SHIFTING THE PARADIGM IN SOCIAL SERVICE PROVISION:
Making Quality Services Accessible for People with Disabilities in South East Europe

2008
SHIFTING THE PARADIGM IN SOCIAL SERVICE PROVISION

Making Quality Services Accessible for People with Disabilities in South East Europe

2008
DISCLAIMER

Materials published in the Disability Monitor Initiative series are not formal publications of Handicap International. They are produced by Handicap International Regional Office for South East Europe as part of a regional initiative to build knowledge on disability in transition. The reports and papers present preliminary analyses that are circulated to stakeholders in order to encourage discussion and debate. The findings, interpretations and conclusions expressed in this report are entirely those of the authors and should not be attributed in any manner to Handicap International, their donors or partners. For copies of this report, please contact Handicap International Regional Office for South East Europe or visit the Disability Monitor Initiative website.

© Copies of the publication are free but Handicap International has the copyright on the publication thus the source must be mentioned.


THE DISABILITY MONITOR INITIATIVE

www.disabilitymonitor-see.org
editor@disabilitymonitor-see.org

HANDICAP INTERNATIONAL-REGIONAL OFFICE FOR SOUTH EAST EUROPE

Hakije Kulenovića br.22, 71 000 Sarajevo, Bosnia and Herzegovina
office@hi-see.org

NOTE: The report reviews progress in the situation of social services for people with disabilities in: Albania, Bosnia and Herzegovina, Croatia, Kosovo (under UNSCR 1244), FYR Macedonia, Montenegro, Romania and Serbia
Acknowledgements

Author:
Diana Chiriacescu

Proofreading:
Charlotte Axelsson
Bojana Bego
Alexandre Côte
Lisa Adams
The author is very grateful for their valuable comments and recommendations, during all stages of the report’s elaboration.

Technical support and research:
The author is also thankful to numerous colleagues and partners from local organizations in South East Europe, who provided information, shared experiences and life stories regarding the evolutions of social services in their countries. This report is also a testimony of their constant commitment and efforts to achieve the positive change in this sector.

Logistic support:
Marica Rakicevic, Bojana Antic, Ajhan Saraqi, Patriot Elezaj

Layout and design:
Suzana Markovic

Translation:
Suzana Stojkovic, Etleva Bisha and Merita Myftari, Dan Tudorascu

The report has been realised thanks to the financial support of:
The European Initiative for Democracy and Human Rights (EIDHR)
The Ministry of Foreign Affairs - France
Handicap International

The author has the sole responsibility for the content of this paper, as well for any remaining errors.

Cover photos:
1. Assistive technologies for children with disabilities, provided by Open the Windows, FYR Macedonia (Copyright Open the Windows)
2. An inclusive school in Godjevo, Montenegro (Copyright: the Day Care Centre Tisa, Bijelo Polje, and Handicap International)
3. Sign language interpreting for deafblind persons, provided by the organization DODIR in Croatia (Copyright DODIR)
Dear reader,

It is a great pleasure for Handicap International to present the third regional report of the Disability Monitor Initiative in South East Europe, addressing the challenging topic of reforms in the field of social service provision for people with disabilities.

Over the last four years, Handicap International (HI) together with its partners has developed activities aimed at supporting good practices in the field of social service reform. HI has also been active in capacity building of local stakeholders to better address the challenges of the sector’s modernisation, in a context of decentralisation and welfare mix. There is a unique ‘momentum’ in the region, in which actors seem committed to ‘shift the paradigm’ in the disability sector, and to work towards a system of community services that is person centred and needs driven. Moreover, the adoption of the UN Convention on the Rights of People with Disabilities in 2006 sets a clear frame for action on national levels as well as for local communities.

These years of exchanges, learning and innovative practices resulted in the compilation of this report which is aimed at reflecting the complexity of the transition period in this sector. The report highlights the stakes of the social service reform as well as the shared responsibilities that need to be undertaken by all stakeholders in order to achieve the change: people with disabilities and their organisations, service providers, national and local authorities, the international community, and civil society at large.

The report also intends to serve as testimony to the complex transformations taking place in the countries of South East Europe. It outlines recommendations for decision makers, not in the form of a prescribed recipe but as a result of participatory exchange, experience gained through practice, as well as the emergence of hundreds of pilot projects carried out by NGOs in their new role as service providers. It also aims to facilitate an understanding of those stakes, mechanisms and strategies that will make community-based services sustainable, qualitative, affordable and accessible to people with disabilities throughout region.

Sarajevo, December 2008

Emmanuel Sauvage
Regional Programme Director, Handicap International South Eastern Europe
Shifting the Paradigm in Social Service Provision

Foreword

Policy makers would probably remember photos and statements included in reports about Kosovo, Serbia or Romania related to the violation of rights of people with disabilities in residential institutions: unacceptable situations that called for action. But who would remember the never seen-pictures and never expressed opinions of the vast majority of persons with disabilities in South East Europe who are isolated in their homes because there are no support services and because schools, health care and employment services are inaccessible?

In 2004, the Disability Monitor Initiative for South East Europe published a report "Beyond deinstitutionalisation: the Unsteady Transition towards an Enabling System". The report made the case for going beyond the debate about residential institutions and advocated for stakeholders already engaged in a two fold transition, from a command to a market economy and from the medical to the holistic approach to disability, to seize the momentum of reforms and to move towards an enabling system of services, allowing for the inclusion of all people with disabilities in their communities.

The report highlighted the initiatives carried out mostly by NGOs, demonstrating the way the inclusion of persons with disabilities in their community could be supported, and was calling for a strong move from stakeholders to develop and implement appropriate policies supporting the scaling up of such initiatives.

Since the time of this report, a lot has happened, notably the adoption, in December 2006, of the UN Convention on the Rights of Disability (UNCRPD) which confirmed that disability is a human rights issue and among other things, reaffirmed the duty for states to engage more in ensuring access of people with disabilities to social (mainstream and support) services.

Since 2005, Handicap International, through its regional activities with DPOs, service providers and public administration has monitored and supported efforts and struggles of stakeholders to make this change happen. It has witnessed significant achievements. Disability is on the social reform agenda across the region and with the adoption of national disability strategies, anti-discrimination legislations, first steps of social services reform processes, several key steps have been made towards an enabling system.

However, we have also witnessed the amazing energy needed by advocates to keep the momentum going in a context of national or regional political tensions, the difficulties of good willing stakeholders facing the reforms' complexity and conflicting agendas, not only in the political sphere but also within the disability movement. After the excitement of pioneering phase, they are challenged by the tough reality of the politics of policy reforms and their implementation.

The present report is a tool for practitioners and policy makers, built upon numerous workshops, trainings and projects, analysing where the region stands and what are the next steps to take to turn reforms into concrete outcomes in the lives of persons with disabilities. It brings a comparative overview of different paths taken in various countries and by different stakeholders in the move towards an enabling system. A certain emphasis has been placed on Romania, as it has engaged in a very wide reform process and its successes and challenges are a great source of learning for all the countries of the region.

A lot has been achieved, but there many things remain to be done as policy reforms are worth only when laws, budgets, procedures, staff training, effectively deliver that concrete support to persons with disabilities to ensure they enjoy equal opportunities to participate in their communities.

With the current and upcoming economic difficulties, there could be a temptation for policy makers to postpone the social services reforms and to marginalize the rights of people with disabilities once again. They would be making a double mistake. They would miss the opportunity to scale up social services that contribute effectively to the inclusion of persons with disabilities into communities and in labor market, that enhance the impact of current cash assistance policies and that can generate numerous long term jobs. Moreover they would take the risks of losing the significant investment made so far. National policy makers with the support of the European Union, notably through Instruments for Pre-Accession Assistance (IPA) and social inclusion strategies, have to make decisive steps that would transform an unsteady transition in an irreversible process towards the full participation of persons with disabilities in South East Europe.

Alexandre Côte
Governance and Social Inclusion Advisor, SI.EM.PR.E
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>5</td>
</tr>
<tr>
<td>List of boxes, spotlights, figures, tables and photos</td>
<td>8</td>
</tr>
<tr>
<td>Acronyms and Abbreviations</td>
<td>9</td>
</tr>
<tr>
<td>Glossary</td>
<td>11</td>
</tr>
<tr>
<td>Executive summary</td>
<td>15</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td>19</td>
</tr>
<tr>
<td><strong>PART I – THE PROCESS OF SOCIAL SERVICE PROVISION, FOR PEOPLE WITH DISABILITIES</strong></td>
<td>23</td>
</tr>
<tr>
<td>1.1. Social services for persons with disabilities – the essential component of an enabling system</td>
<td>23</td>
</tr>
<tr>
<td>1.1.1. International frameworks in the field of rights of people with disabilities</td>
<td>24</td>
</tr>
<tr>
<td>1.1.2. International frameworks supporting policy reforms in the field of social services for people with disabilities</td>
<td>25</td>
</tr>
<tr>
<td>1.1.3. The right balance between the provision of mainstreamed and specialised services – a twin track approach</td>
<td>27</td>
</tr>
<tr>
<td>1.1.4. Continuity and comprehensive spectrum of services</td>
<td>28</td>
</tr>
<tr>
<td>1.1.5. 4 A’s in social service provision for people with disabilities</td>
<td>29</td>
</tr>
<tr>
<td>1.1.6. The overall approach to disability</td>
<td>29</td>
</tr>
<tr>
<td>1.2. The stages of the social service provision and the system of regulatory mechanisms and procedures</td>
<td>30</td>
</tr>
<tr>
<td>1.2.1. Stages of social service provision</td>
<td>30</td>
</tr>
<tr>
<td>1.2.2. Main stakeholders involved in the social service provision processes</td>
<td>30</td>
</tr>
<tr>
<td>1.2.3. The regulatory mechanisms and procedures</td>
<td>32</td>
</tr>
<tr>
<td>1.3 The main roles and functions covered by the regulatory mechanisms in the field of social</td>
<td>43</td>
</tr>
<tr>
<td>1.4 Working towards more effective regulations</td>
<td>44</td>
</tr>
<tr>
<td>1.5. Conclusion</td>
<td>45</td>
</tr>
<tr>
<td><strong>PART II – THE ACCESS OF PEOPLE WITH DISABILITIES TO SOCIAL SERVICES IN SOUTH EAST EUROPE: A PANORAMA OF POLICIES AND PRACTICES</strong></td>
<td>47</td>
</tr>
<tr>
<td>2.1 Formal organisation of the systems of social services for people with disabilities in the region. Policies and legal frameworks</td>
<td>49</td>
</tr>
<tr>
<td>2.1.1. Social services framework in Albania</td>
<td>51</td>
</tr>
<tr>
<td>2.1.2. Social services framework in Bosnia and Herzegovina</td>
<td>56</td>
</tr>
<tr>
<td>2.1.3. Social services framework in Croatia</td>
<td>61</td>
</tr>
<tr>
<td>2.1.4. Social services framework in Kosovo (under UNSCR 1244)</td>
<td>64</td>
</tr>
<tr>
<td>2.1.5. Social services framework in the Former Yugoslav Republic of Macedonia</td>
<td>69</td>
</tr>
<tr>
<td>2.1.6. Social services framework in Montenegro</td>
<td>72</td>
</tr>
<tr>
<td>2.1.7. Social services framework in Romania</td>
<td>74</td>
</tr>
<tr>
<td>2.1.8. Social services framework in Serbia</td>
<td>80</td>
</tr>
<tr>
<td>2.1.9. Key findings and recommendations regarding the legislative reforms on social services for people with disabilities, in South East Europe</td>
<td>86</td>
</tr>
<tr>
<td>2.2 Access to social services at community level – the challenge of an outdated gate-keeping system</td>
<td>90</td>
</tr>
<tr>
<td>2.2.1. Global overview about the gate-keeping systems in the region</td>
<td>90</td>
</tr>
<tr>
<td>2.2.2. The gate keeping at macro level – legislations and recent practices</td>
<td>91</td>
</tr>
<tr>
<td>2.2.3. The gate keeping at the micro level – a mechanism that starts to be reformed</td>
<td>92</td>
</tr>
</tbody>
</table>
2.2.4. The collection of data and relevant databases in the field of disability ........................................... 97
2.2.5. Looking ahead .............................................................................................................................. 99

2.3. The spectrum of existing social services in South East Europe ......................................................... 100
2.3.1. The educational services ........................................................................................................... 101
2.3.2. Health care services ................................................................................................................ 109
2.3.3. The habilitation and rehabilitation services ............................................................................... 113
2.3.4. The services facilitating employment ...................................................................................... 126
2.3.5. Supported living and independent living ................................................................................. 128
2.3.6. Overall conclusions regarding the spectrum of services for people with disabilities in the region ... 129

2.4. Delivering quality services – progressing towards welfare mix and better governance .......... 131
2.4.1. The providers of community-based services for people with disabilities in South East Europe .... 131
2.4.2. The quality of social services and the stage of quality standards elaboration ......................... 131
2.4.3. The licensing (authorization) procedures for service providers ............................................... 133
2.4.4. The internal regulatory procedures of social service providers ............................................. 134
2.4.5. The national data collection and integrated information systems, related with social service delivery .................................................... 135

2.5. Funding of social services for people with disabilities and the evolution of contracting procedures .......................................................................................................................... 136

2.6. Monitoring and evaluation of social services providers in the countries of the region ............. 139

2.7. The decentralisation of social service provision for people with disabilities ........................................ 140

2.8. The users’ involvement in different stages of social service provision ........................................ 144

2.9. The situation of professionals and of the specialised qualifications needed in the disability-related services .......................................................................................................................... 145
2.9.1. Overview of the situation ................................................................................................. 145
2.9.2. The situation of social services managers in South East Europe ........................................ 147
2.9.3. Volunteers, self support networks and other informal providers of social services for people with disabilities .......................................................................................................................... 147

2.10. Centralisation of data with regards to the typology of services and existing regulatory mechanisms in South East Europe .......................................................................................................................... 148

PART III – ACHIEVING THE CHANGE – KEY CONCLUSIONS AND RECOMMENDATIONS .......... 153

BIBLIOGRAPHY .................................................................................................................................. 163

ANNEXES ............................................................................................................................................. 167
ANNEX 1 - Brief description of social services for people with disabilities mentioned in this report .......... 168
ANNEX 2 - Disability High Level Group position papers
   2.1. Disability High Level Group position paper on quality of social services of general interest .... 171
   2.2. Disability High Level Group discussion paper on disability mainstreaming in the new streamlined European social protection and inclusion processes ........................................... 174
ANNEX 3 - The group of regional experts in the field of social services for people with disabilities, in South East Europe ................................................................. 178
List of boxes, photos and tables

BOXES
Box 1 Quality systems in European social services for people with disabilities
Box 2 Mainstreaming disability in national and European policies: main elements for ‘shifting the paradigm’
Box 3 How do we know that a services-related policy is well designed and implemented?
Box 4 The “one stop shop” principle in the gate-keeping system for social services
Box 5 The International Classification of Functioning, Disability and Health (ICF)
Box 6 The Disability Creation Process (DCP)
Box 7 Three important organizations with relevance for the occupational therapists in South East Europe
Box 8 A 10-Steps Model of Good Practice for De-institutionalising Young Children into Family Care
Box 9 Brief overview of the main aspects of the decentralization process

SPOTLIGHTS
Spotlight 1 What do people with disabilities say about the development of social services in South East Europe?
Spotlight 2 A participatory approach in policy elaboration in Albania: the case of general quality standards for social services
Spotlight 3 Participation of Disabled People Organisations in policy making processes, in South East Europe – outcomes of a 5-years project (SHARE-SEE, 2003-2008)
Spotlight 4 The reform of the ‘orientation commissions for children with special educational needs’ in Montenegro
Spotlight 5 The particular situation of Centres for Social Work in the countries of ex-Yugoslavia
Spotlight 6 A major challenge for the gate-keeping reforms: reaching the people with disabilities in rural and isolated areas
Spotlight 7 The role of frontline teachers and of support services during the initial stages of inclusive education process
Spotlight 8 Emergence of new early detection and intervention programs in South East Europe
Spotlight 9 A service of sign language interpreters for deafblind persons developed by the organisation DODIR in Croatia
Spotlight 10 The lack of clear regulatory procedures for funding support services in Serbia sends people with disabilities back in institutions
Spotlight 11 Assistive devices and technologies, provided by the organisation ‘Open the Windows’ in Macedonia
Spotlight 12 Quality specialised services provided by Hans Spalinger Association in Simeria, Romania
Spotlight 13 Psychosocial support services for people living with /or affected by/HIV, provided by the organisation Q Club in Serbia
Spotlight 14 An example of capacity building for deinstitutionalisation, in the system of social protection for children with disabilities from Romania (2001-2004)
Spotlight 15 Pioneering initiatives of supported employment in Croatia and Romania
Spotlight 16 The inventory of quality standards for social services that exist currently in Romania and Albania
Spotlight 17 High level quality management in a public social service: the Centre for Social Work (CSW) from Banja Luka, Bosnia and Herzegovina
Spotlight 18 Introducing Physical Medical Rehabilitation (PMR) in Albania

TABLES
Table 1: Funding mechanisms for social services (public and private) in South East European countries
Table 2. Mapping of existing qualifications related to services for people with disabilities in the region (Dec. 2007)
Table 3. Existing services for people with disabilities in South East European countries (Dec. 2007)
Table 4. Centralised situation of existing regulatory mechanisms and procedures in the countries of SEE

FIGURES
Fig.1 Twin track approach in disability-related services, towards an inclusive community
Fig 2 Spectrum of services that are needed in communities, for people with disabilities
Fig.3 The PDCA cycle (the Deming wheel)
Fig.4 Main stakeholders involved in the process of social service provision
Fig.5 Relations between users and service providers in the commercial sector
Fig.6 Relations between users and service providers in the social sector
Fig.7 Main stakeholders involved in social service provision, and their roles in the definition and implementation of regulatory mechanisms
Fig.8 The chain of regulatory procedures in the process of social service provision for people with disabilities

PHOTOS
Page 94 Capacity building program for new evaluation and orientation commissions in Montenegro. Copyright Handicap International
Page 97 People with disabilities in rural or isolated areas lack access to basic assistance and support services. Copyright Handicap International
Page 106 A young girl with disability and her teacher in Godijevo, Montenegro. Copyright Day care Centre Tisa, Bijelo Polje and Handicap International
Page 106 A successful inclusion story in Bucharest, Romania. Copyright Handicap International
Page 112 Early intervention services provided by Alpha Transilvana Foundation in Romania. Copyright Alpha Transilvana.
Page 118 Sign language interpreting service for deafblind persons, at University courses. Copyright DODIR
Page 118 A sign language interpreter providing assistance to a deafblind person in a local shop. Copyright DODIR
Page 120 Prosthesis production and delivery in Kukes Hospital, Albania. Copyright Handicap International
Page 120 Prosthesis production in Mostar, Bosnia and Herzegovina. Copyright Human Study
Page 120 Computer adaptations for people with disabilities in Skopje, Macedonia. Copyright Open the Windows
Page 122 A young beneficiary of curative pedagogy services in Romania. Copyright Hans Spalinger Association
Page 129 Personal assistant for deafblind persons in Croatia. Copyright DODIR
Page 145 A psychologist working in the day care service Zracak Nade, Pijevija, Montenegro. Copyright Zracak Nade
## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ASD</td>
<td>Autism Spectrum Disorders</td>
</tr>
<tr>
<td>BIH</td>
<td>Bosnia and Herzegovina</td>
</tr>
<tr>
<td>CSCl</td>
<td>Commission for Social Care Inspection, United Kingdom</td>
</tr>
<tr>
<td>CSW</td>
<td>Centre for Social Work</td>
</tr>
<tr>
<td>DCP</td>
<td>Disability Creation Process</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development, United Kingdom</td>
</tr>
<tr>
<td>DPO</td>
<td>Disabled People’s Organisation</td>
</tr>
<tr>
<td>D-HLG</td>
<td>Disability High Level Group of the European Commission</td>
</tr>
<tr>
<td>EASPD</td>
<td>European Association of Service Providers for Persons with Disabilities</td>
</tr>
<tr>
<td>EAR</td>
<td>European Agency for Reconstruction</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EDAMAT</td>
<td>European Disability Action for Mainstreaming Assessment Tool</td>
</tr>
<tr>
<td>EDF</td>
<td>European Disability Forum</td>
</tr>
<tr>
<td>EFQM</td>
<td>European Foundation for Quality management</td>
</tr>
<tr>
<td>EPHA</td>
<td>European Public Health Alliance</td>
</tr>
<tr>
<td>EPR</td>
<td>European Platform for Rehabilitation</td>
</tr>
<tr>
<td>EQUASS</td>
<td>European Quality Assurance for Social Services</td>
</tr>
<tr>
<td>EQRIM</td>
<td>European Quality in Rehabilitation Mark</td>
</tr>
<tr>
<td>EU</td>
<td>The European Union</td>
</tr>
<tr>
<td>EIDHR</td>
<td>European Initiative for Democracy and Human Rights</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GTZ</td>
<td>Gesellschaft für Technische Zusammenarbeit, GmbH</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HI</td>
<td>Handicap International</td>
</tr>
<tr>
<td>HISEE</td>
<td>Handicap International South East Europe</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSO</td>
<td>Handicapporganisationernas Samarbetsorgan (The Swedish Disability Federation)</td>
</tr>
<tr>
<td>ICF</td>
<td>International Classification of Functioning, Disability and Health</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IPA</td>
<td>Instrument for Pre-accession Assistance</td>
</tr>
<tr>
<td>ISO</td>
<td>International Standards Organisation</td>
</tr>
<tr>
<td>MFA</td>
<td>Ministry of Foreign Affairs, France</td>
</tr>
<tr>
<td>MHADIE</td>
<td>Measuring Health and Disability in Europe</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>OMC</td>
<td>Open Method of Coordination</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OSCE</td>
<td>Organisation for Security and Co-operation in Europe</td>
</tr>
<tr>
<td>PDCA</td>
<td>Plan-Do-Check-Act</td>
</tr>
<tr>
<td>SEE</td>
<td>South East Europe</td>
</tr>
<tr>
<td>SGI</td>
<td>Services of General Interest</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
</tr>
<tr>
<td>SSGI</td>
<td>Social Services of General Interest</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>The World Health Organisation</td>
</tr>
<tr>
<td>WB</td>
<td>The World Bank</td>
</tr>
</tbody>
</table>
Accreditation*
Accreditation is a voluntary process that offers service providers recognition for obtaining standards of excellence defined by an accreditation agency. (*As defined by Andy Bilson and Ragnar Gotestam, "Improving standards of child protection services - a concept paper" UNICEF Innocenti Centre (Florence: UNICEF and World Bank, 2003)

Benchmarking (in the field of social services provision)
An evaluation procedure that refers to the appreciation of the results that have been achieved by a social service provider in comparison with more successful organisations, considered as reference of best practice. It can be used also as a peer evaluation procedure.

Community-based services (CBS)
Services provided at the community level and organised in partnership with or by the members of the community with the involvement of users in the prioritization of needs, the planning and the evaluation of services.

Community-based rehabilitation (CBR)*
CBR is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families, organizations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services.

Contracting of social services
The process in which the State establishes a contract with a social service provider (public or private) to deliver the services that the State guarantees. In the sense of this report, contracting also refers to putting the purchasing of services into a legally binding agreement.

Decentralisation
The process of transfer of responsibilities, capacities and resources, from the State level (central authorities, government) to the level of local authorities and decision makers (municipalities and decentralised bodies of the ministries).

De-institutionalisation
The change in the provision of social and medical services for people with disabilities, from institutional settings and practices towards community-based services, which are person centred and needs driven.

Enabling system*
An enabling system is a system of services oriented towards supporting people with disabilities to reach and maintain their optimal level of independence and social participation. This goal is achieved through ensuring them an equal access to mainstream services existing at the community level (ordinary medical, social, education, and employment services), with individualised support services according to each one's needs and expectations, and referral to specialised services when needed.
*(Beyond De-institutionalisation: The Unsteady Transition towards an Enabling System in South East Europe, HISEE, 2004)
European Social Model*
A vision of society that combines sustainable economic growth with ever-improving living and working conditions. This implies full employment, good quality jobs, equal opportunities, social protection for all, social inclusion, and involving citizens in the decisions that affect them.
*As defined by the European Trade Union Confederation, www.etuc.org

Gate-keeping*
Gate-keeping is the system of decision-making that guides effective and efficient targeting of services for people with disabilities or other vulnerable groups.
* As defined by Andy Bilson and Ragnar Gotestam, "Improving standards of child protection services - a concept paper" UNICEF Innocenti Centre (Florence: UNICEF and World Bank, 2003).

Licensing/authorization
A mandatory procedure carried by authorities, through which providers are given the permission to deliver social services, after proving the compliance with minimum quality standards or criteria agreed at national level in the respective domain of intervention.

Mainstreaming disability
The political process whereby the needs and rights of persons with disabilities are integrated into the planning, development, implementation and legislation of general policy. Effective mainstreaming of disability requires the inclusion of persons with disabilities in decision-making processes in all arenas of policymaking, at all levels of government, and at all stages, including planning, implementing and evaluating the effectiveness of these policies. (EDAMAT. www.edamat-europe.org)

Monitoring of social services
A continuous process of systematic collection of information, according to specific indicators, meant to provide the managers of a service (and other relevant stakeholders) with data of the extent of progresses and achievement of service's objectives.

Provision of social services under a public mandate
A general frame for provision of social services, in which public authorities delegate the management and provision of these services to various providers (evaluated and selected at local level) using correspondent procedures of (sub)contracting and funding.

Quality Standards*
Quality standards provide a set of criteria that can be used to monitor the management and provision of services, the quality of services as well as their outcome. They ensure equitable and transparent transfer or delivery of services to the beneficiary.
*As defined by Andy Bilson and Ragnar Gotestam, "Improving standards of child protection services - a concept paper" UNICEF Innocenti Centre (Florence: UNICEF and World Bank, 2003)

Regulatory mechanisms in the field of social services
Sets of inter-correlated instruments meant to control, coordinate and improve the provision of social services, both at system level and at individual and service level. The regulatory mechanisms are defined by central public authorities and implemented by local authorities or agencies, mandated for this role. They regulate: (a) the demand and the access of users to social services, (b) the supply of these services by various providers and (c) the provision of social services itself.

Services of General Interest*
Services of General Interest (SGI) in European Union cover "both market and non-market services that are considered by the public authorities as being of general interest and submitted to specific public service obligations". Examples of SGI: energy, telecommunications, audiovisual broadcasting and postal services, water supply, waste management, education or health.

Social Services*
In the context of this report, social services cover a large and diversified range of services which are intended to improve the standards of living of the population, especially of individuals and groups in vulnerable situations. They are linked to national welfare schemes and are important tools for the implementation of public policies in the field of social protection, non-discrimination, the fight against poverty and exclusion. They are not conditioned by the contribution of the users and enhance capacities of individuals for full inclusion and participation in society. They respond to social needs and social deficits, which the market cannot manage, or which can be even generated by the market. The States are responsible for ensuring the access of all citizens to social services.
*Description based on the EC Communications, as well as on the perspective of several European platforms that are active in the field of social services - Social Platform, Eurodiaconia, EASPD.)
Social Services of General Interest*

Social services of general interest (SSGI) are a specific part of services of general interest. Social services can be regrouped in two broad types of services, the functions and organisation of which can vary significantly across the EU: on one hand, statutory and complementary social security schemes and on the other hand, other services provided directly to the person that play a preventive and socially cohesive role, such as social assistance services, employment and training services, social housing, child care or long-term care services. These services play a vital role in societies and provide an important contribution to the fulfilment of basic EU objectives such as social, economic and territorial cohesion, a high level of employment, social inclusion and economic growth.


Social Services for Persons with Disabilities

Social services (both specialised and mainstreamed) that contribute to the concrete implementation of the fundamental social rights and ensuring equal opportunities for people with disabilities.

Territorial (geographical) maps of services

The territorial maps are charts of the existing as well as needed services at territorial level (municipality, department, region etc), renewable within specific intervals of time (3/5 years). Any proposal for opening new social services, or for extending the existing ones, is generally analyzed in relation with these territorial charts.

Total Quality Management

A generic management tool, originated in the concept developed by the American W. Edwards Deming, after World War II, for improving the production quality of goods and services. It relies on principles like: management commitment to continuous improvement and quality, employee empowerment, customer focus and fact-based decision making.

Twin track approach to inclusive service provision

A way of operating the change process towards an enabling system through mainstreaming disability in all social service policies on the one-hand, while simultaneously developing specific measures for people with disabilities who require particular services (i.e. individualised support services, supported employment, door-to-door transportation, anti-discrimination legislation etc). This approach aims at equalizing opportunities for people with disabilities, in order to enhance their participation in economic, cultural, political and social life. (the twin track perspective is originated in the DFID Paper called: “Disability, poverty and development”,2000)

Universal Design or “Design-for-all”

An approach to the design of products, information packages, services and built environments which are accessible to everybody, including persons with disabilities regardless of their impairments or specific needs. (EDAMAT, www.edamat-europe.org)

Welfare mix (or the mix model of social service provision)

In the context of this report, the welfare mix refers to a plurality of social service providers (public, for profit, not-for-profit, informal), as well as to the policy and governance measures that are related with the existence of this plurality of actors.
EXECUTIVE SUMMARY

Introduction

What is the purpose of the report?
The current report aims at examining the ways in which policies and practices evolve in the social services sector in South East Europe, as well as the impact of this change process on the lives of people with disabilities. It aims at identifying the main stakes, priorities and steps forward that should be undertaken in order to modernize this sector in an effective and sustainable way.

What does the report cover?
It reviews the progress of what is usually called ‘services addressed directly to persons’ and does not refer to social security schemes (cash transfers, allowances, financial arrangements for people with disabilities). It makes an overview of the existing ‘spectrum’ of services for people with disabilities in South East Europe, as well as of the way in which these services are organised and delivered in each country (regulatory mechanisms, responsible agencies, participation of users in decision making, the situation of professionals working in the disability-related services).

PART I – A theoretical overview of the process of social service provision

What is the purpose of this chapter?
Part I presents a general overview of the conceptual framework of social service provision, in relation with the needs of people with disabilities: the main stakeholders and their corresponding roles, the spectrum of services that is needed at the community level, the chain (and the roles) of regulatory mechanisms, the importance of service coherence, continuity and sustainability, at the local level.

Social services are important tools for fighting poverty and exclusion
In the last decades this domain was under major transformations worldwide, related with a change of paradigm in the field of disability: from a medical and protective model to a social and inclusive one, focusing on rights, equal opportunities and full participation of people with disabilities in social and economic life. With this new paradigm, social services at the community level have to be accessible for all citizens, including people with disabilities. They have to be available and affordable for these people. They have to be provided with good quality standards. They have to be organized in a way that reflects the choice and interests of people with disabilities.

International documents support the shift of paradigm in the disability and social services sectors.
Several trends and frameworks at the European and international level influence and support the reforms taking place in South East Europe, in the field of disability and social services. The UN Convention on the Rights of Persons with Disabilities, the Council of Europe’s Disability Action Plan to promote the rights and full participation of people with disabilities, the overall EU Disability Action Plan 2003-2010 as well as the Communications on Social Services of General Interest (SSGI) in the European Union, set the frame for the modernisation of social services, in a region in which countries are already enrolled in a process of preparation for EU accession.
A twin track approach is important in the sector of social services for people with disabilities.

Following a twin track approach in the social services sector should allow for the promotion of a wide network of community based social services, complementary with one another, to ensure a so called ‘continuity of care’, aiming at the social inclusion of people with disabilities. It is a useful approach for South East Europe in order to eliminate the false questioning (and the reductionist choice) of either mainstreamed or specialized measures in the field of social services for people with disabilities. In an inclusive community, all types of services that lead to participation of people with disabilities, and the full respect of their human rights (mainstream, support and specific services) are equally needed.

The welfare mix is a concept that impacts the organization of services in SEE.

In comparison with the old systems in South East Europe, where States were the unique service providers in the social sector, nowadays a variety of new providers emerge, including non-profit, informal providers (families, self-support networks, volunteers) and even for-profit providers in some countries. Consequently, the relations between them and the State need to be well defined at policy level, regulated and monitored.

New types of regulatory mechanisms for social services are needed in the context of welfare mix and decentralization of service provision.

The regulatory mechanisms in the field of social services are instruments meant to control, coordinate and improve social services, both at the macro and micro level. They are a lever for developing quality, accessible, available, accountable, affordable social services for all citizens, including people with disabilities.

In South East Europe, their design and implementation represents major stakes within the social sector’s reform. Gate-keeping procedures, licensing and accreditation, quality standards, monitoring and evaluation of services, as well as the creation of an integrated system of information and feedback, are important mechanisms to be elaborated at national levels, for sustaining the welfare mix and for guaranteeing sustainable and quality services for people with disabilities in their communities.

PART II – The Access of People with Disabilities to Social Services in South East Europe: a Panorama of Policies and Practices

What is the purpose of this chapter?

This part of the report explores the way in which people with disabilities have access to social services in the countries of the region. It looks first at the evolutions of national policies related with modernisation of social services, as well as at the way in which these services are organised and delivered concretely.

The general description of the situation in the region is multi-layered: after a brief look at each country’s policy on disability and social services, the report focuses on each domain of intervention (education, health care, habilitation and rehabilitation, access to employment, supported and independent living) and analyses comparatively the national situations. Finally, the development of regulatory mechanisms in each country is also described.

South East Europe is a region facing a challenging transition period.

Simultaneous processes are taking place in the last decade, requiring from all stakeholders strong capacities for strategic thinking, partnership, redirection of resources, transparent decision making and good governance: the shift of paradigm in disability, de-institutionalisation of disability, decentralisation of service provision as well as the emergence of new types of services and service providers. At the policy level, this complex transition needs to be reflected in new strategies and legal frameworks.

How do States reform the social sector? Overview of policies and legal frameworks in the field of disability and social services (2.1)

This part makes an overview of the main strategic documents, legal frameworks and organizational arrangements at national levels, in the field of disability and social services. It also highlights the way in which different responsibilities are shared, within the social service provision, between central and local authorities, civil society, disabled people organizations, institutes of social protection and other specific agencies.

How do people access social services at community level? The challenge of an outdated gate-keeping system (2.2)

Gate-keeping mechanisms in the sense of this report, are defined as "the system of decision making that guides effective and efficient targeting of services" for people with disabilities and other vulnerable groups*. If organised effectively, they provide information and referral procedures that help people to access the most adequate service for their needs, in the shortest time possible.

In South East Europe, referring people with disabilities to community services was (and still is) predominantly a medical-based procedure. At present, several SEE countries acknowledged the urgent need for change in this domain and they started to reform the gate-keeping procedures either at macro level (of needs assessment and planning at local level), or at micro level (of the person with disability himself/herself), by revising the referral criteria and the general assessment of the disability situation of each individual. The sub-chapter 2.2 presents these recent evolutions.

What kind of services spectrum is available for people with disabilities in South East Europe? (2.3)

Widening the spectrum of sustainable and quality services at local level remains the key focus of national reforms. The chapter 2.3 looks at the panorama of these services in different countries of the region, considering that their comparative description is relevant for local stakeholders in order to avoid unnecessary hesitations and blockages during the process further on. The various types of services are presented in accordance with the articles of the UN Convention on Rights of Persons with Disabilities: education, health care, habilitation and rehabilitation, supported living and independent living, access to employment.

Delivering services – new mechanisms are needed for progressing towards quality and better governance (2.4)

This sub-chapter deals with several regulatory mechanisms that are in a process of transformation (or under construction), in order to allow the existence of a plurality of social service providers in South East Europe, as well as to improve the quality of these services: licensing and accreditation, introduction of quality principles and standards, the development of internal regulatory procedures at the level of providers, as well as the creation of an integrated system of information and feedback at the national level.

New roles of local authorities emerge in the process of social service provision (2.5-2.7)

While decentralization is progressing in the region, in the field of social service responsibilities (subchapter 2.7), new funding mechanisms are required, especially for non-profit providers (subchapter 2.5) as well as adequate monitoring and evaluation procedures, in a context of welfare mix (subchapter 2.6)

A new place for users of social services, in all stages of decision making (2.8)

In South East Europe, users of social services are not yet actively involved in all types of decision making related with the provision of social services. However, several steps forward have been taken, mostly at the ‘macro level’ related with the planning and mapping of services, as people with disabilities lobby for new types of services and legal frameworks and become more involved in community planning processes.

The number of professionals and qualifications needed in the social and medico-social sector remains largely insufficient in the region. Several professions emerged only recently (e.g. job coaches/mediators, personal assistants), some are almost non-existent (e.g. occupational therapists). Complex settings are needed at national levels for the initial and continuous training in these new domains as well as for the official recognition/certification of new professionals.

PART III – Key conclusions and recommendations

Monitoring the change in South East Europe

This part starts with a retrospective look on the progresses done since 2004, the date of the report "Beyond De-institutionalisation: the Unsteady Transition towards an Enabling System in South East Europe". It revisits the recommendations of this previous report and highlights the stage of their implementation.

Key directions for improvement in the field of social services: an issue of shared responsibilities

A list of needed interventions is also summarized for the upcoming period that will require particular attention and strong commitment from all stakeholders involved in the reforms: authorities and policy makers, people with disabilities as users of services, service providers themselves, along with donors, media, civil society organizations, universities and training providers, research institutes and statistic agencies, international agencies etc.

The recommendations focus on: the enlargement of the services spectrum, the elaboration of a coherent and articulated framework of regulatory procedures, building capacities at local level for increasing the speed of the sector's modernisation and better governance.
In 2004 Handicap International launched, in the frame of the Disability Monitor Initiative, its first regional report called “Beyond De-institutionalisation: The Unsteady Transition toward an Enabling System in South East Europe”. This report offered a wide panorama of the situation of people with disabilities in this region, in countries characterized by a complex transition phase in the 1990s, due to the end of communist regimes and to the Balkans wars. In that respect, Handicap International pointed out the fact that the legacy of the old system was causing resistance to the establishment of community-based and inclusive systems of services for people with disabilities. The de-institutionalisation process had started in several countries of the region, but was still "unsteady and uneven, being rather the sum of isolated initiatives than the coordinated implementation of a comprehensive and coherent strategy". Good practices and pilot services were emerging as well, but without long term sustainability, due to a lack of holistic and coherent strategies for the development of services at national levels.

During the last four years, significant changes took place in the region in the field of social services. The reform of social services sector (within the most general reforms of social welfare systems) has became progressively an acknowledged priority for the governments in South East Europe, as well as for all the other stakeholders involved in the disability sector: people with disabilities themselves and their representative organisations, the social service providers and the local authorities and decision makers.

This change process is strongly connected with a progressive "shift in paradigm", both in terms of disability perspective at large, but also with regards to the general way of providing services in communities: from a centralized, paternalistic and medical model of service provision towards a social and holistic approach, in which the respect of human rights becomes an overarching requirement; shifting from segregation towards inclusion, from focusing on the disability towards recognising the abilities of people in all aspects; from considering people with disabilities as patients or passive beneficiaries of services, towards a new perspective of citizens, who have the right to access (and choose) mainstream community services like everybody else.

The purpose of the report

The current report aims at examining the ways in which policies and practices evolve in the social services sector in South East Europe, as well as the impact of this change process on the lives of people with disabilities. It aims at identifying the main stakes, priorities and steps forward that should be undertaken in order to modernize this sector in an effective and sustainable way. The report is therefore a “picture in motion” of a complex transitional stage, describing a wide laboratory of social change.

The report reviews the progress of what is usually called ‘services addressed directly to persons’ (or ‘personal social services’, in other European documents) and does not refer to social security schemes (cash transfers, allowances, financial arrangements for people with disabilities).

---

2 The report presents the situation of social services for people with disabilities in the following South East European countries: Albania, Bosnia and Herzegovina, Croatia, FYR Macedonia, Montenegro, Romania, Serbia, and Kosovo (UNSCR 1244). The terms ‘region’ and ‘regional’ will refer therefore to these countries/locations in the current report.
The structure of the report

Part I presents a general overview of the conceptual framework of social service provision, in relation with needs of people with disabilities: the main stakeholders and their corresponding roles, the spectrum of services that is needed at community level, the chain (and the roles) of regulatory mechanisms, the importance of services’ coherence, continuity and sustainability, at local level.

Part II examines the existing policies and practices in the region and illustrates the various aspects of the ongoing change process. It highlights the challenges and complexity of the transition process, since South East Europe is a region where the de-institutionalisation of people with disabilities, the decentralization and diversification of social services at community level are taking place simultaneously.

Part III presents the main conclusions and recommendations of the report for the further stages of the reforms in the region.

The methodology

The first part of the report was developed in 2005-2006 and is originating from a series of research, field projects and comparative analysis carried out by the regional staff of Handicap International, with the active participation of local partners and organizations. In 2006, Handicap International proposed a specific working paper, focusing on the importance of a comprehensive regulatory system in the field of social services, as a key element for change and better governance. During 2006-2008, this conceptual framework has been analysed and discussed with a large number of stakeholders in South East European countries. Numerous workshops and seminars, at both national and regional level, have been conducted in this period (with more than 400 participants involved), highlighting the discrepancies between legislations and practice, the need for urgent reform and modernisation, as well as the need for a better access of people with disabilities to community based services. Part I is therefore an overview of this general framework related to social service provision, as it was proven to be significant for people with disabilities in South East European countries.

The regional work of Handicap International in South East Europe, through a wide number of projects and local initiatives, allowed during the years for an additional observation of the particularities and evolutions of these services, in the daily practice. For elaborating parts II and III, a considerable number of field visits, interviews, local consultations, focus groups, country briefings and legislative reviews have been done in 2006-2008. The aspects that are chosen and illustrated in detail in the second part represent those elements that have a significant impact on the transition process in this part of Europe:

- the reform of the gate keeping systems,
- the emergence of new types of services and providers delivering social services at community level (non-profit, informal or for-profit providers);
- the corresponding regulatory mechanisms and procedures that start to be developed in each country,
- the development of new professions and qualifications in the social and socio-medical sector,
- the new roles of local and central authorities in a mixed model of social service provision.

Considering the further monitoring processes in the region, the spectrum of community based services is described with reference to the articles 19-27 of the UN Convention on the Rights of Persons with Disabilities.

Additional attention has been given to the evolutions of social service reforms in Romania, as a country that already passed through the process of EU accession. Its lessons learnt are considered significant for the countries of the Western Balkans. Unfortunately, the timeframe and resources of this project did not allow a similar research and analysis in Bulgaria (EU Member State from January 2007).

Regarding part III, the formulation of conclusions and recommendations starts from the premise that there is ‘no model that fits all national contexts’, especially for such a complex process as the social service provision in the disability sector. However, the access of people with disabilities to sustainable and quality social services in communities, in an inclusive perspective, cannot be guaranteed if certain common elements of reform are not taken into consideration among the countries of the region. The final part invites stakeholders from each country to explore further the particular ways in which these elements can be effectively introduced, implemented and improved at national levels.

A participatory approach has been used in all stages of the research and data collection. More than 150 organisations participated in the various activities of Handicap International, during (and related to) the elaboration of this report. These persons and organisations represent all types of stakeholders, with relevant roles in the reform of social services in the region: people with disabilities and their families or representatives, disabled people

---

4 (a) Axelsson C., Adams L., Granier P., 2004
(b) Granier P., Physical Rehabilitation Services in South East Europe, working paper, Disability Monitor Initiative (Handicap International South East Europe regional office, 2004), www.disabilitymonitor-see.org;
(c) Chiriacescu D., Les mécanismes de régulation des services sociaux destinés aux personnes en situation de handicap, Institut Superior de l’Action Sociale, Université Charles de Gaulle, Lille 3, France (master degree paper, 2005)
organizations, parents’ organizations, professional NGOs, local and central authorities, public and non-profit service providers. The report tries to present objectively their testimonies and perspectives on the change process and to illustrate with examples the challenging steps of this shift in paradigm, in the disability sector.

The subsequent message of the report is that, without falling in the trap of an excessive legalism (in the field of social service provision), a wise regulatory system can serve effectively the transitional contexts in South East Europe. This system should contribute to an improved governance of social services at community level and could promote (if well designed) the involvement of users in all stages of the service delivery process. Understanding the particularities of this regulatory framework, elaborated in a multi-stakeholder approach and adjusted to the countries’ specificities, could be one of the key aspects of a necessary progress towards effective inclusive communities.

To whom is this report addressed?

• **To people with disabilities** as self-advocates, to their families and representative organisations. Handicap International considers that a common (and in depth) understanding of all stakes related with social services provision will provide them with a crucial opportunity to participate more actively and effectively at this unique time of reform. People with disabilities have a major role to play in the planning, evaluation and overall provision of social services at community level. They are the key actors and they need to have opportunities to develop the same understanding and common language as authorities’ representatives, professionals and service providers.

• **To service providers in the social sector** – their active participation in all stages of the reform process is a must. The bottom-up perspective in the elaboration of new legislative documents and regulatory procedures, as well as the constructive use of the good practices provided by them at community levels, require their constant presence at the ‘reform table’. In this context, they need to prove a good understanding of the ‘global picture’ of service provision and to take into consideration the perspectives of all other relevant stakeholders when delivering a specific service in the community.

• **To local and central authorities** that are involved in the overall reform of the social service sector. Their current task is very difficult, complex and challenging. They deal with a sectoral reform, in the time of simultaneous decentralization and de-institutionalisation of disability, in countries affected by deep structural reforms. However, their responsibilities in this domain have nowadays a different weight, since disability is no longer an issue related exclusively to social protection, but is a human rights issue. The shift in paradigm, the legally binding international documents, the community-based and the mainstreaming approaches require from authorities’ representatives a radical change in attitudes and in working methods. This report intends to reflect this change and to highlight the progresses made, together with the main stakes that authorities face in the region.

• **To representatives of international organizations and agencies** acting in South East Europe. Their role in the current process of social services transformation is obviously very important. They are usually the main donors for the transitional stages of these reforms, and often they act as consultants and technical advisors. The experience shows that, when a coherent, participatory and holistic approach is developed in the preparatory stages of the reforms among international actors and with all relevant national stakeholders, its positive impact is evident both in the quality of policy measures and at the level of their implementation. This report advocates strongly for an imperative coordination of the international stakeholders (agencies, donors, technical advisors and consultants) with the national stakeholders, in all actions related with reforms of social services provision.

In conclusion, the report proposes a look on the evolution of social services for people with disabilities in South East Europe, reflecting various perspectives and roles in a period of intense reform. It is a picture of a complex and challenging process of social change. It intends to witness the way in which the disability movement, along with all other relevant stakeholders of the region, progress towards the development of quality and sustainable social services at community level. At the half way of these reforms, the signs of change are rather positive, however many steps remain to be done. The following years will show us if the ‘shift of paradigm’ has really happened, if communities have become more accessible for all, and if the reform of social services sector has improved, for real, the life of people with disabilities in South East Europe. Hopefully, the effective support, the further commitments and coordinated actions of all stakeholders together will achieve sustainably this change.
1.1 SOCIAL SERVICES FOR PEOPLE WITH DISABILITIES – THE ESSENTIAL COMPONENT OF AN ENABLING SYSTEM

There is currently no common definition of social services among the European countries. Handicap International acknowledges the fact that social services can be approached and defined in two ways:

- a narrow sense, implying referrals to services that address strictly social needs of the people (housing, social care services for children, elderly and persons with special needs, participation in social/community life, social security and other types of social protection measures etc)
- a broader sense, referring also to a wider range of services with social function like education, basic health care and access to employment.

In the context of this report, social services cover a large and diversified range of services which are intended to improve the living conditions of the population, especially of individuals and groups that face marginalisation and exclusion. These services are linked to national welfare schemes and are important tools for the implementation of public policies in the field of social protection, non-discrimination, the fight against poverty and exclusion. They are not conditioned by the contribution of the users and their aim is to enhance capacities of individuals for their full inclusion and participation in society. They respond to social needs and social deficits, which market cannot manage, or which can be even generated by the market6.

The States are responsible for ensuring the access of all citizens to social services.

By choosing this perspective, the report focuses on the fact that a large variety of services in communities are impacting on the life of people with disabilities, and all these services have to be accessible to people who need them: early intervention programs, education, day care and rehabilitation services, vocational training and access to employment, housing, primary health care, leisure services, various support services (e.g. personal assistants, assistive technologies, interpreters etc.) as well as social security measures.

Social services are important tools for the reduction of poverty and for the inclusion of people with disabilities. They can provide a framework for exercising human rights (e.g. facilitating the access to education, health care, housing, vocational training), as well as to access more specific rehabilitation or therapeutic interventions.

One of the major transformations ongoing worldwide is related with a change of paradigm in the field of disability: from a medical and protective model to a social and inclusive one, focusing on rights, equal opportunities and full participation of people with disabilities in the social and economic life. The promotion of an enabling system becomes the key aspect for achieving these goals.

---

6 This description is based on the latest communications of the European Commission and the perspective of the European platforms (Social Platform, Eurodiaconia, EASPD among others) that positioned themselves during the last years in order to clarify the role of social services within the “services of general interest”, at European level.

The present report review the progresses of “services addressed directly to persons” and will not tackle the situation of social security schemes or cash benefits for people with disabilities.
The final goal of any social service addressed to people with disabilities is the active participation of the person in the social life. This is why these services often target activities related to social autonomy, the personal development and the individual well-being. Social services cannot therefore always have, like other economic or commercial activities, objective and measurable results in the short term. The monitoring and evaluation as well as the funding of these services must take into account this aspect.

For all these reasons, social services at community level have to be accessible for all citizens, including people with disabilities. They have to be available and affordable for these people. They have to be provided at good quality standards. They have to be organized in a way that reflects the choice and interests of people with disabilities.

This shift in paradigm impacts the sector of social services in South East Europe as well. The development of a wider spectrum of accessible and quality social services for people with disabilities at community level, as close as possible to people’s home, represents currently a major change of perspective for this region. From large residential settings in remote areas to community based services; from the medical and “defectology” approach to a provision of social services based on the respect of human rights, of choice, and real needs of people with disabilities, these changes are ambitious and demanding.

However, the modernization of social services in South East Europe is taking place in a good momentum. At European level, the modernization of social services is ongoing as well, benefiting from the contribution of numerous stakeholders that are significant for the social services sector: the EU, the Council of Europe, the representative European platforms in the social and disability sectors etc. At international level, the UN Convention for the Rights of Persons with Disabilities set the frame for mainstreaming disability in all areas of policy reforms, including social services. Paragraphs 1.1.1 and 1.1.2. present the main trends and frameworks at European and international level, which influence and support the reforms taking place in South East Europe, in the field of disability and social services.

1.1.1 International frameworks in the field of rights of people with disabilities

The UN Convention on the Rights of Persons with Disabilities8 (UN Convention) was adopted by the UN General Assembly in December 2006 (General Assembly resolution 12/13/2006). It marks the first time that the goal of full and equal participation of people with disabilities is legally protected by the international community. The UN Convention clarifies how all categories of rights apply to people with disabilities and how adaptations should be made in order for them to fully exercise those rights. The UN Convention highlights, through different articles, that States must ensure the access to quality services responding to the diversity of needs of people with disabilities.

The Convention came into force on the 3rd of May 2008, following Ecuador’s ratification on the 3rd of April. By December 2008 the UN Convention was signed by 137 countries (from which 81 signatories to the Optional Protocol). 45 countries ratified the UN Convention (from which 27 ratified also the Protocol). The signatories from South East Europe are, so far: Bulgaria that signed the Convention; Croatia - signed and ratified the Convention and the Optional Protocol, FYR Macedonia – signed the Convention, Montenegro – signed the Convention and the Optional Protocol, Romania – signed the Convention and the Optional Protocol, Serbia – signed the Convention and the Optional Protocol.


With a particular importance for the countries in South East Europe as members of the Council of Europe, this Action Plan intends to offer a practical tool for developing and implement viable strategies in the disability sector and for mainstreaming disability throughout all the policy areas of the member states.

According to art. 1.1 (Mission statement) the Disability Action Plan “aims to provide a comprehensive framework that is both flexible and adaptable in order to meet country-specific conditions. It is intended to serve as a roadmap for policy makers, to enable them to design, adjust, refocus and implement appropriate plans, programmes and innovative strategies” on disability for the decade 2006-2015 (http://www.coe.int/t/e/social_cohesion/soc-sp/Rec_2006_5%20Disability%20Action%20Plan.pdf).

---

The Disability Action Plan contains 15 areas in which actions have to be taken and includes specific referrals to people who experience the need for a more specific of support. It is a planning-oriented document that implements the shift from the medical model of disability towards a social and human rights based model in the strategies' elaboration. It is also seen as a basis for cooperation among the 47 member states of the Council of Europe.


This document is one of the results of the European Year of People with Disabilities in 2003, launched in order to achieve a sustainable and an operational approach to disability-issues throughout Europe.

Three operational objectives are central to this framework: achieving full application of the Equal treatment in Employment and Occupation Directive (2000/78/EC), reinforcing mainstreaming of disability issues in relevant Community policies, and improving accessibility for all.

The goal of the Action Plan is to mainstream disability issues into relevant Community policies and develop concrete actions in crucial areas to enhance the inclusion of people with disabilities. As an instrument to support mainstreaming of disability issues in key EU policies, the European Commission will publish a biennial report on the overall situation of people with disabilities in the enlarged EU, taking on board new developments in the Member States. At the same time, the European Commission proposes to reinforce the involvement of stakeholders and key players in the policy dialogue in order to bring about far reaching and lasting changes within the economy and society as a whole.

The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UN Standard Rules) Resolution 48/96, annex, of 20 December 1993 includes: an introduction, a preamble, 22 different rules for promoting the full participation and realizing human rights, as well as a description of the monitoring system of these measures.

The UN Standard Rules are divided into three sections:

- preconditions for equal participation,
- target areas for equal participation and,
- implementation measures.

The legal binding character of the UN Convention, together with the procedural character of the UN Standard Rules create a strong framework for policy measures and action, in relation with the respect and full exercise of rights of people with disabilities.

All types of social (including support) services that are needed at community level are mentioned in the UN Standard Rules text. This document is therefore an important guideline for policy development in this sector.

While the UN Convention "is a legal framework that delineates the rights of persons with disabilities and protects them, the Standard Rules help to describe the specific target areas, procedures and mechanisms necessary to achieve equalization of opportunities. There is a complementary and symbiotic relationship between the Standard Rules and the UN Convention in preserving, protecting and enhancing the dignity, rights and quality of life for persons with disabilities."

Essential documents are also:

- The Convention on the Rights of the Child, 1989;
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979;
- The Universal Declaration on Human Rights, 1948.

1.1.2. International frameworks supporting policy reforms in the field of social services for people with disabilities

The situation of Social Services of General Interest (SSGI) in the European Union

The acknowledgement of the fact that social services contribute substantially to the design of a European Social Model (presented at the Summit of Lisbon, 2000), as well as the impact of the European Union's legislation on the provision of services in general, has brought about significant efforts towards the modernisation and reform of social services. This implies full employment, good quality jobs, equal opportunities, social protection for all, social inclusion, and involving citizens in the decisions that affect them*, cf. European Trade Union Confederation, www.etuc.org.
this sector. Social services of general interest are key instruments to offer every citizen the possibility to fulfil his or her potential. Therefore they have to be universally accessible, and delivered at affordable prices. They constitute as well a significant sector for job creations and economical growth in Europe.

The process of modernisation of social services is taking place in all EU countries and is responding both to changes in society (demographic ageing, new and developing needs of the users) and the need for ensuring the sustainability and efficiency of public funding. The process which currently proceeds in the European countries aims towards ensuring a better quality and effectiveness of the social services, "stressing the prioritisation of the individual needs of the users and fundamental values and goals of society – like social rights, social justice, social cohesion and balanced social and economic development"15.

In a Communication from 200616 on Social Services of General Interest, the Commission resumes this trend, characterizing the process of modernization of social services in Europe as:

- "the introduction of benchmarking methods, quality assurance,
- the involvement of users in administration,
- decentralisation of the organisation of these services to local or regional level,
- the outsourcing of public sector tasks to the private sector, with the public authorities becoming regulators, guardians of regulated competition and effective organisation at national, local or regional level,
- the development of public-private partnerships and use of other forms of funding to complement public funding".

In addition to the 2006 Communication mentioned above, a second document was released by EU in November 200717: "Services of general interest, including social services of general interest: a new European commitment" (Accompanying the Communication on "A single market for 21st century Europe"). This communication emphasizes the importance of social services for social, economic and territorial cohesion, economic growth, a high level of employment and social inclusion. This communication makes an important step further in précising the specificities of social services in the internal EU market:

- the person-oriented character;
- the preventive an socially cohesive role;
- the need for comprehensive and personalized services, conceived and delivered in an integrated manner; the diversity of users;
- the asymmetric relationship between providers and beneficiaries which is different from a commercial supplier / consumer relationship;
- the need for tailor-made solutions taking into account the particularities of the local situation and cultural traditions;
- the guarantee of proximity between the service provider and the user while ensuring equal access to services across the territory;
- the large need for autonomy of the service providers, in order to address the variety and the evolving nature of social needs;
- the strong dependency of social services from public funding; the significant role of non-profit providers as well as voluntary workers in the delivery of social services.

The Communication proposes also a strategy to promote the quality of social services of general interest across the EU, which will aim at:

(a) Developing, within the Social Protection Committee, a EU quality framework providing guidelines on the methodology to set, monitor and evaluate quality standards and,

(b) Supporting cross European bottom-up initiatives aimed at developing voluntary quality standards and promoting the training of public authorities in the field of public procurement.

**The Strategy of Social Inclusion in the European Union**18

Within the framework of the Social Inclusion Process established by EU leaders in 2000, the European Union has provided a framework for national strategy development as well as for policy coordination between the Member States on issues relating to poverty and social exclusion. Participation of actors such as NGOs, social partners and local and regional authorities has become an important part of this process. The key challenges of the strategy by 2010 are the following:

- to eradicate child poverty by breaking the vicious circle of intergenerational inheritance;
- to make labour markets truly inclusive;
- to ensure decent housing for everyone;

---

15 Conclusion of the Conference "Social Services of General Interest in the European Union – Assessing their Specificities, Potential and Needs" Brussels, 28-29th June 2004 (in the document "Key issues to be taken into account and further explored").
• to overcome discrimination and increase the integration of people with disabilities, ethnic minorities and immigrants;
• to tackle financial exclusion and over-indebtedness.

Several other international documents refer to the importance of social services (and especially community-based social services) for the inclusion process and the participation of people with disabilities at social and economic life:
• The Council of Europe Directive 2000/78/EC of 27 November 2000, establishing a general framework for equal treatment in employment and occupation;
• The Madrid Declaration (2002) issued at the European Congress on Disability
• The Resolution of the Council and the Ministers for Education meeting with the Council of 31 May 1990 concerning integration of children and young people with disabilities into ordinary systems of education
• The Resolution ResAP(2001)1 on the introduction of the principles of universal design into the curricula of all occupations working on the built environment ("Tomar Resolution"), adopted in 2001,
• The Salamanca Statement on Principles, Policy and Practice in Special Needs Education 1994, UNESCO.

1.1.3. The right balance between the provision of mainstreamed and specialised services – a twin track approach

One of the specific aspects of the social services for people with disabilities is the need for the right balance between mainstreamed services and specialized ones provided at community level, within a so called twin track approach.

This concept, already acknowledged and used in many other policy areas (gender related policies, children’s rights etc.), was promoted in the disability sector by DFID in 2000. The twin track approach affirms the necessity of mainstreaming disability effectively in all development and policy making initiatives and, parallel to this, support additional initiatives that address the specific needs faced by some people with disabilities, as well as empowering individuals and DPOs in order to achieve the people’s participation and inclusion.

This approach promotes that all community members, regardless of their position or abilities, have the opportunity to reach a full participation in the community life through adequate measures taken by their community.

Following a twin track approach in the social services sector should allow for the promotion of a wide network of community based social services, complementary one with another, to ensure a so called ‘continuity of care’, aiming at social inclusion of people with disabilities. It is a useful approach for South East Europe in order to eliminate the false questioning (and the reductionist choice) of either mainstreamed or specialized measures in the field of social services for people with disabilities. In an inclusive community, all types of services that lead to participation of people with disabilities, and the full respect of their human rights are equally needed:

The access of people with disabilities to mainstream services in the community (education, health care, vocational training and employment, housing, social services and social protection) is a fundamental right, as for any other citizen. These services should become inclusive and accessible for all categories of citizens, persons with disability among others. As will be described in the following chapters, the transformation of ordinary services, in line with these new objectives and perspectives, represent a major priority for the region.

Fig. 1 Twin track approach in disability-related services, towards an inclusive community

In order to facilitate this process, a specific category of social services is generally developed in the disability field called support services; they aim at enhancing the self-determination and participation of people with disabilities in society by providing for equal opportunities. Their main role is to support the access of people with disabilities to various services and resources of the community. The support services are key elements for mainstreaming disability and include for example: the provision of ortho-prosthetic and assistive devices, personal assistant schemes, support teachers for accessing education in regular schools, support persons and mediators for accessing regular employment, interpreters for persons with sensorial disabilities, accessible housing or home adaptations, in-home support for independent living etc.

The specialised services are an extended category of social services, also needed, in order to address sometimes more complex needs of persons with severe/multiple disabilities. They have to be provided in the community as well, based on a person-centred and inclusive approach, respecting the choice and interests of the users and their families. The specific rehabilitation services, the residential care in small family-like settings, the respite care units, the sheltered workshops, the specialised day care centres for persons with complex needs and high level of dependency, are few examples of the services that should be developed at the community level, for responding to these specific needs of some people with disabilities.

Several examples of mainstream, support and specialized services for people with disabilities are presented in Annex 1.

1.1.4. Continuity and comprehensive spectrum of services

The twin track approach is linked, in the disability sector, with the concepts of “spectrum of services” and of a “continuity of support”.

The spectrum of services required at community level means that a large variety of measures have to be developed simultaneously, in order to realise the rights and address the needs of people with disabilities. Since social services have to respect a clear person-oriented character, the changing and various needs of people with disabilities, throughout their lifetime, determine the necessity for a wide variety and typology of services: from early intervention to educational services, health care and rehabilitation, vocational training and access to employment, day care, housing, support services, leisure and travel-related services etc. Each of these services covers a specific part of the life span of people, enabling them to participate actively in all aspects of socio-economic life.

Figure 2 proposes a graphic illustration of this important aspect of disability services at community level, highlighting the importance of support services all along the spectrum. As will be shown in the next chapters, the enlargement of this services spectrum represents a major challenge for the reform processes in the region.

Fig 2. Spectrum of services that are needed in communities, for people with disabilities

The continuity of support refers to a specific requirement in the disability service sector. It means that between all services provided for people with disabilities, strong functional and informational links have to be developed, allowing the person to benefit from appropriate services during all stages of life. This requirement is particularly important at the passage from one age cycle to another; from the primary to the secondary school, from the childhood to adulthood, from the educational stage to employment, from employment to retirements, as well
as when the person needs different categories of services simultaneously (like education and rehabilitation, for example). At these passages, from a cycle to another, specific support services might be needed additionally. This particularity of the disability service sector is very important to be considered when designing the national system of regulatory procedures for social services.

### 1.1.5. 4 A’s in social service provision for people with disabilities

The following parameters are often used as general principles (and sometimes good governance indicators) for a modern social service provision, in the disability sector at European level. They are also known as the "4 As" of social service provision and they summarize in an accurate way the main characteristics of a qualitative system of services at community level:

1. **Accessibility of social services** - Services can be accessed and used by all citizens who need them.
   
   In the context of this report and of social service provision in general, the accessibility has to be considered in a broad and multi-layered sense; it includes the reference to the services’ availability and affordability (the next two parameters described in this paragraph). In South East Europe, making community services accessible for people with disabilities represents a major stake and challenge. This aspect involves not only a transformation of the built environment (as usually considered in the region), but also a reform of the referral and information systems – the gate keeping mechanisms – the correct assessment of people needs, the local assessment and mapping of existing and needed services, the reform of the funding and cost calculations per service etc.

2. **Availability** - Services exist and are available when needed.

   This principle plays an important role in South East Europe: people with disabilities in the region often lack access to adequate services at community level due to simply not being available, both in terms of geographical coverage and typology. Developing new services and ensuring that all others are available represents a priority, which includes new technical and financial resources, as well as additional professional qualifications and staff.

3. **Affordability** - Social services must be provided for free, or have an affordable price for all citizens who need them.

   This refers to all measures required to allow marginalised populations a financial access to social services at community level.

4. **Accountability** - Service providers are financially and organisationally transparent.

   This principle refers not only to the transparency of the financial management of the service but also to the overall organisation of the service: clear manuals of policies and procedures, internal regulations, and qualitative and transparent human resources management etc.

In addition to these 4A parameters, the **good quality** of the service (analysed against quality principles and related standards), its **sustainability** and the **continuous improvement** represent further elements for good governance in the social services sector.

In terms of advocacy message, the most common expression summarizing these important requirements is the one that promotes the “development of qualitative and accessible social services at community level” since these two key (overarching) aspects are often used for incorporating all other parameters described above.

### 1.1.6. The overall approach to disability

When discussing the way in which social services should be designed for people with disabilities, it is important to refer to the implicit disability approach that is considered. This will be reflected further on in all aspects related to policy design and general organisation of services: from planning to concrete delivery and evaluation.

There is an active process towards putting this new perspective into practice as well as towards mainstreaming of disability, which is about disabled people participating at all levels of society, without facing any barriers. Mainstreaming means that: “the needs of disadvantaged people need to be taken into account in the design and implementation of all policies and measures, and that action for disadvantaged people is not limited to those policies and measures which specifically address their needs.”

A holistic and comprehensive perspective on disability, created in Canada by Patrick Fougeyrollas and his collaborators, called **The Disability Creation Process** (sometimes named also as the ‘Quebec’ model of disability) contributes significantly to a comprehensive understanding of the disability situations, in a social perspective. This model enables to implement services, research, professional trainings and advocacy with a social approach to disability. It classifies the components of disability creation process from an anthropological, holistic and cultural perspective.

---

20 Discussion Paper of the EU Disability High Level Group, on “Disability mainstreaming in the new streamlined European social protection and inclusion processes” (October 2007), page 1, http://ec.europa.eu/employment_social/index/good_practis_en.pdf (see also Annex 2)

1.2. STAGES OF THE SOCIAL SERVICE PROVISION AND THE SYSTEM OF REGULATORY MECHANISMS AND PROCEDURES

1.2.1. Stages of social service provision

It is difficult to talk about developing an effective, quality social service, if equal attention is not paid to the planning, direct provision, monitoring, evaluation and improvement of that specific service.

Similarly, from a macro perspective, an efficient system of social services, at national or local level, will be achieved only if planning, coordination, monitoring and evaluation of the system are regularly carried out.

These phases of the service delivery, as well as the more general provision process, can be described using the 'PDCA cycle' (plan-do-check-act)\(^{22}\). This model (known also as the “Deming wheel” or “the continuous improvement spiral”) illustrates very well the stages of all service provision processes:

**Fig. 3. The PDCA cycle (the Deming wheel)**

![PDCA cycle diagram]

- **PLAN**: Plan ahead for change; analyse the context and predict the results. Establish the objectives and processes necessary to deliver results in accordance with the relevant specifications.
- **DO**: Execute the plan, implement the service or the process.
- **CHECK**: Monitor and evaluate the results against the initial objectives;
- **ACT**: Take action to improve the process, before the next cycle or implementation.

Once the accomplishments of an implementation cycle are stable, the next cycle can start again and the previous results can be standardized or capitalized.

In the social services sector, this simple model is very useful, because it helps to analyse better the different steps of the provision process, at both national and local level, as well as at the level of the social service provider itself.

At all these levels there are specific agencies or persons in charge of planning, implementing, evaluating and improving the provision (respectively the concrete delivery) of social services.

In addition, this model facilitates the design and elaboration of regulatory mechanisms and procedures that ensure a qualitative and coherent provision of the services. For each of these levels of intervention, a specific set of ‘regulatory measures’ exists, in order to control the process and to coordinate the action of different stakeholders or agencies. These regulators exist at both macro level (of the community, or of the system of social services) and at the micro level (of the specific service itself).

1.2.2. Three main stakeholders are involved in the social service provision process:

- **The users of social services** are persons with disabilities (and eventually their families or legal representatives);
- **The social service providers** are both public and private;
- **The State**, which usually plays a regulatory role, together with a role of service provider in some countries.

**Fig. 4 Main stakeholders involved in the process of social service provision**

---

\(^{22}\) The so called ‘PDCA cycle’ is a model for quality improvement, described by the American statistician W. Edwards Deming in the 1950’s, in relation with the total quality management (TQM). His model consists of four repetitive steps used for continuous improvement and learning. In the 20th century, the model was widely extended in several other fields like project management, human resources management, processes analysis, continuous development etc.
There are many other actors who usually intervene in the process of service provision (donors, legal advisors, disability activists etc), however these three categories mentioned above are the key ones, especially from the perspective of the regulatory system that governments need to design in each country.

State actors usually refers to:
- central authorities (ministries, central commissions, national inter-sectorial committees etc.);
- local authorities (either deconcentrated bodies of the ministries – like school inspectorates, Centres for Social Work, Local Directorates for Health etc. – or local elected authorities).

Social service providers are usually grouped in 4 categories:\[23\]:
- Public providers (public agencies, institutions, professionals);
- Not-for profit organisations providing social services (NGOs);
- For-profit companies providing services;
- "Informal" providers (like families or volunteers).

The last three categories can be grouped under the label of "private providers".

Users of social services, in the disability sector, are:
- Persons with disabilities (children, adolescents, adults and elderly);
- Persons with disabilities who are facing multiple vulnerable or at-risk conditions (poverty, gender or ethnic-related discrimination, people affected by HIV and AIDS, people who are exploited or abused etc.);
- Families or legal representatives of persons with disabilities.

In general, in the commercial or business-oriented services sector, the laws of market economy govern the offer and the demand. The business or companies offer services that are asked for by consumers and for which the consumers are ready to pay. As such, one can say that offer and demand for commercial services are self-regulated.

In the social sector this direct regulation is not possible. The reason is simple: the users of services are not always paying for social services. In this context, the State usually intervenes as a regulatory body, and ensures that the offer and the demand for social services are coherently balanced at local and national level, in relation with the rights defined in it national legislation, the public resources and with the real needs of people.

The State becomes a regulator of the offer and of the access to social services.

The public authorities (at central or local level, depending on the organisation of the system of services in each country) receive specific demands from people with disabilities, in relation with the services they need at community level.

The authorities also map and centralise the offers of services, from the level of both public and private providers.

The next chapters will demonstrates how these relationships between the three types of actors are connected to the design of the regulatory systems in each country.

In order to fulfil its regulatory role, the State should design transparent regulatory mechanisms for each type of relationships with the stakeholders. When regulating the demand, State usually establish gate-keeping procedures at local and/or national level; when regulating the offer, State is developing licensing and accreditation procedures, quality standards, contracting and funding procedures, monitoring and evaluation procedures etc.

---

\[23\] As presented by Brian Munday in the study ‘European Social Services – A Map of Characteristics and Trends’ (Council of Europe, 2002)
1.2.3. The regulatory mechanisms and procedures

In South East Europe, the introduction of a coherent system of regulatory mechanisms and procedures for social services represents one of the key aspects of the reforms. For this reason, the report pays specific attention to their description, in this conceptual framework of social service provision.

In this report, regulatory mechanisms in the field of social services are instruments meant to control, coordinate and improve social services, both at macro and micro level. They are a lever for developing quality, accessible, available, accountable, affordable social services for all citizens, including people with disabilities.

From a country to another, the regulatory framework can be designed differently, however its overall role is to ensure that social services cover the real needs and ensure the rights of the population, and that they are provided in an effective and efficient way. Each of the three main stakeholders who are relevant in the process of social services provision (users, providers and State) plays a different role in this context. The figure no. 7 illustrates these roles, as well as the place of regulatory mechanisms and the different responsibilities covered by central and local authorities in their definition and implementation.

The regulatory mechanisms are represented by thick arrows. Their role is to coordinate: the access of users to the system of social services, following their needs and demands, the offer (supply) of services according to these needs, as well as the concrete delivery of social services, respecting essential principles as quality, accessibility, accountability, and affordability for all users who need them.

Fig.7. Main stakeholders involved in social service provision, and their roles in the definition and implementation of regulatory mechanisms

The authorities are at the same time:
- the guarantor of ensuring fundamental human and social rights of all citizens;
- the recipient of the expressed needs of the population, in terms of social services;
- the guarantor of qualitative provision of social services, in accordance with these needs and through a regulatory frame that applies both to public and private providers at the community level.
The regulatory mechanisms are presented further on within the frame of delegation of public services or social services under a public mandate. This frame allows for the existence of multiple types of social service providers, contracted by public authorities in order to cover the need for services at local level (the welfare mix). Both private and public providers can be coordinated and monitored under the same scheme, using the same regulatory procedures. In this case, the provision of social services is delegated to different local providers, private or public. The frame of social services under a public mandate is currently used in many countries of the EU and it has contributed to a continuous improvement of the network, the spectrum and quality of the social services during the last 30 years.

The main regulatory mechanisms and their corresponding procedures can be categorised as following:

| THE GATE-KEEPING MECHANISMS (Referral, information and direct access to social services) | At the level of the general system of social service (macro):  
• Needs assessment (which types of services are needed to ensure fulfilsments of rights)  
• Elaboration of territorial maps of needs and services  
• Defining national access criteria to social services  
At individual level (micro):  
• Assessment of the individual situation  
• Decision making and orientation to community services |
| QUALITY-RELATED MECHANISMS (Quality principles and/or standards) | • General principles (rights based, values and non-prescriptive standards)  
• 'Technical' standards, taking into account more specific quality requirements for different categories of services |
| CONTRACTING AND FUNDING MECHANISMS | • Call for offers/tenders/project applications for social services at local/national level  
• Licensing/authorisation of social service providers  
• Purchasing and contracting of social services at community level  
• Funding of social services at community level |
| THE INTERNAL REGULATORY MECHANISMS (at the level of the service provider) | • Internal regulations (human resources, relations with users, safety regulations etc.)  
• Quality management and improvement procedures;  
• Strategic planning procedures and follow up;  
• Internal and external communication procedures ;  
• Evidence-based decisions and measures etc.  
More generally: manuals of policies and procedures. |
| MONITORING AND EVALUATION MECHANISMS | At macro level (the system of social services at local level)  
• Monitoring of social service provision at local level  
• Periodic evaluations and articulation with the gate-keeping system at macro level;  
At the level of service providers (micro)  
• Internal evaluation of service providers (self-evaluations)  
• External evaluations of the social service  
• Auditing and control procedures  
• Regular monitoring of service delivery. |
| THE OVERALL SYSTEM OF INFORMATION AND FEEDBACK | • Data collection and flow of information that ensures the transparency of the system at all levels, and facilitates decision making and planning. |
A detailed illustration of the links between regulatory mechanisms and procedures is presented in figure no. 8:

**Fig.8 The chain of regulatory procedures in the process of social service provision for people with disabilities**
(1) The gate-keeping mechanisms

In this report, gate-keeping mechanisms are defined as *the system of decision making that guides effective and efficient targeting of services* for people with disabilities and other vulnerable groups.

Gate-keeping mechanisms control the balanced distribution of social services at the territorial level, in accordance with the real needs of users. In this report, the gate keeping system is presented as a combination of assessments and decision making procedures, targeting both the individual (micro) level and the local territorial (macro) level.

The process of directing people towards adequate resources in communities requires several key elements:

- an agency responsible with the assessment of people's needs,
- a system of procedures and rules for directing people towards community services,
- a chain of existing services and resources that respond to these needs;
- a flow of information and data that allows redirection of resources and adjustments in decision-making, in accordance with people's needs and choices.

The main procedures of the gate-keeping system are:

**A. The needs assessment at administrative level (community, department, other relevant administrative unit)**

In order to be effective, social services have to address the rights and respond to the real needs of the population. The evaluation of these needs of services (in terms of diversity, number, availability and quality of services) contributes to an efficient distribution of existing public resources, allocated for sustaining and/or developing the most important social services at the local level.

*Example:* For similar needs of the population, the distribution and organisation of social services could be different in rural and urban areas. Additional transportation means could be needed in rural areas as well as an increased number of mobile teams of professionals.

This is the reason why the needs assessment is a procedure organised at the territorial level (region, department, municipality) and is usually coordinated by the public authorities.

The aim is to identify and collect the demands for specific services in the respective territory. In order to obtain this overall information, all stakeholders involved in the gate keeping system (evaluation and referral commissions, service providers, local agencies for people with disabilities (if they exist), DPOs, municipalities for example) should periodically produce statistical data and information, centralising the needs for social services. In Europe, this procedure represents a good instrument of planning the regular allocations of public resources.

**Implementation particularities for the needs assessment:**

- In order to become effective at local and national level, the assessment of users’ needs and the data collection in all territorial units of the country/entity/location should be realised with similar standardised forms (while still taking into consideration that people with disabilities are not a homogenous group and that the regions have geographical differences);
- Since this procedure requires a final centralisation of the collected data, the European countries that already apply this procedure tend to give the overall responsibility for its implementation to a single body or authority, at the local level;
- The presence of the users’ representatives and/or DPOs in these evaluation bodies (committees) is imperative.

**B. The territorial maps of social services and needs**

In strict correlation with the needs assessment at local level, some European countries use the so called “mapping of social services”, which is an important instrument for planning and regulating the supply of services.

The territorial maps are charts of the existing and the needed services, renewable within specific intervals of time (3/5 years). Any proposal for opening new services, or for extending the existing ones, should be analysed in relation to these territorial charts. They ensure a coherence of service provision and a good “barometer” for priorities and necessary adjustments in the system.

**Implementation particularities for the mapping of services and needs:**

- The elaboration of territorial maps of services is a procedure with a significant political weight. Since the strategy for investment and allocation of resources for the network of social services depends on this key information, all relevant stakeholders should contribute equally to the implementation of this procedure.

*In France, for example, a large number of stakeholders are part of the elaboration and finalisation of the services maps. The responsible body for achieving this task is a regional commission with a high representation of all stakeholders involved in the service provision: service providers, authorities, users representatives, DPOs, unions of workers etc.*

---

24 Bilson, A., Harwin J. “Gate keeping services for vulnerable children and families”, (Florence: UNICEF Innocenti Centre and the World Bank, 2003), p.11
25 Ibid, p.6
C. The access criteria for social services

The criteria for referral of people with disabilities to various social services in the community are crucial elements for the efficiency of the system. The choice of these criteria (as well as their correlation) plays a major role for respecting several fundamental principles in social services provision:

- user’s right to choose (regarding the type of service and of the intervention that the person will benefit from);
- equal opportunities and rights for people with disabilities to access mainstream services;
- adequacy of service provision to the users’ expressed needs and interests.

Within the framework of these referral procedures, the users and/or their representatives have to play an active role in the selection of the service. They must have equal access to, and a comprehensive picture of, the different options possible, together with information on their rights and responsibilities. In terms of concrete implementation of this mechanism, the most important element is to guarantee the possibility of choice, also for persons with disabilities with more complex dependency needs.

The access criteria are closely linked with the disability definitions in the national legislation (both specific laws on disability and mainstream legislation), as well as with different classification systems used in the disability sector (ICF, DCP model etc.). A good understanding of these classifications and their related tools is significant during the reform of the gate-keeping system.

D. The assessment of the user’s individual situation and the orientation towards adequate social services

These procedures are closely linked with the access criteria mentioned above. The assessment of a person’s needs is primarily intended to lead towards the right choice of adequate services at community level, mainstreamed or specialised, in order to address these needs and improve the person’s participation in the daily life.

The definition and organisation of these assessment procedures play an important role in the mainstreaming of disability at community level. All existing community services should become accessible for people with disabilities. The assessments of needs should be therefore linked more with finding the adequate support for users, rather than orientation of persons towards one service or another.

E. The integrated system of information and feedback

Users and referral agencies, as well as the social workers and assessors, should keep themselves updated about the existing social services in the community, the legislation and rights of people with disabilities, as well as the particularities of each type of service delivery. An effective gate-keeping is strictly correlated with the existence of an integrated system of information and feedback. The adequate flow of information among gate-keepers, rights holders and service providers contributes to better decision making, together with the respect of user’s best interests.

(2) The quality systems

These regulatory mechanisms guarantee the required level of quality for the services needed by people with disabilities.

The delivery of services has to be analysed from a quality perspective, in order to prevent abuse, negligence and lack of respect of the users’ rights and interests. The choice and definition of quality principles, standards or indicators is one of the key steps within the construction of an efficient regulatory system.

In the concept paper called “Improving standards of child protection services” (UNICEF and World Bank, 2003), Andy Bilson and Ragnar Gotestam mention that “quality standards provide a set of criteria that can be used to monitor the management and provision of services, the quality of services as well as their outcome. They ensure equitable and transparent transfer or delivery of services to the beneficiary”.

The quality standards can be grouped in two different categories depending on what is being assessed:

1- Taking into consideration their degree of generality, two types of quality standards can be described:

   • general standards (often formulated as principles) – which reflect general criteria of good governance, applicable to a broader category of social services; quality principles are not prescriptive and can be reached in various ways;
   • technical standards (used for specific fields of action or services) – indicators or requirements that are usually detailed for each specific procedure that occurs within a service. They can imply as well: environmental standards (related to the description of the external conditions of organisation of space etc.), and specific management standards etc.

2- If considering the performance criteria, two types of indicators are usually identified: minimal indicators vs. excellence performance indicators:

   • minimal indicators guarantee a minimum level of good quality for the respective service – these minimum indicators are compulsory for all services providers and they condition the licensing of the service;
   • excellence indicators reflect a high level of quality in services provision; they are usually optional and are used especially within the framework of the procedures of accreditation and benchmarking.

---

26 ICF - International Classification of Functioning, Disability and Health (World Health Organisation, 2001);
DCP - Disability Creation Process (Fougeyrollas and collab., INDCP Quebec, 1999).
Shifting the Paradigm in Social Service Provision

One of the most interesting processes related to the modernisation of social services in Europe is the re-evaluation and design of national standards in this field, trying to balance and harmonise these types of quality indicators (see also Box 1)

**Implementation particularities for quality systems (principles/standards):**

- An important observation to be made is that the development of the quality standards should not lead to a ‘standardization’ of service provision. Even if the formulation can induce confusion, it is obvious that, in the social field, the person-centred approach requires a great flexibility on behalf of the service provider. This is not contrary to the introduction of quality principles and/or standards. Their degree of generality, their content and formulation must allow the balance between flexibility and the obligatory level of quality for the respective service.
- Another important concern related to the standards is their adequacy to the local culture. All standardised procedures have to be appropriated quickly by teams of professionals, for an easy translation and implementation in the daily work. A high level of requirements for the minimal standards, or the rapid introduction of completely new principles into the provision of the service, could produce confusion or side effects.
- Directly related to this aspect is the training of professionals (the frontline workers) and the training of evaluators/assessors. Any application of a new set of standards in a social service requires a preparatory training of these two categories of stakeholders. They are the first to understand the guiding principles of the required standards, the modalities of translation of these principles into concrete actions, the effects and the impact of these procedures on the user’s life.
- In the majority of European countries, the introduction of the quality standards was preceded, with good results, by a pilot phase of experimental application, in order to measure the side effects, the positive impact and the appropriating of the proposed procedures with the expected results.
- The national character of the quality standards is an important requirement to be considered. The minimal quality standards have to be respected by all providers at national level, in order to ensure a balanced provision of quality social services for all citizens of the national territory. This aspect highlights a political, coherent option on the whole national territory, complying with the fundamental principles required for the respective sector. In this way the State guarantees the same approach in the field of social services, with respect to the users and their interests, both in public and private services.

The elaboration of quality principles and standards at national (and not local) level has also another role: the prevention of using the set of standards for the benefits and the particular interests, at local level, in the decentralisation framework, especially if considering the important role of the local authorities in the later procedure of licensing and allocation of the resources for funding of service providers.

- The quality standards or principles have to be developed with the possibility of a periodic revision, in order to facilitate their continuous and progressive improvement. In other words, the legislation should allow flexibility in the standards revision, according to societal changes and the evolution of the service provision itself. It is also necessary to continuously adapt the standardised requirements to the current professional practices. As the necessary change of disability paradigm described earlier in the report, the evolution of quality standards and principles in social service provision requires a continuous progress of what is acknowledged as being ‘standards of good practice’.
- Users and/or their representatives should be involved in the initial definition and design of the standards’ system, as well as in the quality evaluation in all phases of service provision.

**BOX 1**

**Quality systems in European social services for people with disabilities**

The continuous improvement of quality in social services became in the last years an increasing priority for many stakeholders involved in the evolution and modernisation of this sector in Europe, from the European institutions to public and national governments, private providers and people with disabilities themselves. It is the effect, on one hand, of the increased plurality of provision in social services – the welfare mix, and on the other hand an effect of the market competitiveness and the new approaches regarding cost effectiveness. It is also a reflection of the need to have a reference for what is commonly understood as good practice.

At EU level there is currently an expressed focus on the elaboration of common features and criteria of quality, which could be transferred at national levels through quality systems, according to national contexts and respecting the subsidiary principle. In the EU’s last Communication on services of general interest 27, it is mentioned that the European Commission “will support the development, within the Social Protection Committee, of a voluntary EU quality framework providing guidelines on the methodology to set, monitor and evaluate quality standards. Moreover, via the PROGRESS programme, the Commission will support cross-European bottom-up initiatives aimed at developing voluntary quality standards and exchange of experience and will promote training of public authorities in the field of public procurement 28”.

---


28 Ibid, page 13
More, the Disability High Level Group of the European Commission (D-HLG) considers that these common features gathered in European quality systems should also enable service providers in countries where disability services are less developed to enter the system and engage in a quality approach that take them to the appropriate level of quality.

The introduction of quality standards and procedural frameworks in disability-related services is a challenging process:

- There is a need for good balance between formal accountability and standardized requirements, on one hand, and flexibility regarding the delivery of service, on the other hand, in a field that is primarily characterized by adaptability to clients, flexibility in intervention, person-centred approaches;

- A consideration of time factors is needed as well: the results of a ‘good’ service delivery in the disability sector can often occur in a later moment compared with similar services in the community. Many services, especially the rehabilitation-related ones, are provided on long-term basis for achieving lasting and effective results. This aspect has a strong influence on the formulation of principles and standards of quality; they have to take into consideration both outcomes and impact of service provision on the person’s life, and not only the outputs and the concrete implementation elements of that service delivery.

Currently, the majority of European countries design their own system of quality standards or principles. Some countries elaborate standards for specific disability-related services; others include them in broader categories of standards of services.

In this context, some of the most influential quality approaches in Europe, in the field of disability-related services as a part of the social services domain, are the following ones:

**The positioning of the Disability High Level Group on “Quality of social services of general interest (SSGI)”**

(see the full text in Annex 2)

In the context of modernisation of social services in Europe the D-HLG focuses on several common key features and corresponding criteria for quality of social services for people with disabilities:

- Rights (Choice, freedom of choice, self determination, non discrimination)
- Person centred
- Comprehensiveness and continuity
- Participation
- Partnership
- Results oriented
- Good Governance

**The European Quality Principles Framework (EQPF)**

The members of European Association of Services Providers (EASPD) in the 27 Member States of EU have agreed a memorandum on European Quality Principles Framework (EQPF). This document defines measure how to implement and improve quality, supporting the further development of the common features and criteria of quality of social services to people with disabilities and establishing a direct link between quality of life and quality of services. The memorandum highlights the importance of elaborating a common set of quality principles, rather than quality standards, at European level: "Quality standards could be implemented on the national or regional level, but quality principles are the most effective on the EU level. Of course objective and measurable quality standards are needed when developing social services (...) EASPD members are convinced that the best way to ensure high quality service provision in and across Europe is to adopt Quality of Life (QOL) principles as the defining values and to then apply these to specific national and local levels.

The EASPD framework proposes a system based on the following elements:

A) A set of **key values**: Dignity; Equal opportunities; Independent living; Participation in and contribution to society

B) Secondly, EASPD believes that quality of life should be measured against a range of **key domains** so that it fully reflects the range of human experience. These domains must at least include: Emotional well-being; Interpersonal relations; Material well-being; Personal development; Physical well-being; Self-determination; Social inclusion; Equal rights.

C) Third, there are three complementary **indicators of quality** that apply to all these domains: subjective indicators, objective indicators and organisational indicators. Subjective indicators focus on personal responses and rating of satisfaction. Objective indicators focus on a range of external environmentally based conditions. Organisational indicators are essential to ensure efficiency and sustainability of social services.

---


30 Communication from the European Commission "Implementing the Community Lisbon Programme: Social Services of General Interest in the European Union", COM(2006)177 final, 26.04.2006. Modernization of services is resumed by the European Commission in terms of quality assurance, benchmarking, involvement of users in administration, decentralisation of the organisation of these services to local or regional level, outsourcing of public sector tasks to the private sector, with the public authorities becoming regulators, development of public-private partnerships and use of other forms of funding to complement public funding.

31 European Association of Service Providers for Persons with Disabilities, www.easdp.eu

The quality systems developed by the European Platform for Rehabilitation (EQUASS Assurance, Excellence, and Award)\(^{33}\)

Starting from 2000, the European Platform for Rehabilitation (EPR) has developed a set of European Principles of Excellence in Social Services, including the perspectives of Europe's most important stakeholders in the field. On the basis of these Principles of Excellence, the EPR developed three levels of accreditation:

The three levels of certification are based on the same framework and certify three different levels of Quality: (1) EQUASS Assurance, which fulfils the essential quality requirements at European level; (2) EQUASS Excellence (previously called EQR) which encourage quality excellence; (3) EQUASS Award which proves outstanding performance in the provision of services.

All three systems rely on the following 9 principles of excellence, which are translated in specific quality criteria and indicators:

1. **Leadership** - Organisations demonstrate leadership internally, within the rehabilitation sector and within the wider community by promoting positive images, challenging low expectations, best practice, more effective use of resources, innovation, and a more open and inclusive society.

2. **Rights** - Organisations are committed to protecting and promoting the rights of the person served in terms of equal opportunities, equal treatment and equal participation, providing informed choice and adopting non-discrimination and positive actions within their own services. This commitment is apparent in all elements of service development and delivery in the values of the organisation.

3. **Ethics** - Organisations operate on the basis of a Code of Ethics that respects the dignity of the persons served and their families or carers, which protects them from undue risk, that specifies the requirements for competence within the organisation and that promotes social justice.

4. **Partnership** - Organisations operate in partnership with public and private sector agencies, employers and worker representatives, funders and purchasers, organisations of people with disabilities, local groups and families and carers to create a continuum of services and achieve more effective service impacts and a more open society.

5. **Participation** - Organisations promote the participation and inclusion of people with disabilities at all levels of the organisation and within the community. In pursuit of more equal participation and inclusion, organisations work in consultation with representative bodies and groups to support advocacy, the removal of barriers, public education and active promotion of equal opportunities.

6. **Person Centred** - Organisations operate processes that are driven by the needs of both the person served and potential beneficiaries involve users as active members of the service team, respect the individual's contribution by engaging them in self assessment, service-user feedback and evaluation and that value personal as well as service goals. All processes are subject to regular review.

7. **Comprehensiveness** - Organisations ensure that the person served can access a continuum of holistic and community based services, which value the contribution of all users and potential partners including the local community, employers and other stakeholders, and that span from early intervention to support and follow up, delivered through a multi-disciplinary team approach or multi-agency partnership with other service providers and employers.

8. **Result orientation** - Organisations are outcome focused, in terms of both perceptions and achievements, on the benefits to the person-served, their family / carers, employers, other stakeholders and the community. They also aspire to the achievement of best value for their purchasers and funders. Service impacts are measured, monitored, and are an important element of continuous improvement, transparency and accountability processes.

9. **Continuous improvement** - Organisations are proactive in meeting market needs, using resources more effectively, developing and improving services and utilising research and development to achieve innovation. They are committed to staff development and learning, strive for effective communications and marketing, value user, funder and stakeholder feedback and operate systems of continuous quality improvement.

(3) The administrative procedures for licensing (authorisation) and/or accreditation of social services

In the frame of the overall regulatory system, the role of licensing and accreditation mechanisms is to formally recognise the compliance of the provider with the required quality standards and to define a concrete frame of provision of the respective service, for a specific category of users, based on an efficient allocation of resources at the local level.

These procedures have also a function of monitoring the distribution of social services in the territory and their compliance with the existing needs of population.

**Licensing\(^{34}\) (authorisation) is a procedure that attests the right of an organisation to provide a particular service to the users, following the respect of the minimal standards defined by the law.**

\(^{33}\) http://www.epr.eu/index.php/equass

\(^{34}\) The terms “licensing”, “authorization” and “accreditation” are used in this report with their most general senses. However, in some countries the terms are used in different ways: the Romanian “accreditation” of the social service providers is a process related to the compliance with minimal quality standards, and not an optional procedure, like in the majority of the EU States.
Different countries use different terminology for this legal recognition or authorisation of service providers. In this report, the term used is licensing of services, as defined by UNICEF and the World Bank in their series ‘Changing Minds, Policies and Lives’.

The licensing is a certification procedure. Its result is the provision of a certificate or license granted by a local or central agency, for a limited period of time. This certificate guarantees the respect, by the service provider, of the national minimal standards in the respective field of action. The license enables the service provider to implicitly start to receive users within their social service.

The license is generally given to the service provider after an analysis at two levels:

- the adequacy between the service provision and the existing needs of the users, at the local level.
- the compliance with the minimal standards or conditions;

In some countries, like France, licensing is conditioned also by the existing financial resources at the local/central level, since the French legislation stipulates automatic (sub)contracting and funding procedures for licensed service providers.

National practices are very different in relation to this procedure. Romania for example authorizes the delivery of service through separate procedures:

- one that certifies the service provider (accreditation); this procedure is applicable in the same way for all types of social services providers;
- and another for each specific type of service delivered by these providers (licensing).

The licensing procedure does not have to lead though to the automatic contracting and the funding of the service by the local or central authorities. The reverse relationship is however obligatory. All providers that are (sub)contracted and funded by the public authorities have to be licensed.

The license of a service provider is not given for a period that is shorter than 1 year but can be issued also for 3/5/7 years, depending on each country’s legislation.

Accreditation procedures are particular forms of quality certification.

UNICEF and the World Bank propose the following definition: “accreditation is a voluntary process that offers service providers recognition for obtaining standards of excellence defined by an accreditation agency”.

The main objective of accreditation is the analysis of the performance of one service provider, compared to a set of high-quality indicators. The accreditation certifies therefore a high level of quality of the respective service but remains usually an optional procedure.

(4) The contracting and funding of social services

Contracting represents (in the context of this report) the establishment of a partnership and/or financial relationship between a public authority (or a donor) and a social service provider (public or private).

The contracting is a specific regulatory procedure within the framework of public mandate. The local authority (sub) contracts a specific social service with a service provider (public or private) for a limited timeframe. The contract is followed by the public support (in kind, infrastructure etc.) or funding, in various proportions.

The contracts between authorities and service providers contain elements related to the types of services targeted by the respective funding: users, duration of the contract, the rights and the obligations of the partners, the conditions of renewal and the end of the contract. They are official procedures and have a legal value; the contracting follows the licensing procedure and represents a condition for the funding of the services from public sources.

The funding of social services from public sources relies on different calculation procedures from one country to another. The most common cost calculations are the following:

a) the cost per day per user – the service is financed according to the total number of ‘presence days’ of users, per year (the number of users multiplied by their days of presence in the respective service).

A disadvantage of this procedure is the obligation of the service to guarantee a certain percentage of coverage of the overall capacity of the service per year, which is not always possible, according to the categories of the population and of the service’s specificity;

b) the global cost per year (total budget) – the service is funded according to its total budget. This estimated annual budget has to be approved by the partners and has a standard format for all service providers at the national level; from the main budget, the investment costs are usually submitted to a separate procedure of approval;

c) the cost per activity or per project – in this case, the financial coverage from public sources is directed only towards specific activities or projects that the provider develops during a specific timeframe.

---

36 Bilson and Gotestam, ibid..
37 In Romania, however, the accreditation procedure is used with another meaning: it refers to a compulsory procedure of certification of all social service providers, in relation with a set of “general quality standards”, inspired by the EQRM quality system (www.epceur.org). It is accompanied by another compulsory stage, the licensing procedure, which relies on a set of “technical” standards, designed for each type of social service.
In terms of general financing instruments at the State level, following options are the most frequent in the field of social services:

- Funding from the State budget (national/local) - either through public procurement or contract agreements between public authorities and service providers;
- Grants
- Subsidies
- Funding through dedicated Funds for social sector (e.g. Social Innovation Fund) etc.

**Implementation particularities of the contracting and funding procedures:**

- Once the funding mechanisms are available at national or local level, the monitoring and evaluation procedures have to be in place, in order to allow the evaluation of the provider’s accountability and the efficiency of the use of public resources.
- The insufficient (and uneven) allocation of resources for social services is a major obstacle for the development of the sector. Once a social service starts to operate, it has to be sustainable in order to ensure the continuity of the provision at least with at list minimum quality standards. Unstable funding is, in certain way, *more damaging* than a complete lack of public funding, because it affects both continuity and the quality of the service, sometimes in an irreversible way.

(5) **The internal regulatory mechanisms**

The internal regulatory mechanisms are basically planning, monitoring and evaluation tools at the level of the service provider itself (micro level). They are meant to guarantee the respect of the main principles of good governance: the effectiveness, efficiency, relevance of the service, together with the respect of the users’ interests and rights. These internal mechanisms are elaborated by the service providers within their management boards, with the active participation of users and staff members.

They focus on all aspects and components of a service (the infrastructure, the process of concrete service delivery, the partnerships relationships, the relation between users and staff, professional qualifications, etc.)

The most common regulatory procedures at this level are:

- Service or organisational strategies and projects
- Planning tools, ethical codes, internal regulations
- The quality policy and procedures,
- The accountability procedures,
- The functioning of the management board or the board of directors;
- The human resources procedures,
- Individual support plans for users,
- (Self)evaluation and reporting procedures,
- Complaint procedures for users,
- The continuous improvement strategy etc.

(6) **The monitoring and evaluation mechanisms**

Mechanisms of monitoring and evaluation guarantee the transparency, the accountability and the control of the institutional parameters, during all phases of the social service provision.

They contribute also to the promotion of innovation and good performance, through benchmarking procedures, together with the possibility for accreditation of the service (considered here in the sense of the certification for a level of excellence).

Finally, they guarantee, by their contents and their modalities of implementation, the respect of the interests of users and their active involvement and participation in the service provision.

**Monitoring** is a “continuous process of systematic collection of information, according to specific indicators, meant to provide the managers of a service and the relevant stakeholders with data of the extent of progress and achievement of objectives, in the limit of allocated funds”\(^{38}\).

The monitoring procedures allow regular corrections and continuous improvements of the on-going intervention.

**The evaluation** is a “systematic and objective appreciation of an on-going or completed project, programme or policy, its design, implementation and results. The aim is to determine the relevance and the fulfilment of the objectives, efficiency, effectiveness, impact and sustainability. An evaluation should provide credible and useful information enabling the incorporation of lessons learned into the decision-making process of both recipients and the donors”\(^{39}\).

There are two main forms of evaluation at the level of direct service provision:

a) The *internal evaluation* of the service, or the *self-evaluation*, represents an analysis of the performances

\(^{38}\) Glossary of key terms in evaluation and results based management, OECD, 2002

\(^{39}\) OECD Ibid.
and quality of the intervention, realised by those who are responsible for the organisation of the service: the management team, the staff, etc. The participatory principle in the provision of services requires also the involvement of users (or their representatives) in the evaluation process. In the majority of situations, the self-evaluation is annual. It prepares (and conditions) the external evaluation and leads to necessary corrections of the on-going provision of services.

b) The external evaluation – led by persons or bodies who are external to the donors and to the organisation responsible for the implementation of the service (independent assessors).

The process of quality evaluation in the field of social services is rather recent in Europe; the main challenge for this category of procedures remains the need for integrating the specific elements of the social sector in the design of the quality evaluation tools, compared to other existing instruments of the economic sectors (the ISO and EFQM system, for example).

A particular form of monitoring should be added at national and local levels: the one related to the monitoring of the implementation of the regulatory procedures themselves. The way in which local or central authorities or specific responsible bodies fulfil their obligations of regulating the provision of social services is also subject to monitoring and regular assessment. In this process, the role of users and/or their representatives is very important and their participation should be enforced by legal documents.

Implementation particularities for monitoring and evaluation procedures:
- The evaluations are usually carried out based on initial documents called terms of reference. They outline the objectives and the domain of the evaluation, the methodology, and various references used in order to value the performance or to lead the analysis, the necessary resources and timeframes, as well as the modalities for the presentation and communication of the results.

The common aspects evaluated at the level of the social service provider for people with disabilities are the following:
- the respect of the users rights and interests;
- the quality of the service provided to the users, the performance and the achieved results;
- the management of the service (human resources, communication, administration, financial efficiency and transparency, etc)
- the partnership relations and the impact of the service on community level;
- the internal coherence of the service (correlations between activities and goals, communication between departments);
- to what extent did the provided services respond, or not, to the needs of persons with disabilities at the community level.

The evaluation simultaneously targets the structure, the process and the results of the social service.

- The evaluation must be followed by recommendations for improvement. This aspect differentiates the evaluation from a pure control of the rendered service. The final goal of any evaluation remains the improvement of the service’s governance and of the concrete provision of services to direct users.
- An important element for an efficient evaluation is the training and qualifications of the assessors, especially in the case of the external evaluations of social services.
- The results of the evaluations are relevant for the continuation of the subcontracting and funding procedures; in exceptional cases (frauds, abuse etc), the internal and/or external evaluation is followed by the revocation of the provider’s license and funding or by other punitive measures.
- An interesting form of useful evaluation is the benchmarking procedure. It refers to the evaluation of the results that have been achieved by a social service provider in comparison with more successful or effective organisations, considered as reference of best practice.

The United Kingdom introduced an interesting procedure of star rating, addressed to local authorities, regarding their performance in ensuring social services at the county level. This annual procedure is meant to increase the level of responsiveness to local needs, as well as to reduce the discrepancies between different territorial units of the country, in the field of social service provision.

(7) The integrated system of information and feedback

In the general organisation of the regulatory framework, the integrated system of information and feedback plays a crucial role. As a result of monitoring procedures, the production of relevant data and information for all regulators and all stages of service provision is a continuous process. It includes:
- regular data collection and data analysis,
- statistics,
- information exchange at all levels of decision making,
- coordination and reporting.

In other words, this mechanism covers the monitoring function for the overall regulatory frame, influencing the decision-making and adaptability of the system to the changing needs of all relevant stakeholders in the process.

All stakeholders involved in the provision of social services (service providers, users, authorities and gate keepers
et al) should contribute to the correct maintenance of the information system. This mechanism is one of the most poorly organised in South East Europe, due to a lack of coordination between various types of stakeholders and responsible agencies.

1.3. THE MAIN ROLES AND FUNCTIONS COVERED BY THE REGULATORY MECHANISMS OF SOCIAL SERVICES FOR PERSONS WITH DISABILITIES

In this document, the regulatory system is given a particular attention during the reform process. This system is perceived as fulfilling three main functions:

a) A normative function – it sets standards that must be respected by the service providers but also by the decision makers and donors. It offers concrete tools for guaranteeing a minimum set of conditions for the correct delivery of the social service; it fixes “the rules of the game” and makes sure that all relevant stakeholders in the process respect these rules.

b) A corrective function – the regulatory system identifies the weaknesses in the provision of social services and requires corrections or adaptations;

c) A function of promotion and continuous improvement of services delivery (through its specific procedures of evaluation, accreditation and therefore valorisation of the “practices of excellence”). The regulatory system is not only a correction tool, but also a tool for modernisation and innovation in the social service field.

A European overview of regulatory systems shows that the prevalence of these functions is different in different stages of the development of the social service system. In South East Europe, for example, the normative aspect is predominant. Emphasis is put on the design of quality standards and indicators, inspection procedures and evaluation of the outcomes. Less attention is given (unfortunately) to the needs assessment, internal regulatory procedures, subcontracting and funding of different service providers, involvement of users in decision-making. In Western Europe, the modernisation and improvement of social services became the priority in the last years. The emergence of new types of quality evaluation tools and procedures, the possibilities for accreditation and benchmarking, are more developed and highlighted.

Despite the fact that regulatory procedures are usually designed and implemented simultaneously in the national policies, one legislation can target more a specific set of regulatory procedures than others, depending on political goals or on the level of development of the services system itself:

- In a country with limited resources, or after a major crisis (war, economic collapse etc), the implementation of a regulatory system that puts an emphasis on the excellence in terms of practices and the innovative character of the social services is definitely not realistic. In exchange, the normative function is the one that ensures a minimal coherence of the social intervention at the national level and guarantees the respect of minimal quality standards for all users.
- In countries that are in a stage of reforms and ‘renovation’ of the social sector, the corrective function plays usually a more important role. It facilitates and promotes a faster appropriation and implementation of new practices, paradigms or principles, among the service providers, users and decision makers.
- The function related to the continuous improvement of the quality of services has a more significant weight in the well-developed systems of social services. It facilitates the modernisation of the sector and the better response to clients’ needs.

Obviously, such a prioritisation of functions cannot be generalised, but it gives an image on the “political” importance of the regulatory system in the development of the social service system in South East Europe. Different countries can use this general frame to increase the strength of a certain component or another, based on the concrete ‘momentum’ in the evolution of the social services system.

The ultimate result of the implementation of all these mechanisms and regulatory procedures is to provide the users with services that answer to their expressed needs, active choices and of course ensure their rights. The quality standards, the constant evaluation of the service provider and its actions, the prioritisation of certain funding criteria etc. are, finally, only means to ensure a better quality of direct services for users. The elaboration of the regulatory system, together with its implementation, reflects though the “political” vision regarding people with disabilities, their role and participation in the service provision process, as users of these services.

At the same time, the regulatory mechanisms can constitute instruments of change and innovation by themselves and can be designed to promote new perspectives in the social service field. In each country of South East Europe, the elaboration of a regulatory system for social services is a must: first because of the need for social inclusion and equity for the excluded and marginalised populations; secondly because of the need to ensure a correct and efficient use of the resources in the social sector and to target poverty and social exclusion.

---

1.4. WORKING TOWARDS MORE EFFECTIVE REGULATIONS

How can the regulatory system avoid the excess of bureaucracy and become really effective, allowing people with disabilities to access social services in accordance with their evolving needs? This is a question that many decision makers raise in these periods of intense policy change, in the region.

This is also a question that many European countries tried to answer to. There are no miraculous solutions:

1. First, the regulatory system needs to be consistent and non-contradictory. The various rules and procedures need to be articulated in a coherent way, to avoid overlapping, contradictory decisions or recommendations, delays or blockages of any kind.
2. Then, it should avoid negative (unintended) side effects – the rules and corresponding procedures need to focus only on the problems they intend to solve, without creating additional paperwork and waste of resources.
3. The regulatory system should be accountable in any moment, to all stakeholders involved in the social service provision: the authorities, the users and the service providers. Each procedure and rule has to make sense and to produce the intended effect for which it was established;
4. Finally, the regulatory system should be easy to understand by all these actors (and therefore user-friendly)

Spotlight 1: What do people with disabilities say about the development of social services in South East Europe?

In April 2007, more than 100 people with disabilities, social service providers and authorities’ representatives from SEE countries joined in an international conference on "The Access of People with Disabilities to Social Services in South East Europe", in Skopje, FYR Macedonia. It was an occasion for exchange and discussions about the regional reforms in this sector, as well as regarding the modernisation of social services for people with disabilities at European level.

At the end of the two-day event, the participants released a ‘call for action’ document, which summarized their points of view regarding the continuation of social reforms and the necessary shift in approach towards accessible and quality services for people with disabilities, in their communities:

Call for action for the improvement of social services for people with disabilities in the region of Western Balkans

What is the objective related with the development of social services in the region?
The objective to be achieved is that social services are designed and provided in such a way that persons with disabilities are in control of their own lives.
The way services are being provided plays a key role in ensuring that persons with disabilities fully enjoy all their human rights, are able to lead their lives in the way they choose to do and become full and active participants in their societies.
The newly adopted UN Convention clearly defines the objective to be achieved. It is based on a paradigm shift, a shift which needs to happen in the social services sector also.
Knowing that social services are tools and instruments to implement human rights, it is the responsibility of all actors to ensure the accessibility, availability, affordability and adaptability of all services. These elements contribute to guaranteeing that people with disabilities live their lives like everybody else.
Stakeholder approach based on “Nothing about us without us”
The active involvement of organisations of persons with disabilities (DPOs) in the design and implementation of policies is a right in itself and is the only way to ensure that policies fully respect the human rights of persons with disabilities.
The design and implementation of social services is no exception to this rule.
Only through involvement of all stakeholders – being people with disabilities, service providers and authorities – the development of effective and efficient services can become a reality. Authorities, who have the responsibility to fund these services, and service providers, in charge of providing these services, shall accept that disabled people’s organisations are the leading force in the design of service provision. This will sometimes require training for DPOs to be able to play this role at all levels of decision making, at national level, regional/local level and at the level of service delivery. Authorities from their side should ensure real stakeholder cooperation in the development of new services and/or in the reform of existing services.
Any consultation structure to be established at national, regional, local or service level needs to be based on this right.
Choice through wide range of service provision
The service provision needs to take into account the diversity of persons with disabilities. Only a wide range of coordinated services will provide persons with disabilities with a real choice in order to make use of those services which best suit the needs of each individual.
To address the changing needs of persons with disabilities, mainstream (social) services should be made accessible for all. Specialised services should cooperate closely with these mainstream services in order to ensure inclusion and full participation of all.

**Decentralisation but no disparities. Social services as a right**

Decentralisation of services should allow these services are provided in a way which best incorporates the interests of those persons with disabilities which are directly benefitting from these. But decentralisation should not lead to disparities in quality of service among regions or between urban and rural areas.

In order to ensure no disparities, a minimum and gradually increasing standard of social services should be established. Social services need to be considered as a universal right and not a voluntary approach based on budget availability.

**Financial sustainability of social services**

Although in many cases set off through international funding, social services need to work on a stable financial basis. Financial sustainability of social services is a prerequisite for ensuring a proper provision of high quality services.

**Accelerating deinstitutionalisation**

The deinstitutionalisation process needs to be continued, which will require the establishment of alternative community based services with the active involvement of families, when ever this is possible. Each country should establish an ambitious but reasonable timeframe and a deadline by which all large institutions will be closed down and no more people will be accepted in the existing institutions.

International organisations should promote the support for community based services and not to support further discrimination in institutions.

**Staff training**

The adequate training of staff members of service providers is a key element for a human rights based approach in service provision. DPOs need to be an active part of the training of staff members.

**Service provision and cash benefits**

Service provision and cash benefits are not alternatives, but two complementary elements. Persons with disabilities need both cash benefits, including those that compensate persons with disabilities for the extra costs related to their disability, as well as qualitative services. People with disabilities should have the choice to purchase the types of services they require.

**Continuing co-operation at regional level**

The reform and on-going improvement of social services will require that public authorities, service providers and DPOs regularly meet and evaluate progress or lack of it. While this is mainly to happen at national level, the exchange of models and examples among the countries in the Western Balkan region will be useful for all stakeholders in this process.

*Final document of the seminar: “Access of People with Disabilities to Social Services in South East Europe”, co-organised by the National Disability Council from FYR Macedonia, Handicap International, the European Disability Forum (EDF) and the European Association of Service Providers for Persons with Disabilities (EASPD), April 23-24, 2007, Skopje, FYR Macedonia*

### 1.5. CONCLUSION

This first part of the report presented a conceptual overview of the process of social service provision related to the disability sector.

It referred to (a) the various **stages** of service provision (planning and constant revision, delivery of service, monitoring and evaluation), (b) **main stakeholders** involved in the process, and (c) **regulatory mechanisms and procedures** that are needed in an effective system of services at national level.

This overall presentation is justified by the fact that, in a transitional and reform period, all stakeholders participating in this reform (people with disabilities themselves, their families, the service providers, the authorities’ representatives) should have a common understanding and a clear terminology related to this field of action. In this way, they assume their roles as active participants to the policy development and contribute effectively to the modernisation of the sector.

On the other hand, the stakes of the social services reform in South East Europe are numerous for the decision makers. The challenge to manage simultaneously the structural reforms, administrative decentralisation, the process of de-institutionalisation and development of community based social services constitutes a task of great complexity for the national and local authorities, as well as for civil society.

However, the momentum for change is a positive one in the region. The opportunity to build a modern system of social services at the community level, relying on fundamental principles (universal, accessibility, affordability, quality, transparency and participation of the users) and on a human rights-based approach, is now in line with the joint efforts of the EU Member States and of international community. The pre-accession of Balkans countries to EU gives an additional incentive to continuation of national reforms.
This part of the report will explore the way in which people with disabilities have access to social services in their communities in the countries of the region. It will look at the evolutions of policies related with modernisation of social services, as well as at the way in which these services are organised and delivered concretely.

**South East Europe – the impact of transition on social services modernisation**

The countries of South East Europe face a complex and difficult period of transition in their post-communist era, experiencing now democracy and emerging market economies. The collapse of the social protection systems, decrease of public financial resources, as well as the Balkans’ armed conflicts (with additional displacement of population, war casualties and breakdown of education and health care facilities) have created enormous pressure for reform in all governments. Within this context, it is important to take into consideration that, despite several similarities between countries, there are also many differences. The ex-Yugoslavia previously had a social protection system that used to have a certain decentralised structure and was rather comprehensive, since it was influenced by modern concepts and international resolutions. In contrast, in Romania and Albania, with their highly centralised agencies for social protection, the institutionalisation and segregation of persons with disabilities tended to be higher.41

This transition period impacted strongly the social sector by:

- growing inequity and stratification of societies;
- appearance of new groups in need for social protection and assistance (unemployed people, survivors of Western Balkans wars, persons with war injuries leading to disability, refugees etc.);
- increase of problems related to drugs, human trafficking, children exploitation and labour, victims of domestic violence;
- the collapses of the previous social security schemes and the need to modernize the entire systems of social protection;
- as well as, the progressive increase of the number of elderly people, similarly to all European countries.

In the disability sector, significant changes took place in the last decade; they have been related to several (ongoing) processes that happen simultaneously:

- **the shift of paradigm** regarding disability: from a medical approach to a social and holistic one, based on human rights, in all fields of policies and practices. The progressive empowerment of the disability movement in the region created good premises for this shift, which is currently more acknowledged in many domains of the social and economic life;
- **the deinstitutionalisation** of persons with disabilities and services: with a progressive speed and focus in the countries of the region, this process is started, enhancing the debates and initiatives about the creation and development of new community based services;
- **the decentralisation** of responsibilities and administrative procedures, from central government to local level. This process impacts both decision making and the organisation of the social security and social service provision. It represents one of the most difficult aspects of the transition because of the effort of local governments to balance fiscal capacity with their increasing responsibilities in the field of social protection;
- **a variety of new types of providers delivering social services**: non-profit organisations, volunteer, self-support groups;
- finally, the progressive **enlargement of the spectrum of social services** at community level for people with disabilities. This diversification and sustainable development of new and quality social services at local level represents today a major challenge, due to limited expertise and insufficient number of adequate (or qualified) professionals in many of the countries in the region.

---

41 For a more in-depth description of the previous social and health systems in South East Europe, read more in the Disability Monitor Report no.1: "Beyond De-institutionalisation – The Unsteady transition towards an Enabling System in South East Europe." (www.disabilitymonitor-see.org)
These simultaneous processes further require strong capacities for strategic thinking, partnership, redirection of resources, transparent decision making and good governance at local and national levels.

The process of accession to the European Union

The reform of the social sector benefits from several important incentives. The modernisation of social protection systems in the region, as well as of the disability-related policies, is strongly influenced by the accession to the EU. Intensive processes of legislation harmonisation (for Romania and Bulgaria which joined EU in 2007) as well as the Stabilisation and Association Process (SAP) for the Balkans countries, have created links with EU policies and set some target goals. For all countries of ex-Yugoslavia and Albania, the SAP offers the possibility for signing a Stabilisation and Association Agreement with the EU, opening up concrete EU accession perspective. For these countries as well, the Copenhagen criteria for accession remain entirely valid, enhancing further consistency and quality in policy reforms. So far, Croatia has officially the status of candidate country. The Former Yugoslav Republic of Macedonia became a candidate country in December 2005 but accession negotiations have yet to be started. The other countries of the Western Balkans - Albania, Bosnia and Herzegovina, Montenegro, and Serbia, as well as Kosovo (under the UNSCR 1244) are currently ‘potential candidate countries’.

In this context, the EU Disability Strategy and the European Disability Action Plan are becoming reference documents for the South East European region as well, orienting the disability policies and the mainstreaming of disability in policy making.

BOX 2
Mainstreaming disability in national and European policies: main elements for ‘shifting the paradigm’.

At European level people with disabilities are seen as active participants to economy and society and no longer passive recipients of compensation benefits. One of the major EU objectives is to fight discrimination against people with disabilities and enhance their participation in the community life, in a mainstreaming approach.

Mainstreaming disability, as interpreted by the EC Disability High level Group (D-HLG), means that “needs of disadvantaged people need to be taken into account in the design and implementation of all policies and measures, and that action for disadvantaged people is not limited to those policies and measures that specifically address their needs”.

When designing their national policies, States have to consider the fact that “these policies and their subsequent actions taken will be fully accessible to disadvantaged people. Disabled people are at risk of poverty and exclusion, but, also poverty and social exclusion might lead to disability”.

Another important recommendation of D-HLG is that “when implementing the disability mainstreaming approach in the social protection and social inclusion processes, it is fundamental to do it in all stages of action, from early design and preparation to monitoring and evaluation”. Moreover, “the EU charter of Fundamental Rights and the recently adopted UN Convention on the Rights of People with Disabilities must be taken into account”.

Promoting the ‘citizens’ concept of disability means: “disabled people must have the same individual choices in, and control of, their everyday life as non-disabled people. That is to say, policy actions must be designed in such a way that the needs of people with disabilities and the services for these people are placed at the centre of the care and services delivery process”.

---

42 The Copenhagen criteria are the rules that define whether a country is eligible to join the European Union. They have been established at the June 1993 European Council in Copenhagen, Denmark. To join the EU, a new Member State must meet three criteria:
(a) political: stability of institutions guaranteeing democracy, the rule of law, human rights and respect for and protection of minorities;
(b) economic: existence of a functioning market economy and the capacity to cope with competitive pressure and market forces within the Union;
(c) acceptance of the Community acquis: ability to take on the obligations of membership, including adherence to the aims of political, economic and monetary union.

For the European Council to decide to open negotiations, the political criterion must be satisfied. Any country that wishes to join the Union must meet the overall accession criteria. (http://europa.eu/scadplus/glossary/accession_criteria_copenhagen_en.htm)


44 The High Level Group on Disability (European Commission) is set up to monitor the latest policies and priorities of Governments concerning people with disabilities, to pool information and experience, and to advise the Commission on methods for reporting in future on the EU-wide situation with regard to disability (http://ec.europa.eu/employment_social/soc-prot/disable/hlg_en.htm)


46 Ibid., page 2

47 Ibid., page 2

48 Ibid., page 3
Shifting the Paradigm in Social Service Provision

The EU Instrument for Pre-Accession Assistance (IPA)\(^49\) as one of the key levers for further policy reforms

From January 2007 onwards, the Instrument for Pre-Accession Assistance (IPA) is available for candidate countries or potential candidate countries and it covers five domains for assistance:

1. Assistance for transition and institution building;
2. Cross-border cooperation (with EU Member States and other countries eligible for IPA);
3. Regional development (transport, environment and economic development);
4. Human resources (strengthening human capital and combating exclusion);
5. Rural development.

The IPA beneficiary countries are divided into two categories:

a) EU candidate countries (Croatia, Turkey and the Former Yugoslav Republic of Macedonia) are eligible for all five strands of IPA;

b) Potential candidate countries in the Western Balkans (Albania, Bosnia-Herzegovina, Montenegro, and Serbia including Kosovo) are eligible only for the first two strands.

IPA financial resources are allocated per beneficiary country and per component. IPA intervention for strands 3, 4 and 5 is organised via multi-annual programmes.

Social services within welfare reforms – a vast laboratory of change in South East Europe

Part II of this report reflects the way in which States in the SEE countries address the social challenges and goals mentioned above. It is a broad panorama of policies and practices, from legislative reforms and national strategic initiatives, towards concrete delivery of community services and the improvement of people’s access to local resources. As it will be shown in this part, while modernisation of social services is integrated in numerous national strategies as one of the specific goals, the pace of this sectoral reform is variable, from a country to another.

- 2.1 presents the various organisations of the systems of social services at national and local levels, based on legal frameworks and strategic goals;
- 2.2 - pays specific attention to the way in which people with disabilities actually access the network of social services in their communities and how is this access influenced by the organisation of the gate-keeping system;
- 2.3 - describes the spectrum of existing community services for people with disabilities,
- 2.4 - describes the ways in which social services are concretely delivered, in a context of decentralisation and welfare mix;
- 2.5 – presents how social services are funded and/or contracted at local level;
- 2.6 – addresses the monitoring and evaluation procedures for social services;
- 2.7 – looks at the main challenges of the decentralisation process in the domain of social service provision;
- 2.8. and 2.9 - addresses the questions of users’ and DPOs involvement and the situation of the qualified or trained professionals in the disability-related services.

Several illustrative examples from the SEE countries accompany the presentations.

2.1 FORMAL ORGANISATION OF THE SYSTEMS OF SOCIAL SERVICES FOR PEOPLE WITH DISABILITIES IN THE REGION. POLICIES AND LEGAL FRAMEWORKS.

Social protection systems, including both social security schemes and social services, are currently under reform in all countries of the region. The governments initiated these processes during the last decade, most commonly with the (financial and technical) support of international agencies like World Bank and UN agencies, European Union, OSCE, OECD or through bilateral cooperation programs (UK, Italy, Finland, Sweden etc).

The following descriptions and analysis refer to the evolution and perspectives of what the European Commission calls “social services addressed directly to the person\(^50\)” and will not tackle the social security schemes for people with disabilities (or cash transfers, as they are nominated in some countries).

In order to follow the dynamic and characteristics of social services for people with disabilities in this context, it is important to describe how social services systems are generally organized at national level, how the governments choose to reform this domain and which are the concrete priorities for the disability-related sectors.

For some countries, a specific attention will be paid to the initial stages and the strategic design of the reforms. The way in which these initial stages took place (assessment and analysis of national situations, the political choices, the concrete involvement of stakeholders etc) impacted significantly the quality of the final legislative frameworks, as well as the implementation steps afterwards.

\(^49\) Description of IPA as presented on the official website of the European Commission http://ec.europa.eu/regional_policy/funds/ipa/index_en.htm
**BOX 3**

How do we know that a services-related policy is well designed and implemented?

Indicators of Progress in the Reform of Community-based Services for Vulnerable Groups

In 2006, USAID released a study regarding the emerging systems of social services in Europe\(^{51}\). The author formulated a list of progress indicators for the reform processes that could be used for monitoring them effectively. This list seems very significant in the context of social services modernization in South East Europe and is presented in this box.

**Indicators at the level of Policy and Legal Framework:**

- The responsible stakeholders identify and define priority groups at-risk
- Family and community care are promoted over residential and institutional-based care
- The responsible stakeholders identify internationally recognized standards of care and professional practice
- Establish a mechanism for partnering and/or contracting with NGOs to provide social services
- Establish accountability and sanctioning mechanisms
- Engage consumers and advocacy groups in designing and evaluating public policy

**Indicators at the level of structure and types of programs and services:**

- Programs range from prevention to protection and reflect international standards
- Mechanisms are in place to shift from residential care to community care
- Principles and values of practices reflect capacity-building over "relief and rescue"
- Assessment processes are in place for targeting those whom the program is designed to serve
- Client accessibility mechanisms are in place, such as client outreach and citizen awareness/public education
- At-risk groups have influence in decisions of service providers
- An integrated approach is in place in relation to assessment, planning, and intervention
- Mechanisms are in place for community participation and volunteerism
- Public awareness and public education campaigns influence public attitudes and citizen involvement

**Indicators at the level of human capacity:**

- Job functions reflect an integrative approach to assessment, planning, intervention, and follow-up (social work case management and multidisciplinary planning)
- Workforce includes treatment and rehabilitation professionals
- Practitioners are regulated through licensing or certification procedures
- Human services professionals such as social workers, psychologists, and health professionals are educated and trained
- Curricula reflect principles and values of human capacity building, prevention, and community care
- Curricula and programs promote professional standards of practice
- Partnerships between universities, advocacy groups, and public and private service delivery organizations focus on performance improvement through workforce development
- Professional associations advocate to promote quality of service through quality workforce development

**Indicators at the level of Performance Outcomes and Measures:**

- Indicators measure reduced risk and/or improved well-being
- Information systems monitor programs and services
- Information systems monitor clients.


---

2.1.1. Social Services Framework in Albania

Albania is one of the countries of the region with an accelerated rhythm of legislative reforms in the disability sector and the social services domain. With technical support provided initially by international agencies and relying also on very pro-active local professionals and DPOs, important steps have been taken in the past five years at policy (national) level.

- A National Strategy on People with Disabilities was adopted in September 2006;
- A new Law on Social Assistance and Services came into force in 2005;

Corresponding Action Plans exist for the implementation of these documents.

However, the implementation of these legal frameworks is not as successful. Due to a difficult decentralisation process, as well as to the consequent blockages in resources allocation, the timeframes of these initial action plans have not been respected. The development of capacities of stakeholders at local level represents a key priority at this stage; the concrete decentralisation of service provision and the development of new community-based services for people with disabilities require now more vigorous commitment and action at the level of local and national authorities.

Population: 3.152.000 inhabitants (49% live in urban and 51% in rural areas) (Jan 2007)
GDP per capita (PPP) (in relation with EU27=100): 24 (2007)
Un-employment rate: 12,62% (Sept.2008)
Persons with disabilities: 77.250 (estimated in 2005)
HDI Ranking: 69 (in 2008)

Administrative organisation of the country:

Albania is divided into 12 counties (qarku), 36 districts (rrethe), 65 municipalities (bashkia) and more than 300 communes (komuna). The municipalities administrate the urban areas and the communes – the rural areas. The ministries can organise deconcentrated bodies at local level. The links between the elected authorities and these deconcentrated bodies are stipulated in the Law of Decentralisation; in practice however, they are perceived as being still weak.

EU Accession process

Albania signed a Stabilisation and Association Agreement (SAA) with the EU in June 2006. In October 2007, the government of Albania signed also the Framework Agreement with the European Commission for the implementation of assistance under the Instrument for Pre accession Assistance (IPA). IPA will provide Albania with assistance for alignment with EU legislation, for the strengthening of democratic institutions and the rule of law, the reform of public administration, for economic reforms, the respect for human as well as minority rights and gender equality, the development of civil society and regional co-operation, and for sustainable development and poverty reduction.

One of the priorities for action recommended by EU in the framework of this process is the "development of community-based services and aid to dependent persons, including in the field of mental health".

Albania has a statute of potential candidate country to the EU.

The reform process in the field of social services

The reform of social protection (including social services) was initiated in 2000 with a certain number of situational assessment studies, which later formed the base to elaborate the key strategies and national legislation documents:

1. The study of the World Bank called "Vulnerability Needs and Institutional Capacity Assessment – VNICA", included a legal review, institutional assessment and needs assessment in four regions

---

54 INSTAT Albania, www.instat.gov.al
55 Ministry of Labor and Social Affairs, Strategy for Social Services (2005-2010). This figure is correlated with the statistical information of the KMCAP (Medical Commission for the evaluation of the disability situation). This commission is unique for both children and adults with disabilities, but the procedures for the evaluation of various development conditions of children are still poor. For these reasons, the precise data related with the number of disabled children are not available
58 Elena Galliano, 2000
of Albania. The lack of accessible services (especially for rural areas), the problems of single elderly persons in rural areas, households headed by women, the increasing number of children left without parental care, the increase in urban poverty, were mentioned in this report. The study allowed the elaboration of a “Map of the Distribution of the Public and Non-public Institutions of Social Services”, one of the key elements of the situation analysis at that moment. To address the issues mentioned above, the Government with the World Bank’s assistance developed a cross sectoral Growth and Poverty Reduction Strategy in 2001.

2. In 2002, the Ministry of Labour and Social Affairs, together with its specialized agency called State Social Services, conducted two additional studies assessing the level of poverty and social needs of vulnerable populations at national scale: Assessment of the Social Situation and Needs for Services of At-Risk Group followed by the realisation of a “map of social problems” and Assessment of the Criteria and Indices of the Distribution of the economic Aid followed, resulting in a "map of poverty"59.

Following this stage of needs assessment and national situation analysis, the Albanian Government decided to develop a specific strategy and legislative framework for improving the social services sector: with assistance of the World Bank, the government designed a first medium-term strategy for social services (1998-2002) and included also the services-related aspects in the middle-term country strategy for socio-economic development (2003-2007). The key document was elaborated further on (during 2002-2004) with the support of DFID, the British Council and World Bank, and a large number of stakeholders (State and non-profit actors) contributed to its realization. The Strategy for Social Services (2005-2010)60 was released in April 2005 and contains the main directions for work and improvement: from the typology of services that have to be developed at community level, to all regulatory mechanisms and procedures that have to be elaborated, as well as the de-institutionalisation and decentralization of service provision. The Strategy points out key principles that are completely in line with the modernization of social services at European level:

- an increased role of users in the decision making process,
- the plurality of providers,
- the need for continuous quality improvement,
- an increased role of the local government in the organization of the social services system,
- the need for a coherent information system and coordination between responsible bodies in the field of social service provision.

This strategy together with the corresponding Law on Assistance and Social Services61 in 2005, are among the first services-related policy documents in the region. According to these documents, social services in Albania refer to “the whole variety of service provided to individuals and groups in need, who are unable to meet, with their own resources, their life needs with a view to preserving, developing and rehabilitating of individual abilities to fulfil emergency or chronic needs62”. In addition “social services in the community” are defined as “all kinds of social, public and non-public services, which are provided at the local level, to the territory under the jurisdiction of the qark/municipality/ commune63”.

Social services are divided in: social care services and socio-medical care services (art.12) and in residential care services and community care services (art.14). They can be public or private, depending on their main provider and funding mechanism (art.16).

The social services are under the responsibility of Ministry for Labour, Social Affairs and Equal Opportunities while the medical services are under the responsibility of Ministry of Health. The educational and vocational training services are under the responsibility of the Ministry of Education. There is no inter-ministerial cooperation so far regarding the functionality (or the coordination) of multidisciplinary services.

The core goal of the Strategy for Social Services is to “ensure a clear policy for reforming the system of social services, not only for the groups in need but also for all society64.”

Main objectives of the strategy are:

- Decentralisation of social services and an increase in the role of local government in their delivery;
- De-institutionalisation of residential services and their transformation into community-based services;
- Establishment of new social services at local level and their extension throughout the country;
- Ensuring the sustainability and continuity of public and non-public social services;
- Involvement of civil society, of business and individuals as well as of other community stakeholders in the provision of social services;
- Increase in the quality of social services in conformity with contemporary standards;

---

59 Tushi G., National Report on Social Services for Albania, in "Good Practices in Social Services Delivery in South East Europe", ILO South East Europe, 2004
60 The Strategy for Social Services (2005-2010), Ministry of Labor and Social Affairs, Department of Social Services, April 2005
61 Law on Assistance and Social Services, March 2005
62 Law on assistance and social services, art.4
63 Albania is organized in 12 administrative counties (qark), as well as municipalities (more than 15.000 inhabitants) and communes (less than 15.000). (Strategy for Social Services, Definitions, page 10).
64 The Strategy for Social Services (2005-2010)
Despite this good quality legislative framework, concrete implementation of the law and of the strategy on social services is not yet fulfilled. By-laws are still not elaborated for many of the regulatory procedures mentioned in the law; the key responsible agencies for the implementation are not designated in every district or municipality; yet there are no clear monitoring procedures nor regular data collection about the situation of social services in the territory.

**Other important national strategies for social reforms**

Other strategic documents that make reference to disability and to the development of quality community based services for people with disabilities are the following:

**The National Strategy on People with Disabilities** and its related Action plan (2006-2014) represent key steps forward in the disability sector in Albania. The strategy highlights, as a fundamental principle, "the inclusion, participation and equal opportunities for people with disabilities". People are entitled "to the same opportunities as non disabled, in all areas of social life, including education, medical rehabilitation, participation at working and community life". A specific list of priorities is mentioned in chapter II (Services) and III (Education, Employment and Vocational Training) of the Action Plan, regarding the necessary actions and the responsibilities in the field of disability-related social services.

In its annual progress report of Albania for 2007, the European Commission mentions "however, no state resources are allocated to implementation of the national strategy for people with disabilities". The related legislation (by-laws) is still missing and the "coordination between the ministries involved requires improvement. Progress, including new legislation, is needed on de-institutionalisation and aid to dependent persons. Measures to promote access of people with a disability to employment, education, including integrated education, and the environment, goods and services have yet to be developed".

**The National Strategy for Children** mentions the need for “Extension of social service delivery for children to the community and empowerment of local government in this direction” as well as the promotion of education for all.

**The National Strategy for Socio-Economic Development** mentions that a key aspect for improving quality of social services is "the harmonisation of the services providing economic assistance with other social services". This strategy promotes the following: (i) residential care passes gradually onto community-based and mobile services; (ii) the range and location of services expand by need; (iii) participation of local government and civil society in the planning, funding and provision of social services increases; (iv) the sustainability, continuity and quality of services increase; and (v) participation of social business in financing and service provision be promoted.

In 2008, the Government adopted the Social Inclusion Strategy, creating for the first time the premises for addressing all social reform aspects in a cross-cutting manner. This is also a major step towards the elaboration of a National Action plan for Social Inclusion, which is a key requirement of EC during the accession process to EU.

**Legislation in the field of social protection and services**

In terms of legislative documents, the laws that have the most significant impact on the transformation and organisation of social services in Albania are the following:

**The Law on Assistance and Social Services** - is the key document for the services reform, as mentioned above; it represents also one of the first documents of this type in South East Europe. It is in line with all major European trends in the field of social services modernisation.

**The Law on Education and the Law of Health Services** makes references to the gate keeping procedures and type of services that can be accessed by people with disabilities (including the specialized ones). The concrete access of people with disabilities to social services is regulated in Albania by several specific laws. There are 5 specific laws for different categories of persons with disabilities (on war veterans, "labour invalids", blind people, people with mental health conditions and physically disabled), which precise the entitlements for these categories, including the tax exemption or the specific entitlements related to the access to education, rehabilitation programs and vocational training.

There is no anti-discrimination law so far in Albania (which represents a main concern for the DPOs in the country), however several anti-discrimination provisions are present in the Albanian Constitution, the Labour Code and the disability-related laws.

---

67 Ministry of Finance, Progress Report on Implementation of the National Strategy for Socio-Economic Development during 2004. Objectives and long-term vision, June 2005. (Note: from 2007, this strategy was replaced by the National Strategy for Development and Integration)
68 Released by the Council of Ministers in March 2005
Roles and responsibilities in the provision of social services in Albania:

• **The Ministry of Labour, Social Affairs and Equal Opportunities (MoLSAEO)**
  
  “The ministry reviews and develops policies and national legislation; monitors the implementation of legislation; prepares the budget related to Economic Assistance, disability entitlement and social services, plans and delegates funds to local government units and monitors the use of budgetary funds according to their allocation. It licenses the providers of social services. It develops standards and criteria related to social services. The Ministry sets up the Social Fund, to support the implementation of policies and the establishment of new services, as well as sustaining the development of social services in those municipalities/communes that have no financial resources. Monitors the decentralization of service provision”

• **The State Social Service** (a specific agency within MoLSAEO)
  
  The State Social Service operates as an intermediary body between the policy making level in the Ministry of labour, Social Affairs and Equal Opportunities and the implementing level in local government.

  • Monitors and inspects the use of funds and application of standards at all levels of public and non-public services.
  
  • Ensures that services of providers meet quality standards in order to obtain a license to provide the services.
  
  • Is responsible for the implementation and enforcement of legislation.
  
  • Provides training to staff and service providers.

  According to the Strategy, the regional bodies of State Social Service should co-ordinate the activity across various agencies that are linked with social services. They should also be responsible with: the planning of needs at regional level; they collect information and data at regional levels, for monitoring and assessment of the impact of policy implementation; they control of legislation implementation related to Economic Assistance, the disability related issues and services standards.

• **The Social Care Service Unit at regional level** and the **Regional Community Care Committees**. From 2005, MoLSAEO delegated the functions for provision of social care services to these newly created agencies at regional and community levels, initially in several pilot regions. Procedures for local needs assessment and Community Care Plans have been established and piloted; they are currently in process to be extended to all 12 regions. The plans refer to both social services and more general social assistance measures.

• **Local Governments**
  
  According to the Strategy of Social Services, local governments should have extensive role in the provision of social services in Albania:

  • Approve the establishment of social services structures and the local budget that covers the development and extension of social services.
  
  • They are responsible for the use of funds from the state budget and implementation of national standards of social services.
  
  • They have to identify families in need of Economic Assistance, people with disabilities and individuals who are in need of social care services.
  
  • Administer public residential institutions; follow up on services in day centres and community services that are under the jurisdiction of the local government units.
  
  • Approve the activity of NGOs and other providers, which implement projects of social services on the territory of local government units.
  
  • Select, according to the rules of public procurement, the providers of licensed social services to meet community needs.
  
  • Distribute payments related to Economic Assistance and Disability entitlement.
  
  • Formulate and provide statistic data to regions (qarks) and other structures.
  
  • Co-ordinate inter-sectorial actions for protection from maltreatment including information on maltreatment, initial assessment, identification of potential maltreatment, possibilities and needs of the families.
  
  • At the level of local government the individual plan of intervention for each person in need for financial support or social services is developed, as well as the case management. They are also in charge with reviewing the plans for each user.

These extensive (and detailed) roles of central and local authorities, mentioned in both Strategy and Law on Assistance and Social Services, are not all transformed into concrete implementation procedures (by-laws, implementation regulations), thus majority of them still remain unapplied.

**Social Services Offices** are the main agencies responsible for the coordination and delivery of social services at local level (municipalities/communes). They are cumulating so far both delivery and gate-keeping roles (especially with regards to the draft of ‘social service development plans’), but also licensing procedures for private service providers.

---

69 The Strategy for Social Services (2005-2010)

70 Ibid.
In several municipalities exist also a new type of coordination agency called **Child Protection Unit (CPU)**, which was piloted in Kukes and afterwards replicated in four other locations (Elbasan, Fier, Pogradec and Gjirokastra). This local agency is supposed to coordinate both assessment of needs and adequate services provision for children in vulnerable situations. The establishment of this service was supported by UNICEF and international organisations.

**Civil Society**

Civil society stakeholders have responsibilities such as: provision of new social services in the community according to needs; participation in the planning of services in conformity with community needs; assisting through advocacy services in the review and implementation of policies; mobilising individuals and groups in need to take part in the discussions on social issues; identification and reports of cases of maltreatment; developing prevention programmes; co-ordination with local structures; provision of community-based services in networks, with a view of protecting, supporting and social inclusion of children and parents.

**The Individuals**

They identify and report suspected maltreatment and assist other members of the family. They organise themselves in self-support groups in order to help each other. Contribute to the cost of services provided when they have sufficient resources to do so. Work as volunteers, etc.

**The typology of existent social services**

Public social services in Albania are represented by 21 residential centres and 5 day centres (with a total capacity of 1200 places). They operate in Shkodra (5), Durres(2), Tirana(6), Vlora (4), and Saranda, Korça, Lezhe, Berat, Fier and Gjirokaster. They are delivered for orphan children and children with social problems, disabled persons, elderly people and the victims of trafficking. Efforts are made for developing a foster care service in Albania, as pre-condition for de-institutionalisation.

A specific project supported by World Bank ("Social Service Delivery Project") led to the creation of 14 day centres for persons with disabilities.

The private providers are represented mostly by NGOs and church-related organizations and they run counseling centers, day centers, residential homes, foster care services, vocational training units and occupational workshops for people with disabilities.

**Volume of investments in the social services reform (2001-2005):**

15 millions USD (World Bank, DFID and the Albanian Government)

**The assessment of disability situation and people's needs**

The Medical Commission (KMCAP), unique for children and adults with disabilities, assesses the disability situation of the person, establishes the type and degree of disabilities and identifies the rights to specific entitlements.

**Formal participation of people with disabilities in policy making**

For all aspects related with the evolution and implementation of policies in the field of disability-related issues (including therefore social service provision), the National Council on the Affairs of People with Disabilities (established by Prime Minister's Order in December 2005) is entitled to monitor and to provide recommendations (for all stakeholders mentioned above), reflecting the specific interests and perspectives of people with disabilities.

A non-governmental "Albanian National Council of People with Disabilities" (ANCDP) has been officially registered as a judicial subject in May 2006. The National Council is an umbrella organization including the majority of the local and national organizations, foundations, and institutions working for people with disabilities in Albania. The Council produced in June 2007 the Albanian Report on Disability Issues. The report provides updated information regarding the situation of disabled people in Albania and the main recommendations for improvement in the future.
Looking ahead:
This relatively detailed legislation and role division in the field of social services reflects a strong political will for change in Albania, as well as integration of many European trends and goals. In terms of concrete organization of the system of services at national and local level, the challenges for the effective implementation of this change remain numerous, as will be shown in the next paragraphs of this chapter. The local government has new and very complex tasks and responsibilities. In order to implement them, people need to be trained, have to be in sufficient number and have to work on specific implementation methodologies. Some of these instruments are produced, while many of them still under elaboration. The spectrum of services for disabled persons remains poor in Albania; both diversity of services and the correspondent regulatory framework need strong input, support and monitoring in the coming years, in order for this ambitious strategy to be accomplished.

Spotlight 2: A participatory approach in policy elaboration in Albania: the case of general quality standards for social services

An important aspect of the legislative reform in Albania, in the field of social services, was the participation of a significant number of stakeholders, during its design and elaboration at national level. One of the interesting examples of this process was the definition of quality standards for social services. The Ministry of Labour, Social Affairs and Equal Opportunities describes this process, which took place in 2006:

a. A bottom-up approach: The quality standards reflect the best practices in Albania, as representative working groups in four pilot regions define them: Tirana, Vlore, Shkoder and Durrës. In the process of discussion about the standards, were included service providers, but also the users of services themselves and DPOs. The experience of the non-governmental sector was also taken into consideration, especially because several of the models of good practice were developed by them through their international cooperation projects;

b. Participatory process: The principles of social inclusion endorsed by the EU formed the basis of this work. The standards have been created through a process of cooperation between different stakeholders: social service users, providers, central and local authority representatives as well as professionals such as social workers, educators, researchers, etc. The users included representatives from women’s organizations, people with disabilities and elderly people, as well as individual users.

c. Capacity building: Developing standards for social services was an opportunity for developing, at the same time, the capacities of all actors in this field. Gradually, the local stakeholders not only contributed to building the standards, but they acknowledged that their new perspectives and skills would be very significant for implementing the standards and improving concretely the services to the needs of users.

d. Continuous improvement: The national standards for social services are ‘minimum’ standards, rather than ‘best possible’ standards. Considering the current standards as a starting point, the authorities expect that providers will aspire to exceed them in many ways.

In addition to the general standards for social services, Albania chose afterwards to elaborate specific sets of standards for services addressing the needs of different categories of users (children, persons with disabilities, elderly people etc.). This process relied also on the contribution of a large number of representative stakeholders, from public or non-profit structures as well as users’ representatives.

Source: Ministry of Labour, Social Affairs and Equal Opportunities of Albania (presentation of the process during a national seminar on social services reform for people with disabilities, Tirana, May 2006)

2.1.2. Social Services Framework in Bosnia and Herzegovina

With significant progresses in post-conflict reconstruction after the wars in the former Yugoslavia, Bosnia and Herzegovina (BiH) is a country with a very complex administrative organisation (state, entities, cantons, municipalities). Following the Dayton Peace Agreement, this organisation makes difficult the elaboration of a coherent social policy and harmonized measures on the entire BiH territory.

A reform of social services in BiH is yet to be started. It is however acknowledged by all relevant stakeholders as a priority for action in the coming years and the principles of this modernization process, in line with European trends, are acknowledged and formulated in various strategic or planning documents.

The most significant aspect that takes place currently is the adoption and implementation of a National Disability Policy, considered as the “main catalyst of mainstreaming disability issues in BiH”79. The process includes the elaboration of adequate laws and by-law, revising all sectors that impact the persons with disabilities: services, social security and assistance, accessibility etc. This ‘working site’ is a long term one (it started in 2005 and ongoing), and people with disabilities were involved in various stages of this process. Their participation contributed to the fact that disability became progressively more present on the political agenda in BiH.

79 International Bureau for Humanitarian Issues (SDPD program) in BiH, Disability Policy Study, 2007 (www.ibhibih.org)
Population: 4,025,476 inhabitants\textsuperscript{80}.

GDP per capita (PPP) (in relation with EU27=100): 29 (2007)\textsuperscript{81}.

Un-employment rate: approximately 31.8\%\textsuperscript{82}, Labour Force Survey, 2006 Official statistics by the BiH institutions (using the ILO definitions): 29\% for 2007\textsuperscript{83}.

Persons with disabilities: No statistic exists, estimation vary between 400,000 - 600,000 persons among various sources (disabled people organisations, international agencies etc).

HDI Ranking: 75.

**Overall organisation of the country**

- The complex administrative organisation of BiH is partly the consequence of the signing of the Dayton Peace Agreement (1995), after the extremely destructive war that affected the country between 1992 and 1995. The country is organized in two entities, Republika Srpska (RS) and the Federation of Bosnia and Herzegovina (FBiH), each of them benefiting from their own governmental structures. Additionally, the District of Brčko (district under a international supervision status) is a self-governing administrative unit under the sovereignty of BiH.
  - FBiH has 10 Cantons; each of them entitled to establish its own legislation. FBiH has 79 municipalities.
  - RS has 63 municipalities.

**The division of roles in the legislation elaboration** between the State, the Entities and the FBiH cantons is the following:

- The State is responsible for elaborating the overall strategies in the field of social and health sector, social development etc. It is also the one guaranteeing the coherence of legislation between the two entities;
- The Entities are responsible for elaborating the specific laws in the field of social sector;
- In FBiH, the cantons are entitled as well to define their own legislation in the social and health sector, education etc.
- The municipalities are responsible for the implementation of the legislation, but have significant roles in allocating resources, at local level, in relation with this implementation process.

For these reasons, the social security and social protection measures are generally very decentralized in BiH (especially among the two entities, but also among the cantons of FBiH) leading to strong inequities in cash benefits, available services and support to people with disabilities living in these different administrative units.

**EU accession process**

Bosnia and Herzegovina is participating in the Stabilisation and Association Process (SAP) with EU. Negotiations on a Stabilisation and Association Agreement (SAA), which is a central element of the SAP, were officially opened in November 2005 and currently ongoing. In the light of this process, EU lists several priorities for the BiH Government\textsuperscript{84}, among which the ones related with the field of social services and disability are:

- To continue de-institutionalisation, community-based services and aid to dependent persons, including in the field of mental health;
- To make further efforts to improve the situation of persons with disabilities.

Bosnia and Herzegovina has a statute of potential candidate country to the EU.

**Relevant strategic documents for the social sector**

The Medium Term Development Strategy (MTDS) (2004-2007) formed the overall development strategy of the country. The main objectives of this strategy were:

(a) to create conditions for sustainable growth and balanced economic development,
(b) to ensure social stability by reducing poverty and unemployment, and,
(c) to create conditions for full membership in the EU before the end of the decade.

These objectives set out a clearer roadmap for revising the current legislation in all fields of governance, including social protection and disability legislation, in both entities. According to the revised MTDS document from 2006\textsuperscript{85}, several critical elements were supposed to be addressed in the disability sector:

---

\textsuperscript{80} World Bank, 2006
\textsuperscript{81} Eurostat (http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-08-112/EN/KS-SF-08-112-EN.PDF), p.3
\textsuperscript{82} Labor Force Survey
\textsuperscript{83} CIA World Factbook (estimation for 2007)
\textsuperscript{84} Proposal for a Council Decision on the principles, priorities and conditions contained in the European Partnership with Bosnia and Herzegovina and repealing Decision 2006/55/EC (COM(2007)657, November 2007)
- A strong inequity in social protection existing between entities, and among the FBiH cantons. This inequity refers to two reasons: on one hand, the significant differences of financial security measures between war veterans with disabilities and other persons with disabilities (where war veterans can receive up to four times more benefits than the other persons with disabilities), and on the other hand the geographic disparity in assistance and support. The document mentions that BiH has a high number of persons with disabilities who do not receive any kind of assistance, unless they are war veterans with disability or live in the Canton of Sarajevo.

- A prevalence of cash benefits within the overall measures for poverty reduction; a (still) weak development of social services or community support measures.

- A need to enforce the role of the entity level in RS regarding the design and monitoring of financial entitlements and rights implementation for people with disabilities. This aspect should compensate the strong differences existing currently between municipalities, since this domain is highly decentralised.

Starting in 1999, the reform of the social sector in BiH benefited from an extensive support of the Government of Finland. A first program called "Support to the Social Sector in Bosnia-Herzegovina" (SSSP) was developed during various phases from 1999 to 2003, having as main objective to strengthen a mixed model of social welfare based on social rights that is sustainable, inclusive, community based, and client-oriented.

**A Social Inclusion Strategy** is currently under elaboration, with the support of DFID (Nov.2008).

**The reform process in the disability sector**

In BiH the social protection is regulated mainly through entities and cantonal laws (not at the State level), therefore there is a mix of centralized and decentralized mechanisms. From 2005, the Government of Finland supports a significant cooperation program (2005-2009), targeting the development of the **Disability Policy in BiH**. This five-year program includes the elaboration of policies and implementation procedures in various disability-related domains, among them the development of community-based social services. It represents the main strategic document under construction in the disability field.

The expected results of the program are the following:

1) the development of a comprehensive disability policy and strategy based on the new types of services and on the mixed model of service provision;

2) an increased integration of disability sensitive approaches in national policies, programmes and projects; and

3) harmonised criteria of the level of disability i.e. standardised manual (and other procedural tools) for Centres for Social Work (CSWs) and other professionals working in the disability-related activities.  

4) establishment of an adequate and sustainable system for social protection with full recognition of the rights and opportunities of the persons with disabilities, their families and the civilian victims of war.

The key stakeholders for the implementation of this program are:

- the Directorate for Economic Policy Planning and Implementation of BiH;
- the Ministry of Labour and Social Policy of Federation of Bosnia and Herzegovina;
- Ministry of Health and Social Welfare of Republika Srpska;
- municipal authorities;

- civil society representatives, especially from organisations of and for people with disabilities;
- personnel of Centres for Social Work and other centres that provide combined services, including care and employment of people with disabilities;
- people with disabilities including civilian victims of war and families with children, regardless of the cause of disability;

- the Independent Bureau for Humanitarian Issues (IBHI).

A Disability Policy Study published in 2007 under the above mentioned program, revealed the most significant problems that have to be addressed by regulators with regards to disability:

- the existing discrimination between people with disabilities with regards to cash benefit entitlements (war veterans with disabilities vs. Other persons with disabilities; as well as disparities in cash entitlements between entities, and between the various cantons of FBiH);  

- a (still) poor inclusive approach in education, employment, public transportation, housing, culture and sports, despite the general principles that are acknowledged by the relevant stakeholders in these areas;

- disability is not yet properly mainstreamed in all policy sectors;

- the lack of harmonisation between the entities legislation;

- the need for revising all assessment mechanisms regarding the abilities of the people with disability, as well as the definition of disability;

- the need for a clear divisions of roles within a mixed welfare system and the enforcement of public-private partnership in the social service provision.

---


87 www.dfid.gov.uk

These issues will remain priorities for action in 2009.

Legislation in the field of social services
At this moment there is no specific law for social services at the level of Bosnia and Herzegovina. There exist however several entities’ laws that regulate the sector of social services89:

Federation of Bosnia and Herzegovina (FBiH)

- The Law on Basic Social Protection, Protection of Civilian Victims of War and Protection of Families with Children (2000). Amendments to this law were adopted in 2004 and in 2006; however, harmonisation of the amendments is pending. The same law included a provision that obliged the cantons to adopt their own laws on social protection within three months. The adoption of cantonal laws is not yet finalised. This law also regulates the non-governmental activity in the field of social service provision in FBiH.
- Cantonal Laws on Social Security, the Welfare of Civilian War Victims and the Welfare of Families and Children;
- Law on Family90.
- The Law on the Allocation of Public Revenue in the FBiH (Official Gazette of FBiH, Nos. 26/96 and 32/98) specifies the distribution of public revenues between the Federation and the cantons. A significant proportion of the revenue is allocated to the cantons and the regulations prescribe the type and level of revenue allocated to the municipalities, out of which social protection is funded.

Republika Srpska (RS)

- The basic legal act regulating this area in the RS is the Law on Social Protection (with amendments from 2003)
- Law on Children’s Protection (Official Gazette of RS, No. 4/02);
- Law on Family (Official Gazette of RS, No. 54/02);
- Law on Financial Contributions (Official Gazette of RS, No. 51/01);
- Law on professional rehabilitation, qualification and employment of disabled people (Nov.2004)
- Decision on Criteria for the Distribution of Funds of State Lottery for Socio-Humanitarian Activities (2001);
- Decision on Approval of Funding to Institutions for Social Protection (2002).

Brčko District of Bosnia and Herzegovina

The Brčko District Assembly has two new laws and an old one related to social services:

- Law on Social Protection in Brčko District of BiH (2003);

Roles and responsibilities in the social service provision

The social protection in BiH is administered at the Entity level. Since the country lacks a uniform legislation at the state level, social protection is not provided under the same conditions throughout BiH. There are a variety of responsible stakeholders in each entity, as well as in the Brcko District. However, both public and private providers can deliver social services for people with disabilities in BiH. Centres for Social Work are the main focal points for users’ referral procedures and for their information. In many cases they also provide services for people with disabilities.

At national level

- The Council of Ministers is in charge of launching all national strategies and reforms with impact at both entities and Brcko District.

In Federation of Bosnia and Herzegovina

- The Ministry of Labour and Social Policy of the FBiH (Sector for Social and Child Security) is responsible for the social services provision. The federal agencies are responsible for legislation and rules, but the Cantons are responsible for the direct provision of services at local level.

- There are 10 Cantonal Ministries for Social Policy that are linked in the territory with:
  - 2 Cantonal Centres for Social Work (Sarajevo and Bosansko Podrinjski)
  - 57 municipal Centres for Social Work in the entire federation
  - 22 Departments for Social Protection at municipal levels.
In Republika Srpska

- The Ministry of Health and Social Protection establishes government policies relative to social protection. The Law on Social Protection mentions that it is the duty and responsibility of municipalities to find the means for the realisation of rights with regard to: material safeguarding, support and other personal care, accommodation within institutions of social protection, accommodation with other families, safeguarding the means for social work services, and funding Centres for Social Work.
- The ministry administers 44 Centres for Social Work and is functionally linked with 18 Departments for Social Protection in municipalities.

In Brčko District

- The Department for Health, Public Security and Citizen Service is responsible for Government policies related to social services.
- The Centre for Social Work provides four primary services: services for child protection; services for psychosocial protection; services for general protection and protection related to marriage and family; and socio-geriatric services. An interesting characteristic of this process is that employers of the Centre for Social Work are not only the executors of regulations, but are also the creators of the regulations, which are based on their work experiences.

The non-governmental sector opened a network of community based services, mainly in RS and FBiH: day centres, elderly community based settings, programs for psycho-social support and social assistance programs. However, their cooperation with the local authorities is not regulated, in order to allow long-term sustainability measures for these services, as well as an adequate quality control.

Formal participation of people with disabilities in policy making process

All along the elaboration of National Disability Policy Framework (2005-2009), DPOs have been consulted in various stages of the process. Several disability organisations have also contributed to the elaboration of a National Report in the Field of Disability for Bosnia and Herzegovina, in 2007.

A Coordination Board of disabled peoples' organizations exist in Republika Srpska, as well as an Inter-ministerial Body of the Republic of Srpska Government for Supporting and Protecting Persons with Disabilities is also established, composed of representatives of relevant ministries representatives of the Coordination board of disabled people. This Inter-ministerial body has a consultative character within policy making processes. No similar body exist in FBiH, however a Disability Advisor is appointed at federal level.

Looking ahead:

The administrative organization of BiH is such that, very often, progresses and innovative legislation represent a bottom-up process, from cantons or entities towards national level (e.g. the creation of legal Standard Professional Instruments for the Centre for Social Work in Tuzla Canton, the reorganisation and modernisation of working procedures within Centre for Social Work in Banja Luka etc). Local policies and implementation procedures have a more rapid potential to change, than national ones.

A certain number of issues are pending, and they require a concentrated and coordinated decision making between cantons (in FBiH), entities and State:
- a significant number of institutions and services do not have yet a clear status and regulatory framework;
- the revision of the evaluation criteria and classification system in the disability sector is imperative for a harmonisation of social rights at national level;
- the cross-entities transfers of funding remain difficult and unclear;
- the division of regulatory roles in social service provision, including fiscal responsibilities (between State, entities, cantons and municipalities), has to be subject to a wide national debate and analysis.

---

92 Trnka E., Dobraš Z., National Report in the Field of Disability for Bosnia and Herzegovina, 2007, within the project : "Capacity Building of Disabled People’s Organisations in the Western Balkans", coordinated by European Disability Forum and supported by EU (CARDS)
93 Ibid.
2.1.3. Social Services Framework in Croatia

After the war in the 1990’s which led to important human, economical and infrastructure damages in Croatia, the country made impressive progress in terms of economic development and advanced on the road to integration in the EU. It is now one of the wealthiest countries of the region.

Croatia is the only country in the region that ratified the UN Convention on the Rights of People with Disabilities. The ratification process is expected to represent a catalyst for more active reforms in the field of disability-related policies.

One of the characteristics of Croatia is an extremely wide corpus of national strategies and legislative documents that include disability aspects in their texts (over 270, as inventoried by a non-governmental organisation recently). The reform and modernisation of this domain will face a big challenge of legislative harmonisation, within and among these very detailed laws and by-laws.

Croatia still relies on an extensive system of social security measures for people with disabilities, as well as on an institutional system of social services. The main effort for change in Croatia in this domain is the establishment and diversification of new community-based services. After several attempts of renovating the social services sector in 2000-2003, the de-institutionalisation process proved to be very slow and the resistance among public stakeholders (decision makers, professionals of State-run institutions etc.) very significant.

However, the role and influence of non-governmental service providers have increased in the past years and a current national initiative on social welfare development gives additional energy to this reform effort by 2009. Significant examples of good practices have been developed in Croatia, especially in the field of support services for people with disabilities at community level (sign interpreters and personal assistants, supported housing, supported employment).

GDP per capita (PPP) (in relation with EU27=100): 54 (2007)
Un-employment rate: 14,8% (2007)
HDI Ranking: 45

EU Accession process

In 2001 the Croatian Government applied for accession to the EU and was granted with candidate status in 2004.

A significant step for the future evolutions of reforms in Croatia was the signing of the Joint Inclusion Memorandum (JIM) with EU in March 2007. The Memorandum outlines the main challenges in relation to poverty and social exclusion policies, presents the major policy measures for policy harmonisation with EU principles and criteria and identifies the key issues for future monitoring and policy review. In the field of social services, EU highlights several key recommendations for Croatia, within the JIM:

• A more significant development of community based services;
• A greater decentralisation and de-institutionalisation of care;
• Developing services that respond to people’s real needs and choices;
• A wider cooperation between public and private structures in social services provision;
• Continue the efforts to promote people with disabilities and their inclusion in mainstream social activities.

95 According to Bosnjak, V., Stubbs, P., Towards a New Welfare Mix for the Most Vulnerable: Reforming Social Services in Bosnia-Herzegovina, Croatia and Serbia.
96 Eurostat
98 Central Bureau of statistic, Croatia http://www.dzs.hr/default_e.htm)
99 Croatian national census, 2001
100 UNDP, Human Development Report 2008
101 The purpose of the Joint Inclusion Memorandum’s (JIM) exercise is to assist Candidate Countries to combat poverty and social exclusion and to modernise their systems of social protection, as well as to help preparing their full participation in EU policies in the area (http://ec.europa.eu)
102 Joint Inclusion Memorandum, Croatia, March 2007
The reform process in the social welfare sector

The reform process is aiming at harmonization with the overall EU criteria. World Bank support for achieving the independent living and work, and so-called care out-of-home. Any request for such types of assistance has to be submitted to the local Centres for Social Work.

The Social Welfare Development Project (2006-2009). The Social Welfare Development Project (2006-2009) is the second document of this type, after a similar strategy that covered the period 2002-2006. The strategic document from 2007 benefited from a wider participation and consultation of national associations of persons with disabilities. In September 2007, the Disability Action Plan of the Council of Europe was also integrated by the relevant authorities and NGOs representatives from Croatia in the so-called Zagreb Declaration, a significant call for action paper for the entire region.

Important strategic documents for the disability sector

The National Strategy on Equal opportunities for Persons with Disabilities (2007-2015) was adopted in 2007. It is the second document of this type, after a similar strategy that covered the period 2002-2006. The document contains areas of priority action (family and society; education, health and rehabilitation; professional rehabilitation; employment and work; habitation; mobility and accessibility; social support and care; and pension insurance etc), as well as the responsible agencies and deadlines for implementation. Internal criticism existed in relation with the slow implementation of the previous strategy before 2007, especially in the field of personal assistance services, the management of government’s fund for professional rehabilitation and employment and the situation of employing people with disabilities at national level. The strategic document from 2007 benefitted from a wider participation and consultation of national associations of persons with disabilities.

Legislation related with disability and with social services sectors

The Social Welfare Act of 1997 is the basic law regulating the activities of social welfare (including social services). Under the law, social assistance is financed from both the central government budget and the budgets of the municipalities and cities. The law includes the spectrum of entitlements for people with disabilities: counselling, assistance in overcoming specific difficulties, social security benefits and disability pensions, in-kind benefits for the residents of institutions, third person allowance for care, help and assistance in home, support for achieving the independent living and work, and so-called care out-of-home. Any request for such types of assistance has to be submitted to the local Centres for Social Work.

103 The main implementers of this project have been: the Ministry of Health and Social Welfare, the Croatian Employment Service, the Fund for Professional Rehabilitation and Employment of Persons with Disabilities, the Employment Agency - Moj Posao, and several NGOs: the Association for Promotion of Inclusion; the Croatian Association for Professional Aid to Children with Special Needs ‘IDEM’; the Croatian Union of Physically Disabled Persons Associations.


105 Ibid.


The Humanitarian Assistance Act of 2003 defines the concept of humanitarian assistance, including the provision of social service by non-profit providers. This law allows NGOs to establish and deliver social services for various categories of users, including people with disabilities.

The Professional Rehabilitation and Employment of Disabled Persons Act of 2002 is oriented toward the participation of people with disabilities in the open labour market. It introduces also a quota system into employment.

In 2001 a specific Law on Croatian registry of people with disabilities has been released. This law defines the way of collecting, processing and protecting the privacy of data of people with disabilities, and gives this responsibility to the Croatian Institute of Public Health.

The Croatian Parliament has adopted recently a comprehensive Law on antidiscrimination (September 2008), very welcomed by the disability movement.

One of the characteristics of the disability sector in Croatia is an extremely extensive (and fragmented) legislation related with this domain. An inventory of all legislative documents related to various aspects of protection, care and assistance for people with disabilities has been realised by the Union of Associations for Physically Disabled Persons, in 2007. The total number of these documents is 274108. They regulate different aspects of support and care, from the use of guide dogs for people with visual impairments, to various types of cash benefits, accessibility requirements for public spaces etc.

Roles and responsibilities in the social services provision

- **The Ministry of Health and Social Welfare (MHSW)**
  The social services in Croatia are rather centralized and the MHSW has the major responsibility for their provision. The process of decentralization is one of the main priorities in the system and started in 1997 (based on the Social Welfare Act, as well as with its amendments in 2001).

- **The Ministry of the Family, Veterans and Inter-Generational Solidarity (MFVS)**
  This Ministry has responsibility for policies, strategies and services regarding the family, children and youth, people with disabilities, war veterans and victims of war, and old age pensioners. The Ministry has opened a number of Family Counselling Centres, providing part of the services offered previously by Centres of Social Work.

- **The Centres for Social Work (CSW)**
  Centres for Social Work are de-concentrated bodies of MHSW and key institutional structures responsible with the provision of social services and social assistance at local level. Their total number is 87, for about 427 municipalities109. These centres assume the role of evaluating the disability situation of each person (except for the work-related disabilities which are assessed by a medical commission) and orient the person towards appropriate community services.

- **The Ministry of Economy, Labour and Entrepreneurship**
  This Ministry is responsible for the work of the Croatian Employment Services which registers the unemployed, administers unemployment benefit, and provides training, advice and placement services. The Croatian Employment Service consists of a Central Office, Regional Offices and Local sub-offices. People with disabilities are entitled to use these agencies together with all other citizens.

- **The Regional and Local Units of Self-Government**
  Each County has an Office for Health and Social Welfare, the same for cities and larger municipalities. Counties are now the owners of formerly state-run homes for older people, and municipalities make a contribution to the running costs of CSWs110. The counties and other local units can open social welfare homes and institutions, as well as day services. A large number of social homes in Croatia are designed for elderly people and people with physical disabilities. There are relatively small numbers of community-based services for people with disabilities (and especially for persons with intellectual disability) established by public authorities.

Non-governmental organizations can also provide social services for people with disabilities. The most widespread types of services provided by these organisations are the foster care services and small housing units, as well as day services centres or clubs for disabled persons.

Despite progresses in the recent years, the overall system of support for people with disabilities is still viewed by EU as over-institutionalised and bureaucratic111.
Formal participation of people with disabilities in policy making processes

In Croatia there is a Governmental Committee for People with Disabilities (since 1997), consisting of representatives of DPOs and relevant ministries. This committee meets three times a year and has to give the approval for all draft laws related to the people with disabilities, before they enter into discussion in the Parliament. The committee provides the Government with proposals, opinions and professional advice in the field of living conditions, protection and rehabilitation of people with disabilities and their families. The president of the committee is the Deputy Prime Minister; the vice president of the committee is the President of the Union of the Associations of Persons with Disabilities of Croatia. 12 national organizations of people with disabilities are represented in this committee.

A National report on persons with disabilities was realised by Disabled People Organisations from Croatia, within a CARDS program promoted by the European Disability Forum in the Western Balkans countries, in 2006-2007.

Looking ahead:

A significant effort is done in Croatia for harmonizing the legal framework, in the disability sector, with international documents signed and/or ratified so far. However, the disability legislation remains over-fragmented and difficult to be known, understood and used by people with disabilities in everyday situations. An internal revision of this package (considering also the mainstreaming of disability in regular legal documents) is strongly needed. From the perspective of social service policies, several priorities for action are critical for this stage of reform:

- A clearer commitment and measures for de-institutionalisation of persons with disabilities, as well as enhancing policy measures and financial support for a wider spectrum of services at community level;
- Developing clear partnership frameworks between public authorities and private providers of social services, including contracting and funding procedures;
- Increasing the consultation of people with disabilities in policy elaboration stages, as well as at local levels, in order to reflect better their choices and interests in terms of community services’ priorities.

2.1.4. Social Services Framework in Kosovo (under UNSCR 1244)

Kosovo represents a unique situation in the region, being under international protectorate since the end of 1999. In February 2008, Kosovo declared unilaterally its independence from Serbia, but the UN Mission in Kosovo (known as UNMIK) still considers the Security Council Resolution 1244 from 1999 as valid. Benefiting from a specific Law on Family and Social Services, since 2005, the disability-related services remain however poorly developed in Kosovo. This is due to a difficult decentralisation process and a poor spectrum of community based services in general. The disability-related services continue to be primarily provided by non-governmental organisations.

The particular status of Kosovo made difficult so far the establishment of long term strategies in the disability sector, as well as the allocation of concrete public resources for the development of this sector. At the end of 2008, the elaboration of the first Disability Action Plan was finalised. DPOs are gathered in a coalition that is taking an active part in the decision making process at political level. This aspect provides good premises for a participatory work during the further stages of the social services and disability reforms, as well as the fact that disability is acknowledged officially as one of significant priorities for reform within the Ministry of Labour and Social Welfare.

Population: 2,473,000 inhabitants, 2/3 of the population lives in rural areas
GDP per capita: 1729 EUR (2008); no reference to EU27 (PPP) available.
Un-employment rate: 43% (est.2008).
People with disabilities: Estimated at 60,000-100,000 and at 150,000 by UNMIK in 2001.

The current situation and organisation of Kosovo (end of 2008)

During the decade before the armed conflicts in Kosovo, the overall investments and reforms in this region were very weak and Kosovo was among the most undeveloped region of ex-Yugoslavia. Kosovo remains even today
EU member states decide individually whether to recognise Kosovo. However, the EU has commissioned the European Union Rule of Law Mission in Kosovo (EULEX) that is supposed to take over progressively the responsibilities from UNMIK. The EU mission is to assume police, justice and custom duties from the UN, while remaining neutral regarding Kosovo’s status and still operating under the 1244 resolution that placed Kosovo under UN administration in 1999. The process is currently ongoing.

In July 2008 an important donors’ conference took place, in an effort of coordinating the international support in Kosovo.

Kosovo is organised administratively in 30 municipalities and around 1800 villages. Assembly of Kosovo is made of 120 members. The Government has 10 ministries and is lead by the Prime Minister. The President of Kosovo has very limited powers, and most decisions have to be approved by UNMIK.

**EU accession process**

In April 2008, the Government of Kosovo adopted an EU Integration plan 2008-2010. The EU accession represents a strong target for the current leaders. A roadmap for pre-accession has been discussed in Brussels and the Government estimates the signature of the Stabilisation and Association Agreement for 2012.

**Significant evolutions in the disability and social services sectors, in the last decade**

Kosovo passed through several stages in the process of building of its social protection policy: from an initial phase of humanitarian assistance (in the early 2000s), through strong cooperation between local authorities and international community, towards a more clear strategic effort, assumed by the Kosovo Government from 2007.

In the field of disability, several important projects took place in the last decade, however a consistent commitment and strategic planning for this sector started only in 2008.

In 2001-2002, local and international partners carried an important project in the field of community-based rehabilitation (CBR). The project’s main goal was to promote the development of citizenship and equal participation in society of persons with disabilities through CBR education, service, and policy development. Through the project, a significant number of CBR workers have been trained, as well as rehabilitation practitioners (medical doctors, physiotherapists) and a physiotherapy school opened in 2001.

In September 2001, the Ministry of Labour and Social Welfare (MLSW) was created and has been actively supported by international cooperation donors (DFID among others). This ministry is currently in charge with the social policy elaboration and it was the one promoting the Law on Family and Assistance Services, in 2005.

In 2008, the Government of Kosovo (the office for Good Governance, Human Rights, Equal Opportunities and Gender Issues, with the support of the Italian cooperation) launched the process of elaboration of a National Action Plan for People with Disabilities, for the years 2009 – 2011. The first draft of this plan has been released at the end of 2008, after consultation with civil society organizations that took part in all thematic working groups during its elaboration. The finalization of the plan is estimated for the first quarter of 2009.

In the field of social services, a large initiative called Kosovo Social Protection Project (KSSP) took place between 2001-2006, supported by World Bank and DFID. Not all expected results have been reached; however significant investments have been done for reorganizing and improving the Centres for Social Work.

---

118 Declaration of Deputy Prime Minister Hajredin Kuci, April 2008 (Reuters).
119 The project was carried by the International Centre for Advance Community Based Rehabilitation (ICACBR), in partnership with the Association of Disabled People HANDIKOS, UNMIK, members of the Faculty of Medicine at the University of Pristina, the School of Rehabilitation Therapy of Queen’s University Canada and Handicap International.
**Legislation in the field of disability and social services**

There are four primary laws that currently govern the social welfare system in Kosovo together with a number of other laws and regulations that provide more specific direction in certain areas:

- **Law on Social Protection** (1976) and the **Law on Marriage and Family Relations** (1984);
- **Law on Social and Family Services**, 2005;

The **Law on Social and Family Services** (no.02/L-17, April 2005) is the main document regulating the organisation of social services in Kosovo and among the very few in the region that refer very precisely to the sector of social services. The law establishes, among other things, the obligation of the Ministry of Labour and Social Welfare to start the decentralization of social services and to enable the welfare mix. In this sense, between the Department of Social welfare and the Ministry of Local Government a Memorandum of Understanding was signed in 2006, which stated the importance of the decentralization of service provision and specified a set of recommendations for action.

The **Anti-Discrimination Law (3/2004)** is a comprehensive one (not disability-specific as in Serbia). It refers to measures preventing discrimination based on "sex, gender, age, marital status, language, mental or physical disability, sexual orientation, political affiliation or conviction, ethnic origin, nationality, religion or belief, race, social origin, property, birth or any other status" (art.2)\(^{120}\). The disability movement advocates for the reference to all forms of disability in the legal text.

A number of other laws and regulations have direct relevance for social services and disability-related aspects, such as: the **Law on Disability Pension** (2005); the **Law for Employment and professional Rehabilitation for People with Disabilities**; Administrative Regulation on Residential Care/Institutions and Residential Care/Children’s Homes (2000), Administrative Regulation on Detention in Psychiatric Institutions (2001), the **Law on Primary and Secondary Education**, the **Law on Social Assistance Scheme** (2003), as well as those on Child Abduction, Mental Health, and Domestic Violence.

There is not yet a law promoting and protecting the rights of people with disabilities in Kosovo.

Generally, the approach to disability in the legislation is still medical (e.g. Law on Disability pensions, 2005), which is linked with the fact that the gate-keeping system (including evaluation criteria and procedures) has not been reformed yet.

**Roles and responsibilities in the provision of social services**

The Law of Social and Family Services defines precisely the role of different stakeholders in social service provision:

**The Ministry of Labour and Social Welfare/Department of Social Welfare** is regulating and administrating the overall system of social services.

The main responsibilities of the MLSW are the following:

- the overall organization and provision of social and family services;
- development of policies and preparation of strategic plans;
- coordination of activities of government agencies and local and international NGOs;
- specifying professional standards for professionals working in the social services sector;
- provision of social services in exceptional circumstances;
- undertaking or commissioning research;
- inspecting social services providers;
- providing advice and guidance to NGOs; and
- establishing or approving the establishment of residential facilities for people in need by municipalities or NGOs.

The **Department of Social Welfare** (DSW) of the MLSW is the body that defines the policy and procedures regarding further decentralisation and concrete organization of social service provision in Kosovo. The Department for social Welfare has 4 main departments: one related with budgetary planning and poverty assessment, a Division for Social Services, a Division for Residential Institutions (administering the 5 existing institutions in Kosovo) and a Division for Social Assistance. At local level, both Division for Social Services and the one for Social Assistance are related with the Centres for Social Work.

The DSW has more specific responsibilities including:

- advising the Ministry and the Government of Kosovo on the development of policies related to Social and Family Services;
- preparing the implementation regulations, directives and guidance for the application of the Law;
- setting standards and conducting inspections of social and family services;
- reviewing the municipal directorates annual reports and operational plans;
- responsibilities in the provision of foster care, adoption and guardianship etc.

The Division for Social Services within the DSW has coordination units for the main areas of social services mentioned in the law:

- Adoption and Foster Care;
- Child Protection;
- Domestic Violence,
- Trafficking and Sexual Crimes;
- and Family Services and Legislation.

The coordinators in these units are monitoring and advising the work of the Centres for Social Work (CSW) (which are deconcentrated bodies of the MLSW) with regard to the implementation of policy and regulations, and providing guidance and training, if needed, for the CSW staff in their respective areas.

The Division for Institutions is responsible for the Shtime Institution (for people with intellectual disabilities and mental health conditions), two community-based Children’s Homes for children with special needs (Shtime and Gracanica), and the Elderly Home located in Pristina. A certain number of small-size residential settings exist as well in Kosovo, established and managed by NGOs (but they are not under the responsibility of the Division for Institutions). All users of residential care are registered in the databases of the Centres for Social Work, for the follow up.

The DSW has in general strong relationships with the Centres for Social Work through its divisions for social services and social assistance. There are however, weaker links between the Department and the municipal Directorates of Health and Social Welfare, which are the municipal bodies with the responsibility for social welfare provision. The collaboration of the DSW with the Institute for Social Policy and with the NGO sector is still perceived as uneven.

The Centres for Social Work (CSWs)

As deconcentrated bodies of the MLSW, the Centres for Social Work provide frontline social services to the community. They are mainly service providers and monitoring bodies, and their number in 2006 was 31. In municipalities with different ethnic communities (Mitrovica, Kamenica) separate CSW exists for each ethnic group. World Bank supported the modernization of CSW during a three-year project and the staff was trained, among other, in the field of case management.

In several municipalities the CSW cooperate with local or international NGOs in the field of social service provision.

The Institute of Social Policy

The Institute of Social Policy (ISP) has gone through many changes over the past years. With significant support from DFID and international NGOs, the ISP attempted to clarify its mandate within the DSW and as a result primarily focused on three areas: social services mentoring to CSW staff, social research, and a second-level appeals for social assistance and social services cases. In 2005, the ISP gained a status of Department within the MLSW. Its staff increased and its focus became the social research.

According to the Law on Social and Family Services, the key responsibilities of the ISP are to:

- Develop and promote professional knowledge, skills and standards in the area of Social and Family Services;
- Undertake research in the area of Social and Family Services;
- Promote professional excellence through training, expert consultation;
- Publish relevant manuals, research reports and professional materials.

The Institute also established the General Council for Social and Family Services. The Department of Social Welfare established the Council in January 2006, in line with the Article 1 of the Regulation 2001/19 on the Executive Branch of Self-Government Provisional Institutions in Kosovo and the Article 5 of the Law on Social and Family Services. Its main responsibilities are the following:

- Ensuring a register of professionals who work in social and family services institutions;
- Licensing of professionals that provide social and family services in Kosovo;
- Issuing special rules and codes of conduct for these professionals, in order to carry the licensing procedures.

The DWS has the responsibility to train the 21 members of this council. The members are representatives of the MLSW, University of Pristina, and of the NGO sector and communities.

The actual functioning of this council is delayed, however the Ministry of Social Welfare considers its entering into force as a priority, especially due to its role in licensing of frontline professionals and the impact of this procedure on the licensing of service providers.

The Ministry of Health

The Ministry of Health (MoH) is responsible for community-based mental health services, however it is not responsible for the Shtime Institution and the Elderly Home in Pristina. With the support of the World Health Organization (WHO), MoH opened seven regional community mental health centres in 2003 and 2004 in an effort to de - institutionalise the mental health service system.

These seven Community Mental Health Centres provide services and activities as well as sheltered housing apartments, counselling and support groups to adults and some children with psychiatric disabilities. The Centres are equally supported through the municipalities and are operated by professional staff.

- **The Municipalities**

The Regulation 2000/45 on Local Self-Government specifies that the municipalities should ensure social services for their citizens. Most municipalities have a Directorate of Health and Social Welfare, which is mandated by the municipal council to be responsible for the social welfare aspects. According to the current legislation, municipalities are key stakeholders for provision of social services to people in need.

According to the Law on Social and Family Services, the key responsibilities of the municipalities should be the following:

- ensuring the provision of social and family services within their territory, in very close cooperation with the CSW;
- assessing and identifying the needs at the municipal level;
- to prepare annual plans which have to be approved by MLSW;
- to adhere to the regulations, directives and procedures as laid down by the Minister;
- to commission (in the sense of contracting) the provision of certain social and family services to NGOs;
- to provide advice and guidance to NGOs.

The implementation of these legal responsibilities is uneven, since no concrete procedures exist yet in each of these areas of intervention.

Municipalities can establish contracts with NGOs for the provision of specific social and family services and they can also become involved, if approved by the Ministry, in providing direct social and family services, in addition to the services provided by CSWs and NGOs.

- **Non-governmental organisations**

There is a relatively wide network of international and national NGOs acting in Kosovo, but no reliable data exists on their number and type of social services projects they have implemented. In the field of disability, the NGOs contributed to the development of community-based rehabilitation (CBR) services, as well as of foster care services, children's homes, support services like interpreter's training, counselling and resource centres. The activity of non-profit service providers is not yet completely regulated in Kosovo. The licensing procedures are currently under development.

At present, a wide network of CBR services is provided by HANDIKOS122 and includes 10 community centres and 25 local active groups123.

**The assessment of the disability situation** in Kosovo remains underdeveloped. There are no clear responsibilities for this evaluation. Some of the CBR Centres are carrying the evaluation of children with disabilities.

Five different definitions of disability are reported in the Kosovo legislation, leading to uncoordinated referral and orientation procedures, related to disability entitlements and support measures124.

**Formal participation of people with disabilities in the policy making process**

In 2006, a Disability National Council (KNAKK) was established at the Government level. This council is composed of the Deputy Prime minister, 5 deputy ministers and 9 representatives of DPOs. The council has a consultative role for both Government and the Kosovo Assembly.

A coalition of organisations of people with disabilities has been established.


**Looking ahead:**

Kosovo is enrolled today in several strategic reforms (structural and sectoral). The development and improvement of community-based services represents a clear priority within the social welfare modernisation. An effective coordination between national authorities and international support agencies will be of major importance during next years, in this context.

Among many priorities, the field of social services for people with disabilities needs concrete and specific action plans, within the more general Disability Action Plan adopted in 2008, targeting:

- the finalisation of services mapping and new procedures for needs assessment (at local and national level);
- development of coherent regulatory procedures and integrated information systems within the overall system of service provision;
- development of new types of support services at community level, for the most excluded and isolated categories of persons with disabilities.

122 A large NGO of people with disabilities in Kosovo.

123 A local active group consists of a field co-ordinator, a medical health technician and a case manager, and is responsible for identification of persons with disabilities, registration, referral to community centres and distribution of assistive devices and aid materials. At each community centre there are 2 physiotherapy technicians, a psychosocial worker, a centre co-ordinator and a driver. The workers at community centres provide physical rehabilitation services and psychosocial activities for mainly children with disabilities.

2.1.5. Social Services Framework in the Former Yugoslav Republic of Macedonia

The Former Yugoslav Republic of Macedonia seceded peacefully from ex Yugoslavia in 1991, however it was at that time one of the poorest countries in the region. The further openness to external investments, after its independence, made the country more sensitive to economic fluctuations at international level. Macedonia faces today significant challenges in the reform of its social protection system, as well as of the social services legal framework. Despite the acknowledgement of some main principles for modernisation and improvement at the level of the Government structures, as well as inclusion of these principles in several strategic documents, the rhythm of legal reforms is still slow. A unified policy making process is challenged mainly by a fragmentation of roles and responsibilities at the level of Ministry for Labour and Social Policy, as well as a poor correlation of roles in planning and budgeting, at the level of Centres of Social Work and the Social Departments of the local councils.

In exchange, the development of community based services at local level has a more rapid rhythm than in other countries. These new initiatives provided by state and non-governmental organisations, face currently a lack of adequate regulatory frameworks for allowing their sustainable continuation and continuous improvement.

Population: 2,041,000 inhabitants (2006)\textsuperscript{125}.
GDP per capita (PPP) (in relation with EU27=100): 30 (2007)\textsuperscript{126}.
Unemployment rate: 36% in 2006\textsuperscript{127}.
People with disabilities: estimated at 21,835 persons (only persons with physical and intellectual disabilities were included (State Statistical Office, 2006).
HDI Ranking: 68

Overall organisation of the country
Macedonia has 84 municipalities (opstini), from which 10 are composing the capital Skopje. The estimated population in Skopje is 600,000 inhabitants.

EU Accession process
In November 2005, Macedonia received a positive opinion from the European Commission on its application for the EU membership. This opinion recommended the opening the EU accession negotiations. In December 2005 the European Council granted Macedonia with the status of candidate country. The concrete negotiations for EU accession are yet to be started.

The reform process in the social and disability sector
Several important projects were conducted so far in Macedonia, targeting the start of modernization of the social service provision and the introduction of new approaches in the supporting people with disabilities (funded by UN agencies, World Health Organisation, Italian and German cooperation among others). In 2004-2008 for example, the Social Protection Implementation Project was supported by World Bank and coordinated by the Ministry of Labour and Social Policy. This project aimed at initiating the reform of the social welfare system, both in terms of cash benefits and social services. Among its objectives there was a focus on introducing regulatory mechanisms in the services system (planning, monitoring, quality management etc. In practice, the concrete start of this component has been delayed and regulatory frameworks for social services cannot be expected before late 2009-early 2010.

Macedonia signed the UN Convention on Rights of Persons with Disabilities in March 2007.

Important national strategies and legislation in the field of social services
The newly established National Strategy for De-Institutionalisation (2008-2011) represents a potential good catalyst for the revision of the social sector legislation. This strategy fixes a clear roadmap for de-institutionalisation, starting with measures at the level of Demir Kapja institution (which is one of the large residential institutions for people with disabilities). It emphasizes the role of diversifying the network of community based services.

\textsuperscript{125} State Statistical Office, FYR Macedonia
Additional elements for reform exist in the following strategies:

- **National Strategy for Equalisation of the Rights of Persons with Disabilities** (2001);
- **The Poverty Reduction Strategy** (2002);
- **The National Action Plan on the Rights of Children** (2005-2015);

The main laws regulating the social welfare system in Macedonia are:

- the **Law on Social Protection** (2000, amended in 2004),
- the **Law on Family** (1996)
- the **Law on local Self Government** (2002).

The law on Social Protection (amended in 2004 with new articles) mentions new types of possible non-institutional services: home care, day care services as a support to individuals and families, foster placement, group homes, homes for independent living, vocational workshops and counselling services. It opens also the right of non-governmental providers to run social services, which was considered a major step forward in Macedonia, despite of (still) reduced mechanisms for enhancing the sustainability of these private initiatives.

The other relevant legal documents for the disability-related aspects are:

- the **Laws on Primary and Secondary Education** (1999) (which enable the enrolment of children with disabilities in regular schools, in special schools, as well as in special classrooms of mainstream schools);
- the **Law on Child Protection** (2000);
- the **Law on Employment of People with disabilities** (2000) which creates the preconditions for the access of people with disabilities to the open labour market;
- the **Law on Health Care**, which regulates as well the access of people with disabilities to health care and rehabilitation services.

**Roles and responsibilities in the social service provision**

- The **Ministry of Labour and Social Policy (MOLSP)**, together with its 27 de-concentrated **Centres for Social Work** (covering 84 municipalities), are the main stakeholders responsible for ensuring the access of people with disabilities to social services at community level.

According to the Law on Social Protection, these services are organized in institutional and non-institutional care. Because of the lack of legal provisions on the decentralization of financial transfers (in the Law on local Self Government), the Centres for Social Work are not yet reformed and they deal with both cash entitlements and social services provision. They generally lack human resources and expertise in the community-based social services, and the absence of a more general regulatory framework targeting the monitoring and evaluation procedures further challenge their work.

In general, the role of MoLSP in planning, budgeting and decision making is divided among 10 internal Departments (e.g. Department for Social Protection, Department for Equal Opportunities, Department for Child Protection etc).

The types of social services for people with disabilities provided by the State are: the residential institutions, the specialized services (like day centres for children with disabilities for example) and the kindergartens (in Macedonia the kindergartens are under the responsibility of the Ministry of Labour and Social Policy).

The residential institutions are organized according to the target group population: (a) children and youth without parents or lacking parental care; (b) children and youth with educational and social problems and behaviour disorders; (c) children and youth with intellectual disabilities; (d) children and youth with physical disabilities; (e) elderly and adults with disabilities; (f) elderly persons; (g) adults with "moderate and severe intellectual development impairments".

Since 2007, MOLSP with the support of Open Society Institute (Mental Health Initiative) and in cooperation with the non-governmental organisation Polio Plus, started the transformation of Special Institution Demir Kapija, for people with intellectual disabilities. From December 2008, the first service of supported living was established in Skopje and people from Demir Kapija were transferred in this new type of community-based facility. The project will continue for two more years.

During the last years, MoLSP also opened several day centres for children with disabilities at national level in the recent years with the support of UNICEF and the German Technical Assistance Agency (GTZ). 18 such public centres were mentioned at the beginning of 2008. New methods of work with persons with disabilities (as well as significant material and financial assistance) have been provided to these new services. Some of them are in process to be transferred to local municipalities, however the process is delayed by a legal framework that is submitted to interpretations, as well as by reduced financial envelopes at the level of municipalities.

---

In the context in which the fiscal decentralisation is not yet achieved and the role of municipalities in purchasing social services is very limited, the Ministry of Labour and Social Policy keeps the main role in funding innovative services at community level. Since 2006, the Ministry started implementing tenders for social services provided by NGOs and the amounts are gradually increasing. However, in comparison with the other countries of the region, the grants envelopes remain extremely reduced (e.g. the volume of grants in the child protection sector: 16.129 Euro in 2006, 48.387 Euros in 2007)\(^\text{(129)}\).

- **The Institute for Social Protection** is another important stakeholder for the social welfare organization, fulfilling a methodological role in the system.

It was formed in 1961, and its activities are defined in the Law on Social Protection. The main tasks of the Institute are the control and evaluation of social protection policies, analytical research on social problems, programming of social protection development, supervision of the professional activities in Centres for Social Work, as well as of other public welfare institutions. Although there were sporadic initiatives (corresponding with periods of government change) to transform the Institute into an independent institution, it still functions as a part of the organizational structure of the MoLSP. The institute is currently involved in the elaboration of quality standards for social services and will play an important role in the design of a comprehensive regulatory framework for disability-related services.

- **The units of Local Government**, under the Ministry of Local Self Government and operating under the Law on Local Self-government (2002), have gained new competencies related to social protection in the frame of a decentralisation process. However, their cooperation with the Centres for Social Work (deconcentrated bodies of MoLSP) is perceived as weak and the responsibilities are fragmented, especially regarding the planning, budgeting and monitoring of social services at local level.

The local self-government units can theoretically initiate a variety of community based service (including funding, maintenance, infrastructure investment): children nurseries and homes for the elderly; social care for people with disabilities (day care centres), as well as other types of non-residential care activities directed at vulnerable groups. The execution of these competencies is related with an Annual National Program for the Development of Social Welfare\(^\text{(129)}\). In practice, the local authorities have so far produced quite limited initiatives in planning, contracting and/or purchasing social services at local level.

- **The NGOs** have legal possibility to deliver social services in Macedonia, however the legal framework of non-profit sector is not updated. The activity of NGOs in general is regulated by the **Law for Associations of Citizens and Foundation (1998)**.

Their activity in the field of social service provision received a significant incentive through the amendments at the Law on Social Protection (in 2004), and a specific Commission for the Cooperation with NGOs was created within MoLSP in this context. However the cooperation between the State and the NGO sector remains centralised and relatively reduced.

A significant number of NGOs provide social services at community level, but only those registered in the MoLSP database can apply for public tenders. Their number is very low (less than 30 in 2007) and the criteria for accessing public funds are very restrictive (at least 3 years of activity before applying for funds, among others). NGOs are advocating for a rapid revision of these registration, licensing and funding procedures.

**The assessment of the disability situation** and the adequate entitlements and services needed by people with disabilities are decided at the level of **Centres for Social Work**, based on the "Regulation on the Assessment of the Specific Needs of Persons with Physical and Intellectual Disability (2000)". Children with various types of disabilities are assessed by different commissions (2 for sight impaired children, 2 for autistic children 2 for physically disabled – all these in Skopje and Bitola – as well as 12 commissions for children with intellectual disabilities). All these commissions are under the responsibility of the Ministry of Health.

**Formal participation of people with disabilities in policy making processes.**

An umbrella **Union of Organisations for Disabled Persons** exists in Macedonia. In 2007, similar to other umbrella organisations in the region, it has released a National Report of the Situation of Persons with Disabilities, under the CARDS/EDF project\(^\text{(131)}\).

A specific initiative promoting the elaboration of a systematic Law for the Protection of Rights and Dignity of Disabled People was carried by the organisation Polio Plus in 2005, following a vast awareness campaign at national level and the collection of more than 10.000 signatures. The text of this law is not yet adopted in Macedonia, however the profile of this particular civic initiative remains unique in the region so far, in the disability sector\(^\text{(132)}\).

---


\(^{131}\) Within the project "Capacity Building of Disabled People’s Organisations in the Western Balkans", coordinated by European Disability Forum and supported by EU (CARDS).

\(^{132}\) For more details, see Polio Plus webpage, http://www.polioplus.org.mk
In 2007, four Community Disability Action Plans, drafted with the participation of local DPOs and other community stakeholders, have been elaborated at the municipality levels, in Cair, Negotino, Prilep and Veles. This constitutes also a pilot initiative in Macedonia, in the context of a (still) hesitant decentralization process. They had rapid multiplier effects (at least four similar initiatives will continue in 2009).

**Looking ahead**

Numerous priorities for action remain in front of the Macedonian authorities in the coming period:

- a definite start (and concrete implementation) of the reform of the social welfare sector;
- a more strategic approach to all priorities for action formulated by Disabled People Organisations, in the field of disability;
- the introduction of regulatory mechanisms in social service provision;
- consistent budget allocations for the support of the welfare mix, in accordance with the existent legal framework;
- a radical reform of the gate-keeping system, in line with the holistic approach on disability;
- adequate inter-sectorial cooperation in all aspects related to disability and community services.

### 2.1.6. Social Services Framework in Montenegro

Montenegro, previously republic of ex Yugoslavia (and further on of Serbia and Montenegro) proclaimed its independence in May 2006. As a very new state, Montenegro’s reforms are challenged by a significant number of transformations that take place at national and local level, due to this recent change of the governance system. On the other side, because of its small size (only 650.000 inhabitants) the rhythm of these reforms has good chances for rapid improvement. Recent initiatives in the regulatory system for social services, as well as in the development of new community services, show a positive evolution already. People with disabilities are relatively well included in different phases of policy making and are acknowledged as a priority group within the social protection reforms.

On the other side, the de-institutionalisation process and the concrete implementation of a large package of very recent legislative documents are among the most important priorities in the disability sector, for the coming years.

**Population:** 650,575 inhabitants.

**GDP per capita (PPP) (in relation with EU27=100):** 41 (est.2007).

**Un-employment rate:** 12% (2008).

**People with disabilities:** estimated at 10% (65.000), in the absence of reliable statistic data.

**HDI Ranking:** 64

### EU Accession process

Following the recognition of the independence of Montenegro in 2006, the European Council authorised the European Commission, in July 2006, to continue negotiations with Montenegro on conclusion of a Stabilisation and Association Agreement (SAA). The SAA was signed in October 2007. Following a proposal by the Commission, the Council adopted a revised European Partnership for Montenegro in January 2007. In May 2007, Montenegro adopted an action plan for implementation of the European Partnership. From 2007 onwards, Montenegro will also receive pre-accession financial assistance under the Instrument for Pre-Accession Assistance (IPA). In January 2007, Montenegro became a member of the international financial institutions, i.e. the International Monetary Fund, the World Bank and the European Bank for Reconstruction and Development. In May 2007, Montenegro joined the Council of Europe as well.


A specific Secretariat for European Integration will manage the IPA assistance instruments during the pre-accession process to the EU.

---

133 World Bank 2006
135 Montenegrin Employment Centre
137 Instrument for Pre-Accession Assistance
138 http://www.sei.vlada.cg.yu/
Important national strategies for social reforms

Montenegro is a country with a relatively dynamic rhythm of strategic planning. Many documents have been elaborated and released in the last four years:

• The Strategy for poverty reduction and prevention of the social exclusion (2003, renewed in 2007);
• The Strategy on rights of people with disabilities, 2007;
• The Strategy of reform of social and child protection, 2007;
• The National Action Plan for children (2004-2011);
• The Reform of primary health system and strategic plan of development of the health insurance system until 2011;
• The Strategy on Inclusive Education (released in early 2008);
• The Strategy on the Protection of Elderly Persons under preparation.

Legislation in the field of social services

The main legislative documents that refer to social protection and provision of social services for people with disabilities are the following:

• The Law on Education of Children with Special Needs (2004);
• The Law on Social and Child Protection (2004);
• The Law on Non Governmental Organisations (1999) that includes referrals at NGOs as service providers;
• The Law on Health (2004);
• The Law on Protection of Rights of People with Intellectual Disabilities (2005);

The Law on the Use of Guide Dogs and Assistant Dogs for persons with sight impairments was adopted in 2008; the same for the Law on Professional Training and Employment of Persons with Disabilities. The Antidiscrimination Law is still pending, despite the fact that its draft started in 2006.

The legislative corpus in the disability sector is therefore very recent. Implementation procedures are yet to be developed, which leads to numerous obstacles in the daily life of people with disabilities. The general public, as well as public functionaries, are not always informed about the adoption of these new laws and therefore not able to respond promptly to the specific needs of people with disabilities.

Roles and responsibilities in the social service provision

The social services for people with disabilities are provided under the responsibility of the Ministry of Health, Labour and Social Welfare (MHLSW), and their 10 de-concentrated agencies, the Centres for Social Work.

MHLSW provides mainly rather institutionalized services in the following types of structures:

• Schooling and rehabilitation institution for children with hearing and speaking impairments;
• Children Homes;
• Geriatric and Nursing Institution;
• Education and Professional Rehabilitation Institution for disabled children and youth;
• Special institution for children and youth with severe disabilities (Komanski Most – Podgorica);
• Center “1st June” for children with light intellectual disabilities – Podgorica.

In addition to institutional care, MHLSW provides as well several community based social services (through the Centres for Social Work), especially counselling for vulnerable or at-risk groups. Day centres develop progressively in Montenegro as well, and the first one (called ‘Tisa’) opened in 2004 in Bijelo Polje, under the responsibility of the Centre for Social Work, and in cooperation with the local parents organisation (the main promoters of the project) and the local municipality. Benefiting from international support in the initial stages, the centre became a pilot initiative later on.

The Ministry of Education supports a network of mobile multi-disciplinary teams (speech therapists, (special education teachers and psychologists), at regional level (Podgorica, Nikšić, Northern Montenegro and the South region). A significant reform in education is currently taking place in Montenegro, promoting inclusive approaches and methodologies.

The municipalities provide as well social services for people with disabilities, but the decentralization process is very recent and their roles in this sector are limited. In some municipalities (Bijelo Polje, Berane, Pljevlje, Herceg Novi, and Niksic), the local authorities undertook the responsibility of developing (or contributing to) day care centres for children with disabilities, a relatively new type of service in Montenegro.

The NGOs (parents’ organizations and DPOs, with the support of international organizations) are developing innovative community services, especially for children and youth: day care centres, toy libraries, counselling services, educational and rehabilitation services.

The assessment of the disability situation is currently ensured by a socio-medical commission at local level. This is based on a pure medical approach to disability. However, the gate-keeping system is under reform in Montenegro (see also Spotlights 4 and 8). The reform started in the field of evaluation and orientation of children with disabilities, through the establishment of 18 new commissions at the level of local councils, in the main
municipalities of Montenegro (mid 2007). They develop currently new methodologies of work and new internal regulations. Their new evaluation instruments are originated in the Disability Creation Process (the Quebec model of Disability)\(^\text{139}\). The links between these two types of gate-keepers (socio-medical commissions and commissions of evaluation and orientation towards education) are not yet clarified, but the process is planned to be finalised by the end of 2009. For adults with disabilities, an assessment and evaluation is made by a medical commission.

**Formal participation of people with disabilities in policy making processes**

At the level of the Government functions a Consultative Council for the Protection of Disabled Persons, which is in place since 2003. The council was renewed in 2007 and it is currently composed of representatives of public authorities (6 ministries and the Director of National Employment Bureau) as well as of representatives of three national DPOs, the Union of Blind People, Union of Paraplegics and the Union of Parents Organisation.

In 2007, a National Report of the Situation of Persons with Disabilities was produced by Disabled People Organisations in Montenegro (The Union of Blind and the Association of Paraplegics), under a specific EU-CARDS project\(^\text{140}\).

Parents and other umbrella organisations are actively involved in many domains of current legislative reform in Montenegro.

**Looking ahead**

Many progresses have been made in Montenegro in the last four years, in the field of social services for people with disabilities: commitment from authorities for inclusive approaches (even if not fully effective yet); better financial investments in social services, especially from 2007 on; improved participation of people with disabilities and parents organisations in various working groups related to policy reforms. In addition, the recent reform of evaluation commissions for children with special educational needs represents an innovative example for the entire region, as well as the development of the early intervention programs.

The process should continue with more focus on broadening the spectrum of services. If day centres have already achieved big success in Montenegro, it is now time for investing vigorously in support services for independent living (personal assistants, assistive technologies, support teachers, supported employment, in-home support etc). These services are almost inexistent in Montenegro and the favourable reform context should enhance their emergence rapidly. In addition, time has come for developing a coherent regulatory framework in the field of social services: quality standards, licensing of providers, monitoring systems, all these procedures should accompany the so far good start of the reform and should contribute to make these initial investments effective and sustainable.

### 2.1.7. Social Services Framework in Romania

The images of children and persons with disabilities in the Romanian institutions, in the early 1990’s, shocked not only the world but Romanian people as well. Since then, the road towards the EU integration (in January 2007) was paved with many challenges and difficult reforms. The evolution of community-based services, the de-institutionalisation process, the various stages of decentralisation of the social security and service provision, are some of the aspects that characterised one of the most difficult transition processes in the region. They are also a significant source of good practice examples and lessons learnt in several areas of reform (e.g.de-institutionalisation within the child protection system).

The disability movement is weaker and less coordinated than in other countries (of the ex Yugoslavia, for example). Consequently, the participation of people with disabilities in the policy making process is uncoordinated and uneven. However, the overall legislative framework in the field of child protection (including children with disabilities), social services and decentralisation is more advanced.

**Population:** 21,537,563 inhabitants from which 55% live in the urban area and 45% in the rural area\(^\text{141}\).

**GDP per capita (PPP) (in relation with EU27=100):** 41 (2007)\(^\text{142}\).

**Un-employment rate:** 5,8% (September 2008)\(^\text{143}\).

The number of adults with disabilities in September 2008, according to the database of the National Authority for Disabled People, was 557,697\(^\text{144}\). The number of children with disabilities in June 2007 according to the evidences of the Service for complex evaluation, functioning within the General Directions of Social Assistance and Child Protection, was 77,940\(^\text{145}\).

**HDI Ranking:** 62\(^\text{146}\).

---

\(^{139}\) Disability Creation Process, http://www.ripph.qc.ca/?rub2=3&rub=10&lang=en&id_cours_sel=4

\(^{140}\) Within the project “Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Forum and supported by EU (CARDS)


\(^{144}\) National Authority of Disabled Persons (www.anmp.ro)

\(^{145}\) Information presented in the Monitoring Report submitted by Romania under article 44 -1(b) on the Convention of the Rights of the Child, October 2007.

The reform of the child protection system in Romania (integrated in a large project called “Children first”) was very limited and concentrated either in spas (for neuro-motoric rehabilitation) or in large municipalities. A university background in medical rehabilitation at national level, the actual number of rehabilitation centres, experience in foster care or in day care services at community level (before 1989), the creation of new types of services, the decentralisation of service provision from national to local level. Since Romania had practically no previous experience in foster care or in day care services at community level (before 1989), the creation of new types of services was a challenging aspect. On the other side, despite a large number of professionals with a university background in medical rehabilitation at national level, the actual number of rehabilitation centres was very limited and concentrated either in spas (for neuro-motoric rehabilitation) or in large municipalities (rehabilitation units, speech therapy centres, hospitals etc).

The reform of the child protection system in Romania (integrated in a large project called “Children first”) was the main catalyst of change in the social sector. It started concretely in 1997 and focused on four areas:

(a) the reform of the legal and regulatory framework governing the protection of children’s rights; (b) the decentralization of administrative and financial responsibility from the central Government to the local county; (c) the promotion of community-based services as alternatives to the residential care; (d) increasing the role and participation of civil society and non-governmental organizations to child welfare activities.

The international pressures and the appearance of a significant number of child advocates at national level, led to a consistent effort for change, that was carried out in several phases (between 1997 and 2007). The aim was to achieve simultaneously the deinstitutionalisation of these children (among which a large number were children with disabilities) and the decentralisation of the service provision from the national government to local counties and municipalities. In 2001 the Romanian Government adopted the Strategy regarding the protection of children in difficulty (2001 – 2004). This strategy proposed the adoption of a series of radical measures including the closure of large institutions and the establishing instead, of prevention and alternative services at community level.

An evolution of statistics in this field shows that, between 2001 and September 2008, 68% of children under 18 years old have been transferred to community settings. Source: National Authority for the Protection of Child’s Rights (www.copii.ro). In 2004, foreign adoptions were banned except for those by close relatives.

In line with the strategy’s target goals, the Law on Promotion and Protection of Child Rights (2005) marked the switch of the reform from treatment to prevention and early intervention. In the context of this law, the notion of ‘children at-risk’ referred primarily to children at risk of abuse and neglect in their own families, children with disability, children with HIV/AIDS, delinquent children, street children, and children leaving institutions at 18 years old.

The result of these legislative initiatives was the progressive development of new services for children and adolescents, at community level: a wide network of day care and foster care services, family-like settings, counseling centers for families, rehabilitation centres among others, as well as numerous awareness campaigns for the promotion of children’s rights.

Many problems remain still unsolved and the transformation of the entire system continues. A new category of children became vulnerable in the past years, the ones with parents working abroad. Around 350.000 children are estimated to be living alone at home, or cared for by their relatives, at the end of 2007.

Overall organisation of the country

Romania is divided in 41 counties (judet) and Bucharest municipality (with has a county status), as well as 263 cities (oras) and 2685 communes (with more than 16.000 villages). Some of the larger cities can become municipalities, according to specific legal conditions.

At county levels function both elected authorities (county council) and deconcentrated agencies of the ministries (usually called Inspectorates or Directorates). At the level of towns functions a city council and a mayor (elected authorities).

A difficult transition period for the social sector

In order to overcome the heavy legacy of a communist dictatorship that lasted more than 40 years, Romania passed through a long period of reforms and organisational adjustments in the field of social sector. The most significant process took place in the field of child protection, due to international exposure of around 100.000 children placed in institutions in the early 1990s, as well as for the decentralisation of service provision from national to local level. Since Romania had practically no previous experience in foster care or in day care services at community level (before 1989), the creation of new types of alternative services was a challenging aspect. On the other side, despite a large number of professionals with a university background in medical rehabilitation at national level, the actual number of rehabilitation centres was very limited and concentrated either in spas (for neuro-motoric rehabilitation) or in large municipalities (rehabilitation units, speech therapy centres, hospitals etc).

The result of these legislative initiatives was the progressive development of new services for children and adolescents, at community level: a wide network of day care and foster care services, family-like settings, counseling centers for families, rehabilitation centres among others, as well as numerous awareness campaigns for the promotion of children’s rights.

Many problems remain still unsolved and the transformation of the entire system continues. A new category of children became vulnerable in the past years, the ones with parents working abroad. Around 350.000 children are estimated to be living alone at home, or cared for by their relatives, at the end of 2007.

147 No official statistics are available from that period. The figures are contradictory and their estimation varies from 50.000 to 100.000, according to national or international sources
149 From 55.335 children in large institutions in 2000, their number decreased to 18135 in Sept. 2008 (this last figure includes also children placed in residential group homes of small capacity). Source: National Authority for the Protection of Child’s Rights (www.copii.ro).
150 For more information, see the official website of Romania’s National Authority for the Protection of Child’s Rights: http://www.copii.ro/working.htm
151 Romania was the European country with the largest number of children infected with HIV (7500 at the end of 2003), primarily due to the transfusions with contaminated blood, at the end of 1980’s and early 1990’s – according to UNICEF Romania, http://www.unicef.org/romania/ro/health_nutrition_hiv aids_3122.html
152 Estimation of the Federation of Organisations in the field of Child Protection from Romania (www.fonpc.ro)
In the disability sector, the national authority responsible for the protection of rights of people with disabilities changed several times (from the level of Ministries of Health and of Education, to the General Secretariat of the Government and finally to the Ministry of Labour, Family and Equal Opportunities). This situation, as well as separate administrative responsibilities with regards to children and adults with disabilities (two separate national authorities) created many blockages and difficulties in redirecting of resources, coordination of support, continuity of service provision, gate-keeping procedures.

While the situation of children with disabilities living in institutions was addressed more significantly within the program "Children first", the reform of services for adults with disabilities is much delayed. The number of adults living in residential institutions remains very high: 17,137 in September 2008. The spectrum of services available for these persons at community level is extremely scarce and very poor attention is paid to support services for independent living. The gate-keeping procedures, definitions of disability and the access criteria to certain types of services need careful revision as well. At the present moment, the main promoters of community-based services for adults remain the non-governmental organizations, especially in the field of vocational training and supported employment, support for independent living or sheltered housing.

The diversification of community-based social services started progressively in the early 1990's, promoted by NGOs and benefiting from international support and methodologies. After a decade of innovations and pioneering, the concrete reform of this sector at national level was launched in 2001 (in the field of services for children) and in 2006 for the overall spectrum of services, when a national strategy for the development of social services was adopted by the government (as described further on).

With regards to the professionals working in the social sector, a particular aspect of the Romanian transition was the re-introduction of psychology in the list of official qualifications, after 1990. In 1978, due to a discretionary order of the former Romanian president, psychology had been forbidden in the country, the Faculty and the Institute of Psychology were closed down and all psychologists were transferred in under-qualified positions. For this reason, after 1990, the revitalisation of the system of services involving psychological support (counselling centres for families, psycho-social support etc) needed almost a decade to be accomplished.

The 'professional maternal assistant' for the foster care service was a complete new profession in Romania, after the 1990's. It was introduced as an official qualification in 1997, and the training requirements and certification process for foster parents have been adopted in 1998, at national level.

The number of social workers, special teachers and physiotherapists was constantly growing, however majority of them are only available in the main cities or municipalities. The number of support professionals (like support teachers for inclusive education, sign language interpreters or job coaches, for example) is completely insufficient at national level.

Looking "beyond de-institutionalisation" – a priority for Romania

The deinstitutionalization process generated several types of side effects in Romania that have not been always managed effectively by central and local authorities. Due to the large amount of investments and organizational capacities mobilized for reducing the number of institutions, the situation of children and adults with disabilities living within their families was not prioritized at the same level. The number of these persons is much more significant than people living in institutions and they represented, unfortunately, the 'forgotten people' during this transition period. For example, 96 % of the total number of adults with disabilities lives in families. Their access to community services was (and still is) very limited and the lack of support services remains critical for them in Romania. Families with children and adults with ASD (autistic spectrum disorders), persons with complex and multiple disabilities living at home, children with disabilities who have tried to access the mainstream educational chain of services, are particularly affected by this lack of community services and strategic commitment from the level of authorities. Moreover, the precise data about their number and needs do not exist. Many of them are not even included in official registration documents related to disability entitlements. It is now of major importance to locate these persons, to map their needs and to develop adequate support services and measures for their inclusion in mainstreaming services and activities, in their own communities.

Relevant strategic documents in the field of social services and disability

The National Strategy for the development of social services (2006-2013)

In December 2005, the Romanian government approved the National Strategy for the Development of Social Services, accompanied by an action plan for its implementation in the period 2006–2013. The strategy focuses on the need to bring social services closer to their beneficiaries, by sharing responsibilities at regional and local level. It highlights as well the promotion of a welfare mix at national level. To facilitate such a system, the action plan for implementing the 2006–2013 strategy focuses on several key objectives:

- establishing a unified, flexible and transparent legal framework; qualitative management of the system;
- developing an equitable, harmonised and integrated system of services at national level;
- promoting a proactive and participatory culture for the population and the beneficiaries of social services.

154 In December 2008, the number of registered maternal assistants is 16,534, http://www.copii.ro/content.aspx?id=55
It was estimated that the foundations for the national social services system should have been established by 2007, the infrastructure put in place by 2009 and the comprehensive network of services spread throughout the country and accessible to all potential beneficiaries by 2013. In practice however, there are significant delays in implementation, both regarding the spectrum of services and the regulatory system, especially with regards to monitoring, evaluation and contracting of services at local level.

The National Strategy for the Social Protection, Integration and Inclusion of Persons with Disabilities (2006 – 2013) called "Equal Opportunities for Persons with Disabilities – towards a Society without Discrimination" continues a reform that started in 2003. If the first stage focused more on the transformation of residential services, the current strategy announced a particular attention given to families of persons with disabilities, as well as to the employment of people with disabilities in all forms of labour environments (regular, supported or sheltered).

In practice, the real inclusion and participation of people with disabilities in Romania remains extremely weak. No official analysis have been released recently with regards to the strategy’s implementation, however the numerous interviews and field visits during the elaboration of this report shows that the situation of persons with disabilities is not improving in the rhythm anticipated by authorities. Moreover, (and contrarily to the situation in other countries of the region) disability disappears progressively from the ‘political agenda’ of decision makers. As the disability movement in Romania is weaker and not properly organised, this situation is a serious alarming sign for the progress of further reform initiatives.

The National Strategy of Social Inspection (2008-2011) defines the objectives and the institutional framework for this new agency created in Romania in 2006, related to the control, evaluation and guidance of policies and measures in the field of social assistance (including social services).

The signature of Joint Inclusion Memorandum in 2005 represented the starting point for a strategic approach in relation to social inclusion.

Examples of dedicated programs for social services, during the reform process
Several specific programs have been dedicated at national level for the reform of social services. This is not a comprehensive list and their mentioning intents to offer just a rough picture of the overall financial and organisational investment for this kind of reform, during a decade:

- An annual Program of National Interest Projects (PNI), in order to encourage local communities to create social services, according to their needs and resources. From the beginning of 2006, 9 PNIs were adopted, addressed to people with disability persons, elderly persons and victims of domestic violence. In the field of child protection, such schemes of PNI have been developed since 2003;
- The annual program of subsidies provided by the Ministry of Labour, Family and Equal Opportunities for NGO’s providing social services155. According to the law, the funding mechanism consists of a lump sum per user of service per month (actualised every year) and can cover part of the expenditures for personnel (only social workers), utilities, food and direct care materials for the respective services;
- The Social Sector Development Program (supported by World Bank) – The Social Assistance Component (2004-2006) of the program allocated 3 million USD for 70 local projects157;
- The Social Inclusion Project (supported as well by World Bank - 47,2 million EUR), approved by law, in 2007. The project has four main components, from which the component no. 3.1 Disabilities Program aims at developing social services and community projects, training the professional staff that will implement new standards of care and development of monitoring and evaluation system for the National Authority for Persons with Disabilities158.

Legislation related with the field of social services for people with disabilities159
The Law on the National System of Social Assistance (no. 47/2006) – this law regulates the entire system of social assistance provision, both services and cash benefits. The law mentions the responsibilities of various stakeholders in providing assistance at national level and initiates three national agencies in the social sector, with complementary functions:

- The Social Inspection (which entered into force in January 2008) - for monitoring, control and evaluation of all social protection measures at national and local level;
- The Social Observatory – for developing and administrating an integrated system of information at national level, in the social sector (not finalised yet);
- The Agency for Social Cash benefits (not finalised yet).

---

155 According to Law no.34/1998
157 Ibid.
158 Ibid.
159 The list contains the most significant legislative documents currently into force in Romania and is not exhaustive.
The Law on Social Services (515/2003) describes the types of beneficiaries, regulatory framework and the responsible agencies in the field of social service provision.

The Government Decision no. 539/2005 on the National list of social services in Romania – it presents the list of services developed at local level, per categories of users.

The Law on protection and promotion of rights of persons with disabilities (no. 448/2006) promotes active measures of protecting the rights and personal independence of people with disabilities, in order to eliminate the reliance on institutional care. According to the provisions of this Law, all people with disabilities are entitled to education, health care, prevention, habilitation and rehabilitation, and employment. The state institutions have the obligation of providing these services to rights holders.

The Law on the Promotion and Protection of Children’s rights (no. 272/2004) contains references to the way in which social services should be equally accessible for children with disabilities. For developing his/her full potential and personality, the child with disability has the right to a series of educational and rehabilitation services which would allow him/her to reach a maximum level of autonomy as well as social inclusion.

The Law on Mental Health and the Protection of Rights of people with psychiatric conditions (no. 487/2002) contains references to the rights of these persons, the evaluation of their conditions and their entitlements in terms of access to services and support measures.

The Law on the Prevention and Sanction of all Forms of Discrimination (2000 and then updated in 2002 and 2006 – L.34/2006) – is the first comprehensive anti-discrimination law released in the region. Together with the Law regarding the equality between men and women (340/2006), it was one of the main instruments used in the transition period by persons with disabilities, their representatives and even public authorities for sanctioning the lack of accessibility and enabling conditions in communities. The law provides for the establishment of a National Council for Fighting Discrimination 160. This council was established in 2001 and was responsible for applying Romanian and European Union anti-discrimination laws and managing the National Anti-Discrimination Plan. According to the law, the Council reports to the parliament and is politically independent. It has often ruled against government institutions at various levels (particularly local councils). An individual or other legal entity can bring forward a case of discrimination to the CNCD within one year of the case or event occurring. The CNCD is obliged, within 90 days, to investigate the case and rule on whether anti-discrimination laws were breached. The anti-discrimination law covers discrimination based on: race, nationality, ethnicity, language, religion, social category, beliefs, sex, sexual orientation, age, disability, HIV/AIDS, and any other criteria which restrict human rights, equalities and fundamental liberties. If discrimination is proven to have occurred, the Council can issue a fine or a warning 161.

The Government Decision no 1217/2006 on the National Mechanism for Promoting Social Inclusion in Romania

Based on this document, a National Commission for Social Inclusion was set up in 2006, as a component of the Inter-ministerial Committee for social affairs, health and consumer protection. Social Inclusion Units have been organized within each central public authority. At local level, similar County Commission for Social Inclusion are constituted from members representing the de-concentrated public services of central authorities, the local authorities and NGOs. The main role of this national mechanism is to collect quantitative and qualitative data in the area of social inclusion (needed for policy elaboration and revisions); to prepare the monitoring and progress reports regarding the priorities established by JIM and National Action Plans; as well as to elaborate social sector monitoring indicators.

The Law on Social Inspection (no. 211/2007) defines the role and responsibilities of the Social Inspection Agency.

From 2001, Romania has also a Law on Voluntary Work (no. 195/2001), meant to enhance and to regulate the volunteering initiatives. Numerous NGOs rely on volunteers for providing primary services at community level, however their number in specialized services for people with disabilities is significantly smaller.

Roles and responsibilities with regards to social service provision

The Law on the National System of Social Assistance defines the social services under two categories: the primary services (focusing on prevention or proximity measures that can limit the vulnerability of a person or a group at one moment) and the specialized services (their focus is on rehabilitation measures, or at measures enabling better inclusion of vulnerable persons or groups). The social services can be delivered within: residential settings, family-like services (e.g foster care) and day services.

The provision of social services is decentralized at local level. It can be ensured by both public and private providers, which are accredited in this sense.

At the level of concrete implementation, social services in Romania use a case management model, which is the foundation for an integrated approach to assessment, planning and intervention through outreach services to those that are hardest to reach. This aspect is also regulated through a specific set of standards at national level.

160 http://www.cncd.org.ro

161 Romanian anti-discrimination law (34/2006, revising the Law 137/2000)
• The Ministry of Labour, Family and Equal Opportunities (MoLFEO)
The Ministry is responsible of elaborating policies in the field of social assistance and to promote the rights of marginalised groups. The Ministry keeps responsibilities of strategic planning of the social sector, elaboration of legislative documents, coordination and monitoring, inspection, as well as funding in certain areas of priority. At the level of this Ministry, two different agencies are responsible for children and adults with disabilities:
  - The National Authority for Promoting the Child’s Rights is in charge for the situation of children with disabilities;
  - The National Authority for Disabled Persons is responsible for the overall situation of adults with disabilities.
In terms of responsibilities related to services, these agencies are in charge of monitoring the residential institutions that are functioning under the direct responsibilities of county councils.

• The County Councils are in charge with funding the specialised services, including the residential ones.

• The Local Councils are in charge with funding the primary social services and can also subcontract services with NGOs. However, the contracting procedure for private providers in Romania is not fully regulated and its concrete implementation remains to be done.

Local and county councils are also responsible, through their social departments, to identify and map the needs and social services at local level. Many municipalities and counties already have extensive maps of existing social services, a process that was improved after the introduction of the accreditation procedure in 2006 and the establishing of a National (electronic) register of social service providers. However this is not the case for the identification of social needs at local level. The process of analysis and planning at local level does not yet include the participation of users of social services (or users’ representatives) on a regular basis. This aspect impacts significantly on decisions regarding the allocations of resources at local level.

• The Research Institute of the National Authority for Disabled People elaborates the methodological procedures and the quality standards for the services under the Authority’s responsibility (services for adults with disabilities: residential institutions, day services, rehabilitation and occupational therapy services, personal assistants, group homes, sheltered employment etc).

• The Social Inspection Agency performs control, assessment, counselling missions in the field of social assistance (including social service providers)

• The NGOs are providing a wide spectrum of social services for people with disabilities in Romania. In order to do so, they have to be accredited.

The accreditation of social service providers is done at the local level, by specific commissions at county levels. These commissions are subordinated to the de-concentrated agencies of the Ministry of Labour, Family and Equal Opportunities. A second authorisation called licence is released by the National Authority for the Protection of Child’s Rights, in order to prove the compliance with more specific quality standards, for each type of social service in the field of child protection.

At the end of the first year of implementation of the accreditation procedure in Romania (in 2006), 1164 providers were accredited, from which 742 were non-governmental, and 422 public providers. Until today, the licensing and accreditation procedures are often perceived as bureaucratic and overlapping for certain categories of services. This issue is highlighted by service providers as an aspect to be revised.

The evaluation of the disability situation is done by separate commissions, in case of children and adults with disabilities. Their activity takes place at the level of county councils or, in case of Bucharest, at the level of local councils of each sector. In case of children, the assessment of the child situation is done by a “commission for complex evaluation”, which is also in charge with the elaboration of an individual intervention plan. The results are transmitted to a “Commission for Child Protection” which decides the degree of disability and recommends a specific set of support measures; it also ensures a school orientation for children with disabilities. In case of adults, the degree of disability, as well as the corresponding entitlements, is established by a “commission for complex evaluation of adults with disabilities”.

A second instance commission, at national level, deals with complaints related to these initial decisions of the commissions mentioned above.

The disability advocates as well as service providers require an urgent revision of the Order 762/2007, regarding the out-dated medico-social criteria for establishing the degree of disability.

Formal participation of people with disabilities in policy making processes
In Romania the overall disability movement is relatively weak and not well organised. However, several umbrella organisations exist for people with disabilities, as well as an informal platform of DPOs under the form of a

---

163 p. Bucharest is divided in 6 sectors and each of them has an elected local council
164 Call for action within DISABNET, the forum of Romanian service providers in the field of disability.
Shifting the Paradigm in Social Service Provision

National Council of Disability. The members of the Council are included in the Council for Analysis of Problems of People with Disabilities, under the National Authority for Disabled Persons (established in 2007), together with representatives of the Ministry of Labour, Family and Equal Opportunities, the Ministry of Public Health, the National Authority for the Protection of Child’s Rights and a representative of human rights organisation. This advisory council proposes policy measures for improving the situation of people with disabilities and monitors the respect of the legal rights and has a consultative role.

Looking ahead

The current legislation in Romania provides a relatively detailed framework for the organisation and administration of social services. However, a large number of irregularities persist, such as: the unaccomplished regulatory framework (lack of mapping of social needs, comprehensive monitoring and evaluation of social services, specific contracting and funding procedures at local level, among others); the wide discrepancies between regions and counties and between urban and rural areas with regards to the spectrum of services for people with disabilities; gaps between the needs of beneficiaries and the available resources; the absence of strategic community planning in the field of disability; poor management structures and the lack of qualified personnel, especially in rural areas.

The process of deinstitutionalisation is supposed to continue vigorously, especially related to adults with disabilities. A stronger accent should be also put on inclusive practices, from education to employment. Concrete implementation measures and resources (in schools, workplaces, public services) should accompany this approach, which is perceived as losing progressively the commitment of responsible authorities.

2.1.8. Social Services Framework in Serbia

With a relatively extensive package of legislation in the field of disability and social sector, including an anti-discrimination law referring specifically to the rights of people with disabilities, as well as benefiting from a consolidated system of social security measures, Serbia is confronted with significant challenges in the field of social services reforms. The successive changes of governments and political decision makers made the advancement of the social reforms very difficult and rather slow in the last four years. The elaboration of by-laws and concrete implementation measures for the social legislation represents still a priority for action.

The system of services for people with disabilities remains predominantly institutionalised, with a relatively limited spectrum of community-based services and support measures at local level. The process of decentralisation of funding and responsibilities (from the republic level towards municipalities) has started, but is still very recent (2006) and not very advanced in the field of social protection. A significant number of good practices and pioneering initiatives exist in the country, in terms of social service delivery. At the present moment, the existence of dedicated grants for their support represents a good incentive, however, their sustainability in a long term is a major concern, since they are mostly delivered by NGOs, without an adequate regulatory framework at national level.


GDP per capita (PPP) (in relation with EU27=100): 33 (2007)\(^{166}\).

Un-employment rate: 18.8\% (est.2007)\(^{167}\).

People with disabilities: estimated to 7-10\% of the general population, depending on the source of data (governmental agencies, disability movement).

HDI Ranking: 65\(^{168}\)

After a very difficult period in the 1990s, marked by the war in the former Yugoslav republics, the UN sanctions, the armed conflict in Kosovo with NATO bombing, Serbia is recovering and makes efforts to undergo a challenging transition towards democratization and market economy.

Overall organisation of the country

Serbia has 165 municipalities, which are the main local government entities. The capital Belgrade has 17 municipalities and a population of at least 1.6 million inhabitants\(^{169}\). The Autonomous Province of Vojvodina (in the Northern part of Serbia) has its Assembly, Executive Council and Administration. Vojvodina has a Provincial Secretariat for Health and Social Policy, implementing the republic laws and regulations in the field of social protection and also the decisions of the Parliament and Executive Council of the province.

The UN Administered Province of Kosovo (under UNSCR 1244), situated in the Southern part of Serbia, declared unilaterally its independence in February 2008. Currently, Serbia does not recognise this independence.

\(^{165}\) World Bank
\(^{167}\) CIA Factbook
\(^{169}\) Census, 2002
**EU accession process**

Serbia is today a potential candidate for EU membership. Negotiations on a Stabilisation and Association Agreement (SAA) between Serbia and the EU were officially opened in October 2005. Full cooperation with the International Criminal Tribunal for the former Yugoslavia was required before the SAA can be signed. Serbia can also benefit from pre-accession financial assistance under the Pre-Accession Instrument (IPA). The Serbian government participated in the preparation of the 2007 IPA programme and the 2007-2009 Multi-Annual Indicative Planning Document for Serbia was adopted in June 2007.

**Overview on the particularities of social protection in Serbia**

Before 1990, the social protection in Serbia was under the authority of local municipalities. The Centres for Social Work (CSW) (founded by municipalities) were very well developed and considered by local residents as focal points in the field of social protection. By 2000, the post-war evolution led to a centralisation of decision making and funding at the level of the republic. The infrastructure of social services was massively deteriorated, the number of professionals decreased, while the number of persons in need for support increased significantly. Currently, it is the Ministry of Labour and Social Policy (MOLSP) that has the main responsibility of social protection in the country. The funding of both social security benefits and social services is rather centralised at national level. In the field of disability and social services, two dedicated funds are available at this level (the Social Innovation Fund and the Fund for the Organisations of People with Disabilities). Local governments have limited responsibilities, especially related to day services and certain types of allowances for family and child. The evaluation of disability situation is also made by specific commissions at local level.

**Important national strategies and programs for social and disability reforms**

Serbia’s Poverty Reduction Strategy (PRS) identifies people with disabilities as one of the most marginalised populations of society as far as poverty is concerned. An estimated 70% of these people are at the very edge of, or under the poverty line. This strategy is a medium-term development framework aiming at reducing the key forms of poverty in Serbia (as well as strong focus on macro economic stability, and other economic conditions). The PRS offers on one hand an analysis of causes, characteristics and profile of poverty in the country and, on the other hand, the main strategic guidelines for eliminating them in the coming years. The final PRS document was adopted in October 2003 and in February 2005 the Government authorised the Deputy Prime Minister to regularly inform the Government about the implementation process, together with the PRS Implementation Focal Point. The implementation of the strategy is realised with the support of the World Bank, EU, UN agencies, FAO and numerous bilateral cooperation programs (Norway, Sweden, Denmark, UK, Switzerland, USA). The Third National Conference on Poverty Reduction in Serbia, held in Belgrade in November 2007 concluded that several aspects related to social services represent priorities for action within the social welfare reform:

- Introducing standards for the provision of social services;
- Passing from a ‘project approach’ to a ‘system approach’ in the organization of services at national level;
- Continuing the fiscal decentralization in order to allow for more efficient organization of social services at community level;
- Clarifying the role of NGOs as social service providers, in a context of welfare mix;
- Shifting the approach in social service provision and placing the user in the centre of the delivery process; reflecting his/her needs actively as the basis of delivery process).

Additionally, The National Strategy for Social Protection Reform (2005) provides a targeted framework for action in this sector. The main areas for action are:  - the pluralism of service providers and the diversification of social services at community level;  - the transformation of residential institutions, de-institutionalisation of care and the decentralisation of related responsibilities and mechanisms;  - the reform of the financial assistance (cash benefits);  - specific programmes for training and improving professional skills of all stakeholders involved in the protection of social care users (capacity building)  - introduction of a system for accreditations and licensing of services providers.

In this strategy, a specific attention is paid to de-institutionalisation, with an existing medium-term plan for the transformation of institutions, the diversification of alternative services at local level and the training of adequate professionals. The international monitoring reports add strong pressure on the effective realisation of the strategy.

---

The National Program for the Promotion and Support of Foster Care started in Serbia in 2003. In 2007 the statistics of MOLSP were showing that 22% of the 3642 children placed in foster families were children with various disabilities. In 2007, the Ministry of Labour and Social Policy also initiated a support program for the development of social protection strategies at the level of local governments. The program consisted in the assessment and mapping of social needs in more than 160 communities. The program provided also means for implementation of several action plans resulted from this pilot activity.

The National Strategy for Improving the Status of Persons with Disabilities (2007-2015) and the corresponding Action Plan were adopted by the Government in December 2006. More than 400 DPOs were involved in various stages of its drafting process. The process of its implementation is based on bi-annual plans of actions, which precise responsibilities both at national and local levels. The access of people with disabilities to education, employment, basic health care and social services are targeted altogether in this strategic document.

At the end of 2007, Serbia signed the UN Convention on the Rights of Persons with Disabilities, together with the Optional Protocol.

Main legislation in the field of disability and social services provision

There are several legislative texts in the field of disability and social service provision, which constitute a strong basis for the reform process in these sectors:

The Law on Prevention of Discrimination against Persons with Disabilities (2006). As a result of significant advocacy efforts in the last years, the disability movement together with the Serbian Government succeeded to bring into force this very important national law.

Unlike the anti-discrimination laws from neighbouring countries, the Serbian document is designed particularly for the disability sector. The law refers to:

- the general regime of prohibition of discrimination on the grounds of disability,
- specific cases of prohibited discrimination against persons with disabilities,
- legal mechanisms and juridical proceedings for protection against discrimination, sanctions for perpetrators of particular acts of discrimination and measures for promoting social inclusion of persons with disabilities.

The law prohibits direct and indirect discrimination, victimisation, instigation of discrimination, and particularly severe cases of discrimination. It also prescribes which acts constitute prohibited discrimination in fields of proceedings in public authorities, membership in civic associations, access to public buildings, goods and services delivered to the public, public transport, health care provision, education, employment and labour relations, and family and marital relations. Measures for promoting equalisation of opportunities for persons with disabilities, inspired by UN Standard Rules are provided for. It prescribes in great detail mechanisms of judicial protection and sanctions for perpetrators of particular acts of discrimination. The Law had been drafted in co-operation with Serbia’s disability movement and human rights NGOs. According to the law, only persons with disabilities individually can file complaints against discriminatory practices and they have to prove that they have been the victims of those practices. Until now, no official monitoring report has been produced, however the disability movement follows closely the use of the legislative text in practice.

The main law regulating the provision of social services as part of the social protection system is the Law on Social Care and Social Security (2005). The law stipulates the following entitlements for people with disabilities:

- Provision of material (financial) security,
- Allowances for assistance and caregivers,
- Assistance in job training,
- Assistance at home, day care, temporary accommodation at admittance centres, accommodation in institution, or family placement,
- Social work services,
- Financial assistance or ‘in kind’ assistance for exceptional situations.

The law is currently under renovation and a new form is expected in 2008.

The Law on Financial Support to Families with Children (2002) defines the various types of allowances for children and for parents.

---

172 Ibid.
173 The program was supported by DFID, the Government of Norway, the Social Innovation Fund from Serbia and the Standing Conference of Towns and Municipalities. http://www.prsp.sr.gov.yu/engleski/istrazivanje/index.jsp
174 Damjan Tatic, for the International Disability Rights Monitor 2007
175 Damjan Tatic, National Disability Report of Serbia, within the project : “Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Rights Forum and supported by EU (CARDS), 2006-2007!
The Laws on Primary and on Secondary Education refer to disability only as education of children with "developmental difficulties". No reference on inclusive education is made in the law and the transfer of children between the specialized and regular schools is not regulated. The 2005 Law on Higher Education prohibits discrimination on grounds of physical or sensory disabilities. The amendments to this law have been actively promoted by The Association of Students with Disability from Serbia.

According to the Law on Employment and Professional Rehabilitation of Persons with Disabilities and the Labour Code, persons with disabilities can be hired and work under the same conditions as other workers. The Labour Code explicitly prohibits direct and indirect discrimination on the grounds of disability in fields of hiring, training, trade union rights, and dismissal (article 18). The Labour Code requires employers’ to offer another adequate job suited to the capacities of workers who experienced labour accidents and/ or illnesses. A further system of quotas for employers is expected. Additional incentives for inclusion of people with disabilities into labour force are expected from the Law on Vocational Training and Employment of People with Disabilities, currently under elaboration.

As in a majority of the countries in the region, the definition of disability and the eligibility criteria for assistance and care vary from one law to another in Serbia. While the Law on Prevention of Discrimination against People with Disability provides a broad definition, based on the social approach of disability, the other documents are deeply rooted in medical perspectives and start from the evaluation of the degree of impairment (and of the incapacity), rather than evaluating the abilities, capacities and need for individual support of the persons. This situation leads to numerous breaches of the fundamental rights of people with disabilities to access community services (education, health care, employment, social assistance and social security, etc).

A reform of the disability assessment was initiated by MoLSP in 2002, in relation with the evaluation and orientation of children with disabilities towards community services. During a two-year period, new methodologies have been created for the assessment and orientation process, in a social and human rights perspective. Unfortunately, the change of government after the elections blocked completely the process of change, and the assessment mechanism remained until now predominantly medical.¹⁷⁷

**Specific Funds for the social and disability sectors**

The creation of the Fund for Social Innovation (SIF) in 2002 within the Ministry of Labour and Social Policy (MoLSP) represented a key step for the social reform. This structure is conceived as providing management and financial support for the social projects. It offered the possibility to enhance the development of new services at community level and improve the quality of existing ones, while ensuring better access to social services with as wide a range of coverage as possible. The SIF operates with the support of local and international agencies (EAR, World Bank, EU, UNDP, DFID, Governments of Norway and Serbia) and contributes to the development and implementation of reform strategies in the social sector. The main areas of action of the SIF are: management of development processes, systematization of knowledge and experience, capacity building in the field of social sector and financial support to pilot projects. Disability issues are mainstreamed in the activity of SIF and, through its financial support several community based services were developed in the last years in Serbia (day centres for children with intellectual disabilities; training of professionals, foster care services and training of foster parents and supported living for adults with intellectual disabilities).

The Fund for the Organisations of People with Disabilities (FOPD) is used for activities developed by Disabled People Organisations (running costs of these associations, but also day services, toy libraries, transportation, legal advice etc.) The Fund’s sources are the national and local budgets, lottery and international donors.

**Roles and responsibilities with regards to social service provision**

- In terms of general organization of the system of social services for people with disabilities, the main responsible authority is the Ministry of Labour and Social Policy (MoLSP).

Within the Ministry, there are two different departments that are relevant in the context of disability-related services: the Department for Protection of Persons with Disabilities and the Department for Social Protection. Unfortunately, the cooperation between the two departments is still limited, which makes the reform in the social services sector, for people with disabilities, relatively incoherent.

The public system of care for people with disabilities is mainly institutionalized and highly specialized. The alternative services at community level are predominantly the result of recent pilot projects (since 2000), and mainly developed by NGOs. There are 20 institutions with long term residential care for people with disabilities in Serbia, managed by MoLSP (9 for children and young adults, 11 for adults).

- **Centres for Social Work (CSW)**

Serbia has 137 CSW. Centres for Social Work are de-concentrated bodies of the Ministry of Labour and Social Policy but they have in fact a double subordination, receiving also funding from municipalities for several types of allowances, a limited number of support services (e.g. home care) and for their running costs. They are in charge of social assistance and delivery of social work services in the communities, as well as with assessment of needs and orientation of people with disabilities to services.

¹⁷⁷ Source: Handicap International (Regional Office for South East Europe)
• **Institute for Social Protection (ISP)**

The Institute was re-established in 2005 and is currently in process of organisation and definition of its comprehensive roles, in relation with MOLSP. Its main function is methodological, since it is expected that ISP will produce new tools, regulations and standards for the social protection system. Vojvodina also has an Institute for Social Protection, with the same functions as the national one.

• **Municipalities**

Only in the recent past, municipalities started to draw their attention towards the development of community-based social services for people with disabilities (especially day centres, pilot personal assistance services, supported living for people with intellectual disabilities). However, no adequate resources are available for implementing activities necessary to cover for new responsibilities transferred to them within the decentralisation process. In this context, the provision of social services in Serbia remains highly centralized (at the level of MoLSP). A lack of regulatory mechanisms for contracting and funding social services from local budgets, as well as lack of licensing procedures, makes the welfare mix and the cooperation with various types of social service providers very difficult at local level.

• **The Non-governmental organizations**

NGOs in Serbia manage experimental and/or pilot social services at community level, benefiting occasionally from public funding through the Ministry of Labour and Social Policy. This funding is given under three possible mechanisms, and mainly using the two dedicated funds existing at the level of MOLSP (SIF and FOPD, described above):

(a) grants for projects;
(b) annual funding for the national disability organizations-unions (wages for staff and material expenses) and
(c) annual funding for particular program activities. Almost 400 such organizations receive funds from MoLSP.\(^\text{178}\)

• **A Municipal Coordination Body for Social Policy**

This body makes efforts to improve the links between the policy elaboration process and the concrete implementation of legislative documents at local level. For example, a seminar on "Strategic Planning of Social Welfare in Municipalities" took place in July 2007, having as a result the creation of several working groups for children and teenagers, persons with disabilities, elderly persons, unemployed, rural population and Roma population.\(^\text{179}\)

**Formal participation of people with disabilities in policy making processes**

In order to address more effectively the disability related aspects in the policy reforms of Serbia, a consultative body was established at national level in 2002, called the **Council for Disability Affairs of Government of Serbia**. The council is composed by a representative of the MoLSP, the Deputy Minister in charge of the Department for Protection of Persons with Disabilities, representatives of other ministries such as justice, health, capital investments (construction and traffic), culture, education (ministry advisors), one representative of Special Education Faculty, as well as representatives of the following DPOs:

- Blind Union, Deaf Union, Union of associations for persons with intellectual disabilities, Union of Labour Disabled
- Representatives of 4 organisations of persons with physical impairments;
- Representatives of all DPOs from Autonomous province of Vojvodina;

Decisions of the Council are not legally binding and the role of this council is advisory and consultative. Its current role is to monitor the implementation of the National Strategy for the Improvement of Status of People with Disabilities.

**Looking ahead**

The challenges regarding the reform of social services for people with disabilities in Serbia are numerous. Among the most important are: the continuation of the de-institutionalisation process, the revision of the law on social protection and the introduction of coherent and coordinated regulatory framework in the field of social services, as well as development of monitoring instruments for policy implementation (especially with regards to the anti-discrimination legislation).

In order to achieve an effective multiplication of good practices models initiated by NGOs in the field of community-based services, decentralised instruments are urgently needed for contracting and funding these services at local levels, as well as for monitoring their quality according to existing standards.

---

178 Rapid assessment of the situation of persons with disabilities in Serbia, UNDP, 2007

Share-SEE stands for “Self Help and Advocacy for Rights and Equal opportunities in South East Europe”. It is a regional project led by Disabled People Organisations (and co-organised with international partners)\(^{180}\), aiming at enhancing civil society sustainable capacities, at the local and national levels, to fight against discrimination faced by people with disabilities and to influence policy reforms. The project primarily supported organisations of persons with disabilities in their capacity building for advocacy initiatives but included also generic human rights organisations and representatives of the media in its programs.

- The countries of intervention were: Albania, Bosnia and Herzegovina and Montenegro. Kosovo (under UNSCR 1244), FYR Macedonia, Montenegro and Serbia.

More specifically, the project focused on the following aspects:

- An increase in knowledge among organisations of persons with disabilities on human rights instruments and anti-discrimination legal frameworks and mechanisms;
- A strengthening of capacities of organisations of persons with disabilities to make concrete proposals and to build coalitions in order to increase the impact of advocacy initiatives at local and national levels;
- A development of capacities of disability groups for the monitoring of policy reform processes in the role of watchdogs;
- An awareness raising and training of media representatives towards a change of perspective regarding persons with disabilities, abandoning the charity approach in favour of human rights based approach;
- The mainstreaming of disability as a crosscutting human rights issue among other civic movements especially within human rights organisations (as well as mainstreaming disability in general policies at national and local level, not sure if to add it here or in the bullet on policy reform)

Along with other international and local projects developed in the region, Share-SEE has contributed to:

- The drafting and/or adoption of national disability strategies in Serbia, Albania, Bosnia and Herzegovina and Montenegro.
- The drafting of the comprehensive national disability policies in Bosnia-Herzegovina, which started in July 2006.
- The enhancement of the role of Parents Organisations in Montenegro and the support to the development of a network of day care centres for children and youth with disabilities;
- The adoption and implementation of a new law on high education in Serbia towards the inclusion of students with disabilities in universities with the setting up of a support service for students with disabilities.
- The success of a vast civic campaign which collected more than 10,000 signatures from citizens in Macedonia in order to submit a draft of the systematic law on the protection of the dignity and rights of persons with disabilities to the Macedonian Parliament, in January 2006.
- The adoption of local Disability Action Plans in four municipalities in Macedonia and ongoing community planning activities in all countries of the region.

Share-SEE provided financial and technical support to organisations of persons with disabilities (DPOs) for the implementation of local advocacy initiatives (through a mechanism of small grants). These initiatives aimed at increasing the awareness of disability issues in the community and to demonstrate the importance of DPO’s active role in promoting and implementing their rights for the improvement of quality of life of persons with disabilities.

Share-SEE encouraged as well the exchanges between DPOs and other actors of civil society, authorities and service providers by organising conferences, workshops on technical topics and study visits at national, regional and international level. During 2003-2008, Share-SEE supported 12 national, regional and international conferences on disability-related aspects, 9 regional workshops and 16 local workshops on community based services, accessibility, media and disability, UN Convention implementation, antidiscrimination legislation, as well as more than 20 study visits in the region and in Sweden.

(Source: SHARE SEE website, www.share-see.org)

\(^{180}\) Based on a cross-disability and cross-border partnership, the Steering Committee of SHARE SEE is made up of six core partners and is as responsible for the overall management of the project: the Association of Students with Disabilities, Serbia, Centre for Independent Living, Serbia, Information Centre LOTOS, Bosnia and Herzegovina, POLIO PLUS, Macedonia, Handicap International, Regional office for South East Europe and, from 2007, Shia – Swedish Organisations of Persons with Disabilities International Aid Association.
2.1.9 Key findings and recommendations regarding the legislative reforms on social services for people with disabilities, in South East Europe:

a) From the medical towards a social model of disability, based on human rights, the process of change started at the level of national legal frameworks in SEE

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>As presented in this paragraph, <strong>significant legislative reforms have been initiated</strong> in the field of disability and social protection in the majority of the South East European countries. This reflects a general effort of shifting the paradigm in the disability sector and of integrating the main principles and trends from European and international level. The need for passing from a medical to a social and rights-based approach on disability, as well as for providing quality services for people with disabilities at community level are acknowledged in majority of countries:</td>
<td>1. A characteristic of the region is the <strong>large number of national strategies and action plans developed at national level, for simultaneous sectoral reforms</strong> (social protection, disability, child protection etc). The strategies are often very general in formulation and do not always prepare the effective translation of principles and priorities into concrete actions. Their implementation is still weak, especially due to the lack of 'synchronisation' between social reforms and reforms of the local governments (within the decentralisation process). Consequently, the sectoral action plans are rarely respected and their permanent revision and re-design is (unfortunately) a common occurrence in the SEE countries.</td>
</tr>
<tr>
<td>• either in <strong>national strategies</strong> and action plans (poverty reduction, disability-related strategies, social welfare reform strategies and even strategies focusing punctually the social services)</td>
<td>2. Secondly, despite the progressive disability mainstreaming in national strategies, the brief policy overview shows that <strong>disability is not yet mainstreamed in all national legislative frameworks</strong>. At this stage of their development, disability aspects make rather the object of specific laws and regulations. This aspect has a strong impact on the way in which adequate community services are developed, in the field of education, access to employment, health care, community living, access to information, culture and sports etc. This choice requires additional effort for an effective coordination of responsibilities, information, resources, at the level of implementing bodies, as well for maintaining a mainstreaming perspective during this transition period, for all disability-related measures and community responses.</td>
</tr>
<tr>
<td>• or in <strong>national laws</strong> and regulations (social welfare, social services, anti-discrimination legislation, among others).</td>
<td>3. In relation with the previous aspect, a <strong>significant effort will be required for replacing the traditional legislation</strong> (targeting ‘special’ measures in ‘special environments’ for people with disabilities, in a medical and segregating perspective) <strong>from the perspective of the recent strategic frameworks</strong>, based on human rights and a holistic approach of disability. So far, the coexistence of these two different paradigms in the legal corpus of a single country leads to: contradictory provisions, contradictory entitlements for people with disabilities, insufficient quality of delivered services and incoherent responsibilities for implementation among various stakeholders, especially at local level.</td>
</tr>
</tbody>
</table>

Disability is generally mainstreamed in the more recent social strategies in SEE countries: poverty reduction, social protection and the more general social inclusion strategies.
The policy reforms in the field of disability, accompanied in several countries of the region by specific strategies and action plans, highlight the need for a unified definition of disability at national levels, in all sectoral legislations (education, employment, social protection, health etc). The changes of these definitions are ongoing in several countries and international documents (like the UN Convention on the Rights of Persons with Disabilities) influence the process.

Antidiscrimination legislation is emerging more rapidly in SEE countries.

International organisations and donors support the process of social reform and provide technical and financial expertise for change (World Bank, UN agencies, the European Union, together with various international cooperation agencies; UK, Scandinavian countries, Germany, Japan, Italy, Greece, Spain, among others).

As seen in several national examples, the transition’s costs in the social sector are very high and governments alone cannot cover these significant amounts.

In the majority of the cases, this international support is conditioned by a roadmap of results and by monitoring and evaluation processes. The cooperation between international and local stakeholders becomes often a learning process, especially in domains like social services modernisation, new social and disability approaches, in which the SEE governments have more limited experiences.

The pre-accession process to the EU provides additional incentives and resources for this shift of paradigm, including a specific assistance instrument (IPA- the Instrument for Pre-accession Assistance).

Looking ahead:

- There is a need for urgent revision and harmonisation of disability definitions in the national laws and by laws.
- All stakeholders (authorities at national and local level, service providers, people with disabilities as users of social services) should increase their capacities and knowledge about implementation of legal frameworks in the disability-related fields. Generally, increased governance at all levels of policy implementation is required in SEE countries.
- Policy frameworks (legislation, implementation procedures, and resources) have to address more specifically the capacity building and training activities of the stakeholders involved in the social services sector (from decision makers to frontline workers).

The lessons learnt in Romania show that no qualitative reform is possible without a constant and consistent investment in human resources. Unfortunately, the public and international funds are usually used rather for improving infrastructures and developing new types of services, than for upgrading the level and expertise of decision makers and staffs in these new approaches and methodologies of work. When States are investing in both participatory initiatives and qualitative training programs, the rhythm and results of reforms are significantly improved.

- There is a need for effective coordination of international agencies within the various stages and domains of technical assistance for policy reforms, in the field of disability and community based social services.

On the other side, this very significant mobilisation of financial resources leads to effective policy reforms only if several additional elements are taken into consideration:

- The coordination and coherence of technical expertise during the entire process,
- The quality and monitoring mechanisms of the new strategies developed,
- The national ownership of these reforms,
- The improvement of governance capacities at national and local level,
- The time allowed for piloting, trials and adjustments of new policy measures to local contexts. This last element is particularly important from the perspective of current practices and lessons learned in the region, since the constraints of donors and/or of the financial instruments that have been mobilised so far in the social sector often led to very short inception phases or piloting phases, with negative consequences on longer term.

The revision of the overall definition of disability at national level, in accordance with the international principles and documents is the ground for ensuring an effective access of people with disabilities to social services, since it facilitates a better design of (and approach to) individual plans of support and care. Further on, this process strongly requires more effective inter-sectoral cooperation and decision making, as well as clearer commitment for involving people with disabilities at all stages of this change process.
**b) The development of a system of community-based social services becomes progressively an acknowledged priority in all countries; more effort is needed for its internal coherence, better governance and sustainability.**

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services for people with disabilities are on the political agenda for reform in the majority of South East European countries.</td>
<td>1. Gate keeping mechanisms, licensing and accreditation, quality systems, contracting and funding procedures, monitoring and evaluation, data collection and statistics, all the components are yet to be developed and integrated in a unitary regulatory framework, in the majority of countries. When they start to be designed though, they do not, unfortunately, make the object of a coherent and coordinated approach. Separate agencies or departments are responsible for separate procedures, without coordination and exchange among them. As it happened several times in Romania during the pre-accession process, this practice represents a major risk for the future evolution of the services systems and can lead to overlapping, contradiction and blockages in the overall provision process, at national and/or local level.</td>
</tr>
<tr>
<td>In many countries, new types of services are established for people with disabilities, managed by public authorities or non-governmental organisations.</td>
<td>2. There is no coordination between medical and social services within legal frameworks, especially in relation with the situation of persons with complex dependency needs or people needing simultaneous (correlated) measures from different services domains. Providers offering multi-disciplinary services usually lack appropriate regulatory frameworks, funding mechanisms and procedural coordination.</td>
</tr>
<tr>
<td>Decentralisation of service provision is ongoing in several countries of the region.</td>
<td>3. More particularly in this context of reform, the lack of an integrated system of information and feedback for social services, at national levels, makes the planning process and the policy design very difficult in all countries of the region. Despite the overall legal frameworks, the responsibilities of local government in the field of social services planning, management and monitoring, in accordance with the new laws, remain often unclear (or simply delayed). Generally, there is a gap between the responsibilities transferred to local authorities, in terms of services development, identification of people’s needs, follow-up procedures, and the concrete resources for planning, funding, monitoring, as well as the human resources allocation for these new tasks. It is a need for stronger political will and more coordinated measures regarding the effective implementation of these decentralisation procedures and responsibilities.</td>
</tr>
</tbody>
</table>
Looking ahead:

- National legislations should include clearer references related to the wide spectrum of community-based social services needed by people with disabilities in various cycles of life.
  The progressive development of new types of services for people with disabilities should be supported by these new laws and not addressed bureaucratically.
- The social and holistic approach to disability has to be fully reflected in social services policies, including at the level of implementation procedures.
- There is a need for urgent design of comprehensive regulatory frameworks, elaborated in a coherent and articulated manner, in order to allow effective and quality service provision.
- The right balance between cash benefits and social services is one of the aspects that have to be addressed specifically at policy level.
  The consultations with people with disabilities show that their choice is focusing on an adequate balance of cash benefits and social services at community level, which are seen as complementary levers for improving the quality of lives.
- The situation of holistic (and/or multi-disciplinary) services defined in the national legislation has to be more clearly addressed and regulated.
  People with disabilities often need inter-related services, combining early intervention, education, rehabilitation or long term care in a holistic manner. If the national legislation does not allow cooperation and harmonisation of practices and individual planning, this chain of services becomes ineffective.
- There is a need for better coordination between the reform of social services provision and the decentralisation process, especially in relation to funding and monitoring of social service, as well as with the mapping of social needs and development of new community services.

People with disabilities became progressively more involved in policy making processes. Further on, they need to participate to more ‘technical’ stages of the sectoral reforms (legislative modernisation in education, health, social protection, employment etc.).

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>The disability movement is generally stronger and more unified in the Western Balkans countries; the number of coalitions of DPOs, policy making initiatives at national and local level increased significantly. The advocacy campaigns are more efficient and focused; The State representatives start paying more attention to the multi-stakeholder cooperation and, with few exceptions, cooperate better with the representatives of the disability movement.</td>
<td>The participatory decision making is not a usual procedure in SEE. Its introduction and effective implementation needs additional commitments from all stakeholders involved, as well as capacity building and adequate organisational frameworks.</td>
</tr>
<tr>
<td>The newly established Disability Councils (both governmental and NGOs) take progressively their place at the table of negotiations.</td>
<td>At national levels, the disability-related councils or commissions have no legal binding roles. Their consultative status gives them uneven “weight” within similar national reform processes in the region.</td>
</tr>
</tbody>
</table>

Looking ahead

- People with disabilities have to be present in all stages of the policy elaboration and monitoring. Several important processes are taking place currently in the region, impacting tremendously the lives and interests of people with disabilities: the elaboration of new laws on social security schemes and social services organisation; the elaboration of national quality standards for social services, including disability-related services; revision of laws regarding the access to employment and the quota systems, etc. In all these sites for reform, it is of crucial importance to include people with disabilities and their representatives, at a large scale. Their perspective and interests have to be mainstreamed in the national legislations and reflected in all levels of policy implementation.
- People with disabilities have to develop knowledge and capacities in relation with more technical sides of reforms, including decentralisation of responsibilities from central to local levels, budgeting and costing, specific particularities of the domains under reform (education employment, health care etc.)
2.2. ACCESS TO SOCIAL SERVICES AT COMMUNITY LEVEL – THE CHALLENGE OF AN OUTDATED GATE KEEPING SYSTEM

2.2.1. Global overview about the gate-keeping systems in the region

In order for policies to become effective and allow people with disabilities to fully access qualitative social services, the first precondition is to have efficient gate-keeping procedures for these services. As mentioned in part I, gate keeping mechanisms in the sense of this report, are defined as “the system of decision making that guides effective and efficient targeting of services” for people with disabilities and other vulnerable groups1. If organised effectively, they provide information and referral procedures that help people to access the most adequate service for their needs, in the shortest time possible.

The gate keeping system is presented here as a combination of assessments and decision making procedures, realised at both individual (micro) level, meaning at the level of the person in need for services, as well as at the level of a community or region (assessment and planning at ‘macro’ level).

In South East Europe, referring people with disabilities to social services was (and still is) predominantly a medical-based procedure. The access to certain types of services was conditioned by the existence of a “disability certificate”, provided by the so called “categorisation commissions”, which included the type and “degree” of disability. The evaluation of the disability situation and the referral to services were strictly linked. A person with a disability could rarely access a mainstream service in his/her community, since the commission was most often referring these persons to specialised settings almost automatically, based on the existent legal criteria at that time. These services could be special schools, special vocational programs, residential care and sheltered workshops etc. The regular (or mainstream) chain of services and the specialised one (in the field of preschool, school, vocational training, health care, leisure and recreation, housing, etc) were completely parallel, without much possibilities of transfer from one system to another. The same absence of mechanisms for collaboration existed between services for children and services for adults, as well between commissions for children and commissions for adults with disabilities. As a consequence, the decisions of these gate-keepers, their entire methodology and organisation, were the first step towards a segregated life for people with disabilities, as well as a flagrant breach of their fundamental human rights.

Testimony of one family about the annual (mandatory) re-evaluation of disability certificates, in the early 1990s:

“The ‘commission day’ was always the worst day of the year for us. We needed to prepare ourselves, as parents, several weeks in advance, in order to be strong enough in front of the commission’s members. We were trying to keep our calm despite the fact that the attitude of the commission members was completely overwhelming. The meeting was taking not more than 30 minutes, but it was enough for making us feel as the guiltiest and worst parents of the whole world. They never provided us with any help, never asked our opinion regarding the way in which we see our child’s future. As the law obliged us to go to the commission annually, these people were only putting our child ‘in the right box’ every year and were asking if we fulfilled our responsibilities regarding the so called “individual action plan”. Nobody was responsible for that plan but us alone. Nobody was giving us any assistance to accomplish it properly, and sometimes there were complicated instructions in it, like teaching our child to read, develop the fine motor skills and so on. Since we did not want to put our child in an institution, we had to pay all rehabilitation professionals to come to our home and work with our child, sometimes for three times a day. We knew that this is the good thing to do from other parents like us, but for many years, especially in the first ones after finding out about the diagnostic of our child, we felt completely alone and lost.”

(A.V., mother of a child with cerebral palsy, Romania)

After 1990s, this situation changed progressively, however the evaluation and referral system has not fully been reformed. The national legislations include progressively the right and possibility of people with disabilities to choose those services (regular, support, specialised etc) that respond better to their needs and interests. However, a certain range of entitlements (including support services for inclusion and better participation to the socio-economic life) depend of the commissions’ decisions. The practices, evaluation tools and attitudes within these commissions did not change much and do not yet reflect “the shift in paradigm” currently in force in the disability sector.

The evaluation tools and criteria used for assessing people needs and situations are still predominantly medical, and the type of impairment rather than abilities and choices of the person determine the access to services. In some countries, the “disability certificate’ is still conditioning the access to a range of services, and is blocking the access to some of the regular ones. The revisions of the commission’s decisions are still difficult and very demanding from the aspect of bureaucracy involved.

1 Bilson, A., Harwin J. “Gate keeping services for vulnerable children and families”, (Florence: UNICEF Innocenti Centre and the World Bank, 2003).
As is presented in this chapter, several SEE countries acknowledged the urgent need for change in this domain. These commitments are included in strategic documents or concrete action plans, officially approved at national levels. In practice though, few countries have effectively started the reform process:

- either through reforming the composition of commissions and transferring the accent from pre-dominantly medical teams to more multi-disciplinary teams;
- the introduction of case management and person-centred approaches in these commissions;
- or, in some countries the progressive emergence of "one stop shop"-type agencies or bodies for information and guidance of people with disabilities.

**BOX 4**

**The “one stop shop” principle in the gate-keeping system for social services**

Worldwide, the concept of “one-stop-shop” means that a multitude of facilities or services to clients are organized under the same roof (or by a single agency). People often face difficulties and feel confused when trying to find their way among the multitude of procedures for accessing services or cash benefits in their communities. The aim of a “one-stop-shop” agency is to make service delivery more efficient, clear and easily accessible by users at local level.

In the field of gate-keeping procedures, the "one-stop shop" means that all information and referral procedures related to social services at community level are provided in a single place, by a single responsible agency. It represents a contact point and a gateway towards the full range of social services existing in the respective community. In case of multi-disciplinary teams involved in the referral procedures (for children, adults, or for various types of services), it would mean that the activity of these teams or sub-commissions takes place in a single location.

For people with disabilities, this principle is very important since its application allows:

- Reducing the bureaucracy and increasing the efficiency of referral procedures;
- Improving transparency of the referral process, including the possibility of an effective information system for people with disabilities;
- Improved statistical data collection about the needs of people with disabilities and the referral solutions for them;
- A coherent follow up of each individual case, as well as more effective re-adjustments of individual recommendations, if needed.

In order to implement the principle of "one-stop shop" and to establish a local agency for information and referral, specific attention needs to be paid at the following aspects:

- The effective training of staff within the agency;
- The functional correlation between different referral levels (children-adults/ service-focused referrals/cash benefits-direct services etc);
- The development of an electronic system of information for ensuring correct dissemination and feedback;
- Introducing a measurement of customer's satisfaction, for regular follow-up and improvements of the system.

**2.2.2. The gate keeping at macro level – legislations and recent practices**

The responsibilities for assessing social needs at local and national levels, as well as mapping the existing social services, are today defined in several national legislations. In the majority of the countries in the region these responsibilities are attributed to local authorities or deconcentrated agencies of ministries of social affairs. Generally, the overall centralization of data on social needs rely on ministries, or on dedicated departments for social services, within these ministries.

The practical implementation of these procedures is however uneven. There are no clearly defined mapping methodologies or official mechanisms in place for regular consultations of groups in need, in relation with identification of services they might need. Some interesting initiatives emerged in the last four years (in legislations or implemented as pilot procedures) and they can represent a good baseline for a further regional exchange and cooperation in this domain. They are briefly presented further on:

**In Albania**, the Strategy of Social Services (2005-2010) mentions the organisation of so-called planning committees at local level. These committees should be composed of 15 members: members of local government (qark, municipality, commune), representatives of the regional offices of the State Social Services, representatives of NGOs, as well as other stakeholders form the education and public order areas”. These planning committees should assess the needs for social services at local levels and elaborate a regional plan for delivery of social services. Concretely the committees have been set up in several pilot regions, four before 2005, and they are in process to be extended according to the strategy.
The Law on Social Services (2005) mentions as well that the assessment of needs of individuals for the receipt of social services is the responsibility of social administrators in municipalities and communes (art.31).

In Macedonia, Serbia, Bosnia and Herzegovina, Montenegro and Kosovo, several pilot projects took place (or were initiated) in 2007 in relation with the elaboration of “community disability action plans”\(^{183}\). In these projects, the identification of the overall needs and priorities of people with disabilities has been addressed in pilot municipalities, in a trial of setting up the basic procedure for the further planning process. However, since the whole mechanism is still very new, the clear focus on social services mapping and the support measures that are needed by people with disabilities are not yet put in a comprehensive and detailed way. Additionally, this type of participatory assessment and community planning represents a learning process for both citizens and decision makers, due to the parallel start of the decentralisation process. This stage is in fact part of a wider process of improving governance at local level, and several international donors are at the moment investing in capacity building programs at this level.

In Croatia, a loan from the International Bank for Reconstruction and Development allowed the start of a national program targeting the “Social Welfare Development”, in 2005. The aim of the program is the establishment of a new and more rationalised system of social welfare in this country. Several components are prioritised within the reform, among which the improvement of the functioning of Centres for Social Work, the introduction of the “one-stop shop” mechanism for social welfare measures and the introduction of an integrated information system at national level. The project is on-going and the social planning component has been tested in three pilot projects. This led to the establishment of a list of priorities related to the improvement of quality of services at community level, in the perspective of further de-institutionalisation efforts\(^{184}\).

In Romania, the evolution of the decentralisation process (from 2001) and the licensing and accreditation procedures (from 2006) created the basis for a more structured mapping of services at local level. The introduction of a national register of accredited social service providers facilitates a clear picture (map) of existing services in each county and municipality. These maps are available on internet for each county. However a precise map of social needs is not yet elaborated in a similar way.

The main responsibility of identification and assessment of social needs in Romania is shared between the municipal and county authorities. The municipality and city councils (through their Services for Social Protection and Assistance) have primarily a role of identification of needs, prevention and information measures, counselling and follow up of social problems in these areas. The county councils (through the General Directorates for Social Assistance and Child Protection) evaluate the social needs and approve the legal entitlements for each person in need. The existing laws in the field of child protection, rights of people with disabilities and social assistance establish functional links between these two levels of responsibilities. At local levels, the elaboration of the so called ‘maps of needs and services’ is not generalised, however several large municipalities initiated pilot procedures for elaborating them, in cooperation with NGOs and DPOs (e.g. Timisoara, Olt, Cluj, Brasov, Targu Mures etc.).

In addition to that, the Law on Promotion and Protection of Children’s Rights (272/2004) enables the organization of community consultative bodies at lower level, at the initiative of the local public administration authorities. These structures may include local businessmen, priests, teachers, doctors, local counselors, police officers among others. The role of these structures is both to solve concrete cases and to meet the global needs of the respective community (art.103). At the end of 2007, 1482 such bodies existed in Romania\(^{185}\).

At national level, a new agency called the Social Observatory should become operational in 2008. This agency will function under the coordination of the Ministry of Labour, Family and Equal Opportunities and will have as a main role to create an integrated information system in the social sector, contributing to policy making and planning through regular data collection in this field.

2.2.3. The gate keeping at the micro level – a mechanism that starts to be reformed

At the individual level of persons with disabilities, the gate-keeping mechanisms refer to the assessment of the persons’ needs and abilities, as well as orienting and referring the person to a network of community-services, in accordance with the person’s particular choices.

In recent years, the reforms in the overall disability policies started to produce an impact also in the field of evaluation and orientation towards services for persons with disabilities. In Romania, Bulgaria, Albania, Montenegro, Bosnia and Herzegovina, and more recently Croatia and Serbia as well, the reform of the old “categorisation commissions’ and the establishment of new eligibility criteria for both social services and cash benefits represents an acknowledged priority of the governments.

\(^{183}\) Within the Share-SEE project (see spotlight no.3) the support to local coalitions of people with disabilities for the has provided for further elaboration of ‘community disability action plans’, in 24 municipalities


\(^{185}\) Preda N., National Authority for the Protection of Child’s Rights, Romania, *“Capacity building of statutory services at local level within the support of the decentralization process”*, Presentation at the UNICEF regional conference, Sofia – July 2007.
In terms of practices though, there are only few countries that have a more clear commitment towards (or started for real) the transformation of these "categorisation commissions", together with the related gate-keeping procedures at micro level. Romania and Montenegro initiated work in this field up to now, and BiH and Serbia in preparation from 2008-2009:

**In Bosnia and Herzegovina (BiH).** the evaluation of needs and the entitlements for people with disabilities are regulated by specific laws in each of the entities (Federation of Bosnia and Herzegovina (FBiH) and Republika Srpska (RS) as well as in Brcko District.

The main challenge related with the gate keeping procedures in BiH is the strong differentiation of social rights and entitlements between: war veterans with disability, civilian victims of war and other persons with disabilities. The cause of disability represents the main criteria for benefits approval, and not the overall needs of the person. This situation leads to huge discrepancies between the financial entitlements of various groups of people with disabilities (e.g. war veterans with disability can benefit from a care allowance which is 4-5 times higher than the one available for other disabled persons, having similar needs).

An additional factor of inequity in FBiH was, in the past, the fact that the evaluation of disability degree was done at cantonal level, with strong differences from one canton to another. From 2007 the FBiH tried to compensate for this lack of harmonization, and a single Institute for medical assessment of health condition took over the responsibility of establishing the federal procedures for evaluation. The Institute is based in Sarajevo and so far, the criteria of assessment remain medical, however their revision is planned for the coming year.


In terms of referral procedures, both FBiH and RS give priority to financial benefits compared to social services. In the FBiH, several types of entitlements are covered by the cantonal budgets, others by the Federal budgets. In RS, most of entitlements are covered by municipality budgets.

Within the project related to the elaboration of a comprehensive Disability Policy in BiH\(^\text{186}\), a specific component addresses the modernisation of the gate-keeping system. This component will include the revision of the assessment and eligibility criteria for social welfare measures, as well as the elaboration of harmonized evaluation procedures at entities scale. The start of this component is estimated to begin in 2008-2009. A specific attention in BiH is currently paid to the translation of ICF\(^\text{187}\) and development of applicative tools for assessment based on this classification system.

---

**BOX 5**

**The International Classification of Functioning, Disability and Health (ICF)**

The ICF is a classification of health and health related domains, developed by the World Health Organisation (WHO). The ICF was officially endorsed by 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21).

The ICF puts the notions of health and disability in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity. The ICF thus ‘mainstreams’ the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability. Furthermore ICF takes into account the social aspects of disability and does not see disability only as ‘medical’ or ‘biological’ dysfunction. By including Contextual Factors, in which environmental factors are listed, ICF allows to record the impact of the environment on the person’s functioning.

*Extracted from the website of World Health Organisation ([http://www.who.int/classifications/icf/en/](http://www.who.int/classifications/icf/en/))*

**The MHADIE project**

MHADIE (Measuring Health and Disability in Europe) is an EU-funded project which seeks to demonstrate the feasibility and utility of the ICF framework and in particular, aims to determine the potential of the ICF framework as an international standard that could influence and support new European policy guidelines on health and disability. The WHO led the project, which involved sixteen partner organisations across Europe.

The fact that States define disability in different ways leads to serious difficulties in relation with how information regarding disability is collected across the EU. This creates challenges in comparing situations in different EU member states. An important outcome anticipated for the MHADIE project is that the ICF will become the model by which people define and understand disability, thereby providing a standardized and comparable means of collecting disability statistics.

*Extracted from the MHADIE website: www.mhadie.com*

---

\(^{186}\) Support to the Disability Policy Development (SDPD), in Bosnia and Herzegovina (2005-2009), project Information Document, Ministry of Foreign Affairs BiH and Ministry of Foreign Affairs of Finland, July 2006 (operational objective no.3).  

\(^{187}\) International Classification of Functioning, Disability and Health (see also box 5)
In Montenegro, three types of commissions are responsible for the evaluation of disability situations and orientation to services:

- The socio-medical commissions, in charge with the evaluation of needs related mostly to cash benefits, as well as basic social services;
- The newly established commissions that evaluate children with special educational needs and orient them towards school;
- And one central commission (called second-instance commission), which will be available in the near future, for complaints and revisions of the existing decisions regarding people with disabilities.

Montenegro started in 2007 the reform of the commissions dealing with evaluation of children with special educational needs. The process is supposed to last two years and implies a national effort of ‘shifting’ completely the approaches, the methodological tools and the outcomes of these commissions, towards a person centered and inclusive perspective. More details about this process are presented in Spotlight no.4.

Spotlight 4: The reform of the ‘orientation commissions for children with special educational needs’ in Montenegro

In 2007, the Ministry of Education from Montenegro, in collaboration with UNICEF and with technical support from Handicap International, initiated the reform of commissions responsible for the orientation of children with special educational needs towards school.

The members of the 18 newly established commissions for evaluation and orientation (more than 90 persons in total) are involved in a two-year program of capacity building and technical support, in order to develop new instruments for evaluation and referral, creating the basis of an inclusive approach in education and vocational training.

The commissions’ members will elaborate their own evaluation methodologies, having as baseline the Disability Creation Process (DCP) model; they will also develop a manual of policies and procedures for all evaluation commissions at national level. The use of the holistic model of disability allows for a comprehensive evaluation of the disability situation for each individual, including the personal factors, the environment factors and the life habits, in order to define a plan of services that respects the abilities and choices of each person.

The piloting phases of the new methodological tools and the training component related to it are supposed to be finalized by mid 2009.

ICF and the disability movement

It should be also noted that, while the effort of elaborating a worldwide classification is considered useful by the disability movement, the use of the current ICF has not achieved unanimous acceptance among people with disabilities around the world. The main criticism is related to the fact that people with disabilities have been very poorly consulted during its elaboration and also during the testing phases, as well as the fact that ICF is depending highly on professionals and implying large budgets for addressing people’s needs.

The World Blind Union, for example, maintains this type of positioning and highlights that “any classification conceptualising disability as problematic detracts from the image of disabled people and, therefore, there is a need to develop an alternative classification in partnership between the World Health Organization and the international disability rights movement”188.

188 http://www.disabilityworld.org/04-05_04/news/wbu.shtml

189 Fougeyrollas P. Cloutier R., Bergeron H., Coté J., St Michel G. Quebec Classification: Disability Creation Process. International Network on the Disability Creation Process, Quebec 1999 (see also box. 6).
The Disability Creation Process (DCP)

The Disability Creation Process is a comprehensive model of disability elaborated in Canada by Patrick Fougeyrollas and his collaborators. It is associated with measurement tools like Life-H (a measurement of social participation) and MQE (Measurement of Quality of Environment). The DCP model is promoted by the disability movement and is usually presented in comparison with the ICF (the International Classification of Functioning, Disability and Health).

The model defines the disability as an impediment in a person’s life habits resulting from a dynamic interaction between personal factors (impairment or disability) and environmental factors (obstacles and facilitators). Disability is therefore not a fixed state, but a dynamic process that varies according to the context and environment. According to this model, several types of actions can be undertaken to modify these interactions and achieve social participation: reducing impairment (medical care), developing capabilities (rehabilitation), as well as adapting the environment (elimination of physical obstacles, anti-discrimination and accessibility policies).

In Romania, the main gate-keeper at local level is the General Directorate for Social Assistance and Child Protection, organized at the level of County Councils and of the six councils of Bucharest. The evaluation of the disability situation (for both children and adults) is done by specific commissions at the level of County Councils (called ‘services for complex evaluation’ of children with disabilities, respectively adults). The methodologies of these commissions changes progressively, after a reform period that lasted almost five years (2002-2007).

In the case of children, the commission makes an in-depth evaluation of the child’s situation and needs, through a multi-disciplinary team (medical doctor, psychologist, special education teacher and social worker). The service is linked further on with a “commission for child protection” at the level of county council, which is mandated to release a certificate of disability, a certificate for school orientation, and an individual plan of intervention, rehabilitation or protection, according to the child’s needs. With regards to the school recommendation, this is usually given for a 4-year cycle (primary/secondary education), if parents or schools do not require an earlier revision of it. The same service has to monitor the situation of children and to reassess regularly his/her needs. The service should work in close cooperation with the Public Service of Social Assistance at the level of municipality (or city) council. The methodologies used by these commissions changed progressively, after a reform period that lasted almost five years (2002-2007).

In case of adults, the disability certificate is given by the commissions of evaluation of adults with disabilities, at the level of county councils. These are composed by a medical doctor, a psychologist, a social worker and a representative of a local NGO working in the disability sector.
Spotlight 5: The particular situation of Centres for Social Work in the countries of ex-Yugoslavia

The old Yugoslav Social Protection Laws, written in the 1976 and in 1984 defined the Centres for Social Work (CSW) as the key social service providers in the previous social welfare systems. These centers were agencies located in municipalities (usually de-concentrated bodies of the ministries of social welfare) with a mandate to provide social services and social assistance. They still have, in most of the ex-Yugoslavian countries, a wide mandate originating from the old legislation. Nowadays, this extensive role, in the context of the emerging welfare mix and without a new regulatory framework, raises management difficulties and potential conflicts of interest.

The CSW were in the past responsible with the provision of main categories of social services at community level: counselling services, social assistance for marginalised groups, assistance in overcoming temporary difficulties, coordination of the foster care services, as well as the coordination of all measures related to the cash benefits. The spectrum of community-based social services was relatively poor at that time, and in many cases the centres were mainly covering a role of basic social assistance and registration agency, especially through the activity of social workers.

Along with the diversification and development of a wider range of social services at local level, and due to the lack of clear procedures for contracting these types of services with external providers (non-governmental, private), many Centres for Social Work are nowadays in a paradox situation. In many cases, whenever a new type of social services is created at local level, it is ‘attached’ to the existent CSW. The Centres for Social Work become though owners of the newly established public services at community level, or at least employers of social services staff, in addition to their previous roles. They assume therefore, simultaneously, gate-keeping responsibilities and direct provision of social services. The number of their new employees (staff members of these new services) becomes more and more significant and very often the internal management procedures of the Centres cannot follow adequately this rhythm of growth. The situation generates frustration among staff, as well as difficulties in accountability and management, both at the level of Centres for Social Work and at the level of new services themselves.

A particular attention should be given to this aspect, especially in the context of the deinstitutionalisation process, when several large residential institutions will need to be closed or transformed, involving redistribution of resources and staff at local level. The cumulative role of both referral and direct service provision, could lead to the risk of potential conflicts of interest and serious management blockages in this context.
Shifting the Paradigm in Social Service Provision

Spotlight 6: A major challenge for the gate-keeping reforms: reaching the people with disabilities in rural and isolated areas

A major priority stands in front of the gatekeepers during this period of reform: addressing the needs of people with disabilities living in rural and isolated areas. People with disabilities in rural areas are often among the poorest of society. They are seldom registered in any evidence or social-related database, they face stigma and neglect and cannot access even the basic services in their small communities. In their large majority, they lack access to information and they do not have access to information regarding their basic rights.

Reaching the evaluation and referral commissions at municipal or county level (in order to apply for social entitlements or services) is for these people almost impossible. The lack of transportation, the lack of accessible information, with additional bureaucracy, blocks the process from the very start. Children with disabilities rarely have access to the village school. Adults with disabilities can seldom be involved in occupational activities specific to the rural areas. When the disability is acquired, the assistive devices, ortho-prosthetic equipment or personal assistants are seldom accessible for them in these locations. The shortage in number of rehabilitation professionals is critical in the region, and if existing, they are working almost exclusively in the main cities of the country.

Let’s see a concrete situation: G.P. lives in a small village in the Southern Romania. He is 82 years old. He lost one leg in a work accident, 40 years ago. His last prosthesis was made in 1987. It was a made of wood, with metal joints that are hurting him when he walks. He and his wife are too old and without means to travel to the main municipality of the county council, for a re-evaluation of his medical condition and for obtaining a new prosthesis. According to the law, a social worker from the closest municipality should come regularly to his village and help him fulfill the official applications, as well as taking his file to the county commission. This does not happen and the mayor of the village is not very familiar with the disability-related legislation, in order to facilitate this access of people with disabilities to appropriate medical or rehabilitation services. In the same village live 10 more people with disabilities and all of them are facing the same types of difficulties. GP is very poor, the last floods destroyed his house almost entirely, as well as his small vegetable backyard. He has no other revenue than his small pension and he cannot afford to buy a new prosthesis.

Situations like this are dozen of thousands in the region. The improvement of the quality of life of these people should start with the coverage of their basic rights and needs, as close as possible to their homes. The effective design of the gate-keeping system, as well as the link with mobile teams of professionals, should be the first step towards facilitating of this process for real.

People with disabilities in rural or isolated areas lack access to basic assistance and support services.

2.2.4. The collection of data and relevant databases in the field of disability

Disability related statistics, as well as an integrated information system at national level (including aggregated data about disability-related aspects in the regular statistic tools) represent key elements for elaborating effective and evidence-based policies in the field of social services.

In various domains of the services reform (education, health and social care, employment, support and rehabilitation services etc) States should rely on accurate data in order to prioritize the necessary plans for improvement and change, as well as to invest in the development of appropriate services and social protection measures. In the decentralisation processes that are progressively taking place in the region, a redirection of resources from national to local levels and to priorities fields of intervention, require precise information about the number and the living conditions of people with disabilities in their communities, as well as to what extent their rights have been realised. Research and statistics are imperative tools for policy makers in this transition period and the recent UN Convention on the Rights of Persons with disabilities highlights the importance of this
domain in article 31\textsuperscript{191} (Statistics and data collection). Complementarily, the participatory disability assessments, which are not precise surveys, but can still provide good information for defining needs of services, are also very useful. These assessments are usually part of local action planning process and can easily compensate for the lack of data at national levels, in transition periods\textsuperscript{192}.

These various types of data collection facilitate the complementarities between micro and macro planning, which is important in the early stages of decentralisation of social services.

However, such overall and comprehensive information system, that could provide accurate data for gate-keepers as well as for legislators and decision bodies at local level, does not yet exist in the countries of the region, in relation with people with disabilities.

The questions about the number and situation of people with disabilities are not yet mainstreamed in the national censuses. Very few national surveys are carried out in the region in the social field and when they exist, they are mainly the initiative of international donors (especially World Bank and other UN agencies) and they do not include extensive data on disability (Gontier, Adams, 2006).

The main source of data remains the registration of people with disabilities in various gate-keeping agencies, in relation with their entitlements (cash benefits, services, in kind support), in accordance with the national regulations. These agencies (commissions of evaluation and orientation in education, employment bureaus, disability pension funds, Centres for Social Work, the social departments in the local municipalities etc.) are not coordinated one with another and therefore the overall data is often duplicated or missing.

The data collected by these agencies is also strictly related with the definition of disability. In the countries in which a comprehensive law on protecting and promoting the rights of people with disabilities does not exist yet, each specific law (in the fields of education, health, employment, social protection etc) defines disability in its own way. The risk of having inaccurate statistical data in these countries is therefore much higher. While lacking precise data about persons with disability at national level, several countries of the region estimate their number at around 10% of the overall population, following the methodology of the World Health Organisation. However, when comparing these estimations with the percentages of other countries of the region (where data are collected according to existing registrations and entitlements), the results are very different. In these last cases, the percentages vary between 2-4% of the general population, as mentioned above.

In addition, many children and adults with disabilities, in need for assistance, fall ‘through the net’ of social protection entitlements, simply because they do not register as persons with disabilities or do not obtain a disability certificate. Some of these persons might not want to be considered disabled. More often, these people are simply not informed about their rights and entitlements or about the relevant agencies that they have to approach.

The lack of information regarding disability is sometimes compensated by some databases established by local NGOs (either umbrella organisations for disability issues, resource centres for NGOs, or cross disability organisations which initiate national surveys in this sector). Due to limited capacities for research and data collections, the reference groups in these cases are not very extensive. The main concern related to the databases established by NGOs remains the accuracy of data and the guarantee of confidentiality for people with disability participating in these surveys, in the context in which this type of data collection is not yet regulated by the States.

**Good initiatives in data collection about the situation of people with disabilities**

Several initiatives for improvement were developed in the region, in the last four years. An assessment done by Handicap International in 2006 in three countries (Albania, Bosnia and Herzegovina and Serbia)\textsuperscript{193} showed that the national statistics are willing to include disability in their surveys but lack concrete support from relevant ministries\textsuperscript{194}. The assessment identified also some positive steps at national levels:

**Bosnia and Herzegovina** conducted a Living Standards Measurement Survey which included a question on disability in 2001 to 2005, an initiative driven by the World Bank. However, according to the Central Statistics Office, almost no national authority requested the results of the survey or used the data in policy-making. A Labor Force Survey and Household Budget Survey are planned and there is a possibility to include disability in these surveys in 2008.

**Albania** has a more advanced statistical culture and the statistics methodology used by the Central Statistical Office is closer to EUROSTAT standards\textsuperscript{195}. This implies that the Albanian Central Statistical Office would have a stronger capacity to collect data on disability on a national level which should be leveraged by the state. The National Disability Strategy in Albania together with the plan of action represents an incentive for developing

---

\textsuperscript{191} Article 31 of the UN Convention says: “States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention”.

\textsuperscript{192} For examples of how to make a participatory disability assessment at local level see: Axelsson C., A Guidance Paper for an Inclusive Local Development Policy (Handicap International, SHIA and HSO: Lyon: 2008) (www.make-development-inclusive.org)

\textsuperscript{193} Gontier T., Adams L., 2006

\textsuperscript{194} DMI Journal for South East Europe no.3/2006, Disability Statistics Fights Invisibility, www.disabilitymonitor-see.org

\textsuperscript{195} EUROSTAT – the Statistical Office of the European Communities http://ec.europa.eu/eurostat
statistical indicators related to disability. These indicators are necessary in the monitoring process of the strategy implementation.

In 2001, Croatia amended also its Census Act and included two questions about people with disabilities at the last census. A national Register of Persons with Disabilities was also adopted in 2001. Romania has a relatively extensive experience in data collection since 1996 and numerous analyses have been possible at national level in the past years due to these statistics, in the context of policy reforms. Despite the potential duplication of data, especially regarding the group of children with disabilities, Romania has today a relatively precise database of both children and adults with disabilities at national level, as well as for each of the 41 counties and Bucharest municipality. The access of persons with disabilities to services is also inventoried, for both public and private services (accredited by the State). Both the National Authority for the Protection of Child’s Rights and National Authority for Disabled Persons publish each trimester an updated situation of these data, as well as all service providers accredited in this sector in each county of Romania. The main gaps in data remain however in relation with persons with disabilities accessing regular services. They are not included in statistics, except for children with disabilities enrolled in regular schools. This information would be very relevant in order to assess the overall need (and potential gaps) related to support services for inclusion, per types of domain (education, employment, health care, legal counseling etc)

Meanwhile, in relation with more specific data on social services, no country has developed so far an integrated information system for linking the different agencies and stages of the social service provision. From the gate-keepers’ level to the agencies responsible for monitoring and evaluation of social service providers, there is no regular communication and information flow. This major gap in policy development often results in an ineffective allocation of resources and coverage of social needs, unnecessary bureaucracy and duplication of measures, all very time consuming and costly.

2.2.5. Looking ahead

The reform of the gate-keeping mechanisms in the region should be seen as a priority for action in the governmental agendas. Some of the countries, as seen briefly in the last paragraph, committed firmly to this reform. The disability classifications systems start to be modernised, and the eligibility criteria for services start to change. Generally, the progressive introduction of the human-rights based approach in the disability-related reform. The disability classifications systems start to be modernised, and the eligibility criteria for services start to change. Generally, the progressive introduction of the human-rights based approach in the disability-related legislation, as well as in the innovative practices developed at local level, had a visible impact on this component of the regulatory framework in the field of social services.

Specific attention (and resources) should be particularly given to the following aspects further on:

- **The revision of the disability definition** at national level and assurance of a unified definition for all disability-related sectors and entitlements;

- **The harmonisation of various legislative texts** in relation with the access of people with disabilities to a wide range of services at local level, avoiding contradictory entitlements, which often become disincentives for inclusion and participation.

- **The urgent reform of the old ‘commissions of categorisation’** in terms of composition and concrete evaluation and referral procedures, for both children and adults with disabilities. The role of these commissions has to change fundamentally: from a bureaucratic inventory of impairments towards an accessible service that provides comprehensive assessment and advice, in an inclusive approach, and which is responsive, useful and respectful to people.

- **The needs assessment procedures** have to be revised in all fields of intervention: education, access to employment, cash benefits etc. The evaluation of these needs has to become person centred and adapted to the particular situation and abilities of each individual. The person should take active part of this evaluation, together with his/her family or representative. His/her personal choices have to be considered and included in the personal plan of services or in the recommendations for intervention.

- **There is a need for a good balance** between the existence of a coherent plan of intervention or rehabilitation, in each individual case, and the possibility of people with disabilities to revise (and to change) their services chain if they need to\(^{196}\). The plan has to have an orientating role, it should be a guiding instrument for accessing benefits and services, but should never become a constraining tool and a burden for people with disabilities and their families.

- **The introduction of the concept of “one stop shop”** in the national legislations of the South East European countries seems an interesting concept for the regional context. People with disabilities have the right to access information and guidance in order to raise their competence and confidence as users of community social services; the whole referral procedure has to be simpler and more effective. The information regarding the existing services, entitlements and more general social rights has to be accessible for all people with disabilities, both in terms of dissemination as well as of type of supports and communication methods (Braille, easy-to-read). This aspect is particularly important for people living in isolated or

\(^{196}\)The experiences of other countries show that, even if the philosophy of the referral system is the correct one, based on the respect of people’s rights and options, the excessive weight of “the plan” can harm the natural evolution of the person in its community.
rural areas, who usually have significant difficulties to come to the municipal agencies for information or evaluation procedures.

- The design and concrete implementation of an integrated system of information, including adequate statistics and research, regarding the global process of social service provision represent urgent priorities within the reform process.

2.3. THE SPECTRUM OF EXISTING SOCIAL SERVICES in SOUTH EAST EUROPEAN COUNTRIES

"States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs"

UN Convention on the Rights of People with Disabilities, Article 19.

In the light of the UN Convention, the right of people with disabilities to choose their living place and to live in the community with equal opportunities as other citizens is no longer questioned. Ensuring and guaranteeing this right requires from the States an effort in making all community services accessible for people with disabilities, as well as developing specific measures for the support and assistance of people with disabilities in all aspects of life.

In this part, various types of social services existing today for people with disabilities in South East Europe, as well as the way in which they transform themselves and evolve, will be presented.

Before 1990, the social welfare system in the South East European countries was universal and provided for families in terms of guaranteed jobs, pensions and allowances. The system also ensured education and housing, as well as health care. Anyone in need of individual support beyond this universal protection was directed towards the State-run institutional care. The defectology perspective in disability (inspired by the Russian Lev Vygotski) dictated that individuals with disabilities would be better cared for in large, specialized, state-run institutions. As the community-based services were almost inexistent for this category of users (disability was rather "invisible" in the communist regimes), this form of care has remained predominant for decades in South East Europe.

The development of new community-based services together with the need for de-institutionalisation at large scales have been acknowledged by the governments in the region as a priority during the last decade. Romania and Bulgaria started these processes earlier, due to their EU accession status and to the significant pressures of the civil society and international organisations. Their lessons learned and the difficulties encountered during this process are significant for the Western Balkans countries that are currently passing through a similar phase of services modernisation.

The main providers of the innovative services in South East Europe have been the non-governmental organisations: parents’ organisations, service professionals, or DPOs. The opening of new social services at community level (especially day care centers, rehabilitation and counselling services, resource and information centers, home support etc.) was the result of initial 'pilot' projects developed by these associations or foundations, often in cooperation with international donors. The initial purpose was to cover the large gap of services needed for this category of population. In the same time, the management and profile of these services were completely different compared with the traditional residential care. They have been oriented from the very beginning towards a person centred approach, in which the needs and particularities of each user were taken into consideration and transformed into adequate plans for intervention. Inspired by their international partners and the new working methodologies promoted within these new projects, the NGOs became also the first promoters of a quality approach in the field of social services for people with disabilities.

Progressively, those services that proved their professionalism and good results gained a stable position within their communities. From experimental or pilot projects, they became acknowledged community-based services, sometimes confronted with significant entry demands and waiting lists. This stage required consequently a new focus on their sustainability and management. International donors were not able anymore to provide institutional support for them on a long term basis. The need for sustainable resources at community and national levels (as

well as for internal methodological tools and procedures) led progressively to the acknowledgement that new regulatory frameworks need to be developed by the States for these settings, as well as for the public ones. In other words, the South East European countries have faced in the last decade a diversification of social service providers and this “welfare mix” was the main catalyst for renovating the entire social services system in the region.

**Widening the spectrum of sustainable and qualitative services** at local level remains therefore the key focus for all national stakeholders. From a very limited number of segregated and specialised (and mostly institutionalised) services available before 1990, to a variety of person-centered social services that develop progressively at community levels, a large process of change is currently taking place in all countries of the region. The process is still far from covering all gaps; however it shows that alternatives are possible and that different solutions can be found, even in complicated transitional contexts and with limited resources. The following presentation shows a brief panorama of these services in different countries of the region, considering that their evolution and diversification is relevant for local stakeholders in order to avoid unnecessary hesitations and blockages during the process further on.

### 2.3.1. The educational services

"(...) States Parties shall ensure that:

(a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;

(b) Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;

(c) Reasonable accommodation of the individual's requirements is provided;

(d) Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;

(e) Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion (...)".

**UN Convention on the rights of persons with disabilities** (article 24, paragraph 2)

---

**A traditionally segregated education system for children with disabilities**

The previous system of education for children and young adults with disabilities in South East Europe, before 1990, was a segregating one, parallel to, and uncoordinated with, the mainstream education. It encompassed: *special kindergartens* (for 3-6 years old pupils), *special schools* (for 6 to 16 years) and *professional special schools* (for 16 to 18 years and more). The legislation did not allow, in the past, transfers of children from the special system to the regular system of education. In exchange, during the primary school, it was possible to transfer children easily from regular to special schools, if their annual evaluations were proving delays and difficulties in learning. Special schools were scarce and they were mainly located in the main cities of the country or in remote or rural areas and for this reason they were most of the time, implicitly boarding schools, residential institutions, with large capacities (usually from 100 to 1000 children or even more).

Another “traditional” form of education for children with disabilities, still existing today, was the education at home. Legally provided in the majority of countries of the region, this measure is of course far from respecting the quality criteria in education. The number of so called *itinerary teachers* was (and still is) very limited, the number of hours of education per week is significantly lower than in mainstream schools and, finally, the children with disabilities remain completely isolated in their homes, without interaction and social relationships with their peers.198

The positive aspect of the specialised education system was the existence of qualified teachers (called special teachers or ‘defectologists’, graduated at the level of university degrees), using a specialised curricula for addressing learning difficulties related to disability.

**Moving towards an inclusive and mainstream education system for children with disabilities**

Currently, at national levels, the trend is to move away from segregated types of educational provision, especially from the use of residential institutions, and to use special classes within mainstream schools as a stepping stone towards full inclusion. At present a ‘mixed economy’ of special classes, as well as full inclusion within mainstream schools, seems to be the most successful, both for the children and for the teaching staff.199

---


199 Ibid.
The transformation of the special education system in the region is on-going. The current trend is to plan the transformation of a certain number of special schools in so called “resource centres in the disability field”, mainly because of the expertise of special educators in educational and pedagogic matters. Another aspect which is under reform is the set of access criteria and the reform of the evaluation commissions that previously decided the enrolment of children in special schools.

In the same time, the growing number of inclusive education programs in the majority of SEE countries leads progressively towards the introduction of a new philosophy in education and facilitates as well the accessibility measures in the regular schools. Children can be now more frequently enrolled in regular classrooms or in special classrooms within regular schools. However, as in the case of the de-institutionalisation process, the transformation of the education system is delayed by a strong resistance to change (at the level of decision makers, school directors and even parents of non-disabled children, lacking of course basic information on disability and human rights). More than in other sectors, this domain requires a very strong political will within the reform effort, as well as consistent and coordinated resources at local level, for capacity building in the field of disability and human rights, the effective transformation of the school environment, removal of barriers, support services and improvement of attitudes and pedagogic practices in schools.

An important aspect to be considered in the region is the fact that numerous non-governmental projects (like day care centres or multi-disciplinary rehabilitation centres) included educational programs in their profile. In this way, children with disabilities who were isolated at home in the past could finally be enrolled in educational programs. However, the situation of these services was not always clearly regulated by States. Moreover, taking over the responsibilities of education from public schools is proved to be a non-beneficial decision in the context of disability reforms. In absence of consistent policies and resources for this change process, regular schools remained rather reluctant to inclusive practices and consider that day centres (or special schools) can very well assume the education of children with disabilities further on.

**Brief national overviews about the access of persons with disabilities to education**

**In Albania,** the education of children with disabilities is provided in both mainstream and special schools. The Law no. 7952 (1995) for pre-university education, amended with the Law No. 8387 (1998) recognizes the right of education to all citizens, regardless their ‘social status, nationality, language, gender, religion, political opinion, health state or economic level’. According to this law, the special education is a component of the public education system and is organized in special classes and special institutions.

11 special schools exist in Albania, according to the data of the Ministry of Education and Science: 3 in Tirana (one for children with hearing and speech difficulties, one for children with visual impairments, and one for children with intellectual disabilities), as well as one in Durres, one in Elbasan, one in Korçë, one in Shkodër, and one in Vlora. There are also 3 day centers (in Fier, Kurbin and Librazhd) with educational programs. A number of approximately 700 children were attending these special institutions in 2006.

The professional training of teachers for these schools is done at university level. One department of the University “Ismail Qemali” from Vlora is responsible for this training.

In the last years, some efforts were made at national level for promoting and developing the inclusive education. International NGOs are contributing to these efforts with pilot projects in three districts of Albania. Several mobile multi-disciplinary teams are constituted also for assisting children that are isolated at home, due to disability or to blood feud (revenge killings). However, it is estimated that 94% of a total number of 12,000 children with disabilities are not attending schools. The lack of registration and data collection leads to unclear information about the number of such children.

The access of students with disabilities to higher education is even more difficult, due to a lack of coherent accessibility and educational adjustments for them. Financial support is provided however in several cases (scholarships or exemption of taxes). The number of blind students who attend the higher education is significantly higher than the other categories of students with disabilities.

In terms of vocational training for people with disabilities, the existing specialized vocational centers (8 in 2006) are offering special courses for different working profiles. However these centers are insufficient, not adapted to the current labor environment and not always accessible for all categories of disabled students. So far, no data exist about the presence of students with disabilities in regular vocational centers.

**Bosnia and Herzegovina** is a country with rich cultural and ethnic diversity (three main ethnic groups -Bosnians, Serbs, Croats), in which the situation of returnees after the war, the administrative complexity of the country and in the way in which the needs of the ethnic groups should be considered, impact all areas of policy design, including education.

The article 19 of the Law on Primary and Secondary Education (2003) mentions that “Children and youth with special educational needs should acquire education within regular schools in accordance with the curriculum which is adapted to their individual needs (...) Children and youth with severe developmental difficulties could be partially or fully educated in institutions for special education.” Efforts towards inclusion have been done
constant in BiH since 1997. In 2002, an awareness document released together with the start of the Reform in Education, mentioned the fact that incorporating the principles of inclusive education in all aspects of legislative and pedagogical reforms represents one of the main goals for decision makers. However, the changes that are needed for reforming the education system should take place at all levels: from policy design to concrete educational practices in schools. In the last years, several types of approaches have been tested for enhancing this change: from a top-down approach, mostly promoted by international donors and agencies, to a project-based and ‘piloting’ approach in specific communities and areas, promoted by local stakeholders and organisations. Progresses are slow, however they proved to be conditioned (in all cases) from the very beginning, by the inter-ethnic exchanges and the participatory involvement of local stakeholders in the projects design.

In the Federation of Bosnia and Herzegovina (FBiH) the education is regulated by cantonal laws. In Republika Srpska, the laws for pre-school, primary, secondary and university education are elaborated at the entity level. The overall lack of a coordination for educational policies at the level of FBiH and of the country itself have constituted in the past a significant blockage in education. The OSCE has played an active role in education reform in BiH since July 2002, when, at the request of the High Representative and as agreed by the decision of the OSCE Permanent Council, the Mission assumed a key role in the co-ordination and facilitation of the work of the International Community in the BiH education sector.

Recent evolutions were meant to compensate for this long period in which education had no real strategy and policy coherence. A newly established ‘Conference of Ministers in Education in BiH’ creates the premises for harmonising the education laws among entities, as well as among the cantons of the FBiH. The process is however very recent (2007).

In terms of practices, children with disabilities are enrolling into education with difficulty. In a report of OECD quoting official sources, from May 2007, it is mentioned that the percentage of children with developmental difficulties having access to any type of education is around 0,4-0,8%. A very small number of children attend the pre-school program and the early identification of disability is rare. This aspect leads to additional difficulties for the enrolment of children with disabilities in primary school, in parallel with a lack of accessibility in schools and the uneasiness of teachers to address disability-related adjustments.

The children with disabilities attend therefore mainly special institutions as for example the Center for Rehabilitation of Hearing and Speaking in Sarajevo, the Institute for Blind and Poor-Sighted Children and Youth, the Institute for Education of Children and Youth with Special Needs from Mjedenica among others.

When existing, the Centres for Social Work do the evaluation of children with special needs and their orientation to schools for, following a (still) medical perspective.

In Croatia, significant efforts are done in order to increase the number of pupils with disabilities in mainstream schools and the overall education policy is oriented more significantly towards inclusion. The National Programme for Education that is implemented since 2006 particularly emphasises this aspect. According the findings of OECD in 2005, 66% of children with special educational needs were enrolled in regular schools at that time. The overall number of children with disabilities in Croatia, according to the last census is around 11.000. The primary school education is mandatory for all children, including those with developmental difficulties. Children with disabilities can attend either special or mainstream schools (in this last case with a regular or an adapted curriculum, depending on parents’ request). Recent regulations that are related with the Law on Primary Education introduce the position of ‘educational assistant’ in regular schools, for supporting the enrolment of disabled children. In pre-school and primary schools, the children with disabilities are enrolled mainly in regular schools. For the secondary education, the situation changes and the children attend rather special education.

The majority of children with visual and hearing impairments are primarily attending the special schools, but their number in regular schools increases each year. The DPOs are strongly advocating for inclusive education and are providing specialized training for sign interpreters and Braille editing. Specialised training of interpreters exists as well for supporting deaf-blind persons in Croatia.

The number of students with disabilities at universities is officially reported at 205, for the year 2005-2006. The professional training of special teachers is done within the Faculty for Education and Rehabilitation, at the University of Zagreb. For the teachers in regular schools, several training agencies are available: the Teacher Training Agency, the Agency for Professional Education and the Agency for the Education of Adults. These structures include courses related with inclusive education of children with disabilities.

In Kosovo (under UNSCR 1244), children with disabilities receive education in all forms: in special schools, special classes attached to mainstream schools or individually included in mainstream classes.

204 OECD, ‘Education Policies for Students at Risk and those with Disabilities in South East Europe’, May 2007
206 Source: Census Croatia 2001
207 Ministry of Science, Education and Sports, Croatia.
The Law on Primary and Secondary Education (2002) regulates the education of children with disabilities through a specific chapter related with the special education. A Department for Special Education exist at the level of the Ministry of Education, Science and Technology. This department was the one promoting the opening of attached special classes to mainstream schools in 2003 within each of the municipalities of Kosovo.

In 2006, according to the official data of the Ministry of Education, 1030 students with disability were enrolled in primary and secondary education programs, from which:

- A number of 511 children were enrolled in 7 special schools, in Prizren, Pristina, Peja, Mitrovica and Shtime;
- 519 children were attending the 71 attached classes (58 in Albanian, 7 in Serbian, 2 in Bosnian, 1 in Turkish, and 3 in sign language). The number of attached classes in 2004 was around 40, so it doubled practically in two years time.

No data exist about the number of children with disabilities in mainstream schools.

Various reports and assessment shows that between 10-20% of all children with disabilities have access to education. A study carried out in 2006 by the organisation Handikos, in relation with the implementation of the Law on Education, shows that the main causes for this situation are:

- the lack of transportation and adequate adjustments in schools,
- lack of information about children's rights and about legal disposals among families,
- resistance of teachers,
- inadequate curriculum and teaching materials in schools,
- a lack of qualified teachers that can use the sign language or Braille.

With the support of the Finnish Government, a bilateral project focuses currently on the professional training of teachers in the field of inclusive education.

In Kosovo, the special educators are trained within the Faculty of Philosophy in Pristina University.

In FYR Macedonia the Constitution and the Education laws guarantee the right of children and students with disabilities to all forms of education. The national laws in this domain are three: for primary, secondary and respectively higher education. To orient children with disabilities to special schools is still the main tendency in Macedonia.

The regular schools are usually not accessible for children with physical disabilities and therefore children cannot attend easily the nearest school in their neighbourhood, despite the legal entitlements. Inadequate curricula prevent also children with various degrees of intellectual disabilities to access mainstream classes. However, several attached special classes exist in mainstream schools, for children with hearing impairments (in Skopje) and for children with intellectual disabilities (in around 18 municipalities of Macedonia).

Children with severe and profound intellectual disabilities were reported as having no access at education at all, in the early 2000s. A network of day care centres at national level (both public and private) developed progressively in the last 5 years and include educational programs for children with severe disabilities. UNICEF and the German Technical Cooperation Agency (GTZ) are important investors in modern pedagogical methodologies in this sector.

The special institutions for children and youth with disabilities (reported as providing educational programs for these children) are the following:

- One for children with physical disabilities - in Bansko Strumica (around 60 places), providing primary, secondary education and some forms of occupational training;
- One for children with visual impairments – the Centre Dimitar Vlahov, in Skopje;
- For children and youth with hearing impairments - two special institutions, in Skopje and Bitola, ensuring as well primary, secondary education and several occupational training (textile, woodworking, graphics). There is no qualified training for sign language in Macedonia and children are learning the sign language in their families or from their peers;
- For children and youth with intellectual disabilities: two pre-school institutions, four primary special schools (2 in Skopje, one in Veles, one in Strumica) and two secondary special schools (Skopje and Stip);
- A specific institution in Skopje exists for around 140 children with ‘severe and profound’ intellectual disabilities.

Inclusive education progresses slowly but constantly. In 2005, 73 primary schools and 13 kindergartens are reported as including children with (disabilities) special needs.

The special teachers in Macedonia have a university degree (within the Institute of Special Education, Faculty of Philosophy Skopje). The legal framework obliges all teachers that educate children with disabilities to have a university degree in special education. A special education teacher should also exist in all regular schools that include children with disabilities. In practice though this does not happen regularly.

---

208 E.g. UNICEF; and The Disability Report for Kosovo elaborated by the disability movement within the project "Strengthening the Capacity of Disabled People Organisations in the Western Balkans" EU-CARDS(2007)


In Montenegro the focus on inclusive education measures is significant, at least at political and central level. A National Strategy for Inclusive Education was adopted in 2008 and the priorities for change are mainly oriented towards the pre-school, primary school and vocational training. This strategy is linked with the Strategic plan of Education Reform for 2005-2009 and the National Action Plan for Children, (2004), as well as with the so called Book of Changes (2001), a document that served as basis for creating long-term vision of future education system.

The main partners of the Government for achieving this reform are the Finnish Government, UNICEF, Save the Children, COSV and OECD.

The challenges of reform are placed at policy level with the need for revising the existing legislation in education and eliminating the contradictions between different texts of law, that constitute disincentives for including children with disabilities in mainstream schools and at the level of the educational practices. The resistance to inclusion remains significant in Montenegro at level of schools and general public. However, the recent reform of the commissions for evaluation and orientation of children with special educational needs creates a strong baseline for "shift in paradigm" in this sector.

The pre-school education of children with disabilities is organized in the following way:

- mainstream pre-school groups,
- developmental groups in mainstream pre-school institutions,
- special pre-school groups in special institutions

The total number of children within mainstream pre-school institutions in Montenegro is 185 (73 girls and 112 boys).212

In the elementary school, the number of children with special educational needs (including children with disabilities) is 1591 (631 girls and 960 boys). From this number, 1490 study in regular classrooms and 101 in special groups. 21 special classes are organized in 10 mainstream schools, for children with light disabilities. The curriculum for these classes is adjusted.213

According to the Ministry of Education, the number of children with disabilities in high schools is 109.

Such small number is due mainly to insufficient number of trained professionals in these schools. 40 students were attending university courses in the last school year.

An important element in Montenegro (and an example of good practice for the other countries) is the existence of the so called "regional mobile teams", which are multi-disciplinary groups of professionals supporting the education of children with special needs in regular schools. They are cooperating with pre-school institutions, schools, parents and health institutions, in order to provide professional support for inclusion. Four teams exist currently in Montenegro, covering Podgorica, Niksic, South and North of the country.

The accessibility of students with mobility difficulties in schools, despite the existent legal provisions, is not satisfactory. The Association of Paraplegics in Montenegro recently made adjustments in several school buildings (primary and vocational schools) with funding from international donors.

There are five special educational institutions in Montenegro, in Podgorica and Kotor. They include around 440 children and youth in educational programs. However, the education of children with moderate and severe disabilities is viewed by the Ministry of Education as not satisfactory.

A first day-care centre was opened in Montenegro in 2004, in Bijelo Polje.214 A network of day centres, both public and private, is expected to be opened in 2008-2009, in Pljevlja, Berane, Nikšić, and Herceg Novi. It is estimated that they will offer educational and rehabilitation programs for children with more complex disabilities.

Since the law on vocational training and employment of people with disabilities is still under construction in Montenegro, there are no modernised vocational courses available yet. The existing ones are organised for persons with visual impairments and are outdated in terms of type of professions relevance to existing market. Interpreters for sign language exist in Montenegro, but their number is insufficient. Some of them are involved in the ongoing inclusive education programs.

There is no university degree for special education teachers in Montenegro. These professionals are usually trained in Serbia. Around 200 teachers in Montenegro have been involved so far in various short-term trainings organised in the field of inclusive education, especially at the level of elementary school.

---

213 Ibid.
214 Initiative of the Parents Association of Bijelo Polje, in cooperation with the Ministry of Labor and Social Welfare (through the Center for Social Work), the local municipality, UNICEF and Handicap International.
Spotlight 7: The role of frontline teachers and of support services during the initial stages of inclusive education process

The national reports and the field visits in all countries of the region pointed out that the most significant difficulty in promoting the inclusive approach in education remains the general lack of preparation of teachers in regular schools, in the various aspects related to disability. In addition, the lack of accessibility in mainstream schools (from the built environment to the information materials, manuals and curriculum) puts a significant burden on the shoulders of families and inclusive schools themselves.

In a transition period in which neither the legislation nor the curricula are adjusted for inclusion, the role of dedicated and inspiring teachers is crucial. They are supposed to become the front-liners of the change process by developing new pedagogic tools and methods, exploiting creatively the existing curriculum, working closely with families and special teachers for enabling the "reasonable accommodation" in regular schools.

Their experiences have to be widely disseminated and valued, since the success of the reform relies very much on them. Two illustrative examples are presented here, of teachers from two different countries, working in different cultural, religious and economic contexts, who contributed to a successful inclusion of children with disabilities in their classrooms; they relied on an active collaboration with families and with the community support services developed by NGOs in their region.

D.M is a young girl living in Godjevo, Montenegro. Her small village is located in a mountain region and has around 650 inhabitants. The access to the closest city depends on weather conditions and seasons. During the winter, the snow is thick and it is very difficult for cars to reach the main road. The village school receives around 130 pupils. It is located in a 40-year old building, in which little investments have been made in the recent years. The heating system is old and during the winter children keep their coats on all along the class hours. In each classroom the small heater with wood fire cannot fight the cold. However, the school has an impressive library and a handful of dedicated teachers. D.M has been evaluated as having a moderate intellectual disability. She was enrolled in her village school, after being prepared for inclusion by the team of the Day Care Centre Tisa, in Bijelo Polje, some 20 km away from her home. Now she can follow the education program together with her neighbours and colleagues. The teacher tries to adapt the regular curriculum in order to allow her participating the most, and values every single progress she makes. He keeps strong links with the staff of the day centre and evaluates regularly the progresses of D.M together with his colleagues there.

V.S. is a young boy from Bucharest, the capital of Romania, a city with 2,3 million inhabitants. He has cerebral palsy and is a wheelchair user. At the age of 5, his parents brought him for evaluation and educational programs at the Day Care Centre Aurora. He was experiencing significant speech and mobility difficulties and was told by the official commission for evaluation that he cannot attend a regular kindergarten.

Like D.M. in Montenegro, in the day centre he benefitted from the work with a multi-disciplinary team (physiotherapist, speech therapist, psychologist and teachers) which prepared him for the primary school level. After two years of work, the team of Aurora encouraged the parents to enrol him in a regular school. After several negotiations and research for an accessible school, the family found an extremely dedicated teacher who accepted V.S. in her classroom and made extraordinary progresses in adjusting the whole educational environment to his needs. Now she is a resource teacher for other inclusive schools in Bucharest.

In both cases, the teachers had initially no information and knowledge about disability. They were not part of the specific groups of professionals who followed courses of inclusive education in their countries. They relied on

---

215 Article 2 of the UN Convention on the Rights of Persons with disabilities defines: "Reasonable accommodation" means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.
the professional teams of the two day centers, for advice and support, as well as on the two dedicated families; in time, they all became a part of a ‘big family’. They succeeded to make the crucial step of giving these children a normal life, among their classmates, in their own neighbourhood, with relatively simple resources.

These two examples are illustrative for many similar cases in South East Europe. They show that inclusion is possible in various contexts and situations. However, they advocate for a consistent support that needs to be given to teachers in this process: capacity building, adequate tools, professional recognition and continuous training.

In Romania, the education of children with disabilities is guaranteed by Constitution and by the Law on Education (84/1995) with all its amendments. Children with disabilities can receive education in mainstream schools, in special classrooms attached to mainstream schools, in special schools and in the so called ‘educational alternatives’ (day centres, Waldorf and Montessori classrooms, Step by Step, centers for ‘curative pedagogy’ etc). The particularity of Romania is that these ‘alternative’ education providers are officially recognised by the State, regulated by the national law and submitted to accreditation procedures, as all other existing schools. All education providers (public, ‘alternative’ and private) are subject to the same legal rules (in terms of human resources, curriculum etc).

The number of special schools, in 2006 was (according to the last available statistics from the Ministry of Education, Research and Youth): 145 special schools for children with intellectual disabilities (for a total number of 22,550 children), 8 special schools for children with neuro-motoric disabilities (1327 children in total), 8 special schools for children with visual impairments, using however the regular curriculum in 95% of the cases (1610 children) and 19 special schools for children with hearing impairments (2668 children). In 2006-2007, 16,290 children with disabilities have been enrolled in mainstream schools and 27,445 in special schools.

The promotion of inclusive education in Romania was a complex process, which took more than a decade. The overall process was a mixture of successes and set-backs. It started in 1994-1995 with alarming signals from the non-governmental sector and from international organisations: one about the critical situation of ‘invisible’ children (children with disabilities living at home with no access to any form of education, as well as the ones living in remote or isolated areas) and another about the children living in large residential settings. Similar to the majority of special schools in the region, the Romanian ones were located in the main municipalities and therefore needed accommodation premises for children coming from distance. So, together with the overall de-institutionalisation process in general, the residential aspect of these special schools was questioned.

The main promoters of a reform in the field of special education in Romania were UNICEF and a local umbrella organisation called RENINCO, gathering almost 400 professionals and 80 organisations from all regions of the country. RENINCO initiated numerous campaigns of awareness, as well as training programs and publication of materials. Guidelines, toolkits for teachers, informative materials for families etc were developed for disseminating the principles and good examples of inclusive education and of individualised approaches in education.

The whole process experienced a difficult moment in 2000 when, after pressures coming from foreign stakeholders, the Government of Romania decided to transfer 19,000 children from special schools to mainstream schools in a timeframe of 6 months. The decision was based on the fact that many children in special schools in fact did not have a disability, but were from poor and socially excluded families. This was a true fact, however the timeframe and lack of preparation of this huge transfer of children provoked severe protests from all types of stakeholders involved in the education system. Mainstream schools were completely unprepared to receive children with disabilities on large scale, parents were very concerned about the adaptability of their children and the consequences of the transfer and the special schools felt threatened in terms of further continuation of their work. A national evaluation of this decision in the following year (organized by UNICEF and the Government of Romania) showed that the decision was inappropriate and produced a lot of negative effects (among which a critical rate of drop outs after several months, as well as the return of numerous children to special schools). To some extent, this type of radical and hasty measure has jeopardized the whole process of inclusive education.

This entire situation lead to serious revisions of the reform process and ended with the elaboration of a national action plan for inclusion of children with special educational needs, in 2003-2004. The process was taking place in parallel with the reform of the evaluation and orientation commissions, as well as with the transfer of special schools and programs under the responsibility of county councils.

Further on, due to the pre-accession to EU, significant financial resources have been allocated for this domain. Several public schools in the system (as well as NGOs providing educational services) have piloted innovative methodologies and educational practices all along this process. Based on their model, the Ministry of Education decided to transform several special schools (at least one per department) in resource centers for special educational needs of children. The process is ongoing and represents a possible solution for exploiting the.

---

knowledge and resources of special education teachers in these schools. However, progresses are slow and large capacity building programs among teachers do not exist. When organised, their impact is uneven.

The young adults with disabilities are as well confronted with significant problems, since the vocational programs in special schools are not adapted to the reality of the labour market. Young people who cannot pass the baccalaureate examination are in severe risk for exclusion of employment further on.

In 2008, many children with disabilities remain still outside the system of education, especially children with severe or complex disabilities. The first cases of court actions emerge, initiated by parents of children whose right to regular education is denied.

In Serbia children with disabilities (estimated by UNICEF at around 143.000) have the right to access education in both mainstream and special schools. Despite progresses that were made in the recent years, the inclusive education does not benefit yet from the Government’s consistent commitment and investments218. 30% of children with special educational needs (including children with disabilities) are reported as having access to education219.


The existing laws do not prescribe exclusively an obligation of schools or local authorities to provide reasonable accommodations for those pupils that access the mainstream education. The Law on Prevention of Discrimination against Persons with Disabilities represents a better incentive for inclusive practices, since it prohibits the denial of enrolment of a child in school on the grounds of disability. Its implementation is however relatively slow.

Several anti-discriminatory measures are also mentioned in the Law on Higher Education and there are specific articles that mention that universities have to provide adequate conditions of study for students with disabilities, including the organization of classes in sign language. The practice shows however that many students cannot enter the faculty buildings due to lack of accessibility.

More than 200 mainstream primary schools in Serbia offer today special classes, following several long term projects initiated by Save the Children and UNICEF, in cooperation with the Ministry of Education. Considering the general lack of training among teachers with regards to inclusive practices, Open Society Institute and Save the Children are leading a process of elaborating guidelines and training for these teachers.

The main obstacle for inclusion and general education of children with disabilities remains the lack of accessibility in schools and universities; physical accessibility (for almost 90% of the total number of primary and secondary schools) and also the lack of accessible educational materials. An additional difficulty is the lack of curriculum adaptation and of excessive attention given to excellence and performance in education. The number of support teachers is also very limited. The social model of disability and the individualized approach in education are not yet current practices in Serbia, which further hinders the process of inclusive education220.

The vocational training for persons with disabilities is mentioned in the national laws and its modernization will receive a strong incentive once the Law on Professional Rehabilitation of Persons with Disabilities will be released. At present, the professional qualifications are outdated and not in line with the labor market.

In terms of special education, there are 85 special schools in Serbia: 51 primary schools and 34 secondary schools. Majority of them have residential settings as well.

Recent evolutions at national level show that the reform of the old ‘categorization commissions’ is planned by the Government, targeting their transformation into evaluation and orientation commissions. This process was in fact initiated already in 2003-2004 but blocked due to political changes at the level of the government.

The special teachers are trained at university degree. They enroll at the Faculty of Pedagogy and additionally at the Faculty for Special Pedagogy and Rehabilitation (the former Defectology Faculty).

Looking ahead with regards to access of persons with disability to education

Despite the political commitments and success stories in each country of the region, a large number of difficulties slow down the access of children and youth with disabilities to education. The interviews with professionals and parents, as well as the testimonies of responsible decision makers in the ministries of education, focus usually on the following areas of necessary improvement in this sector of community services:

• There is a need for accurate data with regards to the number and residence of children and youth with disabilities, in order to provide them with referral to adequate educational services in the community;

• The reform of evaluation and orientation commissions needs to continue, as well as the shift towards inclusive practices and attitudes;

• Teachers and managers in mainstream schools need to be more aware (and trained) regarding the human

---


220 Conclusion of the National Report on Persons with Disabilities of Serbia, within the project ”Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Forum and supported by EU (CARDS), 2007
rights approach and the inclusive education framework, the same for school inspectors and local decision makers in this domain;

• The ‘twin track approach’ in education needs to be discussed, understood and transformed in clear methods and decisions;

• Better resources are needed for schools and teachers in order to provide for reasonable accommodation for students with disabilities (removal of barriers in schools and universities, both architectural, informational and behavioural, adaptations of curriculum and of the school program, specific adaptations for children with chronic illnesses and children living with HIV/AIDS etc.);

• The statute, role and resources for support teachers need to be clarified, and they need to benefit from continuous training;

• Finally, the role of parents and parents associations, as partners in the educational program, need to be acknowledged and supported actively at all levels.

2.3.2. Health care services

"(...) States Parties shall:

a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

c) Provide these health services as close as possible to people's own communities, including in rural areas;

d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability”.

UN Convention on the Rights of Persons with Disabilities, Article 25

This part looks briefly at the access of persons with disabilities to regular health care (especially primary health care), as well as to early identification and intervention programs. The access to medical rehabilitation services will be described further on, in the paragraph 2.3.3 (Habilitation and rehabilitation services).

The general organisation of the health care system in the countries of ex-Yugoslavia, Albania and Romania is relatively similar:

**The primary health care** is provided at the level of communities in medical centres or health posts, in which family practitioners ensure a first medical consultation to patients: preventive care, general medicine, health care for infants and children, gynecology care, laboratory and diagnostic services, dental care and work medicine. In several countries of ex-Yugoslavia, these settings (called “dom zdravlja”) include also a first aid services.

**The secondary health care** is ensured either in polyclinics or hospitals, by specialist doctors. They provide consultations and treatment to patients at the recommendation of family doctors or primary health care doctors.

**The tertiary health care** is provided in general county (district) hospitals and also in specialised hospitals (chronic diseases hospitals, orthopaedic hospitals, etc). The referral for these services is given either by family doctors or by doctors at secondary level, because the level of care is highly specialised. Tertiary health care units are often training centres for medical professions.

In all countries of South East Europe, the access of people with disabilities to health care is guaranteed by Constitutions and national laws. The recent national disability strategies and/or action plans (in Albania, Croatia, Kosovo, Montenegro, Serbia, Romania) and the anti-discrimination laws represent additional legal backgrounds for enhancing the access or persons with disabilities to medical care on equal basis with all other citizens.
In practice, the gap between national strategies (as well as legal frameworks) and practices remains significant. The critical elements are the following:

- A large number of hospitals and primary health care units are not accessible for wheelchair users, as well for people with sensorial and intellectual disabilities. In addition, people with hearing impairments do not benefit automatically from sign interpreters when addressing the medical system, they have to pay this support service by themselves;
- In several countries the disability movement representatives report cases of denial of access to health care for people with autism and severe psychosocial and intellectual disabilities;
- A large number of persons with disabilities are not covered by medical insurances;
- The access of people with disabilities to life insurances is very limited and discriminatory, especially for persons with severe disabilities;
- The dentistry services, as well as the services in the area of reproductive health, remain globally unprepared for the specific needs of people with disabilities. Gynaecological services are not always adapted for women with disabilities. The doctors are not trained in disability issues (social model, human rights, particularities of various impairments, etc.), which leads to inadequate attitudes and medical practices. People with intellectual disabilities, autism spectrum disorders, psychosocial disabilities, as well as people with complex neuromotor disabilities and people living with HIV/AIDS face additional difficulties and discrimination, in receiving quality medical care, at primary level;
- Not all medicines and medical aids that are necessary for people with disabilities are included in the lists of products covered by the insurance systems. For this reason, people are often forced to buy products of lower quality or to pay for the better products with their own money;
- People with disabilities in rural and remote areas have additional difficulties for accessing even the primary health care. No evaluation of their specific medical needs usually exist in these small communities and the access to medical rehabilitation or more specialised medical treatment is very difficult (no transportation possible to the closest hospital, no information available for addressing the appropriate medical or rehabilitation professionals);
- There are no functional links between medical services and other related community services for people with disabilities, especially the innovative ones (counselling, psycho-social support, occupational therapy etc.). In addition, the inter-disciplinary services, like the socio-medical ones for example, do not have yet appropriate regulations and legal framework; their inter-disciplinary character raises problems related to financial support, selection and management of staff, monitoring bodies and procedures, as well as the nature of the gate-keeping and evaluation procedures.

Several positive evolutions can be listed however in the medical sector in the last four years, with regards to the access of people with disabilities to these services:

In Albania and FYR Macedonia, the World Health Organization (in cooperation with local authorities and stakeholders) supported technical assistance in the field of mental health:

- Developing mental health policies and adjusting the existing legislation, including the elaboration of charters of patient’s rights;
- Setting up community mental health centres and transforming residential services into day-centres and sheltered homes;
- Income generation activities and social clubs for people with psychiatric conditions;
- Awareness raising projects and capacity building in local communities.

Since 2004 in Croatia and since 2006 in Serbia, all health centres are supposed to be progressively adapted, in accordance with the general accessibility (architectural) standards.

The first gynecological clinic for persons with disabilities was opened at the Clinic for Women’s Diseases and Obstetrics in Zagreb in 2001, since then, six more units have been opened in Croatia.

In Kosovo, the Ministry of Health with the support of the World Health Organisation has established a network of Mental Health Community Centers in order to provide different services to people with psychiatric conditions in their communities, as an alternative solution to institutionalization.

The awareness of disability is constantly rising in communities. In this context, the decentralization process in medical care gives to family doctors key roles in referring the medical problems of disabled persons. In Montenegro, a specific program of training for family doctors and pediatricians (in the field of disability) took place in 2008. The Ministry of Health, Labor and Social Welfare is in process to establish 8 developmental counseling centres in the country, focusing on both early detection and intervention, as well as counseling of families and medical rehabilitation services. Additionally, in July 2008 the Montenegro Healthcare Fund adopted several new regulations in the area of health insurance, including improved rules for accessing prosthetic devices.

In Romania, several services promoting the access of people with disabilities to dental medicine, have been piloted recently at the initiative of Special Olympics Romania.

---

222 National Disability Report for Croatia, within the project: “Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Forum and supported by EU (CARDS), 2007.
The progressive development of early detection and early intervention programs for children with disabilities

Very few initiatives related with the early diagnostic and early intervention existed in the region before 2000. When existing, they were located usually in paediatric hospitals or neuromotor rehabilitation clinics, or provided by few non-governmental organisations.

Currently, the early detection of medical conditions that can lead to disability is done in paediatric, neuro-paediatric or specific services organised under the responsibility of ministries of health.

However, there are several types of diagnosis (like autism spectrum disorders (ASD), behavioural disorders, attention deficit hyperactivity disorder (ADHD) etc), that are not diagnosed on regular basis even in specialised medical departments. Many of these children are at risk of marginalization and exclusion later on, if left without appropriate care and support.

The announcement of disability is still done in a rather inappropriate way in the majority of the SEE countries. Testimonies of parents interviewed all around the region showed that the child’s disability is often presented by professionals as an irreversible condition, and as a burden that will harm the life of the family. Despite isolated good examples and initiatives (conferences, short training sessions, awareness activities) that have targeted this particular aspect all around the region, the general practice is rather humiliating and disturbing for families.

The number of professionals specialised in early diagnostic is very low for the region and most of the existing ones are trained or gained additional qualifications for this domain in Western European programs (paediatricians, neuro-paediatricians, neurologists, speech therapists, psychologists, physiotherapists etc). The multi-disciplinary teams for early intervention are extremely rare.

In FYR Macedonia, the early detection is done mainly in Skopje and Bitola, where two specialised centres for early intervention exist from 2003223.

In Montenegro, the counselling and developmental centres, which are now in process to be developed within the primary health system, will ensure the early intervention for children who are diagnosed with a functional limitation. A very important national program (supported by World Bank) was carried on in 2008, aiming at developing a comprehensive national system of early diagnosis for disabled children; another program has targeted the training of family doctors in the field of disability.

In Romania, the development of these services had a more significant impulse from 2001-2002. While for the neuromotor and sensorial conditions the medical diagnostic was relatively frequent, especially in the paediatric hospitals or physical rehabilitation sections of general hospitals, for developmental and learning difficulties, as well as for intellectual disabilities, the early detection and intervention was poorly developed in the past.

In the last decade, several non-governmental organisations have started to develop specific services of early intervention and support for children at risk and their families, in cooperation with local authorities and/or existing public services (hospitals, kindergartens, counselling services): ‘Alpha Transilvania’ in Targu Mures (for children with neuro-motor disabilities), ‘Speranta’ in Timisoara (for children with developmental problems), The Centre for Motoric Rehabilitation (Cluj), Thysia and Albin (Oradea), Sense International (in Bucharest and Oradea, for deafblind children), World Vision etc. The maternity wards or paediatric hospitals in these municipalities have integrated progressively this type of service. A curriculum for early detection of disability and early intervention exists currently at Cluj University, at the Faculty of Special Psycho-pedagogy.

In Serbia, a network of development counselling centres exists in more than 35 municipalities, at the level of health centres (primary health care). They provide ambulatory services for children born with developmental difficulties and multi-disciplinary support in terms of early intervention and referral to more specialised medical rehabilitation.

In addition the Institute for Experimental Phonetics and Speech Pathology (IEPSP)224 has a network of local centres providing early diagnostic and speech therapy for a variety of conditions related to hearing impairment, speech and language disorders.

Spotlight 8: Emergence of new early detection and intervention programs in South East Europe

The reform of the early intervention system in Montenegro (2008)

In 2008, the field of early diagnostic and intervention has benefited from a significant ‘momentum’ in Montenegro, due to the Project of the reform of the primary health care system. This project is led by the Ministry of Health and supported by World Bank. As a consequence, a specific type of service will address the situation of children born-at-risk, as well as the counseling and guidance of families:

The centres for the support to children with special needs225 are innovative services within the primary health care system in Montenegro. They are designed to be additional support services to the

224 www.iepfg.org.rs
225 These services are also known as ‘development counselling centres’ in several programs taking place in Montenegro, and Serbia.
health protection of children at risk of, or with disabilities, as well as focal points for the system of social protection, education, local government and civil society sector. They will play crucial role in building safety nets around the child and his/her family.

The estimate number of children with temporary need for this kind of service is 5 000 and with permanent need around 2 000.

The composition of the multidisciplinary team of these centres, according to the national normatives, is the following: pediatrician (specifically trained in this field), psychologist, nurse, physiotherapist, and speech therapist.

The overall goals of this component of the reform are to:
- Establish and train the multi-disciplinary teams in 6 Centers (Podgorica, Niksic, Bar, Berane, Bijelo Polje, Herceg-Nov) and two units (Rozaje and Pljevlje); train the staff on regular basis;
- Employ a physiotherapist in each of the following 10 Health Centers (Kolasin, Mojkovac, Plav, Kotor, Tivat, Cetinje, Ulcinj, Kolasin, Budva, Danilovgrad);
- Equip the Centers and the services with technical equipment;
- Establish procedures directing infants and children-at-risk towards the Centers (system of orientation) within the health, education and social protection system;
- Set the ground for the full registration of children with disabilities;
- Form the patronage service\(^{226}\) as a stronger link between the Centers and the families;
- Form the national body entitled to supervise and improve the quality of work in Centers;
- Elaborate National Strategy for the prevention of the main causes of child disability;
- Create a network of local educators.

In November/December 2008, the initial training of the professionals employed in these centers was realized. The reform process will continue in 2009.

(Source: Sonja Vasic, local consultant of the project, responsible of the training component)

Organisation Alpha Transilvana (Targu Mures, Romania) – the IMPULS service

Alpha Transilvana Foundation is a non-governmental, non-profit, social service provider organization, which aims to help different categories of disadvantaged persons. It developed a wide spectrum of services including: day care (30 users daily and more than 100 in ambulatory services), vocational orientation, counseling and work mediation services for young adults with disabilities (more than 60 users), sheltered work/social enterprise (15 users), as well as a resource center for NGOs.

Along with this variety of interventions, the foundation initiated five years ago a centre for early intervention for children born with risk of developmental difficulties.

Eva Gyorki, the director of Alpha Transilvana, presents this service called IMPULS: “To describe tangible results when you are working with persons living with disabilities is quite a difficult task. We are already talking about results when we see a smile on the face of a child who never did this before, we see the first steps when a lot of people already was giving up the hope, and we see the spark of hope in the parents eyes. These are the results worth fighting for: But we could also talk about statistic figures: more then 500 children included in the prevention, early intervention and monitoring program of our organisation; over 10,000 working hours of the multidisciplinary team; more then 350 children born with risk integrated in mainstream kindergartens, after following our programs; over 1000 of parents benefitting from our services; and 6 public awareness campaigns emphasizing social inclusion for persons with disabilities.

The children we are working with are scaled, at birth, with 6 or less on APGAR scale and are born with less than 1500 gr. In our service, the intervention program is multidisciplinary and addresses children and families together.”

For children up to 3 years of age, the foundation is providing physiotherapy, speech therapy, hydrotherapy, psycho-pedagogical services and early educational programs aiming at the most adequate (and rapid) inclusion of children with disabilities into mainstream environments.

Alpha Transilvana is a member of EASPD (the European Association of Service Providers for Persons with Disabilities).

---

\(^{226}\) The ‘patronage services’ are specific forms of service provision for persons with disabilities in the countries of ex-Yugoslavia, mainly consisting in mobile teams visiting users at home, for various types of intervention (education, rehabilitation, counseling etc.).
Looking ahead with regards to the access of people with disabilities to health care

The main priorities for reform and investment in the region are related with:

- the improvement of concrete access of people with disabilities to health care services, from physical accessibility in hospitals and policlinics to the way in which medical doctors address certain types of disability-related conditions professionally.
- the urgent development of a wider network of early detection and early intervention services across the region;
- the financial coverage of medical treatments, rehabilitation services, ortho-prosthetic devices and medicines for people with disabilities, which are not yet addressed consistently in national legislations, leading to significant variations in quality of care among various categories of people with disabilities
- the training of medical professionals in various aspects related to disability (modern approaches of disability, medical interventions in relation with more specific needs and conditions of people with disabilities etc.).

2.3.3. The habilitation and rehabilitation services

"1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

   a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

   b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation."

UN Convention for the Rights of Persons with Disabilities, Article 26

In the sense given by the text of UN Convention, the habilitation and rehabilitation services include a wide range of activities aiming at enabling people with disabilities to achieve their maximum level of independence and participation in socio-economic life.

While habilitation refers mainly to those measures that enable people to achieve ability or a functional level that has never been reached before (due usually to impairment from birth or from very early age), the rehabilitation services focus on restoring (or compensating) of those abilities that have been lost due to an impairment or injury. The differentiation is made in terminology, since these two situations often require different types of services and interventions. In this paragraph, the formulation "(re)habilitation services" will be used when referring to both specific measures as a whole.

The (re)habilitation is obviously not limited to medical care. It is related with a much wider range of activities including physical, psychosocial and occupational therapy, as well as a variety of support services for community living and daily life activities227.

In South East Europe, this category of services was very limited in the past, focusing mainly around the medical rehabilitation. With the exception of Albania, where even the physical medical rehabilitation (PMR) was very poorly developed, the other countries of the region have benefitted from a relatively developed network of medical rehabilitation institutions. These structures were located mainly in remote areas, sometimes in spas, and the services were over-specialised and provided by medical professionals and physiotherapists. The general hospitals in the main cities were also providing physiotherapy, speech therapy and psychological counselling for people with disabilities.

On the other side, many large residential institutions for people with disabilities were also called “rehabilitation centres”, even if their real profile had very little in common with the modern understanding of rehabilitation activities. These institutions were rather a very last (and often lifetime) solution for people with severe disabilities, mental health problems or elderly people with disabilities.

Nowadays, the (re)habilitation services in the region are under transformation and broadening. As the following descriptions will show, the spectrum of these services is constantly developing, together with the way in which

227 For this reason, both articles 19 (Living independently and being included in the community) and 26 (Habilitation and rehabilitation) of the UN Convention are usually considered comprehensive references for a very wide spectrum of services for people with disabilities.
services are provided. The new services are closer to people; they start progressively to take into consideration the person's individual needs and therefore service delivery becomes more personalised. The presence of the NGOs as service providers in this area represents a strong factor of change, due to more innovative practices in the direct service delivery.

The following examples do not represent a comprehensive list of (re)habilitation services. It would be very difficult to do so, since no complex mapping of these services exist in the region, including public and non-profit services. However, the illustration of this variety of services emerging at community level reflects a general trend of progressive development of the sector, with (still) numerous gaps and insufficient sustainability on long term.

The medical rehabilitation

This domain has benefited traditionally from a relatively good network of infrastructures and professionals in the region as earlier described, with the exception of Albania, where the service was completely underdeveloped. People with sensorial disabilities were provided with medical rehabilitation in the general or specialised hospitals, located in large municipalities. For the persons with physical disabilities, these centres were rather located in spas or in the main district hospitals of the country. For people with intellectual disabilities, as well as for people with psychiatric conditions, the overall care services (with very few therapeutic programs) were provided in segregated institutions for this specific category of users.

Today, these large settings are under a strong pressure for modernization. New services arise (even in smaller municipalities) and the typology of providers diversifies: not only public, but also non-profit, for-profit and freelance professionals start to be accredited in several countries, in the field of medical rehabilitation. However, the rural areas remain largely uncovered by this type of intervention. In addition, not all medical treatments or therapies are included in universal or private medical insurances or disability specific allowances.

Albania is the country of the region in which the physical and medical rehabilitation was the less developed in the region. The lack of professionals (as well as of professional training in this domain) has delayed significantly the development of the sector.

Several rehabilitation centres are traditionally functioning under the responsibility of the Ministry of Health in this sector (Physical Rehabilitation department at Tirana University Hospital, the National Centre for Children's Education, Development and Rehabilitation in Tirana, the orthopaedic department within the Military Hospital, and the recently modernised rehabilitation unit of the Kukes hospital228.

Rehabilitation services for persons with disabilities (including medical rehabilitation) are also provided in so-called “development centres”. These centres are either residential or day settings, and deliver educational, physical, psychological, social and medical services for people with physical, intellectual or sensorial disabilities. Six residential development centres exist in Albania (in Tirana, Durrës, Berat, Vlora, Korça, and Shkodra), as well as two day care development centers (Lezhe and Shkodra). The transformation of the residential settings is included in the list of governmental priorities of reform.

During the last four years, major steps forward have been made, both in terms of infrastructure and in professional training.

At national level, a strategic plan on physical and medical rehabilitation was validated by the Minister of Health in March 2007. The plan defines clear priorities and evaluates the resources needed in order to develop rehabilitation services throughout the country. It includes concrete activities, timetables and implementing bodies for this purpose229. In line with this evolution, a comprehensive qualification in PMR is prepared for a number of medical specialists, in order to enable them to work, after one year training, in existing PRM facilities. This PMR Continuing Education Degree Course will consist in five modules of one week, taught between November 2008 and June 2009230.

Since October 2006, the Nursing Faculty in Tirana implements a new and sustainable program of physiotherapy training, based on a 3-years curriculum developed according to European standards and in line with Bologna convention. Three generations of students are involved in this training231.

229 According to Ali Aliu, Program Coordinator for the Physical and Medical Rehabilitation Project of Handicap International in Albania, November 2007
230 The curriculum, based on European Standards, has been approved by the Ministry of Health which will endorse it as a continuing education program. 18 trainees have been already selected for this program. The trainers will be French experts in Physical Medicine and Rehabilitation from the CDFEMER (French College of PMR Teachers). Source: Ali Aliu, Program Coordinator for the Physical and Medical Rehabilitation Project for Handicap International in Albania, December 2008.
231 The educational curriculum for this program was developed by the Nursing Faculty of Tirana, with the support of Handicap International and Belgium experts, coming from: Le Haute Ecole d’Ergotherapie Ilya Prigogine (Brussels) and Haute Ecole d’Ergotherapie de Charleroi.
For ortho-prosthetic technicians, a specific training program on lower limb prosthetics has been developed recently, using the curriculum of Don Bosco University from El Salvador\textsuperscript{232}. It will continue with a similar training for upper limb prosthetics. The curriculum was translated into Albanian and approved by the Ministry of Health. The training program for ortho-prosthetic technicians began in November 2006, in a duration of 18-months\textsuperscript{233}. Additional information about the evolution of professionals in these new rehabilitation domains in Albania is presented in the paragraph 2.9.

**In Croatia**, the medical rehabilitation is provided in 27 specialized hospitals around the country, in general hospitals as well as in the Public Health Institutes (located generally at county levels)\textsuperscript{234}.

**In Kosovo** (under UNSCR 1244), there are two centers for physical rehabilitation offering services for persons with rheumatic conditions and for persons in post-surgery care, but used also by persons with disabilities as out-patients, who need to pay for the services\textsuperscript{235}.

In addition, an extensive network of 12 community rehabilitation centers (CBR) was developed by the organization HANDIKOS in the last decade, with international donor support and following the classic CBR principles. They provide basic physiotherapy and psychosocial services for children with disability and advises for parents of children with disabilities.

**In FYR Macedonia**, the traditional rehabilitation centers are specialized for each type of disability: for physically disabled persons (in Skopje and Ohrid), in the former Institute for rehabilitation of children and youth with visual impairments (Skopje), in the Institute for rehabilitation for persons with hearing impairments (Skopje and Bitola) and in the Institute of rehabilitation for persons with intellectual disabilities from Skopje. Certain medical rehabilitation services are also provided in the more recent day centers for children with disabilities (both public and non-governmental).

**In Montenegro** the largest rehabilitation center of the country is in Igalo, in the Southern part of the country, specialized in physical medical therapy\textsuperscript{236}. The functional rehabilitation for physically disabled is undertaken as well by professionals in three hospitals of the country, but the overall number of physiotherapists (and the geographical coverage of this service) is largely insufficient. In the Northern part of Montenegro for example, due to the lack of professionals, parents of children with neuro-motor disabilities have paid for years a mobile physiotherapist coming in this region every six months, for intensive therapeutic sessions with their children.

At municipal level, medical rehabilitation should be provided at the level of primary health care; 8 developmental counseling centres have been organized recently at these levels, however they are not yet fully functional. Additionally some of the newly established day care centres include also rehabilitation components (usually physio- and speech therapy).

**In Romania**, the medical rehabilitation services are provided by both public and private (not-for-profit and for-profit) providers. Delivered in the past rather in institutionalized settings, the evolution of these services currently progresses towards community based services, managed by local authorities or local accredited NGOs.

The physical medical rehabilitation for children is provided in specific centers under the management of the Ministry of Health: either large centers, located in spas (Baile Felix, Mangalia, Gura Ocnei, Dezna) or rehabilitation centers at the level of counties and municipalities. These centers are relatively well equipped and benefit from qualified professionals, same as in the countries of ex-Yugoslavia. The current trend is to progress towards small rehabilitation services located in municipalities and managed by the General Directorates for Social Assistance and Child Protection (county level authorities). The non-governmental organizations developed as well medical rehabilitation services after 1990s, either in specialized centers (e.g. Cluj, Iasi, Timisoara), or as specific services within day centers or small sized group homes.

For the adults, the medical rehabilitation is provided in public hospitals and mainstream rehabilitation units, as well as in specialized centers per types of intervention and disabilities. These settings are organized under the methodological coordination of the National Authority of Persons with Disabilities and under the Ministry of Health. New services for medical rehabilitation are regularly being opened since 2007, providing ambulatory care for people with disabilities who are not institutionalized.

\textsuperscript{232} The curriculum of the University Don Bosco from El Salvador is the only one benefiting from a worldwide recognition and certified by the ISPO – International Society for Prosthetics and Orthotics. The ISPO recognizes three levels of P&O technician education: Level 1 "Advanced" with 3 or 4 years of formal structured program leading to a University degree (or equivalent) -, Level 2 "Intermediate" with 3 years of formal structured program (entry requirement lower than degree level) and Level 3 "Basis" achieved with a training on the job. The Don Bosco University has developed a modular distance learning curriculum, with the aim to improve the quality of P&O services offered in developing and low-income countries which have suffered natural disasters, wars or other catastrophes.

\textsuperscript{233} According to Ali Aliu, Program Coordinator for the Physical and Medical Rehabilitation Project for Handicap International in Albania, November 2007.

\textsuperscript{234} The Disability Report for Kosovo within the project “Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Forum and supported by EU (CARDS), 2007.

\textsuperscript{235} The Institute for Physical Medicine, Rehabilitation and Rheumatology ‘Dr. Simo Milosevic’.
All these services are currently submitted to an accreditation process, including the freelance professionals, so a precise inventory of them exists at the level of each county and the lists are available on internet. The for-profit services are also expanding very rapidly in this domain, especially in the large municipalities (small size multi-disciplinary rehabilitation centres, physiotherapy centres, among others).

In Serbia, the medical rehabilitation services for people with disabilities are provided in primary health units, in residential institutions and in specific rehabilitation centres. The development counseling centres are located at primary health level and they assume the early rehabilitation services for children. Majority of the general hospitals have also rehabilitation departments, and mainly in larger municipalities (Belgrade, Novi Sad, Nis etc). The most equipped and staffed remain however the rehabilitation centres and clinics, located either in (or closer to) hospitals, or in spas. Specific medical rehabilitation units exist as well in the Military Hospital in Belgrade and in several hospitals in the country (Nis, Kraljevo, Kragujevac) for mine victims.

The occupational therapy

The occupational therapists in the sense acknowledged at international level exist only in Croatia, Romania and Serbia, and at a limited scale. They deliver services in centres for rehabilitation, residential institutions for assistance and long term care, hospitals, elderly homes and day centres.

The profession of ‘occupational therapy’ was associated in the past with simple occupational tasks like crafts, woodwork etc. This traditional form of (re)habilitation was provided in large residential institutions for disabled. It was not necessarily targeting a further inclusion of people with disabilities in their communities and was not considering persons with disabilities in their complex environment and social system.

The occupational therapy professionals did not benefit from a structured educational framework in the past but during the last decade; specific training departments for occupational therapy have been progressively developed. In cooperation with the main European organisation specialised in occupational therapy programs in higher education (ENOTHE), several departments exist currently at university levels in Romania (Oradea, Bacau and Timisoara), Croatia (University of Applied Health Sciences, Zagreb) and Serbia (Health College in Belgrade). The number of professionals is still scarce though, since the career is new and graduations ongoing. Their legal professional status is still in the process of being acknowledged and regulated.

**BOX 7**

Three important organizations with relevance for the occupational therapists in South East Europe

The Council of Occupational Therapists for the European Countries (COTEC - http://www.cotec-europe.org/) was established in 1986 with the purpose of co-ordinating the views of the National Associations of Occupational Therapy. The aim of COTEC is to enable National Associations of Occupational Therapists in Europe to work together to develop, harmonise and improve standards of professional practice and education, as well as advance the theory of Occupational Therapy throughout Europe. COTEC is the European organization for all Occupational Therapists through their National Associations, with the purpose of promoting and supporting mobility of individuals within Europe and increasing visibility of the profession.

COTEC now represents 26 European Countries and more than 120,000 Occupational Therapists. COTEC publishes the European Code of Ethics and the summary of the profession, which is updated annually.

The European Network of Occupational Therapy in Higher Education (ENOTHE – www.enothe.hva.nl) was founded in 1995 within the framework of the European Union on the initiative of COTEC with financial support from ERASMUS. The general aim of ENOTHE is to promote the occupational therapy education in Europe.

THE WORLD FEDERATION OF OCCUPATIONAL THERAPISTS (WFOT- www.wfot.org) is the key international representative for Occupational Therapists and Occupational Therapy around the world. It was founded in 1952 and it is located in Australia.

The chain of support services

As described in Part I, the existence of support services is a pre-condition for people with disabilities to live independently in their community, as well as for participating with equal opportunities to the community life, together with all other citizens.

This category of services includes a wide range of measures that enable the person with a disability to accomplish daily activities, in his/her community and environment.

They aim at supporting the person to participate in education-related activities, daily routines (in-home and out of home), work and employment, leisure, sports, travels, etc. They refer to:

- support staff (personal assistants, sign interpreters, support teachers, coaches for supported employment etc);
• assistive technologies (specific software, technologies for communication and mobility, technologies for learning etc.);
• specific devices like ortho-prosthesis, adapted equipment for communication and mobility, adapted transportation etc.);
• or financial envelopes (like personalised budgets and vouchers) meant to cover specifically for those aids and personal supports that lead to the inclusion of persons with disabilities in regular activities (education, leisure, travels, work etc) and community life.

When analysing the extent of support services’ in one country, the following elements should be looked at:
• the way in which personal assistance services are organised and funded;
• the number and availability of training/qualifications of sign interpreters
• the number and availability of Braille editing centres;
• the existence of guide dogs for people with sight impairments;
• the activity of support teachers and the way in which their training is carried out;
• the existence of support services for facilitating the access of people with disabilities to labour market;
• the way in which supported housing is organised;
• the personalised budgets system (if any);
• the access to a wide spectrum of assistive devices and technologies (wheelchairs and auxiliary mobility devices), prostheses, hearing aids, visual aids, white canes, specialized computer software and hardware, communication tools etc., as well as the corresponding training programs for their daily use.

In South East Europe, the support services are significantly underdeveloped. As the independent life in the community for people with disabilities was not traditionally an option in the previous system, this branch of the social services’ system is only emerging and has recently become acknowledged by authorities and people with disabilities as one of the main priorities for action.

The personal assistants exist in all countries, however their legal situation is not always regulated by national laws. In the majority of countries these service providers are members of the families of persons with disabilities, even for the adult persons with disabilities.

Romania is the only country where the personal assistant for people with severe disabilities is officially an accredited profession. Personal assistants are hired and paid by the municipality. On the other side, the General Directorate for Social Assistance and Child Protection (DGASPC) ensures the monitoring of the service. The accreditation and funding of personal assistants (who are not necessarily family members) were introduced in 2006 and benefit also from a first set of quality standards.

Recent similar initiatives are under development in Croatia and Serbia. The overall number of personal assistants in these countries, and the available budgets for the sustainability of the service, are considered by representatives of disability movement as insufficient.

Sign interpreters exist now in all countries of the region, but their formal training curricula is not developed.

In Albania, the training of sign language interpreters is done mainly by ANAD (The Albanian National Association for Deaf).

In Croatia, the main provider of sign language interpreting for deaf users and deafblind users is DODIR (The Croatian Association for Deafblind Persons), a nongovernmental organisation that developed this service since 2000. 26 interpreters were operational at the end of 2007 and delivering the service for their clients in schools, the court of law, the health facilities, theatres etc. The formal status of this profession is not yet legally acknowledged in Croatia, but the process of formal recognition of this profession started in the late 2008239.

In Kosovo (under UNSCR 1244), a more consistent training in sign language interpreting for deaf persons started in 2005 (10 modules, and another set of 7 modules in 2007) provided by the Finish Association of Deaf with the support of the Finnish Government.

In Macedonia, around 30 interpreters exist but with no legal recognition of their status, and without formal training.

In Romania, the Law that protects and promotes the rights of people with disabilities (448/2006) acknowledges the right of deaf people to have interpreters. The sign language is legally recognised as a distinct language. However the accreditation procedure for sign interpreters is still under development. A course of Romanian Sign Language has been recently introduced at “Babes Bolyai” University from Cluj, at the department of Applied Modern Languages. Several daily TV news journals are translated into sign language, as well as a weekly TV broadcast for people with disabilities.

In Serbia, the professional status of interpreters is not legally recognized; the accreditation certificates are given by the National Association of Deaf and Hard of Hearing Persons after a short training module (7 days). At the end of 2007 there 44 interpreters existed in Serbia and 95 translators (these are people whose skills are at lower level but they are still capable of interpreting, mostly in non-official situations). The interest for the sign language among the general public is increasing (two national TV channels are broadcasting the news in sign language in the last two years) and the main priority of the interpreting professionals is to establish a national

239 Tarczaj Sanja, Country Report for Croatia at the Conference of the World Association of Sign Language Interpreters, Spain (October 2007) and update of information (December 2008).
association in order to lobby for the legalization of their status and for the development of training programs at national level\textsuperscript{240}.

**Spotlight 9: A service of sign language interpreters for deafblind persons developed by the organisation DODIR in Croatia**

Within the Croatian Association of Deafblind Persons "DODIR", the services for ensuring adequate support to deafblind/ deaf persons are provided in activities of everyday life and for the integration of persons in all aspects of society.

DODIR provides two types of services:

1) **Interpreters for sign language** - a specific service, which ensures professional support in communication and access to information for deaf and deafblind people, as well as educational interpreters. These services are based on individual requests of users and they can be delivered occasionally, periodically (during a short time period) or continually (long term),

2) **Support service through a personal assistant**. Besides communication support, the personal assistant accompanies the person with disability in various daily routines, for a better mobility, orientation and independence.

The users of the services are deafblind and deaf persons, as well as other persons with difficulties in communication and mobility.

The sign interpreters and personal assistants are trained during a two-year program and are committed to an ethical code, which clarifies their role as information carriers, not as representatives of users/ acting instead of users. They are providing help and support to the persons in their independent activities, for an improved communication, mobility and everyday life activities.

Through this type of support, people with disabilities have been able to attend the regular education at all levels, including faculty, to access the open labor market and to prevent their marginalization and discrimination at all levels of society.

The service is supported by the Ministry of Health and Social Welfare as well as by local authorities: the City of Zagreb and Osijek, the County of Zagreb, Osijek and Baranja.

The support for independent living of adults with more complex or severe disabilities (including people moving out from long term institutional care) is developed currently as an innovative service in Croatia, Romania and Serbia and experimentally, from 2008, in FYR Macedonia; however the costs for this type of service are rarely included in local budgets. The initial providers were non-governmental organisations (e.g. Association for Promoting Inclusion (API) in Croatia, Pentru Voi in Romania, the Down’s Syndrome Aid Society in Serbia).

In **Croatia**, the service is currently provided by API in Zagreb, Osijek, Bjelovar, Slavonski Brod and Grubišno Polje\textsuperscript{241}. In **Serbia**, the Down’s Syndrome Aid Society has provided this service from 2004 in several apartments in Belgrade. As presented in the spotlight below, the public funding of this service stopped in 2008 and users need to return back in institutions. This is one of the most dramatic examples of the incapacity of authorities to ensure sustainable support for a crucial service leading to independent living of people with disabilities. In **Romania**, the supported living settings are now spread all over the country and ensured by both public and private providers. Their number though is not yet statistically centralised. However, the lack of a clear status and


\textsuperscript{241} Association for Promoting Inclusion (API), Croatia, http://www.inkluzija.hr
legal procedures for this type of service raises major difficulties in its implementation, especially in relation with quality standards and authorisation procedures.242

**Spotlight 10: The lack of clear regulatory procedures for funding support services in Serbia sends people with disabilities back in institutions**

More than 20 persons with intellectual disabilities who left long-term residential institutions and have been living in the community for more than four years thanks to community-based supported living services provided by the Down’s Syndrome Aid Society Serbia, have been forced to go back to the residential institutions at the end of 2008 following the decision of the Serbian authorities to stop the funding of their services. Despite the success of the project and the improvement in the quality of the clients lives since leaving the institutions, the lack of legal frameworks for these kinds of services, as well as the lack of long term commitment from local authorities has lead to a very unfortunate situation. The clients of the supported living program, who have become empowered to participate in community life through the supported living program, are now forced to leave their apartments and return to the large residential institutions that they left four years ago.

This regrettable situation proves once again that the absence of legal frameworks for support services, as well as a lack of clear commitment from authorities for the respect of the fundamental rights of people with disabilities, can turn people the risk of institutionalisation, in any moment.


The adapted transportation for persons with limited mobility is still far from sufficient in the region. This is one of the most needed services in the SEE countries, for persons with reduced mobility. An accessible public transportation is available only in a small number of cities around the region: few large municipalities of Bosnia and Herzegovina (Tužla), Romania (Bucharest), FYR Macedonia (Skopje – a low-floor bus adapted for people with reduced mobility), Serbia and Croatia, where they are only experimental projects. The public procurement regulations do not always include accessibility on the criteria established for the purchase of the public transportation means.

Some municipalities in Bosnia and Herzegovina, Romania, Croatia and Serbia developed also a system of minivan transportation (“door-to-door”), which is available upon request. This system is provided mainly by non-profit organizations, which are facing chronic shortage in funding for this type of expenditure.243

The awareness of the public in relation with transportation needs and with more general rights of people with disabilities have been promoted through several large campaigns of non-governmental associations in the last five years (e.g. Polio Plus in FYR Macedonia, IC Lotos in BiH and the Association of Students with Disabilities in Serbia).

The provision of assistive devices aims at maintaining, increasing or improving the person’s mobility, hearing and vision capacities and enhancing communication and other functional abilities. The majority of producers of these types of devices in the region (when existing) are private for-profit companies and their prices are usually inaccessible for people with disabilities. Many of these products (even when referring to specific types of wheelchairs, equipment for personal hygiene, daily activities, communication etc) are not covered by disability-related insurances. The basic products covered by these insurances are not always fulfilling the quality criteria required by people with disabilities.244

With regards to ortho-prosthetic services, a regional seminar organised in Belgrade by Handicap International and the German organisation Human Study (in September 2007) showed that the passage from the monopolistic State-run providers (of this type of services) to the current diversity of private, for-profit companies that are active in the region, was not accompanied by a simultaneous process of professional training of the ortho-prosthetic technicians. Consequently, training initiatives are currently taking place at regional and national levels for covering this gap, as it will be presented in paragraph 2.9.

In Albania, the Military Hospital in Tirana and the hospital from Kukes deliver ortho-prosthetic devices for people with disabilities. Ortho-prosthetic facilities are being improved at the regional hospital level in Kukes with equipment and qualified staff; the hospital provides also assistive devices and medical rehabilitation, for landmine survivors.

242 Until recently, supported living services were constrained to apply for accreditation as ‘residential units’, since no specific quality standards existed for them. This situation was completely inappropriate, since residential services standards were designed for organizational arrangements with large number of users and therefore very specific living conditions for groups of people (not applicable in case of small individual apartments).

243 For detailed descriptions about the situation of adapted transportation in South East Europe, see: Sestranetz R., Adams L., Free Movement of People with Disabilities in South East Europe: An Inaccessible Right?, Disability Monitor Initiative, Handicap International, 2006

244 Conclusions of the national reports on disabilities produced by Disabled People Organisations within the project “Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Forum and supported by EU (CARDS), 2006-2007
In **Kosovo**, the National Ortho-Prosthetic Center produces prosthesis for lower limbs only; there is no unit for spinal cord devices and no hearing devices are available.

In **Bosnia and Herzegovina**, the orthopaedic aids for persons with disabilities are not equally available to all persons with disabilities, depending on the way in which local legislations are interpreting medical insurance coverages\(^\text{245}\). The quality of the orthopaedic aids is also very uneven, even for the same type of needs.

In **the other countries of the region** the ortho-prosthetic devices are produced by for-profit companies (with usually high costs) and/or by monopolistic State-run companies (in this case, products are covered, partially or totally, by medical insurances). However, the quality of products remain uneven within public services and the waiting lists for specific products are very long (sometimes between 6 months-one year).

Moreover, in many countries of the region, a large category of support services (including parts of assistive devices or technologies) are not included as components of the health system, nor of social welfare. The lack of regulation in this sector impacts negatively their development, the distribution and payment of the technical aids, as well as the quality of the services and products.

As seen in this brief description, many support services have been initiated in the region, so far, by non-governmental organisations or private providers. Most of these services have been initially experimental or pilot projects. They have been dependent on international donors, and once the donors will withdraw, their sustainability will be significantly affected if adequate contracting and public funding procedures will not be available at national levels.

---

**Spotlight 11: Assistive devices and technologies, provided by the organisation ‘Open the Windows’ in Macedonia**

Lidija Krstevska Dojcinska, President of Open the Windows, describes this innovative (and unique) service in South East Europe:

“**At Open the windows (OtW), we are striving for a world where technology enables everyone to fully use his/her abilities.** OtW is a service center for people with disabilities that teaches, trains and promotes “assistive technologies”. Users come to our Center for Accessible Information Technology to learn how to use adapted computers. We assess each user’s needs and wishes, before customizing an individual work program. The work plan incorporates programs that are based on each user’s strengths, interests and choices:

---

\(^\text{245}\) National Disability Report for Bosnia and Herzegovina, within the project “Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Forum and supported by EU (CARDS), 2007.
Shifting the Paradigm in Social Service Provision

• Pre-school: Focus on educative games such as painting, coloring and story telling through illustration. The aim is to develop cognitive skills, speech and motor skills.
• Primary & Secondary School: Work with programs for word processing, presentations and illustration. The aim is to support education by developing computer, social and communication skills.
• Adolescents & College: Users learn Office programs as well as administering and managing networks. The aim is to enhance higher education studies and employment opportunities.

In three years of operation of our organization, there have been 60 users of this Center, with various disabilities: intellectual, visual, physical, learning difficulties and children with autism. Younger children enjoy learning through educational games, while the older students improve their computer skills needed for their education and employment. Indeed, two regular users to the Center gained employment last year and credit the professional team at OtW’s Center for their hiring. One user, who is partially blind, is a teacher for visually impaired students. Thanks to the help she received at OtW, she is able to create lesson plans on the computer for her students. The other, who has a physical disability, is now working on data entry at On.net, a major Internet provider. OtW adapted his computer station and provided the assistive devices. Another example is B. (a student), who is wheelchair user. When she came to our Center, we adapted the computer to match her needs and taught her various computer applications. The skills she learned was put to use when she sent an email to her Mayor informing him of a five-year-old hole on her street. The hole made it difficult for her to go up the street in her wheelchair. A week after she sent her email, the hole was fixed. OtW provides training and consultation on Assistive Technology to people with disabilities, educational institutions, government ministries, day care centers and businesses. We consult parents and teachers on how to adapt the computers. Since its inception, OtW has created 10 accessible IT computer centers throughout Macedonia and has trained over 80 teachers and special educators on how to adapt the computer. These accessible IT centers have enabled over 200 people with various intellectual and physical disabilities to access information technology.”

Open the Windows is a member of EASPD (European Association of Service Providers for Persons with Disabilities) since 2007.

Specialised (re)habilitation services for people with disabilities: moving away from the legacy of the past and promoting high quality in the specialised sector

The specialized services for people with complex or severe disabilities, as well as for people with high dependency needs, are a necessary component of the “spectrum” of services in the region. They need to be provided at community level, as all other services, in a person centered approach and a human rights perspective. From special educational programs to sheltered employment, these services are asked by both families and persons with disabilities themselves, in some contexts, due to the more complex needs for care and support of these users.

These services are numerous in South East Europe and are provided by both public and non-governmental organizations.

With different speeds and depending on domains (educational programs, very specific medical rehabilitation services, occupational activities etc.) the traditional specialized services are usually under current transformation. On the other side, many of the newly established day centers or specific rehabilitation settings are in fact specialized services for various needs of disabled persons. The main challenge for specialized providers has been to 'shift the paradigm' in service provision, to increase the internal quality and to "open the doors" of these services towards communities and social opportunities for users. Consequently, new regulatory frameworks are currently under construction, in order to integrate this shift, to develop new quality criteria and to integrate new types of providers in the specialized sector.

Spotlight 12: Quality specialised services provided by Hans Spalinger Association in Simeria, Romania

Hans Spalinger Association is a non-profit organization from Simeria, Romania, initiated by parents and professionals in 1990. The aim of the association is to support the social inclusion of children and adults with severe or complex disabilities through different types of interventions:
- education (centres of curative pedagogy)246,
- social and cultural activities,
- economic activities (sheltered workshop and social therapy).

246 Anthroposophical curative education and social therapy centres offer educational, early learning, work and residential opportunities for children, young people and adults with a wide range of disabilities and developmental problems.
The services include all forms of education for children with severe intellectual disabilities, ASD, Down syndrome, as well as vocational training (sewing, woodwork, according to the curative pedagogy’s specific methods). All educational curricula are validated by the Ministry of Education. The service is currently funded by State authorities, after being recognized as a good practice model.

Children benefit from transportation, medical assistance, specific therapies (physio-speech therapy, art-therapy, eurythmics, hypotherapy etc).

At adult age, young people with disabilities who were not able to find a working place in the mainstream labour environment are included in occupational (sheltered) workshops within the organisation. The first pilot centre in Simeria (with a current capacity of 120 users) has been multiplied progressively in other municipalities: Simeria, Hunedoara, Orăștie, Vulcan, Cluj Napoca (300 users in total).

Source: Adrian Pintea, director of Hans Spalinger Association

(Re)habilitation services for persons with autistic spectrum disorders (ASD) – a huge need in the region

The history of these services is very recent in South East Europe. They have been promoted in the last decade mostly by parents’ organisations and start to be more significant in Croatia, Serbia and Romania. These associations rely on relatively strong self-support networks of families and benefit from active links with international platforms or professionals. An entire system of services and professionals need to be developed in the region for responding to the needs of these users:

- The diagnostic of ASD needs to be established earlier and professionals need to be trained on large scale in this domain;
- The entire system of services related with the needs of people with ASD has to be developed: early intervention, psycho-social and educational services, counselling for families, medical care, speech and communication therapy, behavioural therapies, occupational therapies, music and sensorial therapies etc. This domain is a ‘ground zero’ in the disability reforms and, despite the rare initiatives that although being very encouraging, remain few isolated good practice examples;
- The awareness of general public, as well as of all levels of authorities needs to be radically improved.

In Romania, it is only recently (November 2008) that the Government acknowledged the priority of designing an appropriate system of diagnostic, medical care, education and (re)habilitation for persons with ASD, after consecutive campaigns of parents organisations. An exact statistic does not exist, however a number of 3100 children with ASD is estimated to be living in Romania; from this number, less than half benefit from specialised services. No reliable data exists for adults with ASD. The Government announced a series of measures on short and medium term, in order to improve the education, care and rehabilitation services for these persons: the creation of regional centres specialised in ASD-related therapies and rehabilitation; inclusive education, promotion of new curricula for children with ASD, training of professionals in this domain and awareness campaigns for the general public247. Many problems remain to be solved, including the situation of young adults with ASD who, after 18 years old, are diagnosed as persons with psychiatric disorders in Romania (since the classification system for adults is not yet revised and does not consider ASD as development disorders). For this reason, many of these persons end up in psychiatric hospitals and do not benefit from adequate therapies and (re)habilitation programs.

In Serbia, Autism Serbia248 is a parents’ organization established in 1977, promoting the rights of children and adults with ASD. It has facilitated the opening of 8 day centres for children and adults with ASD in various municipalities of Serbia and collaborates with 4 regular schools (in Belgrade, Pancevo and Kovacica) for integrating students with ASD in regular or specialised educational programs.

Services for people with disabilities living with HIV/AIDS – an almost inexistent chain of support

The lack of habilitation and rehabilitation services for this category of users is critical in the region. The stigma and social exclusion, with which people living with HIV/AIDS are usually confronted, is doubled in this case by the disability situation. If basic medical services are already insufficient, the social services for these persons are completely inexistent in the countries of ex-Yugoslavia and Albania.

One of the few initiatives in this sense, in Western Balkans countries, is presented in the following spotlight:

services provided in large institutional settings. They had also several significant added values to the system of which they were the initial promoters. Nowadays, the average quality of day centres is definitely better than

On their side, parents’ organizations together with professionals from the non-profit and public systems, vocational training, and respite care for example, among others).

persons, which remained forgotten and undeveloped (like all range of support services for independent living, in itself, but a negative impact for other necessary services of the ‘spectrum’, equally important for disabled

and started to invest in their multiplication. A good initiative centres as main models for community services

Another effect of their popularity was the way in which local budgets included them on the list of municipal

segregation of beneficiaries and services, instead of the necessary mainstreaming. For this particular reason, the

mostly specialised ones; moreover, their specialisation is related with various categories of users, leading to a

all categories of children and adults (with a variety of profiles and care offers), in South East Europe they are

specialised services

One of the negative effects of their rapid multiplication was the establishment of day centres as predominantly

in parallel with service provision, the Q- club team, in cooperation with their partners, advocates for the

recognition, standardization and sustainable support of this type of service by governmental structures.


In Romania, the European country with the highest number of children infected with HIV in the late 1980’s-early 1990’s (mainly through contaminated blood transfusions but afterwards through vertical transmission also), the support services for children and adults have been initiated after 1990: pre- and post test counselling, legal advice, helpline, self help groups, social assistance, educational support for children and adolescents, mobile units for medical care (dentistry, dermatology), various types of prevention services, among others. Romania has a national Strategy for survey, control and prevention of HIV infection (2004-2007). Public and non-profit services exist for education, health care and vocational training of persons living with HIV/AIDS, as well as programs for continuous training of medical professionals.

The particular situation of day care centres in South East Europe

Day centres represent a relatively new type of service in South East Europe and were promoted in the last 10-15 years by non-profit organizations and their international partners. Progressively, the model became increasingly successful among parents, authorities and disabled persons themselves, due to a new approach in the concrete delivery of this service (person-centered and needs-driven) and also due to its small capacity, flexible organization and, very often, multi-disciplinary character. In the last four years, a large number of public day care centres has as well been established, all around the region. They initially covered a large gap in the overall care and support system for people with disabilities, answering to a variety of people’s needs: from pre-school to rehabilitation, vocational training, leisure, counselling, respite care etc. They became soon a sort of “universal solution” in the region, with (unfortunately) some questionable side effects in the long run.

One of the negative effects of their rapid multiplication was the establishment of day centres as predominantly specialised services (either for disabled, for children without parental care or for various groups of vulnerable population). While in Western European countries the day centres are also mainstream services, opened for all categories of children and adults (with a variety of profiles and care offers), in South East Europe they are mostly specialised ones; moreover, their specialisation is related with various categories of users, leading to a segregation of beneficiaries and services, instead of the necessary mainstreaming. For this particular reason, the disability activists in the region have often remained very critical towards this ‘trendy’ evolution of day centres.

Another effect of their popularity was the way in which local budgets included them on the list of municipal investments. In many countries (FYR Macedonia, Montenegro, Romania, and Serbia) authorities considered day centres as main models for community services and started to invest in their multiplication. A good initiative in itself, but a negative impact for other necessary services of the ‘spectrum’, equally important for disabled persons, which remained forgotten and undeveloped (like all range of support services for independent living, vocational training, and respite care for example, among others).

On their side, parents’ organizations together with professionals from the non-profit and public systems, contributed significantly to the rapid development and improvement of these settings, especially in the case in which they were the initial promoters. Nowadays, the average quality of day centres is definitely better than services provided in large institutional settings. They had also several significant added values to the system of

250 In December 2006, 6613 persons were infected with HIV (from which 4488 children) and 5293 were living with AIDS (from which 3526 children). Source: Romanian Angel Appeal Association, www.raa.ro

Spotlight 13: Psychosocial support services for people living with /or affected by/ HIV, provided by the organisation Q Club in Serbia

Q-Club is an organization supporting people living with HIV (PLHIV) in Serbia. The psychosocial support service was initiated in 2006. Currently it has 300 users from all over Serbia and functions in two locations: Belgrade and Kragujevac.

The overall aim of this service is to improve the quality of life of PLHIV and helping them to deal progressively with their new situation and medical condition. People with long-term (chronic) health conditions are very vulnerable in the daily life; the HIV positive people need to fight not only with the virus, but with a lot of new aspects that are overwhelming (complex screening and medical treatment, isolation, discrimination etc.).

People working in this service are experienced counselors, volunteers and professionals, providing: (a) peer support; (b) individual counseling; (c) self-help groups; (d) professional assistance (legal / social); (e) training / education; (f) home visits; (g) support in conducting active social life (free of charge visits to cultural institutions, theatre, cinema, etc.).

From 2007, the Serbian Ministry of Health through Global Fund financed the service. Unfortunately, this unique service in the country is still project-based and has no sustainability on long term. Therefore, in parallel with service provision, the Q- club team, in cooperation with their partners, advocates for the recognition, standardization and sustainable support of this type of service by governmental structures.

services in South East Europe, and these benefits have to be equally acknowledged:

- Day centres have illustrated and put in practice the principle of ‘tailored’ services for people with disabilities; in South East Europe, there are no two day centres that are completely identical, despite their common name. Their variety in terms of sizes, profiles, daily schedules, affirmed the fact that in different communities, people can have different needs and expectations from such a service. Day centres proved that flexibility is possible (and needed) within a social service, and this flexibility should be taken into account within financial or regulatory procedures;
- They were among the first services introducing a person-centered approach in the overall delivery of care for disabled children and adults, as well as new methods of work (in teaching, rehabilitation, coaching etc);
- They have also promoted quality systems and procedures in the overall service provision (principles, standards). The quest for quality had a very rapid evolution in the region and day care centres professionals have been usually in the frontline of this ‘working site’, together with people with disabilities themselves and their representative organizations.

Nowadays, the evolution of day centres is different from country to country. In Albania and the countries of ex-Yugoslavia, their number is continuously growing; they function rather as specialised services for people with more complex disabilities. Very often, they compensate for the lack of access of disabled persons to regular services (like pre-school and education, rehabilitation etc.). In Romania, their profile is continuously transforming. Some of them remained purely specialised services, while many became support services (aiming at facilitating the access of disabled children and adults to regular services or employment).

There are no centralized data regarding their number, however a rough mapping can provide a picture of their overall development in the region:

In Albania, 8 such day centers exist at national level: 5 in Tirana, one in Librazhd, one in Skhoder, one in Polican, as well as 2 multidisciplinary centres in Sarande and Elbasan251.

In FYR Macedonia, a number of 18 public day centers have been developed by the Ministry of Labor and Social Protection, for children aged from 5 to 18 years old and include services of rehabilitation for children with intellectual disabilities. 6 other day centres are provided by the organization PORAKA for youth with intellectual disabilities and several other initiatives have been launched by parents organizations and municipal authorities (Negotino, Veles, Cair etc).

In Montenegro, the first day centre for children with disabilities (called ‘Tisa’) was opened in 2004, in Bijelo Polje. Four new centres are in process to be established in 2008-2009, in Niksic, Berane, Pljevlje and Herceg-Novij and municipalities are currently analyzing various funding schemes for these centres.

In Romania, their number grew considerably, especially during the process of de-institutionalisation of children (1997-2007). From less than 50 day centres for persons with disabilities in 1998 (non-profit), today their number is bigger than 300 (public and non-profit, for both children and adults with disabilities)252.

No precise data exist with regards to the overall number of day care centres in Bosnia and Herzegovina, Croatia, Kosovo (under UNSCR 1244) and Serbia, but the general trends of multiplication and diversification of their profiles are similar.

The transformation of large residential settings and the de-institutionalisation process

Habilitation and rehabilitation services for people with disabilities in South East Europe have been provided traditionally in residential and segregated institutions of very large size (100 to 1000 users). The unacceptable living conditions of disabled persons in these settings have been made public by numerous international organizations, disability activists and media. Awareness campaigns and calls for action became more numerous in the last decade, asking governments for the closure of these institutions and for the rapid development of community based services.

A certain number of pilot projects contributed to the development of alternative modalities of care and support in the last decade (from supported /sheltered living to foster care and group homes). In addition, the particular evolutions in Romania (both positive and less successful) have represented a source of ‘lessons learnt’ for the entire region. Romania was one of the countries with the higher number of institutionalised persons in Europe and, within the entire process of pre-accession to EU (2001-2007), most of institutions for children have been closed. It was proven that the necessary steps forward for the transformation of the institutionalised care system in the disability sector have been done only after the expression of a clear political will in the direction of institutions’ closing (which took place in 2001).

The recent European study253 regarding de-institutionalisation and community living represents a strong incentive for pilot initiatives in the field of community living in South East Europe and mentions that: “evidence

251 Strategy of Social Services in Albania, 2005-2010

252 Cumulative data from the National Authority for Protection of Children’s Rights, National Authority for Disabled Persons and websites of local Directorates of Social Assistance and Child Protection (DGASPC)

from research and evaluation of alternatives to institutional care also supports this change. Where institutions have been replaced by community-based services, the results have generally been favourable. A very large number of research studies overwhelmingly show better results for people receiving services, their families and the staff supporting them. However, experience shows that moving to community-based services is not a guarantee of better outcomes; there is a possibility to unintentionally transfer or recreate institutional care practices in new services. Developing appropriate services in the community is a necessary, but not a sufficient, condition for better results."

A regional report of Handicap International in South East Europe and Open Society Mental Health Initiative addresses this process in a more detailed way and is available from the beginning of 2009.  

**Spotlight 14: An example of capacity building for deinstitutionalisation, in the system of social protection for children with disabilities from Romania (2001-2004)**

In a context of complex and radical change of the care system for children with disabilities in Romania, after the acknowledgement of the de-institutionalisation priorities in 2001 (by the Government and its related agencies for children and disability issues), an interesting experience of transformation of attitudes and practices took place between 2001 and 2004, targeting directors of residential institutions at national level.

The project (called “Capacity building for managers in the system of social services for children with disabilities”) was initiated by the Romanian Authority for Child Protection and Adoption (ANPCA), with the technical and financial support of the French Government, the French National School of Public Health from Rennes, The International Foundation for Child and Family from Romania (FICF) and the Romanian Resource Centre for Social Professions (CRIPS). The project was aiming to encourage the de-institutionalisation process as a local initiative and therefore was targeting a specific group of key actors for change: the decision makers at county levels and the managers of large residential institutions for children with disabilities.

Several stages were designed for this project: first, a “training of trainers”, preparing Romanian managers and services coordinators for becoming change promoters and ‘cascade’ trainers, or multipliers; further training modules have been organised afterwards in 16 departments of Romania. The managers were asked to design, during the one-year training, a complex project of reorganisation of their own residential institution, as a practical assignment, and taking into consideration the new knowledge that they were acquiring progressively from the national and international experts. They were also asked to consider the concrete needs of their communities and the staff-related problems in each specific institution, during the transformation or de-institutionalisation process.

In a second phase, the trainers organised their own modules of training and applicative projects for a number of other 128 managers from 16 departments. Four ‘regional centres for training and resources’ have been established on this occasion, being able to support a long-term capacity building process in this field (in the counties Alba, Dolj, Iasi and Ialomita).

All managers who succeeded to elaborate a quality project of institution’s transformation were rewarded, at the end of the one-year cycle of capacity building, with the EURODIR*) certificate, a recognition of their managerial capacity for ‘shifting the paradigm’ in social services for children with disabilities. Some of the projects received as well a financial envelope that allowed the concrete start of the transformation process.

The project was carried out in three series of one-year training programs and had a significant impact on the transformation of the institutions for children, especially because the managers of these old institutions became themselves the main actors of change.

*) EURODIR is the European Transnational Network of Training Organisations for Directors of Welfare Institutions (www.eurodir.org)
**BOX 8**

**A 10-Steps Model of Good Practice for De-institutionalising Young Children into Family Care**

**Step 1**: Raising awareness (e.g. Why to close institutions? How institutions operate?);

**Step 2**: Managing the process, design of strategic plan and multidisciplinary management team;

**Step 3**: Country level analysis; regional situation of children in institutional care, range of existent alternative services and resources, no. of residential care institutions and staff;

**Step 4**: Analysis of institution stock and flow; assessment of children’s needs and potential family situation (e.g. Special needs e.g. disability, can their parents/relatives be found)?;

**Step 5**: Design of alternative services:
- a range of services needed to prevent admissions (e.g. mother and baby units),
- family based care for children (e.g. return to parents/relative, foster care, adoption),
- alternative use for the buildings to develop new services (e.g. day care);

**Step 6**: Planning transfer of resources from institutional care to community based services (e.g. foster care);

**Step 7**: Prepare and move children; use of care plans and assessment. Use of transition objects, life story book, visits to new placement, visits from new carers;

**Step 8**: Prepare and move staff through counselling, retraining and redeployment;

**Step 9**: Logistics; ensure that the move is planned according to each child’s needs and not driven by the system;

**Step 10**: Monitor and evaluate that each child’s move and new placement follows the care plan. All new placements should be followed-up within 3 months and then at 6 month intervals for 2 years.


**Conclusions regarding the access of people with disabilities to habilitation and rehabilitation services**

The presentation of this variety of (re)habilitation services for people with disabilities aimed at highlighting the positive steps but also the still existing gaps in the organisation and diversification of these services in South East Europe. The spectrum of services is still poor (especially support services) and the legal frameworks are not always able to integrate the emergence of new and diversified typologies of services. The insufficient number of qualified professionals for (re)habilitation services adds more challenges to this development stage.

People with disabilities in the region, together with their families, advocate more vigorously for several key aspects in this context:
- broadening the spectrum of habilitation and rehabilitation services which are supposed to be available at community level, and establishing comprehensive regulatory mechanisms for their official recognition and funding;
- increased focused on support services, as main levers for inclusion and participation;
- increase of training opportunities for professionals and volunteers, in relation with the new positions and job profiles.

**2.3.4. The services facilitating employment**

"States Parties shall (…)

(d) Enable persons with disabilities to have effective access to general technical and vocational guidance programs, placement services and vocational and continuing training;

(e) Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment(…);

(i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace"

*UN Convention on the Rights of Persons with Disabilities, Extract from Article 27*

People with disabilities have the right to work as all other citizens. In order to access the labour market, they often need additional support, in order to prepare for, find, access, retain or regain employment.

As in the field of education and access to all other services of the community, in the labour sector people with disabilities often need ‘reasonable accommodation’, meaning any modification or adjustment to the work environment that enables an individual to perform the essential functions of the job. However, neither the legal frameworks in the region, nor the current attitudes and practices of employers, are shaped for tailoring the work
environments in a ‘reasonable’ way for people with disabilities.

In South East Europe the support services for employment and work have been almost non-existent in the previous regime. Adults with disabilities were working in sheltered workplaces (organised in residential institutions, special schools, ‘cooperatives for disabled’ or specific sections in the psychiatric hospitals). The spectrum of professions and correspondingly, of the vocational training programs organised in the public special schools was very limited: cooking, painting woodwork and crafts, brushes production, phone operators, packaging, massage (usually in case of people with sight impairments) etc. These qualifications still exist in the curricula of many professional special schools of the region. The access of people with disabilities to work was decided by a medical commission (still existing today in many countries), assessing the so called “work capacity” of a person. Many disabled persons were assessed as “incapable” of working or told that the only option available for them was the sheltered work. The entire system of vocational and professional training was segregated: special schools, professional special schools, and sheltered workshops.

The very few people with disabilities accessing regular employment in the past were not able to benefit from any kind of support service in this context; however they had certain incentives like tax deductions from the monthly revenues.

Nowadays, despite many obstacles, people with disabilities enter progressively into the open (and highly competitive) labour market in the region. In addition, the number of people needing support even in sheltered workplaces increases as well. The need for support services becomes therefore critical and refers to the following:

- Assistance for job seeking,
- Mediation for employment,
- Job coach during the working period,
- Individualised support and supervision at the workplace,
- but also: sign language interpreting; assistive devices and technologies,
- Adaptation of the workplace,
- together with a barrier free environment (accessible transportation, buildings and public areas, information etc.).

Unfortunately, the gaps are significant in this sector. The problem starts from an out-dated legislation and continues with old criteria of evaluation for adults with disabilities that prevent them to be declared ‘able to work’, the inadequate incentives for regular companies hiring people with disabilities, an out-dated vocational training system, as well as with the lack of professionals ensuring support services for employment and work. The assistive devices and technologies, crucial for the successful inclusion of several categories of people with disabilities, emerged only recently. Sign interpreters and personal assistants are not yet regulated professions at national levels, and their number is critically insufficient in majority of countries. The quota systems, existing in majority of SEE countries, are not producing significant changes in the employers’ attitudes and habits. Often the companies prefer to pay the fines than to hire people with disabilities in the percentage mentioned by the law. The few positive examples are just a handful of initiatives, mainly promoted by non-governmental organisations.

In FYR Macedonia, a small NGO specialised in assistive technologies (Open the Windows) provides adapted devices and specialised training for people with disabilities who work in regular companies or public workplaces.

In Montenegro, there are seven Employment Bureaus and 14 Offices that are offering mediation in the process of employment of people with disability (in these offices exist sign language interpreters). The companies (public or private) which hire people with disabilities are exempted for tax paying for a two years period.

In Romania several NGOs, as well as a small number of Directions for Social Assistance and Child Protection initiated supported employment projects, including job seeking and mediation between employers and persons with disabilities, for keeping the job on long term. The Centre for Resources and Information for Social Professions (CRIPS) took steps for defining the profile of a job “coach” as a recognized profession in the Romanian Classification of Occupations (COR). Several NGOs develop currently social enterprises (Timisoara, Targu Mures, Iasi, Bragadiru etc) in domains like bakery, printing activities, packaging, tailoring, crafts etc. The Corporate Social Responsibility progressively becomes a lever for including people with disabilities in the labour market, or for financing projects related to supported employment.

In Serbia, a new legal framework is expected, on ‘professional rehabilitation and employment of people with disabilities’. This new law enables the start of reform related to classification systems in the disability field, as well as of commissions that evaluate the work abilities of people with disabilities. The support services for facilitating employment and work (vocational education training, vocational rehabilitation and job coaching) are also included in this legal framework, however they are not developed in practice. The Serbian anti-discrimination law for people with disabilities (2007) is also a significant tool for cases of abuse or misconduct in the labor environment.
Spotlight 15: Pioneering initiatives of supported employment in Croatia and Romania

In Croatia, despite the lack of a legal framework for employment of people with intellectual disabilities, the Association for Promoting Inclusion (API) has initiated a supported employment program since 2000; more than 70 people with intellectual disabilities have accessed a workplace or a vocational training program since then. The service is delivered in Zagreb, Osijek, Bjelovar, Sibenik and Slavonski Brod. The person with intellectual disabilities is given direct support during training and performing a work task. The degree of support is adjusted to the needs of the individual and is present as long as he or she needs support to perform the work task effectively.

The job coaches are specifically trained and also evaluated once a year. API also offers ongoing support and consultation to employers and co-workers to assist employees with intellectual disabilities to succeed in their jobs.

In Timisoara, Romania, "Pentru Voi" Foundation is a non-governmental organization providing community based services and advocating for adults with intellectual disabilities. Laila Onu, the director of the Foundation, presents the supported employment service: "Our mission is to improve the quality of life for persons with developmental disability and their families, based on the philosophy of inclusion. At present, we have 160 service users who benefit of one of our social services which are offered through a public-private partnership with Timisoara Town Hall and financed by the local budget. "Pentru Voi" Foundation is the first one in Romania which offered supported employment services for adults with intellectual disabilities. At the present, we have 33 persons with intellectual disabilities employed on the free labor market and other 56 employed in our social enterprise: Pentru Voi Protected Unit who was created in 2007. In 2008 our social company had a turnover of 204 403 euro and a profit of 50 000 euro. All the profit from 2008 will be reinvested in the protected unit. We have contracts with more than 30 companies from Romania. You can find more details on "Pentru Voi" Foundation on www.pentruvoi.ro".

In both programs (Croatian and Romanian), the supported employment is linked, for a certain number of users, with a supported living program, tailored to the needs of each person.

Looking ahead with regards to services facilitating employment for people with disabilities

In order to increase the number of persons with disabilities having access to work, several measures are priorities for the region:

- the revision of disability definitions in the work-related legislations and the reform of commissions (and methodologies) for professional orientation;
- clear anti-discriminatory legislation in all countries of the region, preventing abuses and misconducts with regards to people with disabilities at work or accessing a job;
- a coherent system of incentives for employers hiring people with disabilities in order to avoid contradictory measures and monitoring the correct implementation of legal documents;
- facilities for employers when providing ‘reasonable accommodation’ for people with disabilities;
- developing the sector of assistive devices and technologies for work-related situations.
- the recognition and financial coverage of professionals (job seekers, job coaches, personal assistants, mediators etc.) linked with supported employment services;
- the reform of vocational training for people with disabilities, in the new contexts of labour market evolution.

2.3.5. Supported living and independent living

States Parties shall ensure that:

(...)

b. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.”

UN Convention on the Rights of Persons with Disabilities, Extract from Article 19

The situation of support services for community living is similar to supported employment. Initiatives arise in all countries, but the regulatory frameworks and the volume of trained professionals or workers within these services are largely insufficient.
Several types of services are most frequent in the region:

**The personal assistant service** exists in all countries, however it is mainly provided by family members or close relatives, who are paid by public authorities with a minimum salary. In Croatia and Serbia, initiatives related to the legal recognition of the service are ongoing. In Serbia, the Centre for Independent Living (CIL)\(^{256}\) has piloted the services since 2003 and has also designed and piloted the corresponding quality standards, during 2007-2008, within a program initiated by the Ministry of Labour and Social Protection. In Croatia, the Association for Promoting Inclusion, but also DODIR (The Association of Deafblind Persons) train personal assistants and promotes the legal recognition and funding of the service at national level.

In Romania, the service is legally recognized and can be promoted in two ways: by family members and by so called “professional personal assistants”, undergoing a short term training in order to be certified. The service is paid by municipalities.

**The group homes and supported living services** are emerging in all countries of the region and are more numerous for people with intellectual disabilities (both children and adults). In Kosovo, due to the reform of the mental health system, these services are available rather for persons with mental health problems and not for other categories of users.

The **in-home support, legal assistance and support for participation in leisure, culture and sports programme** are very limited in the region.

### 2.3.6. Overall conclusions regarding the spectrum of services for people with disabilities in the region

The spectrum of services for people with disabilities is progressively enlarging; however, from pioneering initiatives to a consolidated system of quality services in communities, much remain to be done.

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A transition of services for people with disabilities is taking place: from very specialised and segregated to more diverse and inclusive.</strong>&lt;br&gt;The advocacy efforts that promote the rights of people with disabilities in the region start to produce effects in the services sector and their spectrum is progressively enlarging.</td>
<td>1. New services, new methods of work together with the new disability paradigms arise in the same time in South East Europe.&lt;br&gt;The countries of the region are forced to enlarge the spectrum of services for people with disabilities almost in a decade, pressed by growing lobby groups in the region, the EU accession process, international trends and European values.&lt;br&gt;<strong>The pace of this reform process and the good ‘momentum’ can easily become an obstacle, if cooperation among stakeholders is not effective, and if policy makers and implementing bodies are not trained and prepared for the various stages of this reform.</strong>&lt;br&gt;2. Local authorities are often overwhelmed by the multitude of tasks and responsibilities accompanying the diversification of services spectrum, especially when this is not limited at the disability sector.&lt;br&gt;Managing effectively the transformation of services and their diversity cannot be done without adequate mechanisms of reallocation of resources, community planning and prioritization of needs.&lt;br&gt;Local stakeholders need to be trained and supported in this effort, as well as to be in constant dialogue with users groups and service providers.</td>
</tr>
</tbody>
</table>

---

Shifting the Paradigm in Social Service Provision

Looking back to the emergence of innovative services in the region, one can easily identify several stages of their evolution:

- An initial stage of experimentation and profiling (per type of role/function, activity or per type of users) – corresponding to a need for ‘covering the gap’ of lacking services and interventions for disabled people; this was a stage in which innovative services created their own niche and developed internal methodologies of work, quality tools and management procedures;
- A second stage of piloting successful initiatives – this phase was (and still is) important for those types of services that proved to be successful and effective, and which have multiplier effects; piloting them in various locations and contexts served as model and lessons learnt for their multiplication at national levels;
- A third stage: transition of innovative services towards support to inclusion – this evolution of pilot services is observed progressively in all countries and in all domains (education, employment, independent living etc); innovative services become progressively ‘catalysts for inclusion and community living, even when their profile remains fundamentally a specialised one. This process is influenced by international documents and evolutions (UN Convention for Rights of Persons with disabilities, European action plans in the field of disabilities, access to EU etc.)
- Finally, the inclusion of new services in legal frameworks and regulatory procedures, in order to ensure an official recognition of the service’s statute and sustainability on long term. It is the stage that takes usually a long time and significant amounts of lobby efforts, capacity building at all levels and resources.

1. Despite innovative services that fill progressively the ‘gap’, a large number of services from the necessary spectrum of community services for people with disabilities (see also chapter 1) is still missing or is insufficient.

The most affected are the support services, allowing people with disabilities to access better community resources and regular services like education, health care, employment, leisure, sports and cultural. The roles of support services are not fully known or acknowledged by authorities and the funding mechanisms for them are not yet designed or tested.

2. If existing, the newly established regulatory mechanisms for these services (e.g. licensing and accreditation, minimum quality standards, monitoring and evaluation procedures etc) are often rigid and do not allow tailored and adjusted interventions, in relation with contexts and needs of the users groups.

Looking ahead:

Widening the spectrum of social services at community level is, as seen in this overview, an acknowledged priority that needs adequate resources, commitment, good planning and follow up mechanisms. It is a process that contributes to the necessary transition towards de-institutionalisation and community living of people with disabilities and requires the following steps:

- Design and implementation of needs assessment and mapping of necessary services at community levels;
- Establishment of regulatory mechanisms that allow a mixed provision of social services, by both private and public providers;
- A set of regulatory procedures (licensing, quality standards, evaluation etc) that allows (and encourages) innovation, continuous improvement and adjustments of new services to the needs of users and to the local contexts of service delivery;
- Sustainable investment in support services, related to all sectors of community life (education, health care, work and employment, in-home living, leisure, etc);
- Investment in staff training and development of new qualifications for services related with the disability sector;
- Involving people with disabilities in all stages of planning, setting up and monitoring of these services; improving and/adjusting the spectrum of services in relation with their feedbacks and evolving needs;
- Capacity building of public servants and local authority representatives, in relation with disability aspects and the continuum of services needed by people with disabilities at community level.
2.4. DELIVERING QUALITY SOCIAL SERVICES – PROGRESSING TOWARDS WELFARE MIX AND BETTER GOVERNANCE

The shift of paradigm in the disability field impacts directly the way in which services are concretely delivered to their users. Delivering social services was the responsibilities of State authorities in the previous regimes. Nowadays, the diversification of providers, the accent on quality management and the decentralisation of responsibilities and funding schemes from central to local governments, impose a complex reorganisation of the service delivery process.

Several aspects related with this particular stage of service provision will be presented in this part:

- The diversification of providers and their official licensing/authorisation;
- The quality of services and the introduction of quality principles and standards;
- The funding mechanisms for service delivery in the region;
- The way in which the decentralisation process impacts the social sector and the delivery of community based services.

2.4.1. Who are today the providers of community-based services for people with disabilities in South East Europe?

Similarly to Western European countries, several types of providers operate simultaneously in the social sector, in South East Europe:

- Public providers (entirely paid from public budgets);
- Not-for profit organisations providing social services (NGOs, faith-based organisations etc);
- For-profit companies providing services;
- “Informal” providers (like families, neighbours or volunteers)\(^{257}\).

The last four categories are usually grouped under the label of “private providers”. The co-existence of these public and private providers is usually denominated as “welfare mix”.

2.4.2. The quality of social services and the stage of quality standards elaboration

Social services in the disability field have as main aims to enable participation and equal citizenship for people with disabilities and to fight poverty and social exclusion. This requires social services to be accessible to those who need them and that they have a good quality. The accent on quality is part of an effort of modernization of this sector in the last decade, not only in South East Europe but in all European countries. This modernization is not seen as a “cutting-costs” issue anymore, but mainly as a good reflection of the users’ needs and choices, in a cost-effective way.

Part I highlighted that quality standards (or principles, criteria) are important tools for:

- Introducing a reference (value) system and a normative character in the service provision (especially in the countries with poor regulatory frameworks);
- Correcting and improving the performances within a specific service;
- Benchmarking;
- Monitoring and control of the overall service provision process.

Quality systems can also be used by staff members for additional activities that lead to the improvement of the overall level of care\(^{258}\):

- **staff development** – as means to promote discussion and learning and to identify various training needs for the professional team;
- **planning** - a tool to assist in identifying service requirements and to plan the further stages for improvement;
- **service development** - a framework to develop care provision, in accordance to high quality indicators;
- **policy development** - a basis from which to develop practice-based advocacy for policy development and for the adoption of national minimum standards.

There is no unique format in which standards for social services can be formulated. Different countries (or different quality systems) use different formats and patterns for their key quality criteria. However the European efforts are at this moment directed towards a common framework of general principles and values that should be further translated in national standards in all countries of European Union (as was presented in Box 1).

In the South East European region, the main responsibility for the elaboration of quality standards for social services relies on the Ministries of Social Welfare. However, in several countries of the region (Macedonia, Serbia, Romania) a significant role in this regulatory process is played by the Institutes of Social Protection or similar research institutes related with the Ministries of Social Welfare. They have predominantly a methodological role and are supposed to develop all procedural tools involved in the implementation of various social laws. For this

\(^{257}\) This classification of social service providers has been presented by Brian Munday in the study ‘European Social Services – A Map of Characteristics and Trends’, Council of Europe, 2002.

reason, the capacity building and modernisation programs at the level of these institutes are highly important for the region.

So far, comprehensive packages of quality standards exist only in Romania and Albania. For specific categories of services (day care services, personal assistants, sign language interpreters), these standards have been developed (or are currently under construction) in Croatia, FYR Macedonia, Serbia, and Kosovo (under UNSCR 1244).

**In Albania**, the elaboration of quality standards for social care services is the responsibility of the Ministry of Labour and Social Affairs, who is also in charge with the licensing of social service providers (Law on Social Assistance and Services, 2005). In 2004-2005, the elaboration of the first set of quality standards took place in this country and it included the following areas:

1. Human Rights
2. Development of the client personality, independence and social integration.
3. Personal Care
4. Choice
5. Accessibility
7. Service purpose and suitability
8. Personnel.

Since 2005, several additional sets of standards have been developed, for each category of services, in relation with the users’ profiles (standards for disability-related services, elderly peoples’ services, services targeting the victims of abuse etc). These standards were elaborated in a highly participatory manner, involving working groups composed of both public and private stakeholders, representatives of user’s organisations, local authorities etc. It was a process that represents an example of good practice in the region and which developed a clear ownership of these regulatory procedures for different types of local stakeholders involved in their further implementation. The ultimate responsibility in drafting quality standards for services is ensured, according to the Albanian law on assistance and social services, by the State Social Service, the public central authority within the Ministry of Labour and Social Affairs.

**In Romania** the quality standards for social services were introduced in 2004, after 4 years of research, exploration, trials of various models and approaches. From 2000 to 2004, several initiatives have targeted the development of standards, and mostly in the field of child protection. Some of these initiatives have been promoted by the Government (with the support of international agencies), some of them initiated by the NGO sector. However, due to a lack of unified methodologies and formats, the various standards have been drafted in different ways one from another, which did not allow for a multiplier effect. Finally, after several years of research and re-evaluation of the methodological frameworks, the first set of quality standards were released at the level of the National Authority for the Protection of Child’s Rights, in 2004.

Currently, there are two levels of standards for the sector of social services, related with a double authorization process: licensing and accreditation. Both licensing and accreditation are obligatory procedures of authorization for the Romanian providers.

The **accreditation** is a general certification procedure (managed at the level of the Ministry of Labor, Social Solidarity and Family) that gives the right to public and private providers to deliver social services. The **general quality standards** that are used as the basis for the accreditation procedure are inspired by the EQRM (now called EQUASS) system and are the same for all social service providers (despite of profile, users’ particularities or age etc.) (Directive no. 383/2005). They make the object of a so called “self-assessment questionnaire” that each provider has to respond to and that becomes part of the accreditation file. An external commission of assessors checks as well the compliance of providers’ practices with this set of standards, during a field visit (external evaluation). The nine principles that are translated in adequate standards for the accreditation procedure are the following:

- Principle 1 – Organization and administration of social services
- Principle 2 – Rights
- Principle 3 – Ethics
- Principle 4 – The global, comprehensive and integrated approach in the social service delivery
- Principle 5 – The person centered approach
- Principle 6 – Participation
- Principle 7 – Partnerships
- Principle 8 – Result orientation
- Principle 9 – Continuous improvement

A second level of authorization is the **licensing**. This certification procedure is based on the compliance with the so called **obligatory minimal standards**, elaborated in Romania for the majority of specific social services. They are the equivalents of the more “technical standards”, because they are correlated with the typology of services.
services and with the different types of users. The National Authority Protection of Child’s Rights is in charge with the licensing of social services for children, while for adults this is ensured by the National Authority for Disabled Persons. Both agencies are subordinated to the Ministry of Labour, Social Solidarity and Family.

In Romania, the Research Institute of the National Authority for Disabled Persons is the agency that elaborated all sets of quality standards for services provided for disabled adults at national level.

**Spotlight 16: The inventory of quality standards for social services that exist currently in Romania and Albania:**

**In Romania** there are:
- 1 general set of quality standards, for all social services;
- 7 sets of standards for social services provided for adults (including adults with disabilities):
  - Home care services
  - Residential centers
  - Day centers
  - Sheltered housing
  - Personal assistant
  - Services provided in special protection institutions
  - Services for elderly people
- 14 standards for social services provided for children (including children with disabilities):
  - Foster care;
  - Case management in the field of child protection;
  - Day centers;
  - Day centers for children with disabilities;
  - National adoption;
  - Maternal center (emergency units for mother and infants);
  - Services provided in residential institutions;
  - Emergency centers for children victims of abuse, neglect and exploitation;
  - Counseling centers for families and children;
  - Center for support of family reintegration;
  - Services for street children;
  - Services for the protection of victims of domestic violence.

**In Albania** there are:
- 1 set of general quality standards for all social services;
- 5 specific sets of quality standards for user-related services:
  - Services for disabled persons;
  - Services for elderly persons;
  - Services for children;
  - Services for victims of abuse;
  - Services for Roma population.

The educational and vocational training services benefit from specific quality requirements elaborated by the Ministry of Education, and the health care services are regulated by the Ministry of Health.

**In FYR Macedonia**, the Institute of Social Protection has elaborated the national standards for day care centres for children and adolescents.

**In Serbia**, a process for the elaboration of a set of quality standards for 15 types of social services is taking place at national level (2007-2008). The process is technically supported by DFID experts. A number of local non-governmental organisations are contributing to this methodological site, especially for those types of services that are innovative and were piloted by NGOs in the last decade. The Centre for Independent Living from Belgrade, for example, is developing a pilot set of quality standards for the Personal Assistance Service for people with disabilities, as a result of its extensive expertise in this domain.

**2.4.3. The licensing (authorization) procedures for service providers**

Several countries of the region (Romania, Bulgaria, Albania, Croatia and FYR Macedonia) have introduced procedures of authorisation and licensing (or accreditation) for social service providers. These key regulatory instruments meant, on one hand, a guarantee that all services provided by public and private providers respect a minimal level of quality required by the law and, on the other hand, to register providers at national level, as the basis for planning and monitoring better the social service provision.

**In Albania**, the licensing procedures for social service providers is defined by the Law on Social Assistance and Services (article 18): “The Ministry of Labour and Social Affairs licenses all public and private legal persons
providing social care services. The licensing criteria and procedures are defined by a decision of the Councils of Ministers. The process is already operational.

**In FYR Macedonia**, the social service providers have to be authorised by the Ministry of Social Welfare. This authorisation represents a pre-condition for accessing public funds, mainly through tendering procedures at central level. However, a particularity of the Macedonia system so far was the fact that the release of the authorisation was conditioned by a minimal three years of previous activity in the field of social service provision.

**In Romania**, the accreditation procedure is regulated by the Government Ordinance 68/2003, the Government’s Decision 1024/2004 and the Ministry Order 383/2005. The responsible stakeholder for this process is the Ministry of Labour, Social Solidarity and Family.

The legislation foresees one unique and coherent accreditation system for all the public and private providers who need to comply with the general and the service specific quality standards in order to obtain the accreditation by means of which the state recognizes the right of the provider to provide services. The accreditation is given for a 3 years period. From late 2003 ‘minimum quality standards’ were developed, initially in the child protection sector and subsequently in the field of disability. The compliance with these standards is the key requirement for the **licensing** procedure.

In 2004 an additional general quality system, based on the EQRM (EQUASS) principles, was developed for all the social services as a part of the **accreditation** system. Introducing these types of general principles aimed at a change of attitude of those involved in the service provision and pays crucial attention to issues such as client involvement in the service deliver process, rights of the service users, continuous improvement, stakeholder participation. The quality system is operational since January 2006. An electronic register for accredited service providers allows central authorities to know how many service providers and services exist in the country.

2.4.4. The internal regulatory procedures of social service providers

As presented in Part I of this report, the internal regulatory procedures are meant to guarantee the respect of the main principles of good governance, at the level of the provider itself: the effectiveness, efficiency, the relevance and responsiveness of the service, together with the respect of the users’ interests and rights.

The service providers or their management bodies are supposed to elaborate these tools internally, with the active participation of users and staff members. Here are some of the most common examples of internal regulatory procedures:

- Charts of rights and ethics;
- Manuals of policies and procedures;
- Internal regulations (human resources, relations with users, safety regulations, staff meetings etc.);
- Quality management and improvement procedures;
- The functioning of the management board or the board of directors;
- The procedures for users’ involvement;
- Strategic planning procedures and follow up;
- Internal and external communication procedures;
- Evidence-based decisions and measures;
- Accountability and reporting procedures etc.

In the Balkan region, these internal tools do not exist yet on large scale among service providers. At the level of public social services, the former centralised system of provision did not enhance performance and transparency in management procedures, and neither had a focus on quality improvement. For this reason, the introduction of the procedures creates usually resistance among staff (“too many papers”, “time consuming” etc) or becomes superficial in their implementation.

On the other side, the innovative community services which are run mostly by non-governmental organisations (parents’ organisations, DPOs, professional organisations) do not have a strong background in management and therefore no real knowledge and experience for developing “spontaneously” these tools. Usually, their management and administration capacities are improving ‘on the spot’ and along the way.

However, in Romania and Bulgaria, the NGO sector was the one who initially promoted the introduction of quality criteria and good governance principles in the service provision for people with disabilities. The first drafts of quality standards in these countries have been elaborated with NGOs and their examples of good practices have been incorporated in these standards. Further on, the official introduction of the licensing and accreditation procedures, led automatically to the compulsory implementation of internal regulatory procedures in these social services.

In the other countries of Western Balkans, the introduction and use of these essential management tools are still uneven, as many reforms are in a pilot phase. The development of these methods is realised only in leading organisations, where the background and profile of managers or management boards lead to the promotion of
continuous improvement procedures for the respective service. The advantage of using the previous experience of Romania and Bulgaria could prove significant, since their similar context is more convenient than with the models existing in Western Europe.

As a general evolution, the charts of users’ rights and the manuals of policies and procedures are the tools that are the most known in the region. They are currently under development in several organisations, since their comprehensive character serves very well the ‘structuring’ needs of their managers and users.

**Spotlight 17: High level quality management in a public social service: the Centre for Social Work (CSW) from Banja Luka, Bosnia and Herzegovina**

The example of the CSW is unique in the Western Balkans countries. Following an intense period of reorganisations and internal modernization, the centre succeeded to receive the certification ISO 9001:2000. It is the only public service in the social sector that invested systematically in tools and procedures of quality management. With the support of international partners, the centres’ professionals developed an ethical chart, comprehensive information system for users (all categories of persons in vulnerable situations from Banja Luka), revised its evaluation and referral procedures, waiting list procedures, accessibility requirements for people with disabilities.

Today, the Centre operates in accessible premises, benefits from a dynamic and professional team of professionals and sets the standards for qualitative social work in the entire region. The Centre has also a specific department responsible with the cooperation with NGOs and several social assistance projects in the municipality are run in public-private partnership.

**2.4.5. The national data collection and integrated information systems, related with social service delivery**

The lack of a coordinated system of information and data in the field of social services for people with disabilities is a reality in the majority of the SEE countries. Except Romania and Bulgaria which developed information procedures more rapidly, due to the accelerated reform processes and the accession to EU, the other countries of the region lack both procedural tools and responsible agencies for covering this gap of information.

On the other side, even for the two countries that became EU members in 2007, the integration and coordination of information is still weak, both at local and central level. The collection of data is still fragmented, the gate-keeping agencies as well as decision makers from different levels and sectors (horizontally and hierarchically) do not integrate the relevant data in a comprehensive system.

The most important gap in the field of social services, regarding the relevant data and feedback collection, is the lack of coordination between the bodies that are responsible with various regulatory mechanisms. Responsible agencies for the needs assessment do not cooperate with the licensing agencies, the licensing ones with the funding agencies and so on. This fragmentation of data and information is producing negative side effects, at several levels:

- The level of the person with disabilities her/himself. The person is the one obliged to do a coordination effort (when dealing with individualised plans of interventions containing a variety of measures and referral decisions), and not the system that is supposed to support him/her.
- At the level of decision makers, gaps and absence of relevant data lead to duplication (or lack) of adequate measures and, consequently, the misuse of existing resources at local level. At the present, the choices for the geographical distribution of social services, as well as for their density and profile, their improvement or their transformation, cannot be accurately backed up by data and evidence-based analysis.
- At the level of service providers - they are usually forced to do their own data collection, in order to profile their intervention and to investigate the real needs of users at local level. This aspect is of course a natural evolution and should have become anyway an internal procedure for providers in the long term. However, it remains a narrow information analysis, which in addition could become biased by the interests of providers and by funding opportunities. The risk of inaccurate data is the same as in the case of databases owned exclusively by NGOs, or private bodies.

Of course, good exceptions exist in all countries of the region and efforts are made (usually at local level) in order to develop new and adequate information procedures. However, these efforts do not represent a general trend so far in the Balkans countries.

---

261 In the region, there is one more public service that has a similar certification: the General Directorate for Social Assistance and Child Protection from Arad County, Romania
2.5. THE FUNDING OF SOCIAL SERVICES FOR PEOPLE WITH DISABILITIES AND THE EVOLUTION OF CONTRACTING PROCEDURES

The progressive development of the welfare mix and the diversification of social service providers in the region, determined a need for new funding mechanisms in the social sector. The redirecting of resources within the decentralization process, as well as the new public-private partnerships, led to a progressive transformation of the funding schemes in the region.

Social services are currently provided by public, non-profit, for-profit and informal providers. States should keep the responsibility for guaranteeing the access of citizens to social services and, therefore, need to ensure the sustainability of this system in relation with the local needs.

The diversification of funding procedures is still slow in South East Europe. Even in countries that adopted a relatively complete regulatory framework in the field of social services and which enable and promote this diversification through legislative texts (Romania, Albania) the funding and especially contracting mechanisms are the last to be concretely implemented.

As described in part 1, States use several mechanisms for ensuring a financial coverage for social services:

- direct financing through the state budget (annual envelopes per service);
- direct financing through unit costs calculation (per day/ per user/ per type of activity within the service);
- financing through the local budgets, following a public procurement and/or contracting procedure at local level;
- grants (with different sources of funding, from national to international);
- subsidies;
- the use of dedicated funds (e.g. Social Innovation Fund);
- in kind support (free use of public infrastructure and goods).

In some of the countries of the region, an indirect financial support exists for social service providers:

- tax exemptions for several types of activities or disability related services, as well as customs and import duties exemptions;
- exemption of taxes for donors and sponsors;
- the use of civil service as voluntary work in social sector;
- the redirection of a percentage of the yearly income tax of individuals or companies towards NGOs providing social activities (1% in Hungary, 2% in Romania).

The not-for-profit providers are generally funded by international and local donors and have limited access to public funds. When they do, it is mainly through grants, subsidies or in kind support. The contracting practices between local authorities and the private sector are very limited. They exist mostly in Bulgaria and, to certain extent and in uneven ways, in Romania.

The table below centralizes these funding mechanisms in the countries of the region:

Table 1: Funding mechanisms for social services (public and private) in South East European countries

<table>
<thead>
<tr>
<th>Funding mech./Country</th>
<th>Type of social service provider</th>
<th>State budget (annual envelope per service)</th>
<th>State budget (per unit costs)</th>
<th>Public procurement and/or contracting procedures</th>
<th>Grants</th>
<th>Subsidies</th>
<th>Dedicated funds</th>
<th>In kind</th>
<th>Indirect financial support</th>
<th>Private donations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>Public</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIH</td>
<td>Public</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croatia</td>
<td>Public</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNAP Kosovo</td>
<td>Public</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FYR Macedonia</td>
<td>Public</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montenegro</td>
<td>Public</td>
<td>X</td>
<td>Partially</td>
<td>Partially</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Romania</td>
<td>Public</td>
<td>X Partially</td>
<td>Partially</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serbia</td>
<td>Public</td>
<td>X Partially</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As presented in this summary, practically no country developed yet a regulatory procedure of contracting social services and/ or funding these services through a specific public procurement procedure (a mechanism within the "delegation of social services under a public mandate"). This is one of the main reasons for a limited sustainability of community based services provided by non-public providers.

The sources of funding at State level, for covering the sector of social services, come usually from the State central budget, as well as from the local government budgets, in the countries with more advanced decentralization stages. The international loans, the structural funds and the funds related with international cooperation (Finland, Denmark, Italy, Norway, Germany, UK, Greece as well as EU, the UN agencies and partially World Bank) cover a significant part of the transition costs for the social services sector in the South East European countries.

The financial contribution of the for-profit sector towards social services (donations, sponsorship) remains relatively low in the region, except for more recent positive developments in the new EU countries. These last ones are directly connected with the EU acquis and the introduction of standards for corporate social responsibility in the private sector, but also with an evolution of attitudes regarding the involvement of citizens and companies in social projects.

One of the major obstacles in elaborating a more coherent and effective financing of social services at national levels, especially when related to innovative community services, is the lack of an appropriate information system (coherent and unitary at national level) that leads to the elaboration of unit costs. The unit costs can be calculated per type of service and per beneficiary, on daily, monthly or yearly basis. In the region, the only existing calculations are for several types of services paid from public sources (institutional care, day care, foster care etc.), however these costs cannot be used as unique reference for both private and public providers.

The lack of unit costs has also a secondary effect in South East Europe. It delays the potential introduction of the personalised budgets for people with disabilities in this region. As it was proven by the experience of several Western European countries (UK, Belgium, Netherlands etc.), the personalized budgets change radically the way in which people with disability access social services. The persons can improve the control about the needed chain of services at community level and can "purchase" those services that are considered important for their daily life. Or, in the absence of the reference costs for each of services (cost/ day/ beneficiary, or cost/ hour/ beneficiary etc.), this financial mechanism cannot be introduced yet. The debate regarding the opportunity of these envelopes is currently taking place in the region. The disability movement acknowledges its importance, considering however that people with disabilities do not have yet good capacities and adequate information for administrating effectively these budgets.

Several national examples for the funding of social services will show the relative diversity of funding mechanisms that are currently used in the region, in parallel with the lack of the most significant one, the contracted financial support from annual public budgets, at local level.

In Albania, the main funding mechanism for social services is supposed to be operational at the level of local government units (municipality/commune). The legislation is under construction and service providers are supposed to benefit from contracting procedures with the local authorities. A Social Fund for Innovation has been established, mainly for supporting projects of community-based services.

In Kosovo (under UNSCR 1244), Croatia and FYR Macedonia, the main funding sources for social services are the central and local budgets; the funding is guaranteed only for public providers. Non-profit providers can access public funds, but only based on projects and through a tendering procedure. In Macedonia, the access of NGOs to public funds is additionally conditioned by a minimum period of three-year activity in the social services sector.

In Montenegro, one of the recent sources of funding accessible for non-governmental providers at national level is the Lottery Fund (the Law on Lottery and Entertainment Games, 2006). According to the draft regulations, at least 75% of the funds collected through organization of games and lottery will be used to finance NGO programmes and plans. In 2007, according to Dragan Drobnjak, Chairperson of the Commission for Redistribution of Funds, a total of 2,380,000 EUR were provided to the NGO sector through tender processes, for the following 6 domains: social protection and humanitarian work (5%); persons with special needs (40%); sports (20%); culture and technical culture (10%); non-institutional education (5%); fight against drug-abuse and other addictions (20%).

Local municipalities in Montenegro do not yet have adequate mechanisms for contracting non-governmental providers. However, during the last 4 years, several municipalities provided infrastructure or in kind support for the development of new community services for children and young people with disabilities (Bijelo Polje, Pljevlja, Niksic). One of the acknowledged priorities of the government is finding an adequate funding mechanism at national level that would allow the financial sustainability of multi-disciplinary services at local level (social-educational-rehabilitation services for example).

262 Nexhmedin Dumani, Presentation of the project of "Social Service Delivery in Albania" for the national seminar on "The access of people with disabilities to social services", co-organised by MOLSAEO and Handicap International,, May 2006, Tirana
In Romania, the main sources of funding for the social sector are:

- The State and the local budgets;
- The EU funds (the pre-accession PHARE Program, the Social European Fund – the Operational sectoral program ‘Development of Human Resources’; the European Fund for Regional Development – the Operational Regional program etc.);
- Other funds from international donors: World Bank, The European Commission Development Bank etc.

Social services are funded predominantly from central level, despite the decentralization process that takes place in Romania. 70% of funds allocated in the sector come from central level, and only 30% from local budgets. In addition, these allocations are not based on a strategic planning process, which leads to the fact that the decision regarding the development of new services is strictly correlated with the budgetary opportunities each year.

The main national mechanism for supporting the development of community-based services in Romania during 2003–2007 was a set of large scale projects called ‘Programs of National Interest’, functioning under a tendering procedure each year. These programs targeted mainly the closure of large residential institutions and the opening of new services at community level.

Another source of funding established in 1998 was an annual program of subsidies, regulated by the Law regarding Subsidies for Associations and Foundations (34/1998). These subsidies are addressing only the NGO sector providing social services, and the amounts are calculated per number of users of these services. A fixed amount per capita is established every year as a basis for calculation. The funds cover several types of utilities and the social care staff.

Other EU funds covered a very significant part of the reform in social services, as well as World Bank and bilateral cooperation among Governments.

The concrete funding of public social services is regulated by the Law on the Social Assistance (47/2006), as well as by the Government Ordinance 86/2004 on Social Services. As presented briefly in the previous presentation of the Romanian system, these documents create a distinction between primary social services and specialized social services. Primary social services aim at prevention, the identification of social needs and the limitation of risk situations that individuals may encounter. They are covering the proximity social services which need to be provided as closely as possible to the citizens. Specialised social services are various support and assistance services or interventions, which aim at maintaining, rehabilitating or developing the capacities of socially excluded individuals and groups.

According to the law, the county councils provide funding for the specialized services (including institutions) and the local councils have to finance the primary social services. The local councils can also subcontract (and finance) services with NGOs, but in reality this procedure is operational in a very limited number of larger municipalities and does not benefit yet from reference unit costs at national level. The specialized services have remained under the responsibility of the county councils, because the economies of scale and the availability of more qualified staff allow for more sustainability.

In terms of funding of non-governmental service providers, the Romanian legislation allows it through different official texts (law 350/2005, 17/2000, 215/2001, 272/2004) and promotes it through the National Strategy on Social Services (Government Decision no.22/2005). As general funding mechanisms for the NGOs, four possibilities exist:

- Non-reimbursable funds for activities of general interest (following a tendering procedure – law 350/2000);
- Subsidies (law 34/1998);
- Partnership conventions with the local authorities (G.Ord.68/2003);
- Establishing a contract for delivering social services (G.Ord 68/2003 and Order 71/2005).

In this last procedure, the contract has to be accompanied by an official decision of the local council. In addition, the NGO provider has to provide an invoice for its services, which contradicts the law on associations and foundations (non-profit activities). The regulation of this contract is ambiguous and lacks clarity. Some of the
cultural values, consider also that a certain ‘over-regulation’ exists in Romania today, in the field of funding mechanisms for NGOs268. 

So far, the concrete cooperation between NGO providers and local authorities in Romania has been organized through various “agreement protocols”, “cooperation agreements” or “memorandum of understanding”. The weakness of this form of cooperation is that the long term contracting is not guaranteed. The social service is “purchased” as all other commercial services, on limited periods of time and in strict relation with the available funds at local level.

A draft law on contracting of social services is currently under elaboration in Romania and its release has been the subject of several national public debates in 2006-2007. This document will be a major procedural tool in enabling a proper contracting of social services at local level and will constitute the premises for a more coherent, strategic and sustainable development of social services further on.

In terms of calculation of unit costs for each type of social services in Romania, there is no unified procedure at national level so far. This aspect constitutes an important obstacle in the definition of coherent and effective (sub)contracting procedures at local level.

In Serbia, two different funding mechanisms have been established at national level for covering the transition costs of the reform and enhancing the development of new social services at community level:

- The Fund for the Organisations of People with Disabilities (FOPD)
- The Social Innovation Fund (SIF).

Both funds are used for projects or initiatives at local level and insist on the cooperation (co-financing) between NGOs and local governments.

The FOPD finances only services related to people with disabilities and support mainly the DPOs. The SIF has a wider coverage, extended to all social welfare services. It is covered from budget and donors funds and complements the reform-oriented services (transformation of institutions etc.). From the FOPD have been funded so far: day care centers and day care activities, education and training of children with disabilities, awareness campaigns, projects targeting the removal of barriers and advocacy. From SIF have been funded: day care centers for children with disabilities, kindergarten ‘on wheels’ for children with disabilities, Roma children, children victims of violence, clubs for youth in conflict with the law, services for victims of violence and abuse. In 2002-2006, the FOPD funded 538 projects (4.9 million EUR) and in 2003-2006 SIF funded 212 projects (5.2 million EUR). The lessons learned in this process will be used for exploring solutions for regular financing mechanisms of alternative services, at national level 269.

The public social services are financed in the following way:

- The institutional placement in social welfare institutions and foster families is budgeted from the central level;
- The temporary placement in sheltered settings, as well as the day centres, the home care, the different subsidies for poor families, is covered from the budgets of the local self-governments.

The calculation of costs for the placement in residential institutions (per beneficiary) includes the following elements: the salaries of staff, the office running costs (for prevention, counselling, rehabilitation and monitoring activities), the maintenance costs (building and equipment) the depreciation costs, the material costs (food, hygiene, utilities, transportation etc.).

The calculation of costs for foster care includes both fees for supporting the user of services and the fees of the foster carer (including pension insurance)270.

The private providers of social services have access only to subsidies or grants from public sources, at national or local level. No contracting procedures exist yet in Serbia.

2.6. THE MONITORING AND EVALUATION OF SOCIAL SERVICES PROVIDERS IN THE COUNTRIES OF THE REGION

The monitoring and evaluation of social services is usually the responsibility of Ministries of Social Welfare and/or their designated agencies for this purpose. However, these procedures are poorly regulated and implemented. This situation is a consequence of the poor regulatory framework in general, since the monitoring process is strictly correlated with other key procedures like: the licensing of service providers, the mapping of social services, regular data collection, internal regulatory mechanisms and reporting at the level of service providers etc.

The first trials related to a more comprehensive monitoring of the sector has started initially with a basic set of inventory procedures, initiated by civil society organizations (e.g the Foundation of Civil Society Development in Romania in the 1990s for example), or by authorities (e.g. the Ministry of Labour and Social Welfare in Kosovo in 2007). These exercises allowed a basic data collection about the volume and typology of social service

providers in the respective countries. However, no real monitoring or evaluation methodologies accompanied these national inventories.

Nowadays, the only countries that officially have defined more comprehensive monitoring mechanisms in the social services sector are Albania and Romania.

In Albania the following institutions examine the modalities in which the social service system works:

The **Ministry of Labour, Social Affairs and Equal Opportunities** is legally responsible for monitoring the implementation of social service standards. According to the law, the Ministry covers this role through the Social Service Inspectorate, which is responsible for monitoring the compliance of standards of all public and private social service providers. The **State Social Service** should monitor the performance of the state and non-state social care institutions and gather information, statistics, and reports from local government units. Its conclusions should contribute to the policy development in the social sector. Additional monitoring functions are covered, at national level, by the recent **State Office for the Protection of Children’s Rights**, in all aspects related to the child protection. However, there is a big gap between legal documents and practice. In reality, no in-depth and coherent monitoring reports or analysis of social services have been carried out in the last four years.

In Romania, the monitoring and evaluation of services is strictly correlated with the licensing and accreditation procedures. In order to receive (or renew) the licence, service providers are submitted to internal and external evaluations. The main agency in charge with both monitoring and evaluation of social services delivery is called Social Inspection. It was created in 2007 and covers several responsibilities:

- To control the activity of social services delivery, as well as the accordance of social security benefits;
- To evaluate the impact of service delivery and to recommend improvements;
- To provide counseling and training for social services improvement;
- To collect data at national level and to elaborate a National Register of Social Services, in electronic format.

In practice, very few professionals are trained for qualitative evaluation procedures in Romania and, consequently, the process is rather a control than a real evaluation.

At national level, a new agency called the **Social Observatory** was expected to enter into force in 2008. This should contribute to a comprehensive mapping of social exclusion factors and should create an integrated information system in the social sector, for policy making and reform.

### 2.7. THE DECENTRALIZATION OF SOCIAL SERVICE PROVISION FOR PEOPLE WITH DISABILITIES

Equal opportunities and participation of people with disabilities to the social and economic life in their community depends mainly on the existence of the wide range of social and support services described so far, accessible and qualitative, at local level. As close as these services are to the place of residence, the greater impact it has on people’s lives.

The decentralization of social service delivery has also this role, to bring the provision of services closer to people who need them, and responding better to their concrete needs and expectations. The decentralization is often associated with the multiplication of the types of social service providers, described also with the general term of the ‘welfare mix’.

#### BOX 9

**Brief overview of the main aspects of the decentralization process**

In its very wide sense, the decentralization means the process of transfer of responsibilities, capacities and resources from the State level (central authorities, government) to the level of local authorities (municipalities and decentralised bodies of the ministries). The main scope of decentralisation is to enhance the capacities of local communities to respond better to the needs and interests of their own citizens. At a second level, the decentralisation is meant to improve the control, accountability and transparency concerning the use of existing resources.

Decentralization has several different aspects:

- **political decentralization** – the local government representatives are selected through local elections;
- **administrative decentralization** - the authority and responsibility for service delivery is transferred to local governments;
- **fiscal decentralization** – the local authorities collect taxes from local level and take decision about the local expenditures.

Several types of decentralization are acknowledged at international level and they develop progressively in South East Europe, in the context of the recent reforms:

1. **The deconcentration** occurs when lower levels of government (e.g. regional or municipal) execute various functions or activities on behalf of the central government without having decision making authority.
The lower levels of government essentially function as “branch offices” of the central government. It is the case, in the context of social services delivery in the region, of the School Inspectorates, or of the Centres for Social Work, for example.

2. **Delegation** is the process in which the central government transfers decision making over certain functions to relatively autonomous local governments, which have limited autonomy and are ultimately responsible to the central government.

When local governments become responsible with the provision of certain types of social services, this is a particular case of delegation of functions from central to local level. The same situation occurs in the case of private providers of social services at local levels. The direct provision of social services is delegated to them, however the overall responsibility regarding the welfare and social rights of the citizens remains the State’s one.

3. **Devolution** involves the complete shifts of decision making over finance and management of public services to quasi-autonomous local government units. Devolution usually transfers responsibilities for services to municipalities where residents elect their own mayors and council members, revenues are raised locally and local governments have independent authority to make investments.

It is the case, in the region, of the social services departments within the local self-governments or local councils.

These forms of decentralization are coexisting in every country, for various types of social, economic and administrative responsibilities.

The success of the decentralization depends usually on several factors:

- First, the political will and the support of political leaders. It is important to have the guarantee that, despite the succession of governments and leading parties, the decentralization will be continued on long term;
- The proactive character of the civil society, which enables the monitoring of the whole process;
- The existence (and raising) of adequate resources (human, infrastructure etc) at local levels, on sustainable basis;
- An effective legislative framework that guarantees the stability of results achieved during the process implementation;
- Comprehensive information about the map of services and social needs, as well about the cost of social service delivery for each category of services. This information has to be equally accessible for people with disabilities and decision makers;
- As well as an effective financial envelope, for fulfilling the responsibilities that are committed progressively at local level, during the first phases of decentralisation.

The adequate expertise for managing these responsibilities needs to be acquired through intensive training and capacity building programs. The coordination, investment and support from central level are highly important, as well as the commitment, management and coordination skills at local level. (I would add here also the importance of building capacities of local civil society groups, in order to prepare for the active participation in decision-making processes.

In South East Europe, the local authorities face currently several challenges:

They are confronted with a high number of responsibilities simultaneously, compared with their existing resources. Certain regions or municipalities have a bigger number of persons in risk situations and the local volume of staff in municipal public agencies is not tailored adequately. With the transfer of administrative and organizational responsibilities do not follow sufficient and adequate financial envelopes.

**In Albania**, the decentralization process is defined by the Law on Local Government (2000) and benefits also from a National Strategy for Decentralisation and Local Autonomy (1999). The process is considered highly important for growth and poverty reduction and it is correlated also with the action plan of the National Strategy for Socio-Economic Development.

The main laws that regulate the decentralization process in Albania ‘On the organisation and functioning of local governments’ (8652/2000) and ‘On the administrative-territorial division’ (8653/2000) underline that the primary and secondary education, primary health services and social assistance are functions that are shared between the local and the central government. In each of these areas the precise administrative and financing arrangements involved in sharing have yet to be defined.

Certain functions are exclusively the responsibility of local government (like the local infrastructure, the social, cultural and sport activities etc); other functions are only delegated to local government (for example operating a particular service or facility) (Law on Social assistance and services (2005), art. 17 and law on public procurement, art.18).

Generally, the rhythm of decentralization in the field of social service provision is perceived as slow in Albania and remains a key domain for improvement in order to allow the correct implementation of the specific legal texts related to social services.
In Bosnia and Herzegovina, the local governments have responsibilities in both entities for communal and utility services and for the non-salary costs of some educational and social services. However, the distribution of these responsibilities between entity, cantonal and municipal budgets is asymmetrical.

In Croatia the local self-government units are organized and function in accordance with the principle of local autonomy, and their activities are subject only to the legal control exercised by the responsible state bodies. In cases of transferring state responsibilities to local governments, they are entitled to receive tax revenues from the central government.

The Law on Local and Regional Self-Government was adopted in 2001, and it established the units of local and regional self-government, their scope and organization, as well as their functioning rules. There are two levels of sub-national government in Croatia: cities and municipalities (local self-government), and counties (regional self-government). Municipal and county elections are held every four years.

Each local and regional government has its own statute, which further regulates its scope, organization and functioning, its authority, the methods of consulting the citizens, the organization and work of public services, forms of cooperation, and the rights and responsibilities of local and regional public authorities.

The main responsibilities of local and regional governments are:

- Organization of settlements and housing;
- Town and urban planning;
- Utility services;
- Child-care and social welfare;
- Primary health protection;
- Education and primary-school education;
- Transit and traffic infrastructure;
- Fire-protection and civil defense.

Citizens are involved in the decision-making process through public debates, consultation, and locally- or regionally-organized referenda.

In Kosovo, (under UNSCR 1244), UNMIK (United Nation Mission in Kosovo) has the authority to approve all expenditures and can overrule any local assembly decision. There is a relatively unclear share of responsibilities between the UNMIK (United Nation Mission in Kosovo) authorities and municipalities.

Kosovo’s municipalities have two sources of financing available: own-source revenues and intergovernmental transfers. Municipalities are mainly funded through transfers from the Central Authority and are thus very much dependent on intergovernmental transfers from the Kosovo Consolidated Budget. Generally, the own-source revenues they are able to raise are not sufficient to meet their needs. The legal basis for the financial resources for municipalities is UNMIK regulation 2000/45, which provides that municipalities are responsible for preparing balanced, transparent budgets, preparing and executing a budget plan. The Central Authority is supposed to notify municipalities in advance of the forthcoming fiscal year as to the amount of the planned transfers.

In 2004, the Working Group on Local Government, chaired by UNMIK, developed a Framework for the Reform of Local Self-Government in Kosovo, which was endorsed by the government. With regard to local government financing, the Framework recommends the urgent adoption of a comprehensive law on Local Government Finance, its harmonization with the Law on Self-Government and the introduction of several principles:

- Municipalities should have the authority to manage their own budgets;
- All municipal services should be financed through municipal budgets, which include own source revenues, central to local budgetary transfers, and extra budgetary funds (from central level?);
- The authority to set rates and exemptions for local taxes, fees, tariffs and fines should be guaranteed as a municipal prerogative although central authorities may set allowable rate ranges;
- Municipal grant calculations should include measures to mitigate disparities among municipalities;
- Law should set a mandatory and consistent format for municipal budgets.

In Macedonia, the decentralization process started in 2002, when a Law on Local Self-Government was adopted. This new law transfers powers to the municipalities in the areas of public services, culture, education, social welfare, health care, environment, urban and rural planning, economic development and local finance.

Macedonia has a system of local government based on the level of municipality. In terms of the financial system, the most relevant problem concerns the inadequacy of financial resources assigned to local governments compared with the responsibilities assigned by the Constitution and other relevant legislation.

In Romania, the Law on Local Public Administration (No.69/1991) defines the institutional framework for local governments by re-establishing the system that existed before the communist regime.

---

271 The Local Government and Public Service Reform Initiative, Open Society Institute (http://lgi.osi.hu)
272 The Local Government and Public Service Reform Initiative, Open Society Institute (http://lgi.osi.hu)
273 The local public authorities in Romania are: the county councils and the heads of county councils at the county level, and local councils and mayors at the level of municipalities, towns, and communes. Local and county councils are decision making bodies, whereas mayors and the heads of county councils are executive ones. The law also stipulates that there is no relation of subordination between county councils and local councils, neither between the central government and the local governments. The members of local and county councils are all locally elected for a four-year terms.
The effective decentralization has been targeted as a priority by the Romanian government, additionally related with the goal of a successful accession to EU. In 1998, Romania’s Parliament passed a new Law on Local Public Finance (No.189/1998), which enhanced a significant restructuring of fiscal authority of public service provision. This law fundamentally changed local public administration in Romania by expanding local authorities’ responsibilities in the establishment of expenditure priorities, the approval of investments, long-term budgeting, access to credit from the internal or external capital markets, and assessing and collecting revenues from local taxes and fees. The new law transferred also the authority for the financing of education, social assistance, and certain social services such as housing and community services to local governments (county (“judet”), municipalities, towns or communes).

Social services are impacted by the new legislation and the decentralization process in general (defined by a new Law on Decentralization in 2006), as local governments have become responsible for financing nearly all social assistance benefit programs and services, including orphanages and homes for the elderly. An increasing share of education expenditures relies on this level as well. Local government’s financial involvement in the education sector is also increasing, and in 2001, infrastructure and personnel costs for education were transferred to local government budgets. As for the health care, the municipal councils have much more limited role and responsibility due to the introduction of a National Health Insurance in 1997. Health insurance funds (at the county level) finance the majority of health care costs through contracting arrangements with physicians in local clinics.

County councils have a significant role in financing and administering services for the people with disabilities. They are responsible for personal care services, benefits for transportation and telecommunications, and institutions. Local councils are also responsible for assessing eligibility for services based on central guidelines. The level of involvement of individual local councils depends on the number and type of services provided in the area. Some local councils are also involved in supervising the activities of social workers who work with people with disabilities.

The main gain of the decentralization law of 2006 is the stipulation that the transfer of competencies shall be made simultaneously with the transfer of financial resources and implementation instruments, and the new competencies shall be exercised only after the necessary financial resources are available with the county and local councils. A Strategy for the Acceleration of Public Administration Reform was released in 2004, and this document reinforces the transfer of power from the central to local level as a component of the democratic process.

Montenegro has 21 municipalities. The 2002 Law on Local Self Government envisaged delegation of competences and resources to local government in the fields of education, primary health care, social welfare and employment. A country report (realized by the Union of Municipalities275) argues that the sectoral legislation has not enhanced municipal competence in these fields, or where it has done so, as in the case of pre-school and primary education, has not transferred equivalent resources. The absence of legislation recognizing municipal property rights also inhibits development of municipal utilities.

The government provides direct capital funding for some municipal services such as roads, lighting, water and sanitation, culture and sports. The Union argues that the allocation of these funds does not comply with municipal priorities. Investment grants are available also to municipal budgets but requiring 50 to 70% matching funds, which many municipalities cannot afford.

Municipal expenditure has declined slightly since 2003 from 15% to 13.7% of public expenditure and from 6% to 5.3% of GDP. This presumably reflects the problems already discussed. The inadequate implementation of the Local Government and Local Government Finance legislation makes it difficult to assess the potential adequacy of the new intergovernmental fiscal framework.

Serbia has 190 municipalities. A new Law on Local Public Finance was adopted in 2006. Its impact cannot yet be evaluated as it came into effect only in 2007 budgets. However, it promises to make substantial progress in the equity, transparency and stability of the fiscal decentralization system. The 2006 Law substantially increases the power of local government while limiting that of the central Government. In particular local governments gain the right to determine rates of property tax and to collect it.

Municipalities retain the charge of communal and utility services. The social sector responsibility remains confined to pre-schools and maintenance of primary and secondary school buildings. Local budget expenditure has increased slightly as a percentage of public expenditure (from 13.81% in 2003 to 13.92 % in 2006) but declined as a percentage of GDP (from 6.53% in 2003 to 6.21% in 2006). The responsibilities of local government in the support of social services are very limited and restricted mainly to in kind support or annual small size grants programs.

---

2.8. THE USERS’ INVOLVEMENT IN DIFFERENT STAGES OF SERVICE PROVISION

Users of social services (in this case persons with disabilities, their families or legal representatives) are rarely included as active stakeholders in the planning, decision making or evaluation of social services in South East Europe. From passive recipients of social benefits to active stakeholders in the service provision process, there is a long way to go through for this category of population. States have not included until now this important right of people with disabilities in concrete legal documents or regulatory procedures. Often, people with disabilities themselves are reluctant to take initiatives, or they simply lack basic information and guidance in relation with their rights and opportunities. In general, a ‘culture of participation’ is yet to be built.

However, several steps forward have been taken, mostly at ‘macro level’ related with planning, mapping of services, lobby for new types of services and legal frameworks:

- In several countries (Albania, Bosnia and Herzegovina, Kosovo (under UNSCR 1244), FYR Macedonia, Montenegro, Serbia) local coalitions of people with disabilities have been actively involved in community planning, in the last two years. In more than 100 municipalities of the region these local consultations and planning processes are ongoing, including various priorities in the field of social services;
- The National Councils of People with Disabilities (mentioned in the paragraph 2.1) have the authority to propose and advise the national policies in the field of social services. As their existence is still recent, there are not yet measurable effects of their involvement in this domain;
- The parents’ organisations are among the most active promoters of innovative services in the region, for children with disabilities (in Bosnia and Herzegovina, Montenegro, FYR Macedonia, Romania, and Serbia). Often, those parents’ organisations are strong lobby groups, promoting as well comprehensive general reforms in the social sector (e.g. The Union of Parents’ Organisations in Montenegro, the parents’ organisations in the field of autistic spectrum disorders in Romania etc.). The same applies for the organisations of people with disabilities and independent living promoters.

With regards to participation of users in the planning and decision making at the level of concrete service delivery, the progresses are less significant. A small number of providers (and these are usually the good example mentioned all along this report) have dedicated procedures for increasing the participation of users in the overall running of service such as:

- Complaints procedures;
- Regular feedbacks and evaluations including users opinions;
- Presence of people with disabilities (or their representatives) in the management boards;
- Permanent consultative or advisory groups, made of people with disabilities;
- Promotion of self-representation as mechanism for empowerment and decision-making (especially in the field of intellectual disability).

Even when the law explicitly mentions these procedures (like in Romania, where many of these are part of the national quality standards and licensing requirements), their implementation and monitoring are rather superficial.

2.9. THE SITUATION OF PROFESSIONALS AND OF THE SPECIALISED QUALIFICATIONS NEEDED IN THE DISABILITY-RELATED SERVICES

2.9.1. Overview of the situation

As mentioned in part 2.1, the number of professionals and qualifications needed in the social and medico-social sector for deliver services to people with disabilities remains largely insufficient in the region. Some countries though, such as Croatia, FYR Macedonia, Serbia, and Romania benefit from a wider spectrum of schools, faculties and continuous training programs for these types of professionals.

As a general observation, the shortage in professional staff affects all countries, as well as the migration of professionals towards different sectors of commercial or for-profit activities, and abroad.

Frequently, professionals from certain domains as psychology, pedagogy, sociology etc. occupy in fact other positions in the social sector, like personal assistants and carers, job mediators, occupational therapists among others.
Shifting the Paradigm in Social Service Provision

<table>
<thead>
<tr>
<th>Profession</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Croatia</th>
<th>Kosovo</th>
<th>Macedonia</th>
<th>Montenegro</th>
<th>Romania</th>
<th>Serbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Sociologists</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Educators</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Special educators</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Special teachers</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Educators-rehabilitators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Medical doctors</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Nurses</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Speech therapists</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Social pedagogos</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Ortho-prosthesists</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>P&amp;O technicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Art therapists</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Personal assistants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Foster parents</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**INFORMAL TRAINING**

| Personal assistants               |         |                        | x       |        |           |            | x       | x      |
| Work therapists                   |         |                        |         |        |           |            | x       | x      |
| Home carers                       |         |                        |         |        |           |            | x       | x      |
| Sign language interpreters       | x       | x                      | x       | x      | x         | x          | x       | x      |
| Instructors for guide dogs        | x       | x                      |         |        |           |            | x       | x      |

| CBR workers (community based rehabilitation) | x |

Table 2. Mapping of existing professionals related to services for people with disabilities in the region (Dec. 2007)

As the table shows, the predominance of qualifications is related with the traditional system of ‘defectology’276. On the other side, several professions are almost inexistent in the region (occupational therapists, job coaches and mediators for employment etc). Their introduction requires not only initial training and consistent certification procedures, but also legal recognition and budgeting at national levels. Some professions are still to be properly developed, as well as adequately included in social services systems and funding schemes in some specific countries: personal assistants, occupational therapists, job coaches and mediators for employment etc. Several professions have emerged only in the last decade, in specific countries: psychologists and social workers in Albania, foster parents in Romania etc.

The regulatory frameworks for professional groups are also very superficial. For psychologists for example, regulatory national bodies (authorising the practitioners) exist only in FYR Macedonia and Romania and the specific Law for Psychology Practice exists only in Croatia and Romania.

A particular situation occurs in the field of ortho-prosthetics, one of the important services in the disability sector. While the number of existing services is relatively large (in Bosnia and Herzegovina, Serbia, Romania and

---

276 A scientific field originated in the work of the Russian Lev Vygotski. The defectologists consider that various types of impairments need specialized education techniques and methods, in order to compensate the effects of the “defect”. The special education schools are still numerous in the region and they work with multi-disciplinary teams of teachers, psychologists, speech therapists, physiotherapists and social workers.

A psychologist working in the day care service Zracak Nade, Pljevlja, Montenegro Copyright Zracak Nade
Croatia and, less significantly, in Albania and Kosovo) the number of qualified professionals is still limited and the accessibility of the general public to the services is quite poor, due to excessive prices. Except for Romania where several programs of training exist since 2002-2004, the number of local ISPO\textsuperscript{277} technicians (category I) is only 3 for the whole region (2 in UNAP Kosovo and 1 in Macedonia. A small number of category II technicians exist in South East Europe. Throughout the region there is, at present, one single program of training available for P&O clinicians or technicians and this program is the result of a two years project carried by Handicap International and Human Study\textsuperscript{278}, in cooperation with the prosthetic-orthotic private companies and with the approval of Ministries of Health of each country (Bosnia and Herzegovina, Croatia, Macedonia and Serbia)\textsuperscript{279}. It is estimated that the minimum number of trained prosthetic-orthotic (P&O) technicians that would be needed in the region just for meeting the current local needs is at least 400. As in the other sectors of disability-related services, the insufficient regulatory frameworks at national levels, including licensing of providers, quality standards and funding mechanisms for these particular services, led to an important privatization of the sector in those countries\textsuperscript{280}.

The evolution of professional associations varies from a country to another. Psychologists, speech therapists, physiotherapists, sign language interpreters and social workers are the most organised in the region. In their respective countries, they have been the first promoters of ethical codes of their professions, as well as of the regulatory frameworks for practitioners' work. They are also very well connected with European and international organisations in their respective field of intervention.

**Spotlight 18: Introducing Physical Medical Rehabilitation (PMR) in Albania**

Professions such as physiotherapy or physiatrist (physician specialised in PMR) did not exist under the former Albanian regime. Despite the recent initiatives aimed at training such types of professionals, there was no long-term solution adopted for the country to approach international standards on PMR services, until 2006.

Among European countries, Albania had the lowest number of health professionals per capita: 1.3 physicians for 1000 inhabitants, and 3.7 nurses for 1000 inhabitants. The situation for PMR professionals was even worse as only 3 general practitioners were registered in the entire country and there is no figure available on the number of physiotherapy workers, as they are not legally recognized or even identified as a profession until now.

Before 2006, Physical Medicine and Rehabilitation was not identified as a medical specialisation in Albania. Medical students just followed a 60 hour course on rheumatology and physiotherapy during their studies. The few existing general practitioners completed a nine-month physiotherapy-training course which no longer exists. Similarly, Albania did not have any educational program for physiotherapists or occupational therapists. The people working as “physiotherapists” were either physical education teachers or nurses.

Following a collaboration project between the Ministry of Health (MoH), Ministry of Education, the Nursing Faculty in Tirana, the Albanian Mine Action Education unit (AMAE), and Handicap International, several issues have been addressed between 2006-2008 within a project called: “ACCESS TO PHYSICAL & MEDICAL REHABILITATION IN ALBANIA”:

- A PMR National Plan of Action was developed by MoH defining clear priorities and evaluating the resources needed in order to develop rehabilitation services throughout the country;
- The Nursing Faculty in Tirana implemented a sustainable program for the development of physiotherapy education in Albania, with the support of Belgian experts.
- The training of Category II (ISPO) technicians in ortho-prosthetics has been accomplished for a number of 35 professionals who will become further "on job" trainers in Albania.
- The rehabilitation unit of the Kukes hospital is delivering basic rehabilitation services to clients in need particularly addressing the needs of landmine survivors; ortho-prosthetic facilities are being improved at the regional hospital level in Kukes with equipment and qualified staff;
- There is a Continuing Education Degree Course in PMR delivered to a number of medical doctors in the country, in order to enable them after one year to work operationally in existing PMR facilities.

This PMR Continuing Education Degree Course will be composed of five modules of one week, taught between November 2008 and June 2009. The curriculum, based on European Standards, has been approved by the Ministry of Health which will endorse it as a continuing education program. 18 trainees have been selected. Trainers will be French experts in Physical Medicine and Rehabilitation from the COFEMER (French College of PMR Teachers).
2.9.2. The situation of social services managers in South East Europe

All along this difficult reform process in South East Europe, the situation of social service managers deserves a particular attention.

The managers of public services for people with disabilities are usually medical doctors, psychologists or social workers. In some isolated cases (and especially in Albania), their original qualifications is not connected at all with the social or medico-social sector. The private social services (non-profit, informal, for-profit) are generally managed by professionals of social sciences, with no previous managerial background. Parents become often managers of certain types of services, as frequent promoters of these services at community levels, through NGOs or volunteer initiatives.

The lack of comprehensive training in management (human resources, quality management, financial management, communication and representation etc.) affects significantly the capacity of these persons to deal with the simultaneous challenges of the current reform:

- pressure for rapid improvement of services’ quality, but shortage in funding and human resources;
- new regulations and procedures in the social sector, but bureaucratic practices, administrative blockages and contradictory interpretations of legal documents.

In Croatia, Serbia and Montenegro, the faculties of management (as well as post-graduate management specializations) are available only for students in economics. In FYR Macedonia, a specific master degree exists in human resources at the University ‘Sv. Kiril i Metodij’ in Skopje. In Bosnia and Herzegovina and Serbia, management courses are organized only for managers of public services, and especially directors for Centers for Social Work 281. In Romania there is a recent master degree in “management of health and social services” at the level of the Faculty of Sociology and Social Work (Bucharest). Management courses exist as well for medical related professionals, at the Romanian National School of Public Health and Health Services Management.

During the field visits, interviews and regional events organized for the completion of this report, the general feedback of managers is of an overwhelming situation with extensive workload. Moreover, in the NGO sector, managers are confronted in the last two years with critical shortage in funding and in coordination staff. There is no “second generation” of responsible professionals, willing to continue the work of “pioneers” in the disability innovative services. In addition to the difficult situation of social services funding in the region, this aspect represents an alarming sign for the sustainability of the sector.

2.9.3. Volunteers, self support networks and other informal providers of social services for people with disabilities

After the 1990s, volunteering was not a popular phenomenon in South East Europe for almost a decade (due to the legacy of communist regime, when the concept has been abused by authorities). In addition, the main concept of volunteering (working without compensation) needed a certain period of time for being taken into consideration by general public, in a region dominated by poverty, unemployment and dramatic social transformations.

Nowadays the awareness campaigns and the volunteer initiatives become more numerous; the target groups are rather high school and faculty students. Simultaneously, the legal framework for volunteer activities starts to be adopted, including the reimbursement of volunteer’s expenses and the volunteering contracts:

- In Bosnia and Herzegovina, Republika Srpska adopted its Law on Volunteering in June 2008;
- Croatia benefits from a similar law since 2007;
- FYR Macedonia adopted its Law on Volunteering in December 2008;
- Romania has revised its law in 2006 (first version adopted in 2001) and has now 10 regional centers for volunteers all around the country;
- In Serbia, a draft law for volunteering is endorsed by the Parliament of the province of Vojvodina.

In the social services for people with disabilities, the volunteers intervene rather for socializing and leisure activities but less often in more specialised activities (education, rehabilitation, personal assistance and personal care).

Self support networks exist as well in the region, however not on larger scale. They are more significant among families of children with disabilities (and especially children with autistic spectrum disorders), as well as among people living with HIV/AIDS.

In March 2008, Handicap International organised a regional event in Skopje (FYR Macedonia) in relation with the role of self-support networks and small scale community initiatives in the field of disability. The seminar called “New Solutions for Community Living of People with Disabilities – Making the Most of Existing Resources” looked at the quality of life of people with disabilities through the eyes of families and communities. The key speakers (consultants and self advocates from United States and United Kingdom) introduced the participants to aspects related with family leadership, innovative service provision, personalised funding and community support networks 282.

281 According to interviews and roundtables organized in the region during 2006-2008, with professionals from the social sector.
282 The event was organized in cooperation with: PLAN Canada (Planned Lifetimes Advocacy Networks – www.plan.ca), Neighbours Inc. from USA (www.neighbours-inc.com), Beyond Welfare (www.beyondwelfare.org), GoMADThinking UK (www.gomadthinking.com) and EASPD (the European Association of Service Providers for Persons with Disabilities, www.easpd.eu) and funded by the Ministry of Foreign Affairs of France.
2.10 Centralisation of data with regards to the typology of services and existing regulatory mechanisms in South East Europe

Table 3. Existing services for people with disabilities in South East European countries (Dec.2007)

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of service</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Croatia</th>
<th>Kosovo</th>
<th>Macedonia</th>
<th>Montenegro</th>
<th>Romania</th>
<th>Serbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diagnostic and assessment services</td>
<td>x</td>
<td>x</td>
<td>Partially</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>2</td>
<td>Information and referral services</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>3</td>
<td>Early intervention for infants and children</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>4</td>
<td>Creches (nursery/day care services for children 0-3 years old)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Resources centres for people with disabilities or community resources centres accessible for people with disabilities</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Kindergartens</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>7</td>
<td>Other pre-school services for children (toy libraries, play groups etc.)</td>
<td>NGO</td>
<td></td>
<td>x</td>
<td>x</td>
<td>NGO</td>
<td>NGO</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Children’s club (holiday and weekend scheems, outdoor activities)</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Day care centres for children</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>10</td>
<td>Inclusive schools</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>11</td>
<td>Special schools</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>12</td>
<td>Special classrooms in mainstream schools</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td><strong>Housing for children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Residential settings for children</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>14</td>
<td>Family like settings for children (group homes)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Foster care services</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Type of service</td>
<td>Albania</td>
<td>Bosnia and Herzegovina</td>
<td>Croatia</td>
<td>Kosovo</td>
<td>Macedonia</td>
<td>Montenegro</td>
<td>Romania</td>
<td>Serbia</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------</td>
<td>---------</td>
<td>------------------------</td>
<td>---------</td>
<td>--------</td>
<td>-----------</td>
<td>------------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Adult care and housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Day care centres for young adults and adults</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>17</td>
<td>Residential centres for adults with disabilities</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>18</td>
<td>Home care or housing support services</td>
<td>NGO</td>
<td>NGO</td>
<td>NGO</td>
<td></td>
<td>x</td>
<td>NGO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Sheltered homes for adults with disabilities</td>
<td>NGO</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>NGO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Supported living for adults with disabilities</td>
<td>NGO</td>
<td>NGO</td>
<td>x</td>
<td></td>
<td>NGO</td>
<td>x</td>
<td>NGO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respite care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Respite care and short break services</td>
<td>NGO</td>
<td></td>
<td></td>
<td>x</td>
<td>NGO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational therapy services and home adaptations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Speech therapy</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>26</td>
<td>Physiotherapy</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>27</td>
<td>CBR services (community based rehabilitation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Mobile teams (for multidisciplinary rehabilitation,</td>
<td>NGO</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>education or care services)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Psychological support and counseling services</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>30</td>
<td>Peer counseling/support groups for disabled people</td>
<td>NGO</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>or family members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Social work and social assistance services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Social work and social assistance services</td>
<td>NGO</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Employment related services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Vocational training for people with disabilities</td>
<td>NGO</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Table 3 inventors the existing services provided by both public and private providers. Where services are delivered only by NGOs, the corresponding cell contains the mark “NGO”. Table 4 tries to map the stage of regulatory mechanisms’ development. In some countries, legislation exists for the respective mechanism, but not in a comprehensive and updated way. These cells are marked with “partially” and means that efforts are still needed to accomplish the effective regulatory framework for that particular stage.

The brief ‘mapping’ of existing services for people with disabilities, as well as the overview of development of their corresponding regulatory mechanisms, shows the many steps remain to be done, especially in the field of developing support services (covered today mostly by non-governmental organisations). Moreover, table 3 does not include the aspect of existing number of these services. For many of the listed ones, this current number is completely insufficient and needs particular attention from decision makers and service providers. The simple existence of one service does not mean necessarily that the problem of its availability and accessibility is solved.

The chain of regulatory procedures is also to be completed in many countries, in a comprehensive and coherent way.

The report invites stakeholders from the region to constantly monitor the situation of these services and to update this centralised data.

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of service</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Croatia</th>
<th>Kosovo</th>
<th>Macedonia</th>
<th>Montenegro</th>
<th>Romania</th>
<th>Serbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>Vocational assessment and job placement</td>
<td>NGO</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Supported employment</td>
<td>NGO</td>
<td>NGO</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NGO</td>
</tr>
<tr>
<td>35</td>
<td>Sheltered employment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other support services**

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of service</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Croatia</th>
<th>Kosovo</th>
<th>Macedonia</th>
<th>Montenegro</th>
<th>Romania</th>
<th>Serbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Sign language interpreting</td>
<td>NGO</td>
<td>x</td>
<td>x</td>
<td>NGO</td>
<td>x</td>
<td>NGO</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>37</td>
<td>Editing of Braille documents</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>38</td>
<td>Transportation and related assistance services</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>39</td>
<td>Personal assistant services</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>NGO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Assistive technology and equipment providers</td>
<td>NGO</td>
<td>x</td>
<td>NGO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Ortho-prosthetics</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>42</td>
<td>Other assistive devices or services</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Training for using the assistive devices</td>
<td>NGO</td>
<td>NGO</td>
<td>NGO</td>
<td>NGO</td>
<td>NGO</td>
<td>NGO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3 inventors the existing services provided by both public and private providers. Where services are delivered only by NGOs, the corresponding cell contains the mark “NGO”. Table 4 tries to map the stage of regulatory mechanisms’ development. In some countries, legislation exists for the respective mechanism, but not in a comprehensive and updated way. These cells are marked with “partially” and means that efforts are still needed to accomplish the effective regulatory framework for that particular stage.

The brief ‘mapping’ of existing services for people with disabilities, as well as the overview of development of their corresponding regulatory mechanisms, shows the many steps remain to be done, especially in the field of developing support services (covered today mostly by non-governmental organisations). Moreover, table 3 does not include the aspect of existing number of these services. For many of the listed ones, this current number is completely insufficient and needs particular attention from decision makers and service providers. The simple existence of one service does not mean necessarily that the problem of its availability and accessibility is solved.

The chain of regulatory procedures is also to be completed in many countries, in a comprehensive and coherent way.

The report invites stakeholders from the region to constantly monitor the situation of these services and to update this centralised data.
Table 4. Centralised situation of existing regulatory mechanisms and procedures in the countries of SEE

<table>
<thead>
<tr>
<th>Type of mechanism</th>
<th>Albania</th>
<th>Bosnia and Herzegovina</th>
<th>Croatia</th>
<th>Kosovo</th>
<th>Macedonia</th>
<th>Montenegro</th>
<th>Romania</th>
<th>Serbia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gate-keeping mechanisms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>At macro level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local need assessment</td>
<td>Partially</td>
<td></td>
<td></td>
<td></td>
<td>Pilot</td>
<td>Pilot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mapping of needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mapping of existing services</td>
<td></td>
<td>Partially</td>
<td></td>
<td></td>
<td>Piloted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated information system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>At micro level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual needs assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Partially</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Referral to services</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Partially</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>Licensing/accreditation procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensing/accreditation procedures</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Authorisation</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality standards</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring and evaluation procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation procedures</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contracting and Funding procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracting (with national or local authorities)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding procedures (all types of funding mechanisms included)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
This report has presented a panorama of policies and practices reflecting the major “working site” that is taking place in relation with social services reforms in South East Europe. It is a period of intense reorganization and transformation at all levels, in which not only the political and institutional contexts are in transition, but also attitudes and daily practices are revised, questioned and submitted to a strong pressure for improvement.

The progress towards an enabling system has begun in South East Europe and there are clear signs of progress in the last four years; huge effort is still needs to be deployed for achieving the real ‘shift of paradigm’ in a sustainable way. A brief look at the key directions of reform that were perceived as priorities in 2004, in the report “Beyond De-institutionalisation: the Unsteady Transition towards an Enabling System in South East Europe”\textsuperscript{283}, might be relevant for monitoring this progress and the remaining objectives to be achieved.

### Key directions for building an enabling system, as they have been formulated in the 2004 report “Beyond de-institutionalisation...”

<table>
<thead>
<tr>
<th>Organisations of people with disabilities</th>
<th>The presence and role of DPOs in policy elaboration (at national levels and at local level) increases progressively in all countries. DPOs were involved, in various degrees, in the consultations related with the elaboration (or revisions) of national disability strategies or action plans. In some countries, DPOs became more effective in proposing specific legal frameworks (systematic laws for protection of their rights, anti-discrimination legislation). At national level, the representative umbrella organisations (sometimes through the National Disability Councils), have an advisory role in many policy sites today. At local level, the number of disability coalitions grows as well as their implication in the elaboration of community action plans, together with authorities and other local actors. In 2006-2007, DPOs elaborated national (comprehensive) reports on the situation of people with disabilities in each country, in a project coordinated by European Disability Forum and supported by the EU. These reports have been presented at the second international conference &quot;Steps towards Europe&quot; (Sarajevo, 2008) in the presence of national authorities and European key stakeholders. There are still many steps to be achieved for unifying the voice of the disability movement and for passing from their participation to policy making towards an effective involvement in policy monitoring.</th>
</tr>
</thead>
</table>
| Organisations of people with disabilities should be the leading stakeholders of civil society in lobbying for the rights of people with disabilities and for the provision of adequate services. They should also be consulted and have an advisory role in the development of national policies, services, and other decision making bodies at the national and local level. The main challenge in the region is the building of a unified voice respecting the diversity of the disability movement. | }

Additionally, the organisations of people with intellectual disabilities are not yet sufficiently involved in the existing lobby groups at national or local levels and this aspect needs to be addressed strongly in the coming years. The new ‘working sites’ on social services reforms challenge the disability movement and require a stronger focus on capacity building among DPOs, in new domains like service provision process, regulatory mechanisms, budgeting and funding of disability-related services etc.

**Developing and implementing a National Disability Strategy and establishing a National Council on Disability**

**National Strategies** for promoting and protecting the rights of people with disabilities have been adopted or are under elaboration in all countries of the region. They refer to mainstreaming of disability in all policies related with education, social welfare, employment, health care and access to various other types of services. They equally refer to those specific measures and services that need to address more complex needs of people with disabilities.

The **National Committees on Disability** exist in majority of countries, as it was presented in Part II of the present report; in most of the cases, they are inter-ministerial and include representatives of people with disabilities. Additionally, **national disability councils** have been created, composed by representative DPOs in each country; these councils are supposed to act like a ‘unified voice’ of the disability movement at national level. Their role is consultative in policy elaboration.

The effectiveness of national councils is still to be improved, as well as the representation of people with intellectual disabilities or people with complex disabilities in these lobby groups. The existence of the councils is acknowledged by governments, however not yet fully effective, which makes the consultation process often superficial.

**Reforming the overall legislative framework with regards to disability and disability-related services**

**Adoption of comprehensive antidiscrimination legislation**

As it was presents in Part II, these complex reforms started in all countries, with various speeds. Majority of countries have today strategies, action plans or even laws protecting the rights of people with disabilities.

In several countries the **antidiscrimination legislations** were already adopted. In some countries they are comprehensive antidiscrimination laws, in others they are disability specific. In all cases, their concrete implementation remains the key priority to be achieved and people with disabilities have to play a more active role for making use of these new tools that promotes inclusion and equal opportunities. Mechanisms for compliance and enforcement are still to be adopted, as well as specific bodies for regulating/ and monitoring the implementation of these laws.

**Sectoral laws** are adopted or under construction, like the one for vocational training and professional (re)habilitation of people with disabilities, the laws on the training and use of guide dogs and assistance dogs for people with sight impairments, among others.

In the services domain, policy elaboration advances as well. **National strategies or laws for social assistance and services** exist already in few countries, and they should become a reference for change in the entire region.
Specific legal initiatives are also ongoing for specific components of the **social service regulatory framework**: gate-keeping reforms, quality standards elaboration, accreditation procedures, or even elaboration of a comprehensive set of regulatory mechanisms for disability-related services.

### Changing perceptions on disability

Comprehensive surveys should be conducted on the situation of persons with disabilities, on their needs and expectations, based on holistic models such as the ICF or the DCP,
- Databases should exist to collect information on the individual needs of people with disabilities. These databases should be mainstreamed into existing public services databases such as Centres for Social Work, education, and the Employment Bureau. This will help to identify if their services can reach people with disabilities,
- Improve the access to information for people with disabilities on their rights and available services. This will also provide them with the tools to monitor the change process.

The necessary shift from a medical to a social model of disability, based on human rights, is acknowledged by policy makers in all countries. However, there is still more to be done towards changing the **public perception of disability**.

People with disabilities have better representative structures and their “weight” in the policy making process increased; however their role in **monitoring policies** is still very weak. Capacities need to be built further on for fulfilling this complex role.

Disability-related statistics are not yet available. **Disability is not yet mainstreamed in data collection** and this process represents a key priority for the coming period.

### Training of professionals and civil servants

There is a need to shift away from a system that used to train only disability specialists based on a medical approach, towards training all professionals working in ordinary services (such as social workers, teachers, and nurses) on disability issues.

The **training of professionals** in regular services, as well as of civil servants, remains insufficient. This leads to resistance to inclusion and inadequate practices in the existing community services. Despite the progressive introduction of person-centred approaches, individual plans of intervention and other similar tools that should serve the inclusive practices in mainstream environments, the appropriation and effective use of these tools needs to be improved.

**The capacity building and training of all stakeholders** involved in the access of people with disabilities to community services (from decision makers to frontline workers) should go beyond punctual initiatives; it is a process that **needs to be approached systemically**, in a coordinated and strategic perspective; it is the process that should produce the most tangible shift in attitudes and practices, with significant impact on the daily life of people with disabilities.

### Redirecting resources - orienting a country’s financial and administrative resources towards community-based approaches and supportive social security measures that are not a disincentive to inclusion.

The decentralisation process is ongoing in all countries of the region, with different paces and priorities.

As a general observation, there is weak ‘synchronisation’ between the social service reform and the decentralisation reform. This brings additional difficulty in specific processes like the gate-keeping reform or the funding and contracting mechanisms for service providers, in a context of welfare mix, at local level.

**The gate-keeping reform** started only in very few countries, and mostly at the level of commissions for evaluation and referral for children with disabilities. Old criteria are still in place, in a medical perspective, for evaluating the disability situation. The choice and interests of people with disabilities themselves are not always supported. Local decision making and financial arrangements are not yet in place for supporting these choice and options.

**Participation of people with disabilities in decision making** regarding the access to (and the provision of) services is still very weak.
Additionally, the concrete redirection of resources to create incentives for inclusion is not significant, in domains like education, employment, sports and leisure, among others. The reasonable accommodation of mainstream settings is not a current practice and is not supported financially in systematic ways, by local or national decision makers.

The legal framework for licensing/ accreditation of services, as well for introduction of quality standards for disability-related services is under construction in several countries.

With regards to the specific reform in the field of social services, the 2004 report was highlighting that “services and social welfare should be structured around quality and choice in which the client is proactive, and that governance of social service provision should increase, leading to effectiveness in reaching the individual needs of people with disabilities as users of services”. The present report tried to illustrate precisely this evolution of services’ governance and the key remaining steps to be achieved.

Generally speaking, in comparison with the modernisation trends in Western Europe, where quality and innovation are the key words, the South East European countries pass through a, what could be called ‘procedural’ transition. The very skeleton of a regulatory system is under construction in many countries, as well as the emergence of brand new types of services, financial procedures, and decentralised management arrangements. There is a lack of experience and skills in relation with these new models of social service provision and the legacy of the old institutionalised and centralised systems continue to have an impact since a majority of these countries remain heavily bureaucratic. The evolution of practices needs therefore to be accelerated, in order to synchronize this transition stage with European recommendations and trends.

Modernisation of social services became however a ‘must’ in the region, and the political discourses acknowledged this priority on large scale. Important progresses have been achieved in all countries in the last four years and several preconditions for “shifting the paradigm” in service provision have been acquired (as it is presented in the table above): modernisation of social services is on the political agenda, people with disabilities and their organisations acknowledged the need for change, are better organised and have increased lobby capacities, and service providers get more and more familiar with the main trends and requirements of services’ improvement.

On the other side, the pace of concrete implementation of reforms remains slow, and a discrepancy between declared policy goals and concrete measures for improvement is evident. People with disabilities, as ultimate users of these measures, are still confronted with major difficulties in accessing quality services in their own communities.

Further on, a list of needed interventions is resumed, that will require particular attention and strong commitment in the coming period. All stakeholders involved in the reforms are concerned by these steps: authorities and policy makers, people with disabilities as users of services, service providers themselves, along with donors, media, civil society organizations, universities and training providers, research institutes and statistic agencies, international agencies etc.:

1. The spectrum of services available for people with disabilities at community level should be much wider

People with disabilities reclaim a wider spectrum of services in their communities. From education to employment, health care and rehabilitation, leisure and sports, transportation, vocational training, as well as a wide range of support services, all these need to be available, accessible, affordable and of good quality.

South East Europe is a relatively ‘poor’ region in terms of diversity of services. There is a need for adequate legislation, as well as for more initiatives, creativity and innovation among service providers, in order to respond to the variety of needs of people with disabilities. There are many types of services that do not even exist in some countries (respite care, in-home support, supported employment, social housing, supported living, personal assistants etc.) but that are essential for a full enjoyment of rights and opportunities of disabled persons. There is also a need for a right balance between mainstream, support and specialised services, as a result of people’s requests and life options.

Enlarging the spectrum is a complex process, passing from policy design to professional training and development, through a more general change in attitudes and visions:

- Raising awareness about new types of services, arrangements, professional settings;
- Adjusting the social services legislation, in order to enhance innovation and to include these pilot initiatives in the national system of social services;

Shifting the Paradigm in Social Service Provision

- Designing a financial mechanism that transforms successful pilot services into sustainable solutions for people with disabilities within their communities;
- Training professionals in relation with these new types of services, enabling new job profiles and qualifications, as well as enhancing mechanisms for continuous training.

**Several types of services need to emerge (or to develop) more rapidly** and more systematically, due to their crucial importance in the life of people with disabilities (the list is not exhaustive):

- The *early detection and early intervention* services - with clear competencies and procedures in the field of infants assessment, early rehabilitation, and counselling of families;
- The *pre-school services* for children with severe or complex disabilities;
- *The respite care*, for both children and adults;
- *Foster care* for children with disabilities;
- *Counselling services*, in relation to various cycles of life of people with disabilities;
- *Support services* and particularly supported education, supported employment and supported living, for persons with all types of disabilities and needs; along with accessible transportation (on large scale), assistive devices and technologies, sign language interpreting, ortho-prosthetic services, personal assistant services, among others;
- *Vocational training* for people with disabilities;
- *Occupational therapy*.

People with disabilities have the right to have full access to *adequate health care*, in all medical branches and for all ages. They also have the right to access *leisure services* and to benefit from *all resources of communities*, as other citizens do. These services and resources need to become accessible for people with disabilities.

On the other hand, people’s needs are continuously evolving; the introduction of a human rights approach in social services brings new perspectives about people’s choices, self-determination and participation to social, cultural and economic life. **Social services have to reflect this continuous evolution.** They need to cover basic needs, but also to reflect people’s aspirations and choices. They have to adjust and to be open for constant improvement. Additionally, no deinstitutionalisation can be effective in South East Europe if community-based services are not efficiently developed, in sufficient number and with diverse profiles.

All stakeholders have responsibilities in this complex process of change, and the effort to make it happen should be a collective one:

- People with disabilities need to unify their voice and claim the fulfilment of their rights and needs, as well as asking for new types of services in their home communities. They should use the lessons learned and the good practices from some European and regional experiences and be proactive in analysing quality solutions and find out what best suits their current priorities. Finally, it is of utmost importance that they organize themselves to be stronger and more effective in their lobby for these new services;
- Service providers have to be pro-active at their turn. They need to constantly propose innovative projects, or adjust consequently the existing ones, in order to respond to these evolving needs of people and their basic human rights. They also need to develop new skills and management capacities, but also to create cooperation bridges among themselves, as well with authorities and policy makers.
- Authorities and decision makers have to acknowledge and encourage these new services and create legislative framework that is making them possible and sustainable.

**2. The concrete access of people with disabilities to these community services is to be significantly improved. Comprehensive reforms of gate-keeping systems are required.**

Another aspect of major importance for the region is the reform, at all levels, of the gate-keeping systems:

- At the level of communities and administrative units in terms of needs assessment, mapping of needs, mapping of services, creation of an integrated information system;
- At the individual level of people with disabilities in terms of assessment of individual needs and orientation/referral to services, entitlements, monitoring of people’s satisfaction and evolving needs etc.

At present, people with disabilities still experience difficulties to access services in their communities, for various reasons: from the lack of basic information about their existence to the lack of general accessibility, inadequate attitudes of gatekeepers or professionals, outdated guidance and referral procedures.

The entire gate-keeping system needs to be reformed, starting with the critical aspect of referral legislations and evaluation criteria and procedures in the disability sector. As presented in the previous chapters, only very few countries started this reform. It is, of course, one of the most difficult components to be transformed and this process needs a collective and coordinated effort on behalf of all stakeholders:

- First, there is a need for a political will: Governments have to commit to a policy change which is laborious:
  - changes in legislations regarding: disability definitions, entitlements, referral procedures, gate-keepers responsibilities and domains of interventions, correlation of social security and social services measures;
  - design of needs assessment procedures at macro level and at the individual level of people with disabilities;
  - establish (or modernise) the various types of evaluation and orientation agencies, in relation with the needs of people with disabilities during their life cycles;
  - develop a comprehensive system of information and feedback that allows rapid flow of data, re-
assessment and orientation procedures, as well as reallocation of resources in relation with people’s evolution and needs (based on the principle ‘resources follow the person’);
- allocate resources for these measures and designate responsible stakeholders for their implementation and monitoring.

- This component of reform needs also strong cooperation between people with disabilities, service providers and authorities. The gate-keeping component is very much based on planning and re-directing of resources, in relation with people’s needs and implies an efficient dialogue as well as negotiations frameworks, transparency of decisions, and accountability.
- More significant, a drastic change in attitudes and paradigms is required. From the traditional way of orienting people with disabilities to specialized services, towards an equal access of people with disabilities to all resources and services within the communities. This is a major change that needs to be done in mindsets of people and in concrete procedures. As pointed out all along the report, the resistance to change is still high in this domain of reform, especially among authorities and service providers, but sometimes also among people with disability or their families.

3. **Continuity is needed among services provided for people with disabilities, during the various cycles of their life. Improved coordination between gate-keepers is required, at macro and micro level.**

The continuity of service provision is one of the major particularities of the disability sector. Due to the various and changing needs of people with disabilities, as well as to the gate-keeping arrangements that allow referral and access to all necessary services, the continuity of provision is an aspect that needs particular attention and specific legal settings.

This problem becomes critical in two major situations:
- at the passage from a phase of life cycle to another (pre-school to school, adolescents to adulthood, school to employment, passage to the retirement system etc);
- in situations in which persons with disabilities need a variety of services simultaneously (like intensive rehabilitation along with education services for example).

The bureaucratic blockages, the duplications and/or delays in referral decisions need to be detected and eliminated. The diversity of services is to be enhanced. The regular consultation and dialogue with people with disabilities is a must, along with accurate individual action plans (if needed by users of services) and fluency in the referral process.

4. **Community-based services should become sustainable on long term. Multiplication of funding mechanisms is urgently needed, in a context of ‘welfare mix’.**

The South East European region is relatively rich in innovative projects in the social service provision. As the previous chapters have demonstrated, new services have been introduced progressively during the last 10-15 years, with the support of international donors and NGOs. Different models and methodologies have been “imported” and developed, and some of them have been adjusted to the particularities and the traditions of the region. However, only few of them became really sustainable on long term.

Some of them ended in bureaucratic blockages, due to the lack of public funding or funding not being adapted to their particularities and profiles. Others have exhausted their staff members and could not find the good replacements for the first generations of ‘pioneer’ professionals or volunteers. The quasi-inexistent training programs for new professions or qualifications contributed to the dissolution of these (promising) services. Moreover, enthusiastic and committed promoters have initiated many of them: parents, professionals or people with disabilities themselves. Majority of these promoters did not have sufficient management skills or adequate training for running a service, which brought about difficulties with impact in strategic thinking, partnership relationships and long term financial sustainability of the service.

All these elements are part of what is usually called a “transition period”. This transition is extremely challenging in South East Europe, and in which real pilot initiatives (with multiplier effects and continuous improvement strategies) became, unfortunately, very rare.

Therefore, there is a strong need for recognizing qualitative examples and enforcing those projects that have good chances of multiplication at national levels.

In a context of diversification of providers, the emergence of new funding mechanisms supporting these pilot services is crucial.

There are responsibilities to be shared in this process too:
- People with disabilities are the main witnesses of qualitative initiatives, they need to be actively involved in regular evaluations of services and to put forward those solutions which improved their quality of life;
- Service providers need to constantly monitor the sustainability of their services and develop internal tools such as quality management, costing, human resources policies and an active relationship with the external community. They need to develop better skills for reporting and for cost-effectiveness analysis.
- Authorities (at both local and central level) have to design and implement new procedures of contracting and funding of service providers, in a context of ‘welfare mix’. Despite the clear acknowledgement of this priority in all countries of the region, there is almost no decisive commitment of authorities on this matter so far.
ne the number and quality of training programs is to be improved.

8. Increased knowledge is needed with regards to disability and disability-related services: the number and quality of training programs is to be improved.

The region needs a tremendous investment in capacity building and training, in the field of social service provision. From basic management of services to policy design and decentralisation of service provision, this transition that happens on different levels simultaneously needs to be accompanied by a consequent investment in know-how.
Local and central authorities, social service providers and professionals from mainstream services, DPOs and parents associations, people with disabilities as users of services, media and local donors, all these actors need to have access to capacity building programs or activities related to social services modernisation.

This report has the intention to launch a strong call for action in this domain among international donors, international and national organizations, European agencies, as well as national institutions in charge of reforms. At all levels, in all types of services and for all kind of regulatory procedures, building capacity is indispensable.

The investment in training is one of the most significant keys for the success of reforms. Lessons learned from newly entered EU countries (Romania, Bulgaria) showed that **no real change is possible if resources for training (including continuous training) are insufficient**. Many reform programs have been conducted in these countries during the past four years, with significant budgets and international expertise, but the level of training at local levels, in 'cascade' and for implementing agencies or service providers, have been very poor. As a consequence, excellent policy designs ended up sometimes in bureaucratic and counter-productive procedures, because of a lack of capacities among public officials to apply effectively new measures and tools.

The recommendation of this report is for a programmatic investment in training, and especially at local level. The decentralised bodies and decision makers, as well as service providers themselves and people with disabilities, need to be at ease, and with capacity to implement, the reforms that are thought, designed and validated at national levels.

In addition, the national reforms should reflect the directives and guidance documents from the European Union, as well as international trends and tendencies, since all countries have commenced the process of EU accession. For this reason, regular updates, capacity building programs and exchanges with European stakeholders should be included in the reform agendas of policy makers in the social services sector. However, this implies as well an in-depth understanding of the stakes, tools and effects of all strategic choices for service provision reforms, as well of the use of successful cases studies, lessons learnt and good examples from other European countries as well as from the region.

**9. Clearer roles and shared responsibilities are to be developed with regards to the decentralisation of social service provision**

This report tried to illustrate that the ongoing decentralization process in the region is not necessarily coordinated with the reforms in the social sector. For this reason, local agencies are usually not prepared (and trained) to assume responsibilities that are supposed to be transferred progressively at their level, in the field of social services regulation or modernisation. In this context, sharing responsibilities for the effective management of services system becomes a priority.

There is a need for **clear division of roles between central and local authorities**, as well as among **providers and users of services**, in relation with:

- Assessment of needs and mapping of existent and needed services;
- Developing new services at local level;
- Monitoring and evaluating services;
- Licensing, evaluating and contracting services;
- Funding services for people with disabilities, at local level;
- Quality control and quality improvement;
- Data collection and statistics.

Clear tasks need to be assigned to adequate responsible persons or agencies, in relation with all the regulatory procedures, and the responsibilities should be transparent and monitored at all time.

**10. People with disabilities and their representatives should be more involved in all stages of decision making, in relation with service provision at community level**

Despite that this goal is very much promoted among disability stakeholders, many things remain to be done in South East Europe for its concrete accomplishment. In countries dominated still by significant levels of corruption, bureaucracy and old attitudes towards disabled persons, people with disabilities have not yet a consolidated role in decision making, at any of levels.

When people with disabilities are involved in decision making, it is mostly because:

- They are contributing to the opening of the service or they run the service themselves;
- They are members of community planning boards, in municipalities or communes, and they promote direct measures towards services improvement or accessibility;
- They developed strong leadership capacities and became acknowledged at national levels as relevant advisors, consultants or political actors; however, this type of situation is rather exceptional.

People with disabilities need to be acknowledged and invited to participate in various types of decision making boards. They need to be present actively in policy development in the disability sector, as well as in the development of community action plans. It is also imperative that, when running a service for people with disabilities, there needs to be an evaluation procedure that includes their feedback and opinion about that service.

These are the simplest measures to be taken in all countries, at all levels; the presence of persons with
disabilities at the table of decision-making is no longer an option, it is a must, and all preconditions exist for its realisation.

11. **National policies and legislative frameworks in the field of disability services need to comply with international evolutions in these domains. Revision and modernisation of the service provision approach is required.**

Checking the compliance of policy measures and legislative documents with the social (and citizenship) model of disability, as well as with the main international documents that are relevant in the disability field, should represent a constant preoccupation for all stakeholders.

The UN Convention, the European Commission and the Council of Europe Action Plans, the EC recommendations in the field of social services for people with disabilities, all these documents give a generous basis for modernisation and improvements for South East Europe. However, actors need to be prepared to integrate these documents, to understand them well and to transcribe the relevant principles and measures into their national realities.

An investment is therefore needed for this regular check, update and analysis. Governments, civil society, DPOs, research institutes and universities, should be the front-liners of this harmonisation process.

12. **Local expertise in service provision for people with disabilities should be valued and used, during the next phases of policy modernisation**

In all countries of the region there are relevant stakeholders (providers of services, authorities’ representatives and persons with disabilities or DPOs) that acquired tremendous expertise in the field of social services modernisation. Their knowledge and practical experience, as well as their global vision about each country’s evolution and characteristics, should be better used and valued in the next stages of reforms, and especially when international expertise is additionally solicited.

An example of such regional group of expert practitioners, with significant added value for the reform of social service provision in SEE, is presented in Annex 3.

13. **More systematic links are to be developed with European platforms and agencies involved in social services modernisation and disability-related policies**

Last but not least, a strong mechanism for development and modernisation of services is represented by the regular exchanges with colleagues and organizations from Europe and worldwide. As the report has presented organisations such as, EDF285, EASPD286, EPR287, Inclusion Europe, Workability, ECCL288 or OSMHI289 among others became acknowledged partners or interlocutors for SEE stakeholders. They contributed actively to present and propose new principles, values, practices models and good examples in the Balkan countries. Some of them are continuously accompanying policy reforms or establishment of new types of services all around the region. Others have been investing in capacity building among various lobby groups (DPOs, service providers).

There is a strong need for maintaining the quality of these partnerships and exchanging experiences and resources for the sectors’ modernisation in SEE, which will certainly benefit the development of services and policies in Western European countries as well.

---

285 European Disability Forum  
286 European Association of Service Providers for Persons with Disabilities  
287 European Platform for Rehabilitation  
288 European Coalition for Community Living  
289 Open Society Mental Health Initiative
ADAMS L., PARKER C., Making Community Living Possible for People with Intellectual Disabilities in Bosnia and Herzegovina, Montenegro, Serbia and Kosovo (under UNSCR 1244), Discussion paper, Handicap International and Open Society Mental Health Initiative, 2008 (www.disabilitymonitor-see.org).

ALBERT B., The social model of disability, human rights and development, KAR Briefing Papers, 2004


BADELT C., The role of NPOs in policies to Combat Social Exclusion, Discussion paper, World Bank, 1999


BILSON A., HARWIN J., Gate keeping services for vulnerable children and families, UNICEF Innocenti Centre and the World Bank, 2003


Department of Health, UK, Modernising health and social services: National priorities guidance 1999/00 - 2001/02 1998


EASPD (European Association of Service Providers in the Disability Sector)


EUROPEAN COMMISSION:
- Communication of the Commission on Social Agenda, COM (2005) 33 final, 2005
- Communication of the Commission on Services of general interest, including social services of general interest: a new European commitment, COM (2007) 725, 2007
- European Committee for Social Cohesion (CDSC), Users’ Involvement in Social Services, Final report of the activity carried on in 2003-2004, September 2004
- EU Disability High Level Group, Disability mainstreaming in the new streamlined European social protection and inclusion processes, 2007
- EU Disability High Level Group, discussion paper on Quality of social services of general interest, 2007

FOUGEYROLLAS P., BERGERON H., CLOUTIER R., COTE J., ST-Michel G. *Quebec Classification: Disability Creation Process;* INDCP Quebec, 1999


Government of Albania, *Law on Assistance and Social Services*, 2005


HEIKKILA M., JULKUNEN I., *Obstacles to an increased user involvement in social services*, STAKES, Finland, 2003


IBHI (International Bureau for Humanitarian Issues in Bosnia and Herzegovina), *Disability Policy Study*, 2007 (www.ibhibih.org)

INCLUSION EUROPE, *Consumer involvement in quality evaluation of services*, 2003


JANVIER, R., MATHO, Y., Mettre en œuvre le droit des usagers dans les organisations sociales et médico-sociales, Dunod, 2004

LANGE, C., Third –Sector Organizations in the Process of Regional Integration : EU-Enlargement and Social NGOs – a German Perspective; paper presented at the 6th International Conference of the International Society for Third Sector Research (ISTR), Ryerson University, Toronto, Canada, 2004


McLEOD, D., Community-Based Social Services: Practical Advice Based upon Lessons from Outside the World Bank, December 2003


Netherlands Ministry of Foreign Affairs, Decentralisation and Local Governance, June 2002

National Reports in the Field of Disability within the project: “Capacity Building of Disabled People’s Organisations in the Western Balkans”, coordinated by European Disability Forum and supported by EU (CARDS), 2006-2007

- Albania
- Bosnia and Herzegovina
- Croatia
- Kosovo (under UNSCR 1244)
- FYR Macedonia
- Montenegro
- Serbia

OECD, Glossary of key terms in evaluation and results based management, OECD, 2002


SMITH, N., MIDDLETON,S., ASHTON-BROOKS,K.,COX,L.,DOBSON,B., REITH, L., Disabled People’s Cost of Living, Joseph Rowntree Foundation, 2004


SOCIAL PLATFORM, Elements for a definition of Social Services of General Interest, www.socialplatform.org, March 2003


TUSHI G., National Report on Social Services for Albania, in “Good Practices in Social Service Delivery in South East Europe”, ILO South East Europe, 2004


UNDP, *Human Development Report 2008*


**WORLD BANK:**

- Romania - Local Social Services Delivery Study, 2002
- World Development report 2006 – Equity and Development

**WORLD HEALTH ORGANISATION,** *International Classification of Functioning, Disability and Health*, 2001

**Web resources:**

EUROSTAT: http://epp.eurostat.ec.europa.eu

The Disability Monitor Initiative in South East Europe: http://www.disabilitymonitor-see.org

MISSOC: http://europa.eu.int

Measuring Health and Disability in Europe: www.mhadie.com

UN Department of Economic and Social Affairs (UN DESA): http://www.un.org/esa/socdev/enable/
ANNEXES

ANNEX 1 - Brief description of social services for people with disabilities mentioned in this report

ANNEX 2 - 2.1. Disability High Level Group position paper on quality of social services of general interest (SSGI)
2.2. Disability High Level Group discussion paper on disability mainstreaming in the new streamlined European social protection and inclusion processes

ANNEX 3 - The group of regional experts in the field of social services for people with disabilities, in South East Europe
Diagnosis and Assessment Services - They offer specialised consultations involving pediatric medicine, pediatric surgery, neonatology and child development. Check-ups for children from birth up to 6 years of age are available at polyclinics. The types of screenings carried out during check-ups are physical examinations, growth monitoring, development monitoring and hearing and vision tests. Diagnostic services should also be available for people with psychiatric-related conditions at hospitals and mental health clinics.

Information and Referral Services - They provide information on disability and the services available in the community. They assist people with disabilities and their families by referring them to the relevant services.

Early Intervention Programmes for Infants and Children - Early intervention programmes generally offer a range of services to children diagnosed with disabilities or developmental delays below the age of six, and to their families. They focus on developing a child’s skills in areas of language and communication, social and behaviour, perception and cognition, gross and fine motor and self-help skills. Parent support and training should be available within these services.

Nursery (day care services for children of 0-3 years old) - Facilities that provide occasional care for children under 3. Usually, they need to be registered when they run for more than 2 hours a day.

Kindergartens - educational settings for children from 0 to 6/7 years old.

Other pre-school services for children (play groups, toy libraries, etc) - These services could have mainly educational and socializing profiles and could be organised:
- In specific locations or centers (like the toy libraries);
- At the home of the child;
- At the home of the caregivers or educators.

Children’s clubs (holiday and weekend schemes, outdoor activities etc.) - Facilities that provide out-of-school activities for all children, including children with disabilities.

Day care centres for children - A wide range of settings designed to provide care and specific activities for children, including children with disabilities. The concept is very large. The day centres can be designed for children with/without disabilities. They can have a variety of profiles, from afternoon care for children coming from school, to education and rehabilitation of disabled children. In South East Europe, they were introduced as specialized services for children with special care needs, during the day, as preventative (or alternative) services to the residential care.

Inclusive schools - An educationally inclusive school is one in which the teaching and learning, achievements, attitudes and well-being of every young person matter. Children with disabilities are included individually in mainstream classrooms. An inclusive classroom is typically composed of two teachers: the regular classroom teacher responsible for implementing the curriculum and assigning grades, and the special education teacher whose main task is to make sure that special education students in the classroom are receiving instruction according to their IEP (Individual Education Plan).

Special schools - offer education tailored to the learning needs of a child. They cater to the needs of children with sensory disabilities, multiple disabilities, intellectual disabilities and developmental disabilities. Some special schools teach the mainstream school curriculum while others emphasize areas such as self-help skills, functional academic skills, pre-vocational skills and daily living skills. In addition to education, special schools also provide therapy, parent support and training services.

Special classrooms in mainstream schools - classrooms composed exclusively from children with special educational needs (SEN), but located in a mainstream school.

Residential centers for children with disabilities - settings providing food, shelter, basic educational and leisure activities for children. When the center is designed for children with disabilities, or when the residential setting is attached to a special school, additional rehabilitation services could be included.

Family-like settings for children with disabilities (residential group homes) - These are community-based residential homes for children with disabilities or without parental care, that provide services and support for at least 4 and no more than 8 persons with disabilities. Support care givers are employed for 24/24 hours, in a ratio depending of the complexity of children needs.

Foster care for children with disabilities - Foster care is a system by which a certified, stand-in "parent(s)" cares for minor children or young people who have been removed from their birth parents or other custodial adults by state authority. Responsibility for the young person is assumed by the relevant governmental authority and a placement with another family found. There can be voluntary placements by a parent of a child into foster care. Foster placements are monitored until the birth family can provide appropriate care or the rights of the birth parents are terminated and the child is adopted.
Day care centers for young adults and adults - They aim to enhance the independence of people with disabilities so as to equip them with activities of daily living and community living skills to live in the community. Day Activity Centres also provide care relief for caregivers to pursue economic activity or as a form of respite. Adult day care is a planned program of activities designed to promote well-being though social and health related services. Adult day care centers operate during daytime hours, in a safe and supportive environment. Adult day care centers can be public or private, non-profit or for-profit. The intent of an adult day center is primarily two-fold: (a) To provide disabled adults an opportunity to get out of the house and receive intellectual, social and occupational stimulation and (b) To give caregivers a much-needed break in which to attend to personal needs, or simply rest and relax.

Residential centres for adults with disabilities - settings providing food, shelter, basic health care, social activities, (re)habilitation and leisure activities for adults with disabilities.

Home care (or in-home care) - Home care is a type of support that allows persons with special needs staying in their own home. It might be for people who are getting older, are chronically ill, recovering from surgery or disabled. Home care services include: (a) Personal care, such as help with bathing, washing your hair or getting dressed; (b) Homemaking, such as cleaning, yard work and laundry; (c) Cooking or delivering meals; (d) Health care, such as having a home health aide come to your home (e) Support for managing personal belongings.

Sheltered homes (group homes) for adults with disabilities - Sheltered housing is generally built specifically for people over retirement age or for disabled people. The homes are generally flats, bungalows or both, grouped around a communal facility such as a lounge. They are in fact small residential facilities, built in communities and benefiting from a specialized team that is available according to the needs of the users. This can include help from social services, health services and voluntary services. The sheltered home is usually designed for people with very complex needs (dependency needs) (to be differentiated by "supported living" – see below).

Supported living for adults with disabilities - ‘supported living’ enables people with learning difficulties to live in their own homes, providing flexible, individualised support to people wherever that might be. Technically, the ‘housing’ element is separated from the ‘support’. People live in their own homes, but support services are available and tailor-made, in accordance with the disability and care needs of the user. It represents a step further comparing with the ‘group home’ or sheltered housing. It offers to persons with disabilities more control on their own life.

Respite care and short breaks services - Respite care is short term care of persons with disabilities, helping a family take a break from the daily routine and stress. It can be provided in the client’s home or in a variety of out-of-home settings. Respite care is an essential part of the overall support that families may need to keep their child with a disability or chronic illness at home.

Home adaptations services - An adaptation is an equipment or an arrangement made in the home of a disabled person that will allow her (or her caregiver) greater safety or independence to access the home and its facilities.

Occupational therapy services - Occupational Therapists are responsible for assessing and providing services that help people remain as independent as possible in their own homes. OTs provide a range of services including: (a) Prevention advice - advice and information on methods of carrying out day to day tasks that may help the person with disability to retain his/her independence; (b) Rehabilitation advice to assist people recovering from illness or injury; (c) Provision of daily living equipment to help people maintain their independence; (d) Adaptation of the home environment for users with a permanent or chronic disability or illness. This can include putting in a downstairs bathroom in someone’s own home, changing the bathroom so that they can have a walk-in / wheel-in shower rather than a bath, putting a ramp or handrail at the front and back door etc.

Speech-language therapy - the treatment for children with speech and/or language disorders. A speech disorder refers to a problem with the actual production of sounds, whereas a language disorder refers to a difficulty understanding or putting words together to communicate ideas.

Physiotherapy - health care profession which provides services to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout life.

CBR services (community-based rehabilitation, in the sense of the World Health Organization) – is a comprehensive strategy for involving people with disabilities in the development of their communities. CBR seeks to ensure that people with disabilities have equal access to rehabilitation and other services and opportunities - health, education and income - as do all other members of society. Several types of activities are included in CBR, beyond medical care and rehabilitation: (a) promoting positive attitudes towards people with disabilities; (b) preventing the causes of disabilities; (c) providing rehabilitation services; (d) facilitating education and training opportunities; (e) supporting local initiatives; (f) monitoring and evaluating programmes; (g) supporting micro and macro income-generation opportunities

Mobile teams (for multidisciplinary rehabilitation or care services) - multidisciplinary teams (or freelance therapists) who provide the specialized service at the home (or the school/group home etc) of the user. This service is usually organized when users live in remote areas or when the transportation means are not available.

Psychological support and counseling services - support and training is available for families and parents including counseling, educational talks, support groups, training workshops, and information dissemination and referral.
Peer counseling/support groups for disabled people or family members - /Counseling among peers/ - Peer Counseling offers the opportunity for individuals to work with people who have similar personal experience with disability issues, creating an atmosphere of mutual understanding. This service is provided one-on-one or in small group settings.

Social Work and social assistance Services - The services include casework and case management, counseling, information dissemination and referral, family life education, home visits and financial assistance for people with disabilities and their family.

Vocational training for people with disabilities - Vocational training programs offer training to people with disabilities in vocational skills to prepare for employment.

Vocational Assessment and Job Placement – they assess the vocational needs and the readiness for open employment of people with disabilities. For those ready for employment, job matching and follow-up services are provided.

Sheltered employment - provides a simulated work environment and pre-vocational skills training programs to equip people with disabilities who have the potential and capability for open employment. These businesses operate in the open market, but are funded by a combination of self-generated income, charitable donations or government grant aids or subsidies. Some of the sheltered employment schemes also provide training and support to enable people to access supported or open market employment.

Supported employment - Supported employment facilitates competitive work in integrated (mainstream) work settings for individuals with disabilities. Supported employment provides assistance such as job coaches, transportation, assistance technology, specialized job training, and individually tailored supervision. Supported employment encourages people to work within their communities and encourages work, social interaction, and integration. Additional definitions:

A job coach is a person who is hired by the placement agency to provide specialised on-site training to assist the employee with a disability in learning and performing the job and adjusting to the work environment.

Natural supports are support from supervisors and co-workers, such as mentoring, friendships, socializing at breaks and/or after work, providing feedback on job performance, or learning a new skill together at the invitation of a supervisor or co-workers. These natural supports are particularly effective because they enhance the social integration between the employee with a disability and his/her co-workers and supervisor. In addition, natural supports may be more permanent, consistently and readily available, thereby facilitating long-term job-retention.

Sign language interpreters - Sign language interpreters facilitate communication between people who are deaf or hard of hearing and people who can hear. Sign language interpreters must be fluent in each country’s sign language, which combines signing, finger spelling, and specific body language. The sign language has its own grammatical rules, sentence structure, idioms, historical contexts, and cultural nuances. Some interpreters specialize in oral interpreting for deaf or hard of hearing people who lip-read instead of sign. Other specialties include tactile signing, which is interpreting for people who are deafblind, by making manual signs into a person’s hands.

Editing of Braille documents - the Braille system is a method that is widely used by blind people to read and write. Each Braille character or cell is made up of six dot positions, arranged in a rectangle containing two columns of three dots each. The lines of horizontal Braille text are separated by a space, much like visible printed text, so that the dots of one line can be differentiated from the Braille text above and below. Punctuation is represented by its own unique set of characters. Braille may be produced using a slate and stylus in which each dot is created from the back of the page, writing in mirror image, by hand, or it may be produced on a Braille typewriter or Perkins Brailler, or produced by a Braille embosser attached to a computer. It may also be rendered using a refreshable Braille display.

Transport and Related Assistance Schemes - Transport and related assistance schemes assist people with disabilities in their special transport and mobility needs.

Personal assistants services - Personal Assistants assist a person with a disability to do the things he or she would do for him or herself if they did not have a disability. Typical duties can be categorized into three areas: (a) Domestic tasks, such as housecleaning, cooking, laundry, and shopping, reading, or note taking; (b) Personal care, such as transferring, skin care, positioning, bathing, range of motion exercises, dressing, feeding, toilet assistance; (c) Transportation, such as pushing a wheelchair, guiding someone, assisting with transitions and transfers.

Assistive technology and equipment providers - Assistive Technology (AT) is a generic term that includes assistive, adaptive, and rehabilitative devices, as well as the process used in selecting, locating, and using them. AT promotes greater independence for people with disabilities by enabling them to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to or changed methods of interacting with the technology needed to accomplish such tasks.

Sports and leisure - these services facilitate the integration and participation of people with disabilities in the arts, sports, leisure and social activities.
Annex 2

2.1 Disability High Level Group position paper on quality of social services of general interest (SSGI)

The Disability High Level Group, made up of representatives of all the Members States under the Commission presidency, has drawn up, with the collaboration of organisations representing people with disabilities, providers of services to people with disabilities and stakeholders in the field, a document on the "Quality of the Social Services of General Interest (SSGI)" from the viewpoint of disability.

The purpose of the present paper is to provide guidance and inspiration on how to promote quality social services addressing the particular needs of people with disabilities. It is addressed in particular to actors active in the areas of social protection and social inclusion, including the Member States.

This paper is also to be considered in the context of the European Social Fund programming for 2007-2013, which includes a priority on reinforcing social inclusion of people at disadvantage, including people with disabilities. The considerations in this paper follow the principle of mainstreaming, which can be defined as the systematic consideration of the specific needs of people with disabilities when designing social inclusion and social protection policies.

I. Introduction

In April 2006 the Commission adopted a Communication on Social Services of General Interest (Communication from the European Commission "Implementing the Community Lisbon Programme: Social Services of General Interest in the European Union" COM(2006)177 final 26.04.2006). This communication is a follow-up to the White Paper on services of general interest, which announced a "systematic approach in order to identify and recognise the specific characteristics of social and health services of general interest and to clarify the framework in which they operate and can be modernised". It is a further step in taking the specific nature of social services into account at European level and clarifying, to the extent that they are covered, the Community rules applicable to them.

A specific reference is made in this Communication to the issue of the quality of these services (point 1.2.). Furthermore, the European Disability Action Plan 2006-2007 (Communication from the European Commission on the situation of disabled people in the enlarged European Union COM (2005) 604 final 28.11.2005) has established as a priority to promote access to quality support and care services, considering that: "promoting quality, affordable and accessible social services and support to disabled people through consolidated social protection and inclusion provisions will be at the core of EU mainstreaming actions... Quality aspects of disability-related social services will also be explored, including the need to promote coordinated delivery of services".

In this context, a thematic dialogue on SSGI to people with disabilities has been engaged by the Disability High Level Group with the view of reporting its findings to the Social Protection Committee, for further consideration. The Disability High Level Group has explored in particular how relevant quality aspects of disability-related social services can be taken into account including the need to coordinate the delivery of services.

In preparation of the present position paper, a questionnaire has been sent to all members of the Disability High Level Group to steer their discussion.

II. Action base

- Declaration 22 Annex to the Treaty of Amsterdam (Intergovernmental Conference): "The Conference agrees that, in drawing up measures under Article 100a of the Treaty establishing the European Community, the institutions of the Community shall take account of the needs of persons with a disability".

- The European Social Agenda 2005-2010: its last point deals with SSGI, emphasising the need of: "moving towards a clarification of the role and characteristics of social services of general interest... in order to contribute to their modernisation and quality, having regard to the various areas covered."

- Conclusion 34 of the Spring European Council 2006: "Increasing employment in Europe remains one of the top priorities for reform. Labour market reforms that have been undertaken in recent years are beginning to bear fruit. A key objective is to increase labour market participation, especially of the young, women, older workers, persons with disabilities and legal migrants and minorities. To achieve these objectives, work should be conducted in close cooperation with the social partners."

- The European disability strategy governance principle: Nothing about people with disabilities without people with disabilities

---

290 Composed of one representative per Member State of the European Union, the High Level Group monitors the latest policies and priorities of governments regarding disability in EU. With its information and experience, it advises the European Commission on methods for reporting in future on the EU-wide situation with regards to disability.

III. Common basic assumptions

The Disability High Level group supports the following basic assumptions which are set out in the Commission communication of April 2006 as they are particularly relevant with regards to SSGI to people with disabilities: "Social Services constitute a booming sector, in terms of both economic growth and job creation. They are also the subject of an intensive quest for quality and effectiveness. All the Member States have embarked upon modernisation of their social services to tackle the tensions between universality, quality and financial sustainability. Although social services are organised very differently in the Member States, certain general aspects of this modernisation process can be seen:

- The introduction of benchmarking methods, quality assurance, and the involvement of users in administration,
- Decentralisation of the organisation of these services to local or regional level,
- The outsourcing of public sector tasks to the private sector, with the public authorities becoming regulators, guardians of regulated competition and effective organisation at national, local or regional level,
- The development of public-private partnerships and use of other forms of funding to complement public funding”.

On top of this it should be noted that SSGI as described in the Commission Communication, but in particular Health Care Services, are very important for the well-being of the disabled people. Consequently ‘Health’ and ‘Disability’ strategies need to be coordinated, both at the EU and at Member States level. There is indeed a need for coordination among these types of services in order to deliver integrated and comprehensive solutions to people with disabilities.

IV. Key elements of quality of SSGI to people with disabilities.

4.1 Pre-conditions for quality:

A major pre-condition for quality of social services is access to these services. Access to social services by people with disabilities means that those services are affordable, available, and accessible.

Quality of services is not to be made dependent on organisation of services/nature of the provider (public body/NGO/commercial provider, for profit/not for profit). Quality of services should be a question combining choice of the individual user, availability/affordability of services with some basic quality guarantees.

4.2 Agreed basic principles:

Quality of social services to people with disabilities is a condition for people with disabilities to lead full and independent lives, to reach their full potential as individuals, to contribute to and participate in society.

- Natural observance of human rights and freedoms outlined in the EU Charter of Fundamental Rights - notably its article 26 which recognises as a fundamental right "the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community" - , the UN Convention on the rights of Persons with Disabilities and its optional protocol and other relevant documents
- All services to people with disabilities should be characterised by an individual perspective.
- Choice, freedom of choice, informed choice and self determination are vital.

When implementing fundamental rights of people with disabilities, basic principles for SSGI in the field of disability are:

When considering the issue of quality of social services to people with disabilities, it is necessary to combine security with flexibility, as well as to ensure compatibility among the competences of the Member States with the ones at European level as quality of social services also depends on traditions and diversity.

4.3 Agreed objectives of action at EU level with regards to quality of SSGI to people with disabilities:

- The increasing introduction of market elements in the social sector and the increased cross border services provision are calling for a quality framework at EU level, based on a total quality management approach starting from rights, values and principles.
- The European quality framework is to be implemented through national quality systems that can be compiled in various ways reflecting the diversity of the EU.
- Quality systems within the EU should stimulate and recognise continuous improvement so as to achieve ever increasing performance while being attainable by service providers in terms of efforts and costs.
- European quality systems should also enable service providers in countries where disability services are less developed yet to enter the system it and engage in a quality approach that take them to the appropriate level of quality.
Recommendation emerging by consensus is for work at EU level to focus on common features and criteria of quality which, then, could be declined at national level through quality systems according to national context and diversity of structures and respecting the subsidiary principle. Quality indicators are considered necessary to measure quality of services. They should be qualitative as well as quantitative, should measure inputs as well as outputs.

4.4 Actions at EU level to develop a quality framework:

- **Rights**: Choice, freedom of choice, self determination, non discrimination. Criteria: Systematic information of users, including on what the services and what are good services. Availability of accessible services. Accessible complaints mechanisms. Promotion of full awareness of human rights of people with disabilities, including training and education of providers, professionals, caregivers and authorities.

- **Person centred**: Social services of general interest to people with disabilities should tackle the needs of each individual with the aim to improve the quality of life and equality of opportunities of the persons concerned. In line with the social model of disability, the physical and social environment of the person served should be taken into account. Criteria: Conformance to the requirements and needs of the users. Use of personal budgets to compose the package of SSGI to be delivered to persons with disabilities. Proximity between the provider of service and the beneficiary.

- **Comprehensiveness and continuity**: The continuum of holistic services - from early interventions to support and follow up - involves multi-disciplinary actions and coordination. Furthermore, such a continuum is essential all along the life of persons with disabilities, therefore a life cycle approach is to be taken. The life cycle stages are: children with disabilities, people with disabilities of working age, older people with disabilities. Criteria: Seamless coordination among the centres or establishments providing services as well as when it comes to the benefits and financial aids available to those organisations. Pro-active reduction of barriers to access services.

- **Participation**: Users should be actively involved in the service team and engaged in self assessment and feedback. Criteria: Participation evidence based forms of planning and definition of services, as well as of quality review. Continuous measurement of degree of satisfaction of use. Definition of models for users’ programme review.

- **Partnership**: All potential partners, including employers, the local community, social partners, funding authorities, policy makers are to be involved alongside service providers. Criteria: Decentralisation of the organisation of services to local or regional level bringing the service providers closer to the service users.

- **Results oriented**: Quality is directly related to outcomes for the user, measuring satisfaction is crucial. Quality outcomes areas are to be identified by all stakeholders and used as reference to assess the success of the service in meeting individual needs. Criteria: Personal responsibility of every stakeholder. Records on outcomes. Regular independent assessment of systems and procedures. Flexibility and responsiveness to new challenges.

- **Good Governance**: openness, participation, transparency, efficiency and accountability are to be applied by all types of organisations delivering social services to people with disabilities.

4.6 Financial instruments:

The Council Regulation laying down general provisions on the European Structural Funds states in the second paragraph of the article 16 that: “The Member States and the Commission shall take appropriate steps to prevent any discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation during the various stages of implementation of the Funds and, in particular, in the access to them. In particular, accessibility for disabled persons shall be one of the criteria to be observed in defining operations co-financed by the Funds and to be taken into account during the various stages of implementation.” The European Social Fund could continue to support many projects concerned with the quality of services intended to foster social inclusion and integration through employment.

The new Programme for Employment and Social Solidarity: PROGRESS is a financial instrument that could in principle be used for the support of studies in relation to quality assessment of services including evaluation of the quality of existing services. In this respect, there is strong consensus on the need for a Commission’s study on best practices to identify cases where coordination in the delivery of services to people with disabilities has been successful. Cases where input was generated from users themselves should also be considered while taking into account the diversity of social services.

4.7 Specific aspects of quality to be further considered:

- **Externalisation/Modernisation**: It is an important aspect of modernisation of social services which can enable an efficient management through fair competition (German case to be elaborated on as good practice). In this respect, calls have been made for tender specifications to be based not only of costs but also on quality and sustainability aspects.
- The question of appropriate pensions given to disabled persons is at the centre of social services issues (point to be clarified in the discussions of the HLG).

**V. Conclusion**

- The Disability High Level Group highlights the particular disability relevance of the following issue which has been raised in the Commission Communication on Social Services of General Interest:

"Modernising social services is one of the most important issues facing Europe today; on the one hand, these services play a vital social cohesion role; on the other, their transformation and job-creation potential make them an integral part of the Lisbon Strategy. The conclusions of the European Council in March 2006 confirmed this, reiterating that the internal market for services must be made fully operational, while preserving the European Social Model."

- The Disability High Level Group draws attention to the likely impact that the development of European framework for quality of services relevant for people with disabilities could have in terms of competitiveness. The particular case of the "social economy" enterprises may be an easy entry point for applying quality criteria of SSGI as they are characterised by the importance of not-for-profit providers.

- The Disability High Level Group considers that any new Commission initiative in the area of SSGI area should take into account the key features raised in chapter IV of the present document: basic principles; common strategic considerations; objectives of action at EU level; actions at EU level to develop a quality framework; and of course, common quality criteria.

- Finally, the Disability High Level Group insists on the need to address the issue of the quality of the SSGI and their common quality criteria as an essential element of the European Model of SSGI in forthcoming Commission documents. In particular, the principle of involvement of people with disabilities “« Nothing about disabled people without disabled people » should be considered as one important quality element.


**2.2 Disability High Level Group Discussion Paper on disability mainstreaming in the new streamlined European social protection and inclusion processes (extract)**

**I. Introduction**

The EU Disability Strategy has dramatically changed over the past decade, and it has in many ways helped change the perception of people with disabilities – from them being passive recipients of compensation into them being active participants in the economy and society. Society itself has come to recognise their legitimate demands for equal rights and has realised that participation has a direct bearing on the inclusion of disabled people.

With respect to social recognition of disabled people’s rights and their full inclusion in many different spheres of life, the EU’s overall objective is to fight discrimination and promote participation of people with disabilities in the economy and in society. To achieve these objectives the Commission is developing a coherent and integrated approach which makes use of a mix of instruments, as outlined in its successive Communications on the Situation of People with Disabilities and the European Disability Action Plan, COM/2005/604 and COM/2003/650.

In this context, and as a follow-up to the Communication of the European Commission on the "Situation of disabled people in the enlarged European Union: the European Action Plan 2006-2007" [292], the Disability High Level Group decided to issue a discussion paper to provide guidance on disability mainstreaming in the field of social protection and social inclusion under the Open Method of Coordination (OMC). Therefore, the document will be submitted to the EU’s Social Protection Committee (SPC) to provide guidance on how to design more effective policies addressing the needs of people with disabilities.

**II. Disability mainstreaming in the context of social protection and social inclusion processes**

**II.1. Setting the scene**

In the context of social protection and social inclusion of disadvantaged people, mainstreaming means that the needs of disadvantaged people need to be taken into account in the design and implementation of all policies and measures, and that action for disadvantaged people is not limited to those policies and measures which specifically address their needs. As a consequence of this mainstreaming approach, the Commission’s policy guidelines address the issue of policies for disadvantaged groups in a broad sense, but do not spell out detailed policy proposals addressing the needs of the different groups of disadvantaged people. It is then up to the Member States to ensure that, when designing their national policies responding to Commission guidelines, these policies and the subsequent actions taken will be fully accessible to disadvantaged people. Disabled people

---


are at risk of poverty and social exclusion, but, also poverty and social exclusion, might lead to disability. When implementing the disability mainstreaming approach in the social protection and social inclusion processes, it is fundamental to do it at all stages of action, from early design and preparation to monitoring and evaluation. In this respect, greater emphasis is to be given to data and indicators describing the situation of disabled people so as to specify the impact of mainstreaming on people with disabilities.

II.2. Methodology for Mainstreaming Disability

These efforts would be greatly helped by stronger coordination between the preparation of the national reports on strategies for social protection and social inclusion and the multiannual Commission Communication on subsequent Disability Action Plans.

When considering the issue of how disability has been addressed in all three strands of inclusion, i.e. pensions, healthcare and long-term care, it is essential to assess how the European Social Fund is used and the role it plays, plus the impact of the non-discrimination and accessibility principles on national policies. In this context there is also a need to coordinate with European Regional Development Fund and the European Cohesion Fund.

Within the streamlined processes of the OMC it is equally essential that National Reports on strategies for social protection and social inclusion match with National Reform Programmes under the revised Lisbon Strategy. A link should also be maintained with Social Services of General Interest and the corresponding Communication of 2006. In its White Paper on Services of General Interest published in May 2004, the Commission announced a more systematic approach in the field of social and health services of general interest. The Commission also expressed its intention to adopt, by the end of 2007, a Communication on health and social services of general interest in order to identify the specific characteristics of health with relation to social services of general interest and clarify the framework in which they operate. Quality of disability-related aspects is already being explored by the Disability High Level Group, including the need to promote coordinated delivery of services.

Furthermore, the case for appropriate de-institutionalisation of disabled people placed in large residential institutions is being further investigated and supported. The Commission supports the promotion of social services and their appropriate quality level so as to provide a balance between security, freedom and independence.

Last but not least, when mainstreaming disability into social protection and social inclusion, the EU Charter of Fundamental Rights and the recently agreed UN Convention on the Rights of Persons with Disabilities must be taken into account.

In this context, the EU has endorsed and is promoting the ‘citizens’ concept of disability. This concept is to be understood in the sense that disabled people must have the same individual choices in, and control of, their everyday life as non-disabled people. That is to say, policy actions must be designed in such a way that the needs of people with disabilities and the services for these people are placed at the centre of the care and services delivery process.

It is important to note that the Amsterdam Treaty has specific provisions on gender that have a clear impact in the inclusion and mainstreaming of gender issues in European policies. A recent European Parliament resolution on the situation of women with disabilities in the EU calls on Member States to take full account of the needs of people with disabilities and the special needs of women.

III. The new guidelines for preparing National Reports on Strategies for Social Protection and Social Inclusion and their potential for disability mainstreaming

III.1. Strand on Eradicating poverty and social exclusion

This strand is of general relevance when reporting on the situation of disabled people. People with disabilities are among the social groups facing significant risk when trying to access services relating to employment, education, training, healthcare and social security. That is why there are still considerable challenges in these areas to continue fighting discrimination of disabled people, including intersectional and multiple discrimination (for example in the case of women with disabilities or elderly disabled people).

Additionally, policies and programmes targeting people with disabilities should reflect the social model of disability as reflected in the EU Charter of Fundamental Rights and the UN Convention on the Rights of Persons with Disabilities.

---


295 For further information about social services of general interest see: http://ec.europa.eu/employment_social/social_protection/questionnaire_en.htm

296 Article 2 and 3 of the Treaty

Improving implementation (addressing gaps)

Implementation gaps between what Member States have pledged to do and what has been successfully achieved were identified on an up-to-date basis in the assessment of the NAPs/Inclusion. Against this backdrop the most urgent national objectives covering disabled people need to be taken on board in subsequent national reports. Addressing these gaps is necessary in order to be consistent with the revised Lisbon Strategy and the European Disability Strategy.

Increasing strategic focus and multidimensional approach

Presentation of objectives by Member States should allow them to focus on strategic and key policy priorities. Since all Member States report that people with disabilities remain one of the most marginalised groups, especially when considering access to the mainstream labour market, having coherent policies and programmes to improve their situation and bearing in mind the multidimensional nature of social exclusion is essential. In particular the following issues are relevant for disabled people:

- overcoming discrimination, including multiple discrimination, and increasing integration of people with disabilities
- increasing their labour market participation
- tackling disadvantages in education, training and lifelong learning and poverty throughout the equal access to education and support and enhancing assistance to families and individuals
- enhancing assistance to families with disabled members
- ensuring decent housing and improving access to quality services that are accessible and affordable (health and care services, transport, lifelong learning, etc.)

The Commission Communication on consultation action at EU level to promote the active inclusion of the people furthest from the labour market pointed out that the risk of falling below the at-risk-of-poverty threshold is higher for unemployed persons, inactive persons, single parents, disabled people and the chronically ill.

An indeterminate number of people may thus suffer severe forms of social exclusion, such as homelessness, drug addiction, alcoholism, lack of access to basic healthcare and illiteracy, aggravated in certain cases by ethnic discrimination and/or living in areas of multiple disadvantages. In the EU-25 in 2003, there were approximately 31.7 million people – representing 8.5% of the population of working age (15–64) – who could be considered to be excluded from the labour market. This number includes both the long-term unemployed and inactive persons who either became discouraged after repeated past job-search failures or were willing to work but were not able to find a job, for a variety of reasons, including disability or chronic illness.

That is why, when developing more focused approaches, it is of utmost importance to develop and maintain a multi-dimensional approach to tackling poverty and social exclusion. This would, in particular, mean selecting key objectives and developing a set of actions, both on a multidimensional basis, which are in line with successive European Disability Action Plans. It also includes ensuring that the necessary arrangements are in place to mainstream social inclusion of people with disabilities into other relevant policies.

Reinforcing mainstreaming of disability

The NAPs/Inclusion should also reflect the general approach to disability in Member States and indicate how the disability strategy is integrated into relevant policy fields. A mainstreamed approach together with specific targeted actions may help to remove some of the barriers faced by disabled individuals and their families in entering mainstream society, and therefore support their re-entry into employment through active inclusion. This could include, in particular, counselling, healthcare, child-care, lifelong learning, Information and Communication Technologies (ICT) training for potential workers, taking advantage of new technologies, providing more flexible work arrangements, social rehabilitation, ability to vote, access to transport, information and communication and ICT and to financial services on daily basis. A new approach which looks at policies that favour the integration of young people with disabilities into the labour market would be a great challenge, especially in the light of a continuously shrinking working-age population and low birth rates which in the near future may have an impact on the European economy and its sustainability.

Increasing the labour market participation of disabled people contributes to securing and raising their quality of life. Therefore, Member States are invited to take into account the aid for employing disabled workers in the form of wage subsidies and for compensating additional expenses as proposed in the new Commission State Aid Regulation. Since such aid may have a significant impact on disabled people’s employment opportunities, the Commission encourages Member States to provide an assessment of its effectiveness.

\[
\]

\[
\text{Three operational and central objectives set in the framework action plan with the time horizon of 2010: achieving full application of the Equal Treatment in Employment and Occupation Directive (2000/78/EC), reinforcing mainstreaming of disability issues in relevant Community policies, and improving accessibility for all.}
\]

\[
\]
Strengthening governance

It is very important to involve Member States’ regional and local authorities, civil society, social partners and those representing the interests of people with disabilities in the preparation, implementation and monitoring of NAPs/Inclusion. This also means developing regional and local action plans and national disability action plans. In this respect, Member States could report on this dialogue with and the involvement of the different actors, social partners, NGOs and social service providers, other relevant stakeholders and disabled people. Finally, regional and local authorities and organisations of disabled people have a direct role to play in delivering their valuable contributions to streamlined reports on strategies for social inclusion and social protection. These authorities are the closest to the private sector, individual companies and social and supported enterprises which are potential employers of people with disabilities in mainstream employment.

The recent evaluation of the Open Method of Coordination process in social protection and social inclusion shows that the method was hampered by the limited extent to which disability NGOs were able to make significant input into the process. Within this context, the European Disability Forum (EDF) pointed out the difficulty that its national constituent organisations faced in finding out about and becoming involved in the process301.

Indicators

In order to be able to monitor the progress in implementing objectives and specific programmes it is necessary to specify the indicators to be used. Thus, commonly agreed indicators were developed to supplement national indicators (...).

The full text of the discussion paper can be read at:
http://ec.europa.eu/employment_social/index/good_practis_en.pdf

---

301 Commission staff working document. Evaluation of the Open Method of Coordination for social protection and social inclusion. A synthesis of replies by Member States and other actors to an evaluation questionnaire on the Open Method of Coordination in the fields of social inclusion and adequate and sustainable pensions. SEC(2006) 345 of 08.03.2006.
Annex 3

The group of regional experts in the field of social services for people with disabilities, in South East Europe

At regional level, a group of 25 expert practitioners in the field of social services for people with disabilities has been involved in a two-year program\(^{302}\) of capacity building and exchange of experiences (2007-2009), aiming at contributing to the increase of local expertise in various aspects related to social reforms, modern approaches in disability and social service provision, European trends and values, modernization of social services delivery at international level.

The members of the group are:

- Leaders of disabled people organizations, or of parents organizations, who initiated and manage currently social services of various types;
- Professionals - managers of innovative or pilot social services;
- Representatives of local or central authorities, involved actively in the reform of this sector and representing a strong ‘voice for change’ in their countries;
- University teachers, developing curricula for social workers or associated professions;

All participants at this programme are English speakers and they come from Albania, Bulgaria, Bosnia and Herzegovina, Croatia, Kosovo (under UNSCR 1244), FYR Macedonia, Moldova, Montenegro, Serbia and Romania. They are very well known leaders and professionals in their own countries, with significant experiences in management of social services, advocacy and lobby, policy making, social sciences, human rights and disability issues. The knowledge and new skills gained during these two-year program represents an added value to their previous expertise and recommends them as very important interlocutors for the social services reforms in their own countries, as well for the entire South East European region.

You are invited to address these regional experts for all aspects related to the evolutions of the social services reforms in the field of disability, in South East Europe.

**Albania:**

1. **Merita Vaso Xhumari** – Professor of Social Policy at the Faculty of Social Sciences in Tirana. PhD in Sociology - University of Tirana. Master in European Social Security - Katholic University of Leuven, Belgium. Chief of Social Policy & Research Unit in Social Insurance Institute of Albania. E-mail: mxhumari@icc-al.org
2. **Ingrid Trajani** – Director of the Day Care Centre “The Red House” (developmental centre for children and young adults with associated disabilities). Special Educator. Trainer, accredited by the Centre for the Defense of Children's Rights, Albania, E-mail: trajani@abissnet.com.al
3. **Merita Poni** – Director of the Association Handicap Interalb. Bachelor in Law. Bachelor in Social Work. Master degree in Social Sciences (Gender and Social Welfare).  Master Degree in Inclusive Education (UK). Teacher at the Faculty of Social Sciences in Tirana. E-mail: meritaponi@gmail.com

**Bulgaria:**

4. **Irina Papancheva** – President and Board Member of the Bulgarian Stuttering Association (SIZ). Former Deputy Mayor of Sofia Municipality for Health Care, Social Activities and Integration of People with Disabilities. Master in European Integration and Development - European Politics and Social Integration at Vrije Universiteit Brussel. Currently working in European Disability Forum, based in Brussels. E-mail: ipapancheva@gmail.com

**Bosnia and Herzegovina:**

5. **Esma Karajbic** – Program Coordinator at the Union of Associations for Persons with Intellectual Disability of Federation of BIH “SUMERO”, Sarajevo. E-mail: esma_karajbic@yahoo.com
6. **Aida Hakimi Osmanbegovic** – Paediatrician. Trainer in the field of International classifications in disability - Disability Creation Process (DCP) and WHO International Classification of Functioning, Disability and Health (ICF). Working experience in Western Balkans and Northern Africa. E-mail: aida_hakimi@hotmail.com

**Croatia:**

7. **Sanja Tarczaj** – President of DODIR, the Croatian Association of Deafblind Persons. Member in the board of the World Federation of Deafblind Persons. Teacher at the Faculty of Special Education. E-mail: sanjatarczaj@yahoo.com

---

\(^{302}\) The program was called “Social Services for Equal Opportunities in South East Europe” and has been co-organised by Handicap International and the European Association of Service Providers for Persons with Disabilities (EASPD), with the support of the French Ministry of Foreign Affairs. The program benefitted from the presence of European trainers and will end in 2009 with a certification process of regional experts in social services for people with disabilities.
8. Aleksandra Vuk – Program Coordinator and sign language interpreter, DODIR Croatia. Special educator. E-mail: yukaleksandra@yahoo.com
9. Bojana Bego – Economist, Master Degree in Local Development and working in the NGO/Civil Society sector in the Western Balkans for over 8 years. E-mail: bojana.bego@hi-see.org

Kosovo (under UNSCR 1244):
10. Halit Ferizi – President of Handikos; president of the coalition of DPOs 'Equal Opportunities' in Kosovo, co-chair of National Disability Council, advisory body for prime-minister and government. E-mail: hferizi@hotmail.com
11. Nexhat Shatri – Medical doctor. Advocacy trainer for the disability movement in South East Europe. Experience in community planning and mainstreaming disability in local policy. E-mail: nexhat.shatri@hi-see.org

FYR Macedonia:
13. Vasilka Dimoska - Graduated medical doctor. Specialization in social medicine and health management; training program for Manager/Director in the Public Health Care sector. Currently working as a Program manager in the Republic Centre for support of persons with intellectual disability-PORAKA. E-mail: vasilka1@hotmail.com
14. Vlado Krstovski – Program Assistant at PORAKA, Republic Centre for Support of Persons with Intellectual Disabilities from Macedonia. University degree in social work and social policy. E-mail: v.krstovski@hotmail.com
15. Lidija Krstevska Dojcinovska – President of Open the Windows, the first NGO promoting inclusive technologies for people with disabilities in Macedonia. Special education and rehabilitation professional. E-mail: lidija.krstevska@openhewindows.org
16. Afrim Iljazi – Physiotherapist. Degree in Professional Pedagogy, Master of Business and Administration (MBA) (New York College of Greece). Experience in community planning and mainstreaming disability in local policy. E-mail: afrim.iljazi@hi-see.org

Montenegro:
17. Svetlana Dujovic – President of the Association of Parents of children with disability “Sign of hope”, Pljevlja. President of board of directors of the Union of Parents Organizations of children and young people with disabilities "Our initiative". Teacher in secondary school. E-mail: zracaknade@cg.yu
18. Sonja Vasic – Medical doctor, specialized in physical medicine and rehabilitation. Twenty five years of experience in children's disability, (child neurology, prevention of risk at birth and early intervention). Post-graduate specializations in psychodynamic psychotherapies (Serbia), functional rehabilitation (Germany). Advocacy trainer for the disability movement in South East Europe. E-mail: sonja.vasic@hi-see.org

Republic of Moldova:
19. Lucia Gavrilita – Vice-minister, Ministry of Social Protection, Family and Child from Moldova. Ex-director of the Day Care Centre Speranta (Chisinau), the first innovative service for children with disabilities in Moldova. E-mail: luciagavrilita@gmail.com

Romania:
20. Laila Onu – Executive director of "Pentru Voi" Foundation, for people with intellectual disabilities, Timisoara. Master in management of social services (Romania). Social Worker post-graduate certification. Post-graduate certification in management of the organizations. Member of the Economic and Social Council of Romania. Associated professor at the West University Timisoara, Social Work Department. Experience in community services for people with intellectual disability: day centre, supported employment, supported housing, independent living, respite care, social enterprise. E-mail: laila.onu@pentruvoi.ro
21. Adrian Pintea, Executive manager of the Association Hans Spalinger and The Federation for Curative Education in Romania that implement and develop alternative methods of education and inclusion for the children in need of special care. Teacher in curative and special education. E-mail: apintea@gmail.com
22. Eva Gyorki – Psychologist, director of 'Alpha Transilvania’ Foundation from Tîrgu-Mures, a social service provider organisation. Alpha is offering a chain of services for disabled persons, from early intervention through day care and rehabilitation to vocational orientation and job coaching. Coordinator of the Resource Centre for NGOs. E-mail: evagyorki@yahoo.com
Serbia:

23. Vesna Petrovic – President of the Autism Society Serbia. E-mail: autismpr@eunet.yu

24. Valentina Zavisic – President of Initiative for inclusion VelikiMali. Experience in direct support to children with disabilities and their families, local support services, public awareness campaigns and advocacy activities. E-mail: valentina.zavisic@gmail.com

25. Zoltan Mihok – Coordinator of the HIV/AIDS program of handicap International in South East Europe. 10 years experience in the NGO sector (minorities programs, executive director of “Youth of JAZAS Kosovo” - HIV/AIDS and substance abuse prevention). E-mail: zoltan.mihok@hi-see.org