial system, adhering to professional standards. The financial managers of CCBRT HQ and the disability hospital are qualified certified accountants. CCBRT has established clear financial regulations which can be accessed at CCBRT HQ on demand. These regulations ensure the transparency of operational procedures within the organisation, strengthen administrative and internal control procedures in accounting, reporting, procurement and storing and encourage a systematic approach to handling, disseminating and documentation of information.

CCBRT implements the segregation of duties in its tasks: Single employees or groups of employees do not maintain exclusive control over a complete transaction cycle. In addition, personnel responsible for recording and reporting a transaction have no control over the processing of the transaction. This system ensures that errors or irregularities cannot be concealed. On an annual basis, CCBRT's accounts are audited by a certified external auditor. Audited accounts are presented to the CCBRT Board. The audited accounts are made accessible to CCBRT partners upon request.

The accounting units produce monthly reports to allow the management to track incomes and expenditures in relation to budgets and activities and take remedial action if necessary. CCBRT provides financial reports to partners upon request.

For historic reasons CCBRT has run two parallel accounting systems, producing separate financial reports for CCBRT HQ (including the community programmes) and CCBRT disability hospital. Currently the managers of the accounting departments are in the process of merging the two systems. This process is to be completed early 2008.

To ensure quality in all areas of work, CCBRT has employed 2 full time auditors. CCBRT's auditors check the administrative and financial accountability of the single departments and conduct half yearly

financial audits. An integral part of their work is also to review cost efficiency and work processes of each of the departments and come up with suggestions for improvements.

In all areas of work, CCBRT adheres to Tanzania's laws and health and educational policies. CCBRT management is up to date with legal developments and fully adheres to existing laws governing NGOs in Tanzania. CCBRT has employed two lawyers who are regularly consulted in legal matters concerning CCBRT.

CCBRT implements a policy of transparency, making strategic planning, narrative and financial reports accessible to its partners and other interested parties. CCBRT publishes an annual report and makes it accessible to the wider public on CCBRT's website.

Due to the nature of CCBRT's mandate to serve the poorest of the poor, CCBRT will not be able to become financially sustainable in the medium term. Services offered are either subsidized (CCBRT disability hospital) or free of charge (CCBRT community programmes). However, CCBRT actively works on trying to make its services cost effective (e.g. by providing hostel beds to long term patients to decrease running costs and free space for patients in need of hospital services). By providing services for private patients, income at the disability hospital is increased ('pay-according-to-ability' pricing system). In the future, the management of the disability hospital will look into extending its services to private patients without compromising its services to patients of poor background. CCBRT is developing plans for the establishment of a 'Doctor's Pavilion', where private patients will be served in the afternoon hours. Amongst other services, CCBRT will offer hip-replacements, a surgery for which wealthy clients currently have to travel to India or Europe. This measure will ensure the maintenance and increase of CCBRT's income.

CCBRT strives to increase the organisational sustainability of its services by building strong

partnerships with other stakeholders. In October 2007, CCBRT signed a Memorandum of Understanding with the Tanzanian Government for the establishment of the new Mother and Child Health Hospital. Each year, CCBRT will receive a block grant for salaries of EUR 367,500 as well as the plot for the construction of the new Mother and Child Health Hospital. Additionally, CCBRT aims to broaden its partner base to ensure financial support and professional exchange over the coming years. CCBRT actively seeks the establishment of Public Private Partnerships with the commercial sector. Opportunities are expected in the establishment of the new Mother and Child Health Hospital.

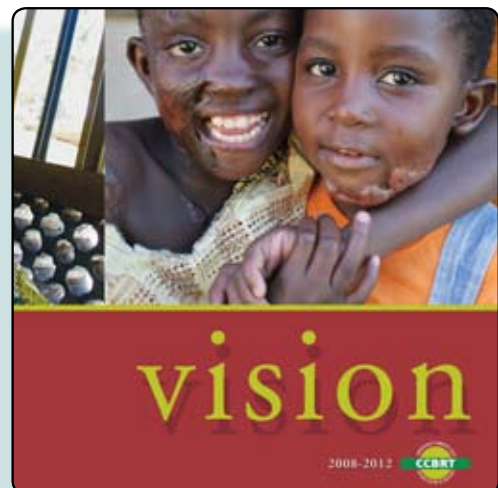
CCBRT is making a concerted effort to develop capacities to implement the Strategic Plan 2008-2012. The development of human resources and expanding the organisation's infrastructure are just two important measures (as described in Giv above).

### ***Reporting and partner relations***

CCBRT will compile one common set of reports for its Board and all partners. There will be one annual report each year which will be comprised of a comprehensive narrative and audited financial report. The annual report is detailed and seeks to meet the general partner requirements. The narrative report will provide a comprehensive overview of progress made in relation to the strategic plan and annual activity plan, outline successes, challenges faced during the implementation as well as lessons learned. This report is distributed to CCBRT's partners and the Board and will be published on the CCBRT website. Depending on partner agreements, CCBRT can provide individualised progress reports.

CCBRT continuously seeks to broaden its support and working relationships with partner organisations / partners who share the same vision. Diversification of the partner base is essential to avoid dependency on one partner and ensure organisational sustainability. CCBRT puts high emphasis on the partnership principle. CCBRT is transparent in all its activities.

CCBRT aims to minimize administration to be able to concentrate resources on the implementation of its activities and achievement of the CCBRT Strategy Plan 2008-2012. Partners are warmly encouraged to contribute towards the CCBRT Strategy Plan 2008 - 2012, rather than select specific programme components for support. CCBRT will provide one financial and narrative report to all partners who support CCBRT's overall strategy plan. During 2008-2012 CCBRT will strive to agree with its partners on one common narrative and audited financial report. CCBRT intends to establish regular partner meetings to report on achievements, present new developments in the organisation and come to a mutual agreement on support, monitoring and evaluation.



## ANNEX 1: KEY DEFINITIONS

### Advocacy<sup>18</sup>

Advocacy is a system of actions directed at changing attitudes, policies, positions, practices or programmes in society. Advocacy refers to any activity that attempts to change mainly government policy, but also attitudes and perceptions within society.

### Antiretroviral (ARV) Drugs

Antiretroviral drugs are medications for the treatment of infection by retrovirus, primarily HIV. Different classes of antiretroviral drugs act at different stages of the HIV life cycle. A combination of several (typically three or four) antiretroviral drugs is known as Highly Active Anti-Retroviral Therapy (HAART).

### Burn Contractures

Burn contractures are deformities resulting from severe burns. A contracture scar is a permanent tightening of the skin that may affect the underlying muscles and tendons and can cause reduced mobility or contractures of joints that limit mobility.

### Cerebral Palsy

Cerebral palsy is caused by damage to the brain parts that control movements and body position. In some cases, even mental capability can be affected. Cerebral palsy can result in muscle stiffness or a loss of control of movement and coordination of movement. In some cases hearing and sight may be affected.

### Cleft Lip / Palate

Cleft lip and palate are birth defects that affect the upper lip and the roof of the mouth. A cleft lip is an opening or gap in the upper lip, often connected to the nostril. A cleft palate is an opening in the roof of the mouth connected with the canal of the nose. Apart from the cosmetic appearance, having a cleft lip / palate results in problems with feeding and speech.

### Club Foot

Club foot (talipes equinovarus) is a congenital deformity of the foot. The foot tends to be smaller than normal, with the heel pointing downward and the forefoot turning inward. If left untreated, the deformity will not go away. It will continue to get worse over time and

the person will walk on the outside of his/her foot and mobility can be severely restricted.

### Disability

The term disability denotes the interaction between a person with an impairment or functional limitation arising from a person's physical, intellectual, or mental condition and the negative barriers of the environment (including attitudes and beliefs, etc.) which result in social exclusion, increased exposure and vulnerability to poverty. Disability is largely a social and development issue.

### Empowerment

This is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into actions. Central to this process are actions which both build individual and collective assets and improve the efficiency and fairness of the organisational and institutional context which govern the use of these assets.<sup>19</sup>

### Epilepsy

Epilepsy is a common chronic neurological disorder that is characterized by recurrent unprovoked seizures. Seizures are transient symptoms due to abnormal, excessive or synchronous neuronal activity in the brain. Not all epilepsy syndromes are life long. Some forms are confined to a particular stage during childhood. Epilepsy can occur in combination with other impairments such as intellectual impairments and personality disorders.

### Home Based Care

Home Based Care (HBC) is the provision of basic nursing care needs by formal caregivers to people with HIV/Aids in their own homes. Services include counselling, adherence control to ARV medication, treatment of opportunistic diseases, as well as training of people with HIV/Aids and their family members in basic care, prevention of HIV transmission, nutrition and other topics.

### Hydrocephalus

Hydrocephalus means, "water on the brain". Hydrocephalus is caused when the regular flow of

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18 CBM (2006)

19 World Bank: <http://web.worldbank.org/>

cerebrospinal fluid (CSF), the liquid that surrounds the brain and spinal cord is blocked or too much fluid is produced. The build up of fluid puts pressure on the brain, pushing the brain up against the skull and damaging or destroying brain tissues.

### **Impairment<sup>20</sup>**

A characteristic and condition of an individual's body or mind which, unsupported, has limited, does limit or will limit that individual's personal or social functions in comparison with someone who has not got that characteristic or condition. Impairment relates to a physical, intellectual, mental or sensory condition; as such it is largely an individual issue.

### **Inclusive development<sup>21</sup>**

Inclusive development refers to the planning and implementation of policies, programmes, projects and actions for human and socio-economic development. It ensures equal opportunities and the exercise of rights (civil, political, economic, social and cultural) for every person, regardless of his /her social status, gender, physical or mental condition and ethnic affiliation.

### **Mainstreaming Disability<sup>22</sup>**

Mainstreaming implies that all development interventions are planned and implemented in such a way that people with disabilities, their needs, rights and potentials, are taken into account on equal terms with those of other population groups.

### **Polio**

Poliomyelitis is an infection that affects parts of the spinal cord, damaging the nerves that control movements. The infection results in a paralysis of different types of muscles and the outcome is a shortening (or contracture) of muscles and tendons (cords) of arms, legs and the trunk. The full range of movement is thereby prevented.

### **Prevention**

The purpose of prevention is to reduce the incidence of disabling illnesses and accidents. Prevention includes activities such as health promotion, human security improvements, preventive health care and environmental health promotion.

### **Project Cycle Management (PCM)**

PCM is a methodology that includes the project analysis, planning, implementation, monitoring and evaluation of projects and programmes, based on the integrated approach of the logical framework.

### **Rehabilitation**

Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not just involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.

### **Spina Bifida**

Spina bifida (meningocele / myelomeningocele) is a birth defect which can develop during early pregnancy. It is characterized by an opening of the spine over the centre tube of nerves (spinal cord). The soft, unprotected area at the back of the child only covered by a thin membrane may bulge and leak cerebrospinal fluid from the spinal cord and the brain. Muscle weakness, loss of feeling or paralysis of the feet, dislocation of the hip, development of club foot, muscle spasms and poor urine and bowel control, hydrocephalus and brain damage are problems that occur with spina bifida.

### **Twin-Track Approach to Disability<sup>23</sup>**

The twin-track approach to disability means both mainstreaming of disability into all strategic areas of development practice as well as supporting specific disability initiatives empowering people with disabilities.

### **Vesico-Vaginal Fistula**

A Vesico-Vaginal Fistula (VVF) is a hole and/or channel between the bladder and vagina or the vagina and the rectum (recto-vaginal fistulae - RVF) developing during prolonged or obstructed labour. VVF causes urine and faeces to leak out of the bladder continuously (incontinence). This can lead to painful infections of the bladder and the kidneys.

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20 CBM (2006)

21 [www.cbm.org](http://www.cbm.org)

22 CBM (2006)

23 CBM (2006)

## ANNEX 1: LITERATURE LIST

### Sources:

CBM (2006), Disability and Development Policy

DFID (2000), Disability, Poverty and Development

Inclusion International (2005), Fact Sheet on Poverty and Disability

Ministry of Planning, Economy and Empowerment United Republic of Tanzania (2006), Mkukuta Status Report Dec 2006

National Bureau of Statistics Tanzania (2005), Adult and Maternal Mortality, <http://www.nbs.go.tz/DHS/ChapterEight.pdf>

Nora Ellen Groce (2005), HIV/AIDS and people with disability, Health and Human Rights, Vol 8 No 2

UNAIDS (Dec 2006), Aids Epidemic Update, Geneva, Switzerland.

UNDP (1995), Human Development Report 1995: Gender and human development. New York, USA

UNDP (2002), HIV/Aids and Poverty Reduction Strategies. Policy Note, New York, USA

United Nations, Department of Economics and Social Affairs (2005), Population, Development and HIV/Aids with Particular Emphasis on Poverty

United Republic of Tanzania (2005), Poverty and Human Development Report



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