UNITED REPUBLIC OF TANZANIA

Ministry of Health, Community Development, Gender
the Elderly and Children

NATIONAL REHABILITATION STRATEGIC PLAN 2021-2026

Contents

Foreword

Rehabilitation is a core health service to be integrated along the continuum of care and across service delivery platforms so that it is available to all Tanzanians that need it. This is the ambition of the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC), and all rehabilitation stakeholders, who recognize its critical role in population health. Rehabilitation is effective in enhancing functioning and supports participation in education, work and daily life. It is a valuable asset to the health system as it helps reduce complications, prevent unnecessary hospitalizations, and facilitates optimal recovery. Furthermore, it plays a crucial role in translating health gains into people's capacity to live socially and economically productive lives, hence interrupting the vicious cycle of poverty and ill-health.

Since rehabilitation emerged in the United Republic of Tanzania decades ago, it has been progressively expanding. Nevertheless, significant unmet needs remain and there are numerous opportunities for strengthening its availability, accessibility and quality. Strengthening rehabilitation in the Tanzanian health system is more pertinent than ever as the prevalence of non-communicable diseases increases, the population ages, and children and adults continue to live with the consequences of developmental conditions and injuries.

This National Rehabilitation Strategic Plan 2021-2026, the first for Tanzania, sets objectives for strengthening rehabilitation that will guide the direction of government and non-government stakeholders alike towards a common goal. The plan aligns with the Government's priorities as stated in the Health Sector Strategic Plan (HSSP) IV, in particular the aim of reaching all households with quality health care.

The plan emphasises the importance of strengthening rehabilitation governance, evidence, and information; increasing the availability of services and expanding finances; building the capacity of the rehabilitation workforce; and increasing access to assistive products. By doing so, more Tanzanians will have access to quality rehabilitation services when and where they need it, whether from primary or tertiary health facilities.

The MOHCDGEC is proud to present the National Rehabilitation Strategic Plan (I) 2021–2026 and is committed to providing leadership in its implementation. Achieving the objectives of the plan will require renewed effort and collective action from stakeholders across the country.

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Acknowledgements

The process of developing this National Rehabilitation Strategic Plan (I) 2021-2026 started with situational analysis of rehabilitation in the country. Thereafter a number of stakeholder consultation meetings were held which identified priorities and actions, and this has led to creation of Tanzania's first National Rehabilitation Strategic Plan.

The efforts of staff at the Ministry of Health Community Development Gender Elderly and Children (MOHCDGCEC), President's Office Regional Authority and Local Government (PORALG) and World Health Organization are all acknowledged. Their dedication and commitment to developing the National Rehabilitation Strategic Plan (I) 2021-2026 and improving rehabilitation services across the country is appreciated.

This strategic plan is based on robust discussion and sound consultation. The MOHCDGCEC is very grateful to the members of Rehabilitation Technical Working Group (RTWG) who have contributed to the development of the National Rehabilitation Strategy (I) 2021-2026. On behalf of MOHCDGCEC, the following group members are recognized and thanked; Presidents Office Regional Authority and Local Government (PORALG), TATCOT, INUKA, ICRC MoveAbiltiy Foundation, Muhimbili Orthopaedic Institution (MOI), Association of Physiotherapist in Tanzania (APTA), Association of Prosthesis & Orthosis in Tanzania (APOT), KCMC-TATCOT, KCMC School of Physiotherapy, KCMC School of Occupation, Comprehensive Community Based Rehabilitation Tanzania (CCBRT), Tanzania Club Foot Care Organisation, (TCCO), Tanzania Community Based Rehabilitation Network and Tanzania Occupation Therapy Association (TOTA).

Specifically, individual contributions from Rehabilitation Technical Working Group Task force members are acknowledged, this includes the World Health Organization (WHO) personnel - Pauline Kleinitz and Jody Mills, as well as MOHCDGCEC personnel - Dr V.T Wonanji, Mr John Samwel, Dr Benadetha Shilio, Dr James Kiologwe, Mr Vincent Kaduma, Ms Tamaly Lutufyo and Mr Shadrack Busweko. These people have tirelessly provided specialist input, advice and guidance on the development National Rehabilitation Strategic Plan (I) 2021-2026.

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MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Acronyms

AP	Assistive products
AT	Assistive technology
CBR	Community based rehabilitation
CCHPs	Comprehensive Council Health Planning
CME	Continuing Medical Education
DHIS	District Health Information Systems
ECI	Early Childhood Intervention
EPHS	Essential Package of Health Services
HI	Humanity and Inclusion
HSSPIV	Health Sector Strategic Plan IV
ICRC	International Committee of Red Cross
IEC	Information, Education and Communicate Materials
KCMC	Kilimanjaro Christian Medical Centre
MOHCDGEC	Ministry of Health, Community Development, Gender, the Elderly and Children
NHIF	National Health Insurance Fund
NCD	Non-communicable disease
OT	Occupational Therapy
PO-RALG	Prime Minister's Office, Regional Administration and Local Government
PT	Physiotherapy
P&O	Prosthetics and Orthotics
SCI	Spinal Cord Injury
TOT	Training of Trainer
TATCOT	Tanzania Training Centre for Orthopaedic Technologists
TBI	Traumatic Brain Injury
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization

Executive Summary

Rehabilitation addresses the needs of people with a wide range of conditions throughout the lifespan, such as developmental conditions, injuries, communicable and noncommunicable diseases, musculoskeletal conditions, and decrements in health associated with ageing. It is a core component of health care, along with promotion, prevention, treatment and palliation, and is delivered in both the community and hospitals. Rehabilitation is required across the continuum of care, from acute to long-term, serving to facilitate recovery, prevent complications, reduce readmissions and optimize health outcomes so that people can return to education, employment and community life.

In the mainland of the United Republic of Tanzania (hereon referred to as "Tanzania"), the need for rehabilitation is growing as health and demographic trends see increasing ageing and chronic disease in the population. The Ministry of Health, Community Development, Gender, the Elderly and Children has recognized the necessity of strengthening rehabilitation in the health system in order to better address existing and emerging need for rehabilitation. This strategic plan is an important step forward in addressing the rehabilitation needs of the Tanzanian people. This plan is built upon the findings of a situation assessment conducted in 2019 and a series of workshops and webinars in 2020 and 2021. The rehabilitation priorities for Tanzania have been identified and four strategic objectives and numerous actions developed. The strategic plan establishes a future vision for rehabilitation whereby all people in Tanzania can access the quality rehabilitation they need at all levels of healthcare and in community settings. The achievement of this vision is underpinned by the following 4 strategic objectives:

1. Strengthen rehabilitation leadership, planning, and generation of evidence and information
2. Increase the availability of rehabilitation services and expand financing
3. Strengthen and expand the rehabilitation workforce
4. Increase the access and provision to assistive products

This is the first Tanzania Rehabilitation Strategic Plan developed for the country. For each objective there are multiple actions and a time frame by which they should occur. Its implementation and results will be monitored closely through its monitoring framework and the evaluation and review processes that have been established.

Introduction

Rehabilitation is a fundamental health service that is relevant to people with a wide range of health conditions, throughout all stages of the life-course, and during all phases of their care[i]. It is recognized as an increasingly important health service in light of the rising prevalence of chronic and non-communicable diseases (NCD)[1] and high numbers of people living with the consequences of injury and developmental disability. Furthermore, rehabilitation is needed to maximize the effectiveness and impact of many healthcare interventions which are becoming increasingly accessible to a wider population in Tanzania. Currently, however, the need for rehabilitation greatly exceeds its availability and issues of quality and access hinder its effectiveness and utilization.

The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) of Tanzania, along with civil society organizations, have been working to expand and strengthen rehabilitation since it emerged in the country in 1948. Efforts were intensified in 2016 with a focal point for rehabilitation (and palliative care) appointed within the Public and Private Health Services Section of the Curative Services Division. This appointment occurred simultaneously to the establishment of the Physical Rehabilitation Platform, which comprises key rehabilitation stakeholders from across the country. The following year, recognizing the scale and complexity of challenges facing the field and the urgency for action, the MOHCDGEC committed to undertaking a systematic approach to developing a national strategic plan and monitoring and evaluation framework for rehabilitation, utilizing the WHO *Rehabilitation in health systems guide for action*[2] methodology and tools.

The process commenced with the implementation of systematic situation assessment of rehabilitation in the mainland of Tanzania, conducted between August and November 2019, and the subsequent publication of a report[3]. The situation assessment was led by the MOHCDGEC, with technical support from WHO and the ICRC, and engaged the members of the Physical Rehabilitation Platform (which was re-named the Tanzania Rehabilitation Technical Working Group) through various stages of consultation. The findings, as outlined in the report, form the basis for the objectives and actions of this strategic plan. The drafting of the strategic plan was delayed due to COVID-19 and therefore occurred between November 2020 and February 2021, utilizing virtual workshops to facilitate consultation with the members of the Rehabilitation Technical Working Group.

[1] MOHCDGEC et al. Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015-2016 http://hdr.undp.org/sites/default/files/thdr2017launch.pdf

[2] WHO. Rehabilitation in Health Systems Guide for Action. 2019 https://www.who.int/rehabilitation/rehabilitation-guide-for-action/en

[3] MOHCDGEC. The Situation of Rehabilitation in the Mainland of the United Republic of Tanzania. 2020.

Rehabilitation

Rehabilitation Concepts that Inform Tanzania's Strategic Plan

Rehabilitation is about functioning. Rehabilitation addresses the impact of a health condition on a person's life with a primary focus on improving their functioning and reducing their experience of disability. WHO defines rehabilitation interventions[4] as those that optimize functioning and reduce disability in individuals with health conditions in interaction with their environment[ii]. Fundamentally, rehabilitation focuses on the functioning of an individual and not on the disease; it does this through a strong emphasis on educating and empowering people to manage their health conditions, adjust to their situation, and remain active[5].

Rehabilitation is for all the population. There is an extensive array of health conditions that benefit from rehabilitation (almost all health conditions). These conditions may impact on the physical body, vision, hearing, cognitive and mental health. Rehabilitation is relevant during all phases of a health condition, including the acute, sub-acute and long-term care phases. It is for all the population regardless of age, from young infants through to older people. Rehabilitation provides benefits to people who have long-term disability as well as those that experience short-term impairments. It also benefits many people with chronic health conditions who may not identify themselves as having a disability nor be legally recognized in a country as a disabled person.

Rehabilitation is essential to healthcare. Rehabilitation is a health strategy alongside promotion, prevention, treatment and palliative care. Rehabilitation personnel are health professionals who require competencies in healthcare to deliver effective interventions. Rehabilitation is part of Universal Health Coverage[iii] and expands the focus of health beyond preventive and curative care. Rehabilitation should be available at all levels of healthcare, from tertiary care through to primary healthcare settings, and when needed, it should be available in community settings such as homes and schools.

Rehabilitation is a specialized as well as highly integrated form of health care. Rehabilitation may be delivered through specialized rehabilitation facilities and programmes, especially for people with complex and intense rehabilitation needs. In these facilities and rehabilitation programmes, there is provision of more specialized interventions with sufficient dosage (frequency and duration) to meet a person's needs. Rehabilitation is also a highly integrated form of healthcare and is incorporated in a wide range of other health specialties and services. In this way, rehabilitation is integrated into the care of those who undergo neurological, mental, orthopedic, cardio-pulmonary, pediatric, geriatric, women's health, pulmonary and other healthcare[5].

[4] Rehabilitation interventions are a form of health intervention. A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions. Examples of these acts in the context of rehabilitation include: manual therapy, exercise prescription, provision of assistive products, education and modification of home environment.

[5] WHO. Rehabilitation in Health Systems. 2017. https://apps.who.int/iris/bitstream/handle/10665/254506/9789241549974-eng.pdf?sequence=8

Rehabilitation is highly person-centered and individualized, and strongly engages the user. Rehabilitation is always tailored to the individual needs of a person and is orientate around the goals they set. During rehabilitation, interventions are tailored around these goals and consider the individual and their environment. Rehabilitation engages the person and, where appropriate, the family and carers in their rehabilitation process. It places a focus on educating and empowering a person to manage their health condition.

Rehabilitation is evidence based, outcome focused, time-bound and its dosage matters. Effective rehabilitation necessitates the use of evidence-based interventions, delivered with sufficient dosage to achieve the desired outcomes. Effective rehabilitation focuses on achieving optimal outcomes for a person, and the measurement of outcomes is an essential component of quality rehabilitation. Rehabilitation is a finite process within an agreed time frame. The length of a rehabilitation episode varies, but always there are time-bound goals and, after achieving these, the rehabilitation comes to an end. Some people may require rehabilitation intermittently throughout their life and, when this occurs, the rehabilitation episode re-commences with new goals and ceases once these are achieved. For many people, there is a need to undertake informal and self-directed rehabilitation at home or in their community so as to maintain their functioning.

Assistive product provision is an important component of rehabilitation. People with difficulties in their functioning benefit from a wide range of assistive products, such as those for mobility, vision, hearing, communication and cognition. Provision of assistive products is also a rehabilitation intervention and essential component of health services. The provision of most assistive products requires assessment, fitting, training, follow-up and maintenance support. Ensuring the assistive product is well fitted, is suited to the individual and appropriate for the environment they operate within, is an important component of the provision process.

Rehabilitation necessitates a multidisciplinary workforce. There are many different rehabilitation professions, the most common are physiotherapists, occupational therapists, speech and language therapists, audiologist, prosthetists and orthotists, and psychologists, among others. Rehabilitation specialists within the medical and nursing professions also contribute to the rehabilitation workforce. Delivery of effective rehabilitation very often requires inter-professional collaboration between these disciplines.

Rehabilitation may be delivered outside of typical health services. Around the world, most of the rehabilitation delivered sits within health services, however some occurs outside of the context of a 'typical health service'. Rehabilitation is delivered in schools for children with developmental disabilities, in early childhood intervention programmes, and for people with disabilities living in their community settings. The precise configuration of these services can vary across and between countries but the importance of it being available wherever needed remains.

Rehabilitation Needs

The need for rehabilitation is large and growing. Health trends that keep people living longer with chronic communicable and non-communicable disease, increasing incidence of injuries and survival of people living with the consequences of injuries, as well as ageing populations, all

result in a growing need for rehabilitative health care[iv]. According to the Global Burden of Disease study, the prevalence of conditions associated with severe disability (and hence linked with rehabilitation needs) has increased in Tanzania over the last 20 years[v]. Additionally, as the Tanzania health system advances and provides a greater scope of medical and surgical interventions, the need for rehabilitation increases in order to optimize the outcomes of these interventions.

Current rehabilitation needs are largely unmet. Data that directly informs the unmet need of rehabilitation in populations is not available, however Global Burden of Disease data, along with rehabilitation personnel-to-population data, as well as reports and experiences from practitioners and consumer groups suggests that there is significant unmet need for rehabilitation in Tanzania[3,6.] Also, when combining the current unmet need for rehabilitation with current health trends, there is potential for unmet needs to actually increase unless significant investment in rehabilitation occurs.

The Value of Rehabilitation

Rehabilitation delivers better health outcomes. The goals of rehabilitation move beyond diagnosis and acute medical care. Rehabilitation is designed to maximize functioning to enable people to have better health and well-being. Rehabilitation has the potential to make significant cost savings across the health system by supporting timely discharge, preventing of complications and decreasing re-admission rates. Rehabilitation also makes an essential contribution to the outcomes of medical and surgical interventions.

Rehabilitation improves a range of education, employment, economic and social outcomes. Effective rehabilitation delivers better health and functioning outcomes and improves quality of life. In so doing it commonly enables people to return to work, undertake education and training, have a livelihood and participate in their home and community life. Additionally, rehabilitation enables a person to be well and to function to their optimal level, which can decrease the burden of care, either informal family care or formal state funded care, both of which result in savings to people's family, community and society. Rehabilitation is an investment in human capital that contributes to health, economic and social development.

Access to rehabilitation supports realization of the rights of people with disabilities. Access to rehabilitation supports the realization of all people's right to health, including people with disabilities. As many people with disabilities experience long-term impairments, they particularly benefit from access to rehabilitation and assistive products.

[6] Institute for Health Metrics and Evaluation (IHME). Tanzania. http://www.healthdata.org/tanzania

Rehabilitation Situation in Tanzania

Rehabilitation in Tanzania

The establishment of the Tanzania Rehabilitation National Strategic Plan is timely given both the necessity for concerted, coordination action and the current opportunities for effective implementation. Rehabilitation needs continue to grow in the country, with health trends indicating increasing prevalence of musculoskeletal, sensory and mental health conditions, as well as other non-communicable diseases. These conditions are associated with substantial disability and are largely amenable to rehabilitation[7]. Concurrently, the Tanzania population is ageing, and with the urban migration of young people leaving many older people in rural areas without family support, rehabilitation is more important than ever to ensure they are supported to maintain optimal functioning and independence.

Several existing platforms hold promise for facilitating the successful implementation of identified actions within the National Strategic Plan, including dedicated rehabilitation representation within the MOHCDGEC, a multidisciplinary and highly engaged Tanzanian Rehabilitation Technical Working Group, and supportive development partners. Furthermore, there is an emerging body of motivated rehabilitation workers comprising several core rehabilitation disciplines that have established a presence in national, zonal and regional hospitals across the country.

The degree of **integration of rehabilitation within health-related policies and plans** can serve as a barometer for the maturity of rehabilitation in health system, as it suggests a degree of awareness of the role and value of rehabilitation to population health. In Tanzania, rehabilitation appears within several seminal health-related national policies and plans, including the National Health Policy 2017; the Health Sector Strategic Plan IV (2015-2020); and the Strategic and Action Plan for the Prevention and Control of Non-Communicable Diseases in Tanzania 2016 – 2020. However, it is absent from a number of content-relevant plans, such as for maternal and child health, vision/eye health, and emergencies/health security. Of further concern is the apparent absence of real investment in the implementation of rehabilitation objectives where they are included, and the lack of monitoring of their effectiveness.

There has been a gradual expansion of **rehabilitation in health services**, with the rehabilitation departments present in national and zonal hospitals as well as a growing number of regional hospitals. Rehabilitation is still, however, largely lacking in district hospitals and primary health care facilities, and community-delivered services, such as in homes, schools and workplaces, are very limited. This situation results in barriers to access for large proportions of the population, especially those in rural and remote communities who have to travel long distances to access nation, zonal and regional hospitals. There are no established **referral pathways** between services or levels of the health system, with most people either being lost to follow up post-

[7] Institute for Health Metrics and Evaluation (IHME). Tanzania. http://www.healthdata.org/tanzania

discharge or returning to the facility they were discharged from, rather than accessing ongoing rehabilitation closer to home.

The **rehabilitation workforce** is under-developed, and their limited availability poses the greatest constraint to the expansion of rehabilitation in the health system. Tanzania has restricted capacity to produce workforce nationally with qualifications available for only physiotherapy (diploma and bachelor), occupational therapy (diploma), and prosthetics and orthotics (diploma and bachelor). The availability of bachelor programmes are currently threatened by newly imposed faculty requirements by the Tanzania Commission of Universities (TCU). In part due to the restricted capacity of education and training institutions, as well as issues relating to attraction and retention, the number of rehabilitation workers in Tanzania is very low, including when compared to several neighbouring countries: there are only 0.07 physiotherapists, 0.03 occupational therapists and 0.02 prosthetists and orthotists per 10,000 population. Other core rehabilitation disciplines, including speech and language therapy, audiology, and psychology are largely missing, and there are no rehabilitation specializations within nursing or medicine. Community-based rehabilitation workers are not officially recognized but are utilized by a small number of nongovernmental services.

Rehabilitation **infrastructure and equipment** are integral to the delivery of quality care and to ensuring that rehabilitation workers' skills are utilized to their fullest capacity. They are also important aspects of the work environment and reflect the profile of rehabilitation among service users and health care staff. In Tanzania, rehabilitation infrastructure and equipment are inadequate, especially within public facilities, and is demotivating to the rehabilitation workforce who consider the lack of investment in their workspaces and tools as disregarding their value or contribution.

The provision of **assistive products** such as wheelchairs, walking aids, hearing aids and other devices for activities of daily living is also inadequate, with many people facing financial barrier to accessing the products they need. There are significant inconsistencies between facilities in how insurance and government subsidies for products are applied, and inefficiencies in procurement and distribution result in higher costs for services and end-users. There are no national quality specifications for assistive products by which they can be regulated.

While a plan for a **long-stay rehabilitation** unit at Muhimbili Orthopaedic Institute (MOI) is being explored, currently there is extremely limited availability. Their absence results in people being prematurely discharged, including those with complex needs and high dependency, and disrupts continuity of care which can compromise health outcomes. Long-stay rehabilitation units can also serve as centers to foster excellence and build specialization, and they greatly contribute towards the goal of strengthening rehabilitation within the country more broadly.

Rehabilitation research fosters excellence and innovation and can advance the profile of the field in the country. Larger national and zonal hospitals appear to undertake small research projects within their facilities, often in conjunction with international universities, however the limited number of rehabilitation professionals with postgraduate degrees and the fact that master and doctorate courses are not offered in Tanzania restricts opportunities for research guidance and supervision. There are no national grants for rehabilitation research, but good relationships exist with international universities, which may present opportunities for research collaborations.

2.8 Expand financing for rehabilitation and assistive products through integration in

The development and use of **national clinical practice guidelines** are an important way to ensure that the rehabilitation interventions that are being provided have been proven to be effective, and to standardize care across the country. The rehabilitation professional associations have published several guidelines for specific conditions, but to date, no national clinical practice guidelines for rehabilitation have been developed. There is potential to adapt and adopt existing clinical practice guidelines from other countries, which has been done by some other African countries, however this requires a robust and systematic academic process, and the resulting products need to be disseminated effectively to ensure they are taken up. Additionally, protocols and guidelines should address the deficiencies in multi-disciplinary teamwork that exist in Tanzania and promote more collaborative approaches to the care provided.

Priorities for Strengthening Rehabilitation

The report of the rehabilitation situation assessment highlighted several critical challenges facing rehabilitation and revealed substantial unmet needs in the population. The following priority areas are considered central to strengthening rehabilitation in Tanzania:

Rehabilitation governance and information

1. Bolstering the governance, planning and leadership capacity for rehabilitation within the MOHCDGEC proportionally to the scale and scope of action required will be central to the success of the National Rehabilitation Strategic Plan. The focal point for rehabilitation within the MOHCDGEC requires the support of a skilled multi-disciplinary team with the resources to effectively lead the implementation of the National Rehabilitation Strategic Plan.

2. Rehabilitation data is currently not integrated in the HMIS at any level. Crude Information, such as rehabilitation workforce numbers at health facilities, are generally available at a local level but are not centralized. Within hospitals, rehabilitation professionals record their clinical notes in a patient's main health record, but no data is collated or analyzed to inform decision making. The lack of rehabilitation information collected and collated is underpinned by the absence of national indicators built on rehabilitation data. Tanzania requires a monitoring and evaluation framework to shape rehabilitation data collection, and rehabilitation integrated in the Health Management Information System (HMIS) to support data collection across the levels of the health system.

Rehabilitation service delivery, financing and infrastructure

3. An increase in the political commitment to rehabilitation is needed in order to achieve the increase in investment that is required to expand rehabilitation services. Rehabilitation does not have an allocated budget line within the MoHCDGEC administrative structure and further integration into health financing mechanisms is required. Rehabilitation

requires adequate resourcing to implement and sustain the actions of the National Rehabilitation Strategic Plan.

4. Rehabilitation must be integrated into the packages of care within health financing mechanisms. As it is a highly integrated health service, it should be included in multiple packages that address a range of health conditions. This should be complemented by collaborative approaches to care with rehabilitation workers included in multi-disciplinary teams.

5. There is a large gap in the rehabilitation available in primary health care and in district hospitals. This introduces financial and geographical barriers to access and inefficiencies in service delivery. Rehabilitation needs to be integrated in all levels of care in order to be accessible, affordable, equitable and efficient. It should also be delivered within the community. Outreach services and community-delivered rehabilitation needs to be established to ensure people can access rehabilitation in their homes, schools and workplaces.

6. The absence of long-stay rehabilitation facilities results in people with complex rehabilitation needs being prematurely discharged. When this occurs, they do not achieve their maximum level of health and functioning, which limits their independence with everyday activities, can delay or prevent their returning to work and school, and can result in families providing unnecessarily high levels of care.

7. Rehabilitation workers are being under-utilized and interventions are less effective because rehabilitation departments do not have the infrastructure and equipment needed. Adequately supplying rehabilitation departments will both improve cost-efficiency, quality of care, and the profile of rehabilitation in health care. Rehabilitation infrastructure and equipment require a significant injection of investment to ensure it is fit-for-purpose and can facilitate the full range and scale of needs within the population. It will further need to be expanded in conjunction with the ongoing establishment of rehabilitation in district and primary care facilities, as well as in the community.

Rehabilitation workforce

8. The number of rehabilitation workers as well as number of posts for their employment in health services need to be scaled substantially. This will require substantial collaboration with and investment in education and training institutions, and ongoing advocacy for the expansion of rehabilitation posts across all levels of the health system.

9. The composition of the rehabilitation workforce needs to be expanded to include core rehabilitation professions, specifically speech and language therapists, audiologists and psychologists. The unavailability of these professionals means considerable rehabilitation needs are going unmet.

10. The capacity of rehabilitation education and training institutions needs to be bolstered through investment in faculty, infrastructure and equipment, and enabled to provide bachelor-level degrees.

11. Quality assurance and improvement mechanisms require strengthening through equipping the national regulatory body to establish and enforce registration processes and standards for continuous professional development.

Assistive products

12. Many people are not achieving optimal rehabilitation outcomes because they cannot access or afford the assistive products they need. The procurement, distribution and financing of assistive products needs to be reviewed and updated to improve consistency, efficiency and reduce cost.

13. The range of assistive products needs to be expanded to meet the needs of people with cognitive impairment and difficulties with self-care, in addition to postural and mobility impairments. A priority list of assistive products should be established and included within the Medical Stores Department catalogue.

At the time of writing, the MoHCDGEC operates according to the vision, mission and objectives of the National Health Policy 2017. The policy presents a vision of "a healthy community that contributes effectively to individual as well as to the nation's development towards becoming a middle-income country", and emphasizes equity and quality in health service delivery. The objectives of the policy serve to ensure basic health services reach every household and reflects a recognition of the need for rehabilitation to be strengthened. In particular, the objective X (10) within the policy calls for "Improved rehabilitation for persons with disability", while numerous others having a cross-cutting impact on rehabilitation service delivery, including in the context of particular health conditions, such as noncommunicable diseases (vii); injuries (xii); and care for the elderly (xvi).

The National Health Policy 2017 is supported by the Health Sector Strategic Plan IV (HSSPIV). HSSPIV positions rehabilitation strongly within its response to non-communicable diseases, mental health and substance abuse disorders, and road injury, and promotes an integrated approach to service delivery. It further highlights the role of community-based rehabilitation in the context of services for persons with disability and states the need for rehabilitation experts at all levels of care.

Rehabilitation objectives are also included in the Strategic and Action Plan for the Prevention and Control of Non-Communicable Diseases in Tanzania 2016 – 2020, which explicitly identifies the need to:

- strengthen physical rehabilitation services (strategic intervention vi);
- support rehabilitation services at all levels of care, and
- strengthen community-based rehabilitation (strategic actions 3.10.3.2.6.1-3).

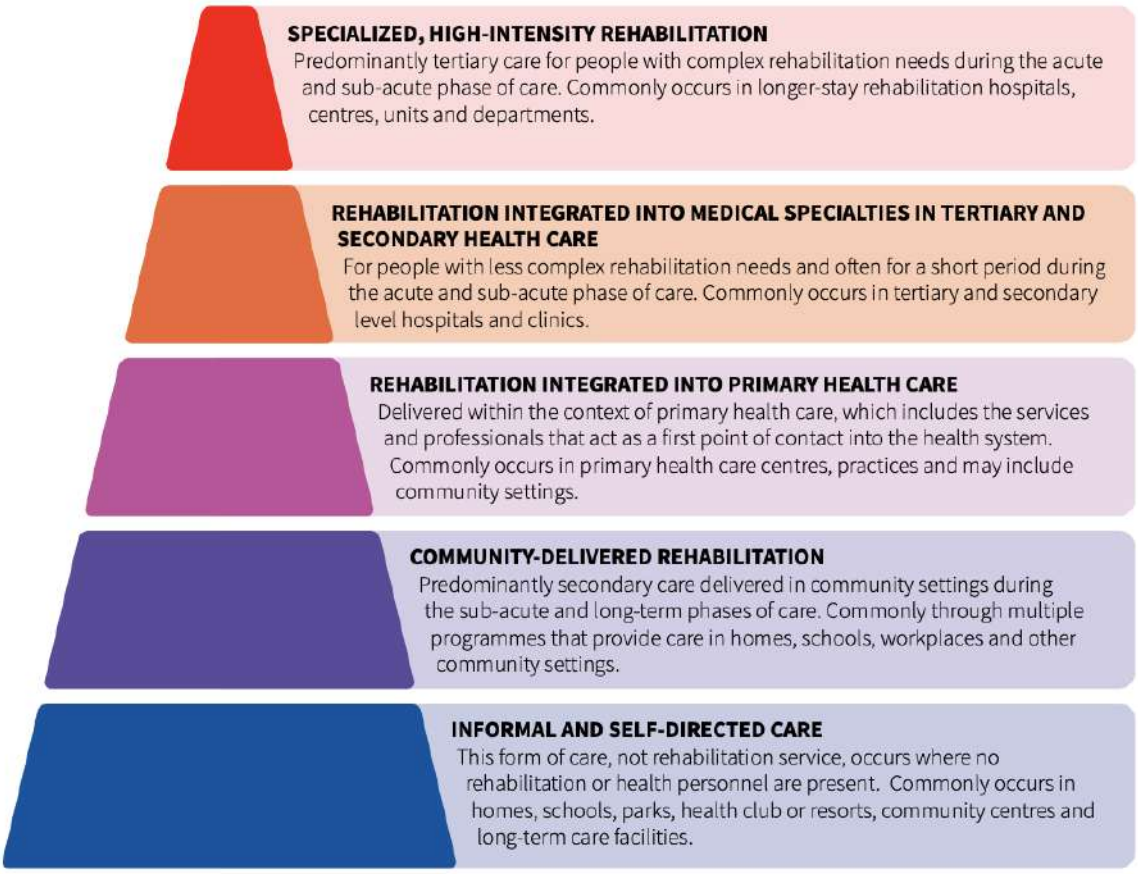
The National Rehabilitation Strategic Plan (I) 2021-2026 aligns with the visions and missions of these policies and plans. It serves to operationalize their objectives by defining specific priorities and actions for strengthening rehabilitation in the Tanzanian health system, as well as defining indicators for their ongoing monitoring and evaluation. Importantly, the Strategic Plan positions rehabilitation as an essential health service for all the population and as a core component of universal health coverage.

Over the period of the Rehabilitation Strategic Plan, further decisions will be made regarding the structure and organization of rehabilitation in Tanzania. To support this decision making, the core types of rehabilitation and where and how they should develop are described below in the Rehabilitation in Tanzania Healthcare Framework (Figure 1). It outlines key types of rehabilitation and reflects their structure and organization within health services. The framework is based on that described in the WHO Rehabilitation in Health Systems – Guide for Action.

In all countries, the population requires access to a range of rehabilitation; these are characterized broadly as different 'types of rehabilitation'. The Rehabilitation in Tanzania Healthcare Framework illustrates these types of rehabilitation and suggests an optimal mix be developed based on the rehabilitation needs in each country. The different types of rehabilitation include:

- *Specialized high-intensity rehabilitation*: This is required for people with complex needs who require higher dosage and intensity of rehabilitation in longer-stay facilities. They are commonly managed in designated 'rehabilitation beds' and access multi-disciplinary care.
- *Rehabilitation integrated into medical specialties in tertiary and secondary care:* This is characterized by its highly integrated nature across a range of medical specialties in tertiary and secondary healthcare, commonly hospitals or clinics. Typically, this type of rehabilitation is provided over the shorter period.
- *Rehabilitation integrated into primary care:* This occurs in primary healthcare (defined as the entry point to the health services), through a range of primary healthcare settings and programmes. This care may be delivered by rehabilitation workers or by other primary healthcare workers who are trained in provision of a limited set of rehabilitation interventions.
- *Community-delivered rehabilitation:* This is defined through its delivery in community settings, it can be a form of primary, secondary or tertiary rehabilitation care. This care may be delivered by rehabilitation workers undertaking outreach into homes and schools or through mid-level rehabilitation workers such as CBR workers.
- *Informal and self-directed care*. This occurs through the combined efforts of the person, family, carers, peers etc. This type of rehabilitation in not a service but recognizes the very important contribution made by the person and their families, carers and others to the goals of their rehabilitation.

Figure 1. Core Types of Rehabilitation being developed in Tanzania



Rehabilitation services can broadly be categorized in the types described in Figure 1. Each type of rehabilitation described in the framework (Fig 1) are at a different degree of maturity in Tanzania; specialized, high-intensity rehabilitation is not yet available but being considered; rehabilitation integrated into tertiary and secondary care is the most developed in Tanzania but still requires substantial development; and rehabilitation in primary health care has not yet emerged. A limited number of community-delivered rehabilitation services do operate, however these tend to focus on pediatric rehabilitation and are run by nongovernmental organizations. Informal and self-directed care is heavily relied on in Tanzania given the challenges with accessing rehabilitation follow-up post-discharge.

Additional Guidance:

Community-delivered rehabilitation within the education system

In recent years, Tanzania initiated national assessment campaigns within the education system to assist with identifying children with disability and ensuring their appropriate placement in schools. These campaigns, which operate through multidisciplinary teams conducting outreaches, present an important opportunity for children and their families to access rehabilitation. Assessment campaign teams should include rehabilitation professionals, including physiotherapists, occupational therapists, and where possible, speech and language therapists. This will greatly facilitate accurate and timely referral to rehabilitation services, as well as provision and guidance in the use of assistive products, such as hearing aids, postural and mobility devices and other products that facilitate learning and development.

Rehabilitation in primary health care

Given the scarcity of rehabilitation in primary healthcare, a multipronged approach will be required to increase access at this level. Where prioritized, rehabilitation workers should conduct outreach clinics into primary healthcare settings and, where possible, be located in larger primary healthcare facilities. In addition, integrating rehabilitation in primary health care in Tanzania will require non-rehabilitation workers to deliver basic assessments and interventions and create a stronger linkage with the community and other levels of the health system. WHO is developing a package of rehabilitation interventions for primary health care, along with training resources and tools to facilitate decision making. This package addresses a proportion of rehabilitation needs associated with some of the most frequently presenting health conditions at the primary health care level. Tanzania can harness such resources to support the transition of rehabilitation into primary health care. The WHO Training in Assistive Products (TAP) resources[8] will further support the delivery of a range of assistive products at the primary health care level.

[8] https://www.who.int/news-room/feature-stories/detail/personnel-training-in-priority-assistive-products-(tap)

Rehabilitation Strategic Plan 2021-2026

Vision

All people in the United Republic of Tanzania are able to function to their fullest and have the highest attainable level of health and well-being.

Mission

To build a health system that can deliver high quality, timely rehabilitation to all that need it.

Goal

To increase access for all citizens to equitable and quality rehabilitation, delivered by qualified multi-disciplinary professional teams.

Tanzania's Strategic Objectives and Areas of Action

Tanzania's National Rehabilitation Strategic Plan has four strategic objectives, with multiple areas of action under each. The following list summarizes these, and the proceeding table expands on each area of action to include more specific actions.

1. **Strengthen rehabilitation leadership, planning, and generation of evidence and information**
    1.1 Strengthen leadership structures and coordination processes

    1.2 Strengthen rehabilitation planning and integrate it across health planning

    1.3 Develop routine reporting and accountability mechanisms for rehabilitation

    1.4 Integrate rehabilitation into the national health management information systems

    1.5 Create policy relevant research and information for decision making

    1.6 Undertake public awareness raising activities about rehabilitation

    1.7 Strengthen public-private partnerships for rehabilitation

2. **Increase the availability of rehabilitation services and expand financing**
    2.1 Develop specialized rehabilitation services and further integrate rehabilitation in tertiary and secondary levels of healthcare

    2.2 Expand delivery of rehabilitation including assistive products within primary healthcare and community settings

    2.3 Improve early identification of children with developmental delays and disabilities and expand access to pediatric rehabilitation services in community, early childhood, and education settings

    2.4 Harness digital health for rehabilitation

    2.5 Improve the quality of rehabilitation through development and utilization of clinical management guidance

    2.6 Improve the continuum of care through stronger referral systems both within healthcare and between health and social, community, and education services.

    2.7 Address gaps in rehabilitation infrastructure and equipment, prioritize investment in these and implement the Basic Standards for Rehabilitation Vol 6

Insurance Fund (NHIF).

3. **Strengthen and expand the rehabilitation workforce**

    3.1 Scale the availability of rehabilitation professions, including physiotherapy, occupational therapy, prosthetics and orthotics, speech and language therapist, audiologists and clinical psychologists at all levels of healthcare and explore options for a mid-level rehabilitation cadre.

    3.2 Support continuing professional education for rehabilitation workers.

    3.3 Integrate rehabilitation into pre- and post-service education and training for health workers, including for nurses and doctors.

    3.4 Strengthen licensing and regulatory mechanisms for all rehabilitation professions

4. **Increase the access and provision to assistive products**

    4.1 Improve national coordination and regulation for assistive products and reduce import taxes

    4.2 Establish a Priority Assistive Product List and increase government financing for assistive products

    4.3 Improve rehabilitation assistive product central procurement through integration of rehabilitation in the Medical Stores Department (MSD)

OBJECTIVE 1. STRENGTHEN REHABILITATION LEADERSHIP, PLANNING AND GENERATION OF EVIDENCE AND INFORMATION					
Area of Action	**Actions**	**Core Output**	**Key Agency(s) Responsible**	**Resources and Inputs**	**Timeline**
1.1 Strengthen leadership structures and coordination processes	1.1.1. Establish a National Multidisciplinary Steering Committee for Rehabilitation to provide high-level guidance and oversee the implementation of the rehabilitation strategic plan. Initially develop terms of reference for this group to agree on precise composition and role. 1.1.2. Establish and adequately staff a rehabilitation focal unit within MoHCDGEC which will oversee development of rehabilitation in Tanzania and implementation of this plan. 1.1.3. MoHCDGEC to ensure the Rehabilitation Technical Working Group (RTWG) meets every 3 months and creates 4 RTWG sub-groups to support implementation of the 4 objectives. Each group should include at least one the MoHCDGEC Focal person/NCD director/Rehab stakeholder groups/development partners representative. 1.1.4. Establish routine coordination mechanisms between rehabilitation and stakeholders from the disability, education and early childhood sectors.	**1.1.1. High-level Rehabilitation Steering Committee created and meeting 6 monthly** **1.1.2. Focal unit, comprised of core rehabilitation professions, responsible for rehabilitation within MoHCDGEC established** **1.1.3. RTWG and 4 sub-groups meeting every 3 months**	**MoHCDGEC**	Committees and working groups formed with existing human resources and small meeting expenses	Year 1.
1.2 Strengthen rehabilitation planning and integrate across health planning	1.2.1. Integrate rehabilitation into national health strategic plan (HSSP IV) and all future plans. 1.2.2. Integrate rehabilitation and assistive products across a range of health planning, particularly for essential healthcare packages, mental health, NCDs, vision, and hearing. 1.2.3. Implement the MOHCDGEC Basic Standards for Health Facilities as it applies to rehabilitation, and track progress towards achieving these. 1.2.4. Integrate rehabilitation into emergency preparedness planning processes across health.	**1.2.1 Rehabilitation included in HSSP IV** **1.2.2 Rehabilitation integrated in essential healthcare packages and other sectoral health plans** **1.2.3 Basic Standards are disseminated, implemented and tracked** **1.2.4 Rehabilitation integrated across health emergency management**	**MoHCDGEC**	Meeting expenses for establishing rehabilitation standards	Year 1 and ongoing

1.3 Develop routine reporting and accountability mechanisms for rehabilitation	1.3.1 Finalize the rehabilitation monitoring framework, indictors and targets. 1.3.2 Identify gaps between current and required data sources that will enable reporting on the indicators in the monitoring framework. 1.3.3 Establish routine reporting processes and formats for rehabilitation. 1.3.4 Create reporting templates for therapy departments and units for annual data collation (in line with strategic plan monitoring framework requirements) coordinated through the NCD Department (including for rehabilitation infrastructure and equipment).	**1.3.1 Strategic Plan Monitoring Framework created** **1.3.2 Strategic Plan Activity Monitoring Template created for quarterly reporting from therapy district and regional hospital and P&O Units** **1.3.3 Biennial reporting on Framework and Template**	**MoHCDGEC**	Meeting expenses and existing human resources for reporting	Year 1 Report every 2 years
1.4 Integrate rehabilitation information into the national health information system	1.4.1. Integrate rehabilitation data from therapy units at the district and regional hospital level into the routine information collection system (DHIS2). 1.4.2. Work with stakeholders to ensure complete data sets in future MOHCDGEC information collection. E.g., rehabilitation included in national health accounts and the human resources for health database.	**1.4.1 Pilot of rehabilitation data integration into hospital level DHIS2** **1.4.2 Expand integration of rehabilitation data across information systems**	**MoHCDGEC**	Training	Year 2
1.5 Create policy relevant research and information for decision making	1.5.1 Attain funding for rehabilitation research that has a focus on health policy and systems. 1.5.2 Build rehabilitation research capacity harness existing capacity in Tanzania as well as seeking international support.	**1.5.1 Rehabilitation research/ publications** **1.5.2 Rehabilitation research capacity building/training**	**MoHCDGEC International partners**	Research grant costs, Research capacity building costs	Year 3
1.6 Undertake public awareness raising activities about rehabilitation	1.6.1 Create educational and promotional materials on rehabilitation services. 1.6.2 Undertake a public awareness campaign to promote rehabilitation, including hosting awareness raising activities in hospitals and undertaking activities in the community.	**1.6.1 Rehabilitation promotional materials** **1.6.2 Campaign conducted**	**MoHCDGEC UTUMISHI, TAMISEMI, training institutions, professional associations**	Development of materials, printing costs Campaign event costs	Year 3

1.7 Strengthen public-private partnerships (PPP) for rehabilitation	1.7.1 MoHCDGEC to map and identify the key opportunities for PPPs regarding rehabilitation, in particular the stakeholders delivering rehabilitation that should have service level agreements, considering the need for greater geographic availability of rehabilitation. 1.7.2 MoHCDGEC to engage with private enterprises during rehabilitation planning and request and support regular data collection from them. 1.7.3. MoHCDGEC to identify priority private facilities that should be considered for secondments of government staff.	**1.7.1 Service level agreements with private rehabilitation providers**		Meeting expenses and existing human resources	Year 2-3
OBJECTIVE 2. INCREASE THE AVAILABILITY OF REHABILITATION SERVICES AND EXPAND FINANCING					

Area of Action	Actions	Core Output	Agency(s) responsible	Resources	Timeline
2.1 **Develop specialized rehabilitation services and further integrate into tertiary and secondary levels of healthcare**	2.1.1 Complete the business plan, commence construction, and open a new national rehabilitation center in Dar Es Salam with in-patient rehabilitation capacity for people with complex rehabilitation needs requiring longer stays. 2.1.2 Continue to expand rehabilitation workers across national, zonal and regional hospitals, through establishing new posts.	**2.2.1 New facility planned, government committed, and construction completed** **2.1.2 Increase number of national, zonal and regional hospitals that have rehabilitation workers**	**MoHCDGEC**	Construction of new facility Financing for expanding rehab workers across all levels of hospital	Ongoing
2.2 **Expand delivery of rehabilitation, including assistive product provision, within primary healthcare (PHC) and community settings**	2.2.1 Expand rehabilitation workers into prioritized district hospitals through establishing new posts. Prioritize district facilities based on their size, population need, and community outreach etc. 2.2.2 Develop outreach into PHC and community settings. Identify and pilot a model whereby rehabilitation outreach/ home visits occur in collaboration with Ward-based primary health care. Consider joint rehabilitation (OT/PT, P&O) visits alongside Ward community health workers. 2.2.3 Utilize the WHO Basic Rehabilitation Package and WHO Training for Assistive Products (TAP) resources to train existing PHC workers so they can deliver a limited set of rehabilitation interventions, including provision and training in the use of assistive products. Build PHC worker capacity to identify rehabilitation needs and make early referral to appropriate services. 2.2.4 Set up district wheelchair service provision, repair and maintenance team, which will conduct outreach to selected PHC clinics and community health centers. 2.2.5 Undertake a review of options for the effective, sustainable and scalable delivery of rehabilitation in	**2.2.1 Increased number of district hospitals have rehabilitation workers** **2.2.2 Increased number of community rehabilitation outreach visits increased** **2.2.3 Increased number of existing PHC workers who are trained in rehabilitation** **2.2.4 Increased number of PHC facilities that can provide an assistive product**	**MoHCDGEC**	Financing for planning, training, equipment and scaling up the integration of rehabilitation into primary health care	Year 2 -3

	community settings.				
2.3 **Improve early identification of children with developmental delays and disabilities and expand access to rehabilitation services in community, early childhood, and education settings**	2.3.1. Work with maternal and child health services to strengthen newborn screening and monitoring of developmental milestones, including for hearing and vision. 2.3.2. Work with maternal, child health, early childhood and education services to promote family-centered approaches that will facilitate diagnosis and community-delivered support/services, and when indicated, referral to specialist health and rehabilitation services. 2.3.3. Integrate rehabilitation workers in education outreach services so as to provide assessments and treatment plans for children with more complex developmental needs.	**2.3.1 Early identification mechanism strengthened and children with delays and disabilities being referred** **2.3.2 A mechanism for collaboration and coordination is established across sectors and management pathways are developed and supported** **2.3.3 Rehabilitation workers routinely integrated into specialist education outreach services**	**MoHCDGEC MCH, Ministry of Education**	Finance initiative to expand the early identification across MCH services Financing for rehabilitation input in education stings	Year 2-3
2.4 **Harness digital health for rehabilitation**	2.4.1. Develop and test a suitable approach to utilize telehealth support for PHC when managing people with rehabilitation needs in the community. 2.4.2. Integrate rehabilitation into digital health initiatives that occur within government health services and across healthcare.	**2.4.1 Undertake a pilot digital health project**	**MoHCDGEC**	Initial project financing	Year 1-3

2.5 **Improve quality of rehabilitation through development and implementation of resources that improve clinical management of common health conditions**	2.5.1 Select priority health conditions and create a multidisciplinary working group that develops resources that will improve the quality of rehabilitation care for these conditions. Consider the development of Standard Operating Procedures with agreed care pathways, treatment protocols, clinical practice guidelines, education and consumer pamphlets and support for in-service training.	**2.5.1 Health conditions selected, working group established and resources that improve quality of rehabilitation developed**	**MoHCDGEC** **Professional associations**	Meeting expenses and existing human resources, potential for local consultant project costs	Year 2
2.6 **Improve the continuum of care through stronger referral systems, both within healthcare and between health and social, community, and education services**	2.6.1 Develop a guideline that identifies the referral pathways for key health conditions that benefit from rehabilitation, and integrate rehabilitation into national guidance for referral of common health conditions. 2.6.2 Cooperate with the Tanzania disability sector to develop a directory of services for people with disabilities that includes rehabilitation services.	**2.6.1 Document and disseminate referral guidelines for common health conditions that need rehabilitation** **2.6.2 Rehabilitation integrated into national disability service directory**	**MoHCDGEC**	Meeting expenses and existing human resources, potential for local consultant project costs	Year 3-4
2.7 **Address gaps in rehabilitation infrastructure and equipment, invest in these and implement the Basic Standards for Rehabilitation Vol 6**	2.7.1 Review the Basic Rehabilitation Standards, Volume 6, and support their dissemination and implementation. Ensure accessibility of rehabilitation facilities is integrated into them. 2.7.2. Invest in rehabilitation infrastructure. Prioritize rehabilitation in health infrastructure and equipment budges.	**2.7.1 Basic Standards for Rehabilitation Vol 6 is updated** **2.7.1 New investment in rehabilitation equipment and infrastructure occurs and the Basic Standards for Rehabilitation is implemented and achieved**	**MoHCDGEC**	Financing of new infrastructure and equipment	Ongoing

2.8 **Expand financing for rehabilitation and assistive products through integration in health and social service financing mechanisms, especially the NHIF.**	2.8.1 Identify opportunities for further financing for rehabilitation and assistive products, ensuring that rehabilitation and assistive products are included in the national health insurance schemes. 2.8.2 Explore opportunities for Public Private Partnerships (PPP) for rehabilitation and assistive product service provision. Undertake a pilot PPP for assistive products to demonstrate its potential.	**2.8.1 Rehabilitation services integrated into health financing mechanisms, especially the NHIF** **2.8.2 Undertake a pilot PPP for assistive products**	**MoHCDGEC** **NHIF**	Meeting expenses and existing human resources. Project costs for initial PPP	Year 1 onwards
OBJECTIVE 3. STRENGTHEN AND EXPAND THE REHABILITATION WORKFORCE					

Area of Action	Actions	Core Outputs	Agency(s) responsible	Resources	Timeline
3.1 **Scale and strengthen the availability of rehabilitation professions, including physiotherapy, occupational therapy, prosthetics and orthotics, speech and language therapy, audiology and clinical psychology, and explore options for all levels of rehabilitation cadres**	3.1.1 Collaborate with KCMC to increase the capacity of education and training programs for physiotherapy, occupational therapy and prosthetics and orthotics to ensure availability of bachelor awards, to increase student intake, and strengthen the quality of teaching and learning. 3.1.2 Commence detailed planning for the establishment of education and training programs for speech and language therapy, audiology and clinical psychology. 3.1.3 Implement recruitment processes for international rehabilitation workers where domestic production is not yet established or adequate. 3.1.4 Undertake a comprehensive economic and feasibility analysis for the establishment of a mid-level rehabilitation cadre, including qualification, scope of practice, regulation, employment and supervision/oversight.	• **Road map for the development of speech and language/audiology and clinical psychology programs** • **Process document for international recruitment of rehabilitation professions not yet available domestically, including numbers required to fill current and emerging posts**	**MoHCDGEC (incl. Human Resources and Management), MoE, KCMC, TATCOT, national professional associations and P&O**	Existing human resources and additional costs for meetings, training, infrastructure	Ongoing
3.2 **Support continuing professional education for rehabilitation workers.**	3.2.1 Collaborate with national rehabilitation professional associations to expand opportunities for continuous professional development. 3.2.2 Utilize online platforms to ensure continuous professional development opportunities are widely available, including to those in rural and remote areas.	• **Five year plan for continuous professional development opportunities targeting priority competency gaps and sub-specialization needs for physiotherapy, occupational therapy and prosthetics and orthotics**	**MoHCDGEC (incl. Human Resources and Management), National professional associations KCMC, TATCOT**	Meetings expenses	Year 2

3.3 **Integrate rehabilitation into pre- and post-service education and training for health workers, including for nurses and doctors.**	3.3.1 Develop rehabilitation modules to be feasibly implemented in pre- and post-service education and training of doctors and nurses. 3.3.2 Coordinate with relevant education and training institutions to have rehabilitation modules appropriately integrated within their curricula.	• **Rehabilitation modules for integration in health worker pre-service curricula** • **Select rehabilitation training modules from WHO Basic Rehabilitation for PHC resources**	**MoHCDGEC (incl. Human Resources and Management), MoE, KCMC, TATCOT**	Curriculum adaptation and meeting expenses	Year 2
3.4 **Strengthen licensing and regulatory mechanisms for all rehabilitation professions.**	3.4.1 Strengthen the capacity of the Tanganyika Medical Council to establish and enforce: 1). Registration processes for all rehabilitation professions. 2). Standards for licensing of all rehabilitation professions, including continuous professional development, in collaboration of national rehabilitation professional associations. 3). Standards and processes for registration and licensing of international rehabilitation professionals seeking employment in Tanzania.	• **Allocated human resources within the Tanganyika Medical Council responsible management of rehabilitation regulation** • **Registry of rehabilitation workers in Tanzania** • **Standards for licensing of national and international rehabilitation workers**	**MoHCDGEC (incl. Human Resources and Management), National professional associations, KCMC, TATCOT**	Existing human resources and additional costs for meetings	Year 3
OBJECTIVE 4. INCREASE ACCESS TO ASSISTIVE PRODUCTS					

Area of Action	Actions	Core Output	Agency(s) responsible	Resources	Timeline
4.1 **Improve national coordination and regulation for assistive technology (AT)**	4.1.1. Establish a multi-stakeholder working group for assistive technology (AT), ensuring it meets regularly for planning and coordination activities. 4.1.2. Establish a focal person for AP in the Medical Stores Department (MSD). 4.1.3. Advocate and integrate AT into relevant health and social service planning. 4.1.4. Reduce taxes on imported AP, including componentry for common products, ensure AP is part of the Class A group. 4.1.5. Develop Safely Standards for common AP and support integration of AP into the medical regulatory mechanisms. 4.1.6. Undertake a review/report on the cost effectiveness of investing in national AP production.	**4.1.1. Working group for Assistive Products meeting regularly** **4.1.2. Establish a focal person for AP within the MSD** **4.1.3. Advocacy activities for assistive products** **4.1.3. AT included in relevant health and social service planning** **4.1.4. Reduced tax on imported AP** **4.1.5. Safety standards for AP** **4.1.6. Report on Local production**	**MoHCDEC MSD, CCBRT INUKA ICRC TOTA, APTA, APOT, Training Institutions**	Meeting expenses.	Year 1
4.2 **Establish a Priority Assistive Product List (APL) and increase government financing for assistive products**	4.2.1. Establish a plan and perform an analysis on the need and costing of a national APL. 4.2.2. Undertake development of the APL, including consensus meetings, finalization of the list and funding for APL. (Link financing of APL with area of action 2.8). 4.2.3. Support awareness raising and dissemination regarding APL and increased funding of assistive products.	**4.2.1. Plan and report for the development of a national APL** **consensus meetings** **4.2.2. APL established and funding from the government is assured** **4.2.3. AP awareness raising and APL disseminated.**	**MoHCDGEC, stakeholders, professional associations, training institutions**	Meeting expenses. Consultant for activity ii. In-depth costs to be estimated in time.	Year 1
4.3 **Improve assistive product central procurement through the Medical Stores Department (MSD)**	4.3.1. Review and streamline procurement systems and ensure integration of AP into Medical Device List (MDL). Include guidance for specifications and utilize WHO UNICEF Procurement manual.	**4.3.1. Procurement process reviewed** **4.3.1. Procurement strengthened through more streamlined processes** **4.3.1. AP included in MDL**	**MoHCDGEC, MSD**	Meeting expenses	Year 2-3

	4.3.2. Tendering systems are routinized and strengthened over time, and private suppliers are invited to bid on tenders.				

Monitoring, Evaluation and Review of the Plan

The MoHCDGEC recognizes the need for the Tanzania National Rehabilitation Strategic Plan to be monitored, evaluated and reviewed in order to track progress towards the plan's intended objectives and desired goals. To do this, the government will establish a monitoring framework with selected indicators for the plan. An indicator is a measure that determines whether the objective and key activities of the strategic plan are being achieved, its purpose is to monitor the change over time. The selection of indicators for the monitoring framework will be balanced across the 4 objectives of the plan and aligned to its results chain. A baseline and target for each indicator will be set. The information and data needed for each indicator will be collected at appropriate regular intervals and reported on, some indicators can be disaggregated, and reporting will reflect disaggregated results. On some occasions, the indicator will require the creation of new data sources, such as rehabilitation integrated within the DHIS2 reporting system. Objective 1 of this strategic plan contains actions to further integrate rehabilitation into the health information system, which will create the data sources for future monitoring.

The monitoring process will include an annual evaluation meeting in which the activities of the previous year are reviewed. This meeting will be convened by the MoHCDGEC and will be attended by the RTWG and other rehabilitation leaders and stakeholders. It will include a short report/update on the implementation of the rehabilitation strategic plan activities and core outputs, as well as updated information from the monitoring framework, which will be interpreted together to understand results. Updates will be shared by MoHCDGEC and other key stakeholders engaged in implementation of activities, and the meeting will be used to review and reflect on progress, including what has and has not been achieved and why. The meeting should occur prior to the annual operational planning process so the meeting outcomes feed directly into annual operation plans.

The monitoring framework includes the following terms:

- **Indicator name**: The name of the indicator.
- **Indicator definition**: Defines how the indicator is measured.
- **Baseline**: The current numerical level or starting point of the indicator.
- **Target**: The numerical goal of the indicator, or what is trying to be achieved.
- **Data source**: Where the numerical data for the indicator will come from, i.e., where it is collected, kept and therefore sourced for the purpose of monitoring.
- **Responsibility**: The agency responsible to collect the data, most of the time this is the Rehabilitation focal unit within MOHCDGEC. However, on some occasions this unit may require another agency/stakeholder to assist them in the data collection.
- **Reporting frequency**: How often the data for the indicator will be collected and/or reviewed for monitoring.

OBJECTIVE 1. STRENGTHEN REHABILITATION LEADERSHIP, PLANNING AND GENERATION OF EVIDENCE AND INFORMATION							
	Indicator's name	**Indicator definition**	**Baseline**	**Target**	**Data Source**	**Responsibility**	**Reporting Frequency**
1.	**Rehabilitation Steering Committee Meetings**	*Number of Rehabilitation Steering Committee Meetings that occur annually*	0	2 per year	MOHCDGEC, meeting minutes	Rehab focal unit within MOHCDGEC	Annually
2.	**Rehabilitation Technical Working Group Meetings**	*Number of Rehabilitation Technical Working Group that occur annually*	0	4 per year	MOHCDGEC, meeting minutes	Rehab focal unit within MOHCDGEC	Annually
3.	**Integration of Rehabilitation in Strategies, Plans and Reports**	*Number of MoHCDGEC strategies, plans or reports that have integrated rehabilitation*	2 (HSSP & NCDs)	5 in 5 years	Review of related docs	Rehab focal unit within MOHCDGEC	Annually
		Number of PO-RALG health related plans that have integrated rehabilitation services	0		CCHPs	MOHCDGEC Focal Unit, RMO, Regional Rehabilitation Coordinators	Annually
4.	**Number of Health Insurance Schemes and Packages that include rehabilitation.**	*Number of NHIF health packages that have included rehabilitation*	-	10 in 5 years -	NHIF and others Health Insurance companies	Rehab focal unit within MOHCDGEC	Annually
		Number of Corporates medical schemes that have included rehabilitation	-		Corporates medical schemes	Corporates HR department	Annually

					(e.g. TRA, NSSF and BOT)		
5.	**Rehabilitation Facilities that Comply with Reporting – both private and public**	*Percentage of MOHCDGEC rehabilitation facilities (therapy departments and units) and private registered facilities that reply to annual survey and therefore comply with reporting expectations*	0	Year 1 – 70% comply, then 10% increase every 2 years	Biennial rehab facility survey	Rehab focal unit within MOHCDGEC	Every 2 years
6.	**Health Facilities that Report on Rehabilitation through DHIS2**	*Percentage of health facilities that report on rehabilitation through the DHIS2 routinely*	0	Year 1 – 50% report, then 10% increase every 2 years	DHIS2 dashboard	Rehab focal unit within MOHCDGEC	Annually
7.	**Rehabilitation Health System and Policy Research Studies**	*Number of health system and policy research studies that relate to rehabilitation and occurring within Tanzania*	0	1 each year	Academic institutions	Rehab focal unit within MOHCDGEC	Annually

OBJECTIVE 2. INCREASE THE AVAILABILITY OF REHABILITATION SERVICES AND EXPAND FINANCING							
	Indicators name	**Indicator definition**	**Baseline**	**Target**	**Data Source**	**Responsibility**	**Reporting Frequency**
8.	**Rehabilitation Bed Density**	*Number of rehabilitation beds [9] / Total population of country x 10 000.*	1 bed per 2.4 million people (24 SCI beds)	1 bed per 500,000 after 5 years	Biennial rehab facility survey	Rehab focal unit within MOHCDGEC	Every 2 years
9.	**Rehabilitation Facilities that Meet the Basic Standards**	*Percentage of MOHCDGEC rehabilitation facilities (therapy departments and units) that meet the Basic Standards for Health facilities as it applies to rehabilitation*	tbd	50%	Biennial rehab facility survey	Rehab focal unit within MOHCDGEC	Every 2 years
10.	**National and Zonal Hospitals with Three or More Types of Rehabilitation**	*Percentage of National and zonal hospitals with three or more types rehabilitation professions/departments available and offering services*	4	50%	Biennial rehab facility survey	Rehab focal unit within MOHCDGEC	Every 2 years
11.	**Regional Hospitals with a Rehabilitation Department**	*Percentage of Regional hospitals with a rehabilitation department offering at least one type of rehabilitation*	tbd	75%	Biennial rehab facility survey	Rehab focal unit within MOHCDGEC	Every 2 years
12.	**District Hospitals and Health Centers with Rehabilitation Department** units	*Percentage of district hospitals and health centers with rehabilitation department*	175	50% of district hospitals in 5 years	Biennial rehab facility survey	Rehab focal unit within MOHCDGEC, Regional, Rehabilitation	Every 2 years

[9] Rehabilitation beds are inpatient beds allocated / dedicated for patients whose purpose for being in hospital is to receive high-intensity, longer-stay rehabilitative care. These beds are mostly managed by rehabilitation medicine doctors however orthopedic surgeons, neurologists and geriatricians also commonly oversee. Typically, the patients who use these are: SCI, TBI, multiple complex fracture, amputee, severe stroke etc

						Coordinators	
13.	**Rehabilitation Service Utilization**	*Number of patients that receive rehabilitation services / Total Population x10.000*	tbd	-	DHIS2, paper reports or from other reporting program	Rehab focal unit within MOHCDGEC, Regional Rehabilitation Coordinators	Annually
14.	**Rehabilitation Service Uptake**	*Number of rehabilitation sessions provided / Total population x 10.000*	tbd	-	DHIS2	Rehab focal unit within MOHCDGEC	Annually
15.	**Outreach Program Uptake**	*Number of rehabilitation sessions provided by outreach programs a year*	tbd	-	DHIS2	Rehab focal unit within MOHCDGEC	Annually
16.	**Rehabilitation Waiting Times**	*Total of waiting days for the first rehabilitation session/ Total number of new rehabilitation clients*	tbd	-	DHIS2	Rehab focal unit within MOHCDGEC	Annually
17.	**Rehabilitation Expenditure**	*Total national rehabilitation expenditure as the percentage of total national health expenditure.*	tbd	-	National health accounts	Rehab focal unit within MOHCDGEC	Annually

OBJECTIVE 3. STRENGTHEN AND EXPAND THE REHABILITATION WORKFORCE							
	Indicators name	**Indicator definition**	**Baseline**	**Target**	**Data Source**	**Responsibility**	**Reporting Frequency**
18.	**Rehabilitation Personnel Density**	*Number of rehabilitation workers / Total population x 10 0000*	1.133 workers per 100,000	10% increase every two years	Medical Council Tanganyika	Rehab focal unit within MOHCDGEC	Every 2 years
19.	**Rehabilitation Graduates**	*Number of rehabilitation personnel graduating annually*	tbd	5% absolute numbers annual increase	Training Institutions	Rehab focal unit within MOHCDGEC	Every 2 years
20.	**Professional Development Opportunities**	*Number of 1+ day long professional development opportunities*	tbd	-	Professional Associations and training institutions	Rehab focal unit within MOHCDGEC,	Every 2 years
21.	**Standards for professional licensing of rehabilitation professions**	*Number of rehabilitation professions with standards*	tbd	All	Medical Council Tanganyika	Rehab focal unit within MOHCDGEC	Every 2 years

OBJECTIVE 4. INCREASE ACCESS TO ASSISTIVE PRODUCTS							
	Indicators name	**Indicator definition**	**Baseline**	**Target**	**Data Source**	**Responsibility**	**Rep Fre**
	Assistive Products Uptake	*Number of assistive products provided*	tbd	-	DHIS2	Rehab focal unit within MOHCDGEC	An
	Assistive Product Expenditure	*Total government assistive product expenditure as the percentage of total national health expenditure*	tbd	-	National health accounts	Rehab focal unit within MOHCDGEC	An
	Timely Provision of AP	*Total of waiting days from prescription to provision of AP/ Total number of new clients*	tbd	-	DHIS2 MSD	Rehab focal unit within MOHCDGEC	An

Agencies and Processes to Support Implementation of the Plan

The implementation period of the Tanzania National Rehabilitation Strategic Plan is the point in which the plan directs the actions of government and relevant stakeholders. This will happen over the 5-year period of the strategic plan, from 2021-2026.

To support the implementation of the plan, the MOHCDGEC, along with the Rehabilitation Technical Working Group, commits to convene a joint annual planning meeting that corresponds to the annual evaluation meeting previously mentioned. The annual 'operational' planning meeting will entail coordination and planning between stakeholders engaged in activities within the plan. Operational planning occurs both between stakeholders at the meeting and then within each agency's own planning processes. Attempts will be made to ensure that the timing of the annual rehabilitation strategic planning meeting complements the planning processes and timeframes most commonly used by government.

The implementation of the strategic plan can be characterized as a 'plan, do, evaluate' process. This process should occur each year and it is recommended that the annual evaluation and planning meeting occur on the same day with appropriate stakeholders. Figure 2 illustrates the 'plan, do, evaluate' process.

Implementation of the strategic plan will occur through the guidance and hard work of the four smaller sub-Rehabilitation Working Groups that sit under the larger RTWG, these would be focused on:

1. Rehabilitation governance and information
2. Rehabilitation services
3. Rehabilitation workforce
4. Assistive Products

Key agencies represented on the committees and smaller working groups include:

FOUR WORKING GROUPS	KEY AGENCIES
1. Rehabilitation governance and information	
2. Rehabilitation services	
3. Rehabilitation workforce	
4. Assistive Products	

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Figure 2. Annual Cyclical Evaluation and Planning processes that support implementation