Under the request of UNICEF Moldova

Assessment and Recommendation on Child Disability Prevention and Care System in Moldova

Alfredas Zabieta
Chisinau, 2009
Abstract

Children with disabilities and their families in Moldova constantly experience barriers of inclusion in the society and the enjoyment of their basic human rights. As the other Post Soviet countries, Moldova experienced a difficult transition period, which brought people together and enforced them to fight for their fundamental rights and a better life. In the past two decades, not only the attitude but also the mindset of people has changed towards people with disabilities and their role in the society. Therefore various small local groups have joined forces to create regional or national non-governmental organizations that lobby for reform, changes in legislation and develop different programs of health assistance, inclusive education and social care.

The Assessment and Recommendation on Child Disability Prevention and Care System in Moldova report attempts to provide an integrated perspective based on the aspects of early intervention, inclusive education and child rights protection of children with disabilities in Moldova. This Report is based on a wide range of different sources. These include accounts? by persons with disabilities, their families and members of their communities, professionals, volunteers and non-governmental organizations, representatives of the Government, as well as country reports submitted by the Open Society Institute, UNICEF, UNESCO, including to human rights treaty bodies responsible for monitoring the implementation of international human rights treaties. All findings of the report consequent from the human rights approach to disability, which is focused from a child’s limitations arising from impairments, to the barriers within society that prevent the child from having access to basic health, educational and social services, developing to the fullest potential and from enjoying her or his rights.

Finally, this report should help answer the questions how and in what way those barriers to the participation of children with disabilities as full members of their communities should fall.
Acknowledgement

The assessment and recommendation on Child Disability Prevention and Care System in Moldova was commissioned by the UNICEF Moldova. Many people contributed with their knowledge and good will to prepare this report. I would like to express my appreciation of the time taken by all the beneficiaries I had discussions with.

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In the final phase of this report a tremendous contribution was comments, recommendations and suggestions from many respectful people working in various organizations, interested to improvement of situation of children with disabilities in Moldova. Special thanks to Ms. Åsa Olsson, Child Protection Officer UNICEF Moldova, Mr. Vasile Cusca, director of Social Protection Department at the Ministry of Labour, Social Protection and Family, and Dr. Ivan Puiu, head of NGO “Voinicel”, whose comments and remarks were very valuable to make this Report better in regard of both, structure and content.

I would like to thank all the persons I met and interviewed for their time, and input to this report. I believe that their input to this report has been crucial and that the enthusiasm they all showed during my workshops and discussions with them will continue in the interest of the development of early intervention, inclusive education and social protection areas in Moldova.

I finally thank UNICEF Moldova for having given me this opportunity to contribute to this very important assignment - Assessment and Recommendation on Child Disability Prevention and Care System in Moldova. Alfredas Zabieta, Evaluator, Social Development Expert
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Abbreviations

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<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>CEE</td>
<td>Central and Eastern Europe</td>
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<td>CIS</td>
<td>Commonwealth of Independent States</td>
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<td>CPA</td>
<td>Central Public Administration</td>
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<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<td>EAQS</td>
<td>Equitable Access to Quality Services</td>
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<td>EI</td>
<td>Early Intervention</td>
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<td>FTA</td>
<td>Foreign Technical Assistance</td>
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<td>ICD</td>
<td>International Classification of Diseases</td>
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<td>IE</td>
<td>Inclusive Education</td>
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<td>IES</td>
<td>Institute of Education Science</td>
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<td>LPA</td>
<td>Local Public Administration</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MCB</td>
<td>Medico Consultative Board</td>
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<td>MDL</td>
<td>Local Currency, Moldavian Leu</td>
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<td>MLSPF</td>
<td>Ministry of Labour Social Protection and Family</td>
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<td>MoE</td>
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<td>MPPC</td>
<td>Medico-Psycho-Pedagogical Commission</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>Open Society Institute</td>
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<td>UN</td>
<td>United Nation</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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Executive summary

Child disability prevention and care are important areas at both policy and professional levels. It relates to the right of children and their families to receive the support they are entitled to and might need. The aim of Early Interventions (EI), Inclusive Education (IE) and Social Care is to support and empower the child, the family and the services involved. It helps to build an inclusive and cohesive society that is aware of the rights of children and their families.

The Assessment and Recommendation on Child Disability Prevention and Care System in Moldova analyse the real situation of children with disabilities in Early Intervention, Inclusive Education and Social Protection sectors. This report brings out the following findings:

1. The existing EI policy measures do not ensure that EI reaches all children and families in need as early as possible. Partly this problem is solved by the National Centre of Mother and Child which provide EI services during prenatal and postnatal period and provide follow up services to about 1000 children from all over the country. The fact that the Centre is situated in Chisinau, many parents do not access the centre and those who do might not be able to come back to Chisinau for additional examination and follow up services. Family Doctors Centres are not EI services and Family Doctors are not always able to detect at time the disability or risk of disability. Therefore the availability of EI services for residents living in districts (especially remote ones) becomes a problem.

2. The existing IE policy measures do not ensure that IE reaches all children according to their place of residency. Practice shows that only 2.7% of approximately 12 800 children with disabilities of age seven to 18 years old are using IE services. Furthermore, 68% of these children are placed in residential educational institutions, so that they are physically and socially excluded from families and community.

3. The existing social services policy measures do not ensure that social services reach all children and families in need, according to their place of residency. There is only 30 Day Care Centres for children with disabilities established in the country. Moreover, seven districts do not have any services provider at all; approximately 1 800 children with disabilities lives there. Policy measures do not support and are not able to ensure the coordination of education, social and health services at central, regional and local levels.

4. There is lack of professional capacities in medical staff which are involved in EI detection, therapies, and prevention. Doctors are applying outdated methodologies of detection, so that usually the problems of detection of neurological and psychical disorders occur. This problem is most relevant to the doctors working in remote districts.

5. The physical environment of schools does not fit the needs of children with disabilities. The lack of professionals involved in IE and the shortage of training methodologies and tools, make schools not acceptable (and not available at the same) for children with disabilities and their families. This kind of situation implies parents’ decision to choose residential institution instead of IE institution.

6. Availability of information is a major problem. Information about EI services/provision should be extensive, timely, clear and precise and disseminated at local, regional and national levels to families and professionals of all services.

7. There is no monitoring and evaluation framework and structures in Moldova, which fit international community agreed concepts and standards. Monitoring and evaluation have a strategic role to play in informing policy making processes and aims to improve relevance, efficiency and effectiveness of policy reforms.

8. Institutions situated in Chisinau, Balti, Ciadur Lunga, Criuveni and some other districts provide high quality services, due to the professional staff, up-to-date technologies and use of international standards.
9. Despite some non-systematic difficulties, there are some NGOs (in all three sectors, health, education and social services) which are functioning in a high professional level and share practice of multidisciplinary work with family as well as other conceptually important methods for all country.

10. Taking in to account that EI provision and services should be available as close as possible (in the meaning of distance) to the families and should be focused to family: all three types of services (health, education, social protection) are being provided only in Chisinau, Balti and Criulen.

11. Current situation does not ensure same quality of service for people due to the geographical differences (e.g. scattered, rural or remote areas).

12. In general, both, EI and IE provision and services are not reach by all families and young children in need of support, due to different socio-economical backgrounds and unequal access to the information. However, all services and provision are cost free for the families. Despite the fact that sometimes those services are not at the best quality, public funds still cover all costs related to EI and IE through public services, insurance companies, non-profit organizations, etc.

13. EI and IE services/provided by NGOs such as VOINCEL, SPERANTA (Criulen and Chisinau), ASCODE involve professionals from various disciplines and different backgrounds. Co-operation with families as the main partners of the professionals is ensured, taking into account that: (1) Professionals initiate co-operation and have an open and respectful attitude towards the family, in order to understand their needs and expectations and avoid any conflict arising from different perspectives on needs and priorities, without imposing their point of view; (2) Professionals organise meetings in order to discuss the different points of view with parents and together set up an agreed written document, called an Individual Plan or so.

14. According to the activities of NGOs mentioned above could be stated that the team building approach exists. Despite their different backgrounds, corresponding to their disciplines, EI teams/professionals work in an inter-disciplinary way before and whilst carrying out the agreed tasks.

15. Inadequate co-ordination of health, education and social services sectors implies that these services are not involved in the process of early detection. So that, sometimes gaps or significant delays occur that affects (a) further intervention and (b) waiting lists (in a sense of overloaded services or teams). Furthermore, inadequate co-ordination of provision implies that services do not ensure continuity of the required support when children are moving from one institution to another. Families and children should be fully involved and supported.

16. The setting of preschools usually does not ensure a free place for child coming from EI services/provision because of insufficient number (only 33 all over the country) of such type institutions with inclusive education services.

17. Early Intervention and Inclusive Education policy-makers dis-communicate and this results in lack of discussions and common researches in this field. It should be taken into account that EI and IE policies are the common responsibility of families, professionals and policy-makers at local, regional and national levels. This report gives recommendations for each sector (Early Intervention, Inclusive Education and Social Protection) and an Action plan which clearly describes what and how it should be done to improve the current situation. Particular changes in the situation in all of these three sectors depends on the development of legal framework, establishment of necessary institutions network, staff trainings and creation of monitoring and evaluation system both, at national and sectoral levels. The core aspect of recommendations is that child disability prevention and care system should be made as close as possible to the client and fit the needs of children with disabilities and their families.
1. Introduction

Recent administrative and economic reforms in Moldova evidently transformed social policy. Experience shows that currently Moldova is under way of intensive search for innovations in their implementation. Various non residential community based social services are being set up, new methodologies of services provision are being developed and proposed and essentially new ideologies and holistic approach for disability evaluation as determination of work capability and for professional rehabilitation of the persons with disabilities are under discussion.

Over the recent years, the Government of Moldova has demonstrated reasonable activeness in seeking changes in the area of integration of persons with disabilities– the most vulnerable group of the society. The situation of children with disabilities could be evaluated in two different ways. First, the Government’s achievements in early intervention should be unambiguously admitted and evaluated internationally; second way is to evaluate the achievements of NGOs introducing inclusive education programmes which fit the needs of the community and especially the needs of children with disabilities and their families. There are community based social services programmes functioning in some Local Public Administrations which help to continue the development of children self-dependent skills, as well as it gives an opportunity for family members to participate in social life and to enter the labor market.

However, Moldova still does not have a unified policy regarding persons with disabilities, including children. There is only limited information on child disability at the national level, because usually data is not aggregated; there is not enough available information on discrimination against children with disabilities, as well as on disability prevention, early detection and intervention. The aspect of children with disabilities inclusion to the education system is more an exception rather than ordinary practice. Not enough attention is paid to this and many other violations of the rights of children with disabilities. It is because of weak administrative capacities and human resources in the sector of children rights protection.

1.1 Main goal and structure of the report

The goal of this report is to present the results of the assessment of child disability situation and to recommend the strategies and mechanisms to address the issues of child disability prevention, early detection and intervention as well as prevention of discrimination and exclusion.

The assessment covers the fields which are significant to children with disabilities from birth (or even before) until they become 18 years old. Health protection is one of the most important things of child proper development and his/her further integration to self-dependent social life. Therefore, firstly the situation should be analysed in the aspects of early detection, intervention and prevention.

The next phase of the analysis is dedicated to the public environment which should ensure not only the prevention but also intervention mechanisms fighting against discrimination and exclusion. The components of that environment are education and social security (social benefits, privileges, community social services). Also, during this phase of the analysis attention is paid to the situation of child rights protection and how they are being ensured for children with disabilities, especially regarding the right to be provided with on-time and high quality medical services, the right to attend school according to the place of residence and the right to be provided with social support.

Finally, the report ends with the conclusions and recommendations, where the information is delivered throughout the following aspects: availability, proximity, affordability, interdisciplinary and diversity.

1.2 Key issues addressed

In the frame of social care system (including institutional and human capacities) is dominating basically only stagnant approaches? to persons with disabilities as members of the society, to the determination of the disability, to the education of persons with disabilities and to the assessment of the disability.
This should be emphasised especially when the situation of children with disabilities is being analysed. It is important not only to state the fact or define the situation, but also to try explain and to go deeper into the problem in the wider context of relationship within the society and existing stereotypes.

It is necessary to analyse the main law regulating the situation of persons with disabilities – The Law on social protection of persons with disabilities which was approved by the Parliament of the Republic of Moldova on 24 December 1991 and its influence on persons with disabilities in the frame of recent 18 years. This law is important for all system of social protection and especially for the persons with disabilities, because it is a framework-law which indicates the definition of and social protection of persons with disabilities. It also ensures the persons with disabilities rights to services of social infrastructure, labour, social assistance, as well as promotes the creation of associations and unions protecting the rights of persons with disability.

Thus, according to this Law, a Invalid is a person «that, due to the limitation of vital activity as a result of physical or mental deficiencies, requires social assistance and protection ». On the other hand, in the Convention on the Rights of Persons with Disabilities (2007) is stated, that persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Comparing these two definitions, the attention should be drawn to the fact that the definitions in the legal framework are outdated. 1) The term “invalid” should be replaced with “person with disabilities”. The term “disability” means, with respect to an individual: (a) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (b) a record of such an impairment; or (c) being regarded as having such impairment; 2) The person is not limited itself, but he/she is being affected of the existence of unnatural barriers of the environment; 3) The term of “physical or mental deficiencies” should be replaced with “physical, mental, intellectual or sensory impairments”; because of respect for inherent dignity and respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; 4) The persons with disabilities do not require social assistance and protection (not more and not less than other social vulnerable people). They require only for equality of opportunity accessibility to social life;

The law on social protection of person with disabilities stipulates central and local state bodies to create necessary conditions for free accessibility of persons with disabilities to blocks of flats, public and industrial buildings and constructions, accessibility of public transport, transport communications, telecommunications and information.

The law stipulates the rights of persons with disabilities to medical, professional and social rehabilitation according to the Individual Rehabilitation Programme which is based on medical-social expertise.

The law also regulates free qualified medical assistance covered by the state budget in all state medical institutions. At the same time, persons with disabilities who are in need of permanent assistance are being provided with the care in residential institutions with rehabilitation facilities. Those persons with disabilities who are the residents of the Republic of Moldova have the right to be provided with prosthetic and orthopaedic appliances, special locomotion means, phonon amplifiers and signalling devices, individual devices and equipment for free or under advantageous conditions.

This law also guarantees the right to education in pre-school and comprehensive school-type institutions for persons with disabilities. Therefore all necessary conditions for their education should be created (access ways to the institutions, entrances, special benches, etc.). In case of health conditions of persons with disabilities do not allow them to attend the comprehensive educational institutions, they may study in special institutions or they may benefit by home education, at the parents’ choice.

In addition, persons with disabilities, have preferential rights to attend specialized secondary and higher education institutions. In case they are matriculated, they are entitled to additional scholarships alongside the pensions or disability allocations.
Moreover, the law also guarantees *the right of the persons with disabilities to work within enterprises under the normal conditions or in special sections for persons with disabilities* or to undertake individual work. According to the legislation, in case the working capacity was lost during the work, the same enterprise must employ the person providing all working conditions. If this is not possible, then the employment agencies are obliged to do it.

Most of the rights of persons with disabilities have a declarative character and are not applied at all. There is no monitoring mechanism of exercising the rights of persons with disabilities to education, free health care, information, labour, culture life, etc. Persons with disabilities are still excluded from social life. Thus, although the Law on social protection of persons with disabilities guarantees free access to apartments, public and industrial buildings and the areas and obliges engineering companies to plan facilities fitting the needs of persons with disabilities, so far most of the buildings are constructed without mentioned facilities. Limited physical access to kindergartens, schools and universities minimize the possibilities of the persons with disabilities to study and violates their right to education. Until present, the Republic of Moldova has not had coherent social policy on integration of persons with disabilities in the labour market or on provision of professional training and professional orientation services.

Medical, social, and psychological rehabilitation of persons with disabilities have an increased importance both, for the person and the country. Unfortunately, the Republic of Moldova lacks social services for rehabilitation of the persons with disabilities, as well as the legislation that would encourage the creation of such services and would motivate persons with disabilities to participate in the rehabilitation process. The consequences of this fact cause significant psychological and moral damages for the persons who become disabled. These persons frequently perceive disability as something for the rest of their lives and they are placed in a passive position without undertaking any recovery actions.

It is important to highlight a significant change in the approach to the ‘problem’ of disability. Historically, disability has been perceived through the so-called Medical Model, which basically sees the persons with disabilities as the problem, and tries to adapt him/her to fit into the world as it is. As a result of curing or managing the illness or disability, it revolves around identifying the illness or disability, understanding it and learning to control and alter its course. Therefore, the response to the disability has been mainly as one of the ways of social compensation through charity and the development of specialists caring services outside the society. However necessary and well intentioned they might be, such responses have compounded the problem of exclusion and under-participation.

In the past two to three decades, this traditional approach has slowly started giving the way to the Social Model of disability, which proposes that barriers, prejudice and exclusion by the society (purposely or inadvertently) are the ultimate factors defining who is disabled and who is not in a particular society. Many, more recent measures have thus placed stronger emphasis on identifying and removing the various barriers to equal opportunities and full participation in all aspects of life. The lobbying of NGOs representing persons with disabilities in several cases has led to changes in governments’ social care policy to one of civil rights which can empower persons with disability to live an independent life. The new approach is already being implemented in many countries, albeit in very different ways and at different speeds.

Similar regulations functioning in some European countries exclusively defines the sectors typical only for people with disabilities, for example: (a) social integration system of persons with disabilities and its assumptions and conditions; (b) institutions/organizations implementing persons with disabilities social integration; (c) regulations determining the level of disability and level of working capability and (d) possibilities of professional rehabilitation and issues related with it. Other issues such as education, employment, environment and etc. should be integrated into particular laws regulating particular issue. These key issues illustrate the fact that the attitude of both, Government and society, to the persons with disabilities are not corresponding to the nowadays concepts of understanding and acceptance of disability. This is obvious not only for experts, but also for persons with disabilities and for NGOs representing them. However, currently there are no changes. The same situation is with children with disabilities; therefore, it is
very important to go deeply into the problem and to recommend adequate decisions, which will deal not only with the consequences (exclusion/discrimination) but also with the preconditions.

2. Methodology of the assessment

The approach of the assessment is based on these main factors: (1) Availability, in order to assess if EI reaches all children and families in need as early as possible; (2) Proximity, in order to assess decentralization of services/provision, EI services and/or provision if it is located as close as possible to the families in order to facilitate better knowledge of the conditions of the families’ social environment; (3) Affordability, in order to assess if EI provision and services reach all families and young children in need of support, despite their different socio-economical backgrounds, it is necessary to ensure that cost free services/provision is made available for the families; (4) Interdisciplinary, in order to assess how early childhood services/provision involves professionals from various disciplines and different backgrounds in order to ensure quality teamwork; how Co-operation with families (as the main partners of the professionals) is developed, this co-operation should be ensured, taking into account that: professionals have to initiate co-operation and have an open and respectful attitude towards the family, in order to understand their needs and expectations and avoid any conflict arising from different perspectives on needs and priorities; (5) Diversity, in order to assess the co-ordination of sectors and if services provision is adequate: the variety of sectors involved should guarantee the fulfilment of aims of all prevention levels through adequate and co-ordinate operational measures. This implies that health, education and social services should be involved in early detection and referral in order to avoid gaps or significant delays that might affect further intervention as well as waiting lists in the case of overloaded services or teams).\(^1\)

The assessment and the elaboration of recommendations were done in three main phases: (1) Desk phase, (2) Field phase and (3) Synthesis phase.

**Desk phase** (21.09.2009-25.09.2009). During this phase the relevant programming documents were reviewed and the following tasks accomplished: the expectations regarding the meetings in Field phase were delivered; the structure of the report elaborated; intervention logic of upcoming activities elaborated; the questions of evaluation elaborated; the methodology and evaluations tools developed; provisional indicators and their verification means identified; work plan for the finalization of the second phase proposed; final time schedule confirmed; relevant documents systematically reviewed and the Head of the Programme EAQS (UNICEF Moldova) and Programme Assistant interviewed.

**Field phase** (28.09.2009-09.10.2009). During this phase the following tasks were accomplished: detail work plan with an indicative list of people to be interviewed, surveys to be undertaken, dates of visits, itinerary, and name of team members in charge were submitted; adequate contact ensured, during the consultation with, and involvement of, the different stakeholders; the most reliable and appropriate sources of information used to harmonize data from different sources; all field works at the end of the phase summarized; the reliability and coverage of data collection discussed, and preliminary findings and Power Point Presentation presented for the representatives of UNICEF. Besides that, two roundtable discussions were organized. During the first round table, the representatives of NGO “Humanities” (organization which takes support for families with children with disabilities) were invited. Second round table was organized inviting all key stakeholders in the field of Early Intervention: representatives of two Ministries (Health and Labour, Social Protection and Family), NGOs, Rehabilitation Centres and local experts.

**Synthesis phase** (12.10.2009-02.11.2009). During this phase the final report was elaborated in close collaboration with UNICEF Moldova, taking into account all comments, recommendation and suggestions. The specific types of assessment, sources of information and data collection methods, interviews and observations were made. After the field phase an analysis of services providers and mapping of three main sectors: early intervention, inclusive education and community based social services provision, in the entire country was conducted. These sources of information were used as background for the reflection of the situation and the elaboration of recommendations trough the integrative approach. Another important part of

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\(^1\) Early Childhood Intervention Analysis of Situation in Europe. Key Aspects and Recommendations. Europen Agency for Special Needs Education, 2005
the phase was the interview with UN Children Rights Protection Committee member Dr. Dainius Puras (Child Psychiatrist, the main author of UN documents, related to the rights of children with mental disability. During this phase the recommendations were elaborated. Recommendations are sorted out according to five aspects described above and according to three sectors (for each separately) – Health, Education and Social Protection.

Sources of Information and Data Collection Methods. Three types of data collection methods were used for triangulation of data. More specifically, data was collected through the review of documents, interviews (focus group, face-to-face) and by observation: Interviews. Information was collected from key persons associated with early intervention and social inclusion. This was in the form of interviews/discussions using prepared questions, which covered the range of information needed for each of the main analytical points indicated in the ToRs. The interviews sought to obtain factual information as well as the perceptions and experiences of the various individuals interviewed. Document review. Substantial information regarding the legal framework of the system, monitoring and management were obtained from several basic documents influencing policies regarding children with disabilities and their families. Observations. During the data collection phase (i.e. interviews, field visit and discussions) the observations were made in order to formulate objective views. Special attention was paid to cases such as the institutional network, level of professional capacity of practitioners, management aspects of the system, data bases, correspondence of national legal framework to international juridical documents (especially from UN law system). Field visits. The evaluator visited two institutions: Straseni Special School Internat and Inclusive School “Pro Success” in Chisinau. After the site visits the all the information were analysed and the main findings of the assessment study were identified.

3. Prevention, early detection and intervention

3.1 Conceptual framework

A brief conceptual excursus? is needed since the term early intervention is often understood differently, depending on specialization: social specialists, practitioners, medics, educators and decision-makers (representatives of Ministries and parents associations), etc. Moreover, the excursus is very important in perceiving and recognizing the conceptual background or the approach which is the base of recommendations.

Most of international documents published in the past 20-30 years, related to concepts, principles and methods of EI, show consecutive evolution of the ideas and theories. Different authors’ inputs from various theoretical perspectives have contributed to the evolution of concepts and, consequently, practice. Their contributions are twofold: 1. They have developed a new concept of EI, in which health, education and social sciences, particularly psychology, were directly involved. This corresponded to a new situation; as in the past these sectors had relatively different and not always inter-related impact; 2. They have highlighted the progression of change from intervention mainly focused on the child to an increasingly broad approach, where the focus was no longer solely placed on the child, but also on the family and the community (Peterander et al, 1999; Blackman, 2003).

Recently the predominant definition of Early Intervention in Europe is2:

EI compose of services/provision for very young children and their families, provided at their request at a certain time in a child’s life, covering any action undertaken when a child needs special support to:
• ensure and enhance her/his personal development,
• strengthen the family‟s own competences, and
• promote the social inclusion of the family and the child.

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These actions are to be provided in the child’s natural setting, preferably at a local level, with a family-oriented and multidimensional teamwork approach.

3.2 Facts about early intervention

**Legal framework.** Several strategies, plans and conceptions are elaborated and adopted in the sphere that was assessed. Moreover, some regulations regarding EI for children with disabilities or for children with a disability risk could be found in the normative acts regarding the status of persons with disabilities. However, there are no separate normative document (at the State level) for children with disabilities which could be integrated through holistic approach involving all needed mechanisms and procedures, professional competences oriented not only to child but also to professionals, family and community as well.

**Institutional framework.** Most existing institutions and organizations are quite well developed: they have all necessary diagnostic and therapeutic equipment, provide high quality specialists’ services and adopt methods and approaches which correspond to the international standards. However, the weakness is that most of these institutions and organizations are concentrated in Chisinau (or with some exceptions in Balti and Ceadir Lunga), so that the services are hard to be accessed for the residents of province. If this situation is considered in the frame of “make the service closer to client”, then even the minimal scope of EI services have to be provided at the local level (e.g. Centres of Family Doctors), in some cases even in primaria level. Moreover, with an exception of Follow Up services and some NGOs, EI services are not provided for children in age of 0 to 3 years. The existing institutional framework weakly coordinates it’s functioning, because of lack of valuable database which users would be the members of inter-institutional network.

**Statistics.** In recent years, the number of children (under 18 y. o.) with determined disability has nearly not changed. In 2008 there were 15 313 children with disabilities. Twenty three percent of them are children who are 0 to 6 y. o., what is approximately 3500. Forty seven percent of them are children with the first level disability (severe disability); 44% of them are children with the second level disability (medium disability); and only 9% of them are with the third level disability (light disability). However, these numbers do not reflect the real situation, due to the fact that Medical Consultative Board (MCB), which determines the level of disability in Family Doctor Centres located in each district, is using medical and not the social model of disability determination. Therefore, many cases related to light intellectual development disorders are not being registered.

3.3. Child disability detection - tools and methodologies

There are only two main options to determine the disability or factor of disability risk: (a) before the birth and after the birth and (b) in the period under 6 years old (in some cases even after) by the family doctor. Both options will be analysed separately (see below) as well as the mechanism of determination of the disability level will be analysed (it relies on the specifics of diagnostics). Current system of Early Intervention is set out in Annex 2.

The National Centre for Mother and Child Care offers services of EI to about 1000 children from all over the country. This institution offers services of detection of the disease and medical treatment of it, including recovery and rehabilitation services through their Follow up Centre (3 diagnostic rooms and one consulting room). The centre has modern equipment for diagnostic and offers multidimensional evaluation services. Bayley Neuro Development Screening and PSEED III – Bayley Scheels of Infant and Tolerant Development screening methods are used to evaluate the risks of premature babies.

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3 The situation of the children in Moldova in 2008, National Bureau of Statistics, Nr. 02-11/68 din 29.05.2009
The Bayley Neuro Development Screening is used to evaluate the risk during the development of a child. Children with high risk are called by staff centre after three months for examination; those with moderate or low risk are asked to come after six, 12, 18 and 24 months.

One of the main challenges the specialists of the centre face is the attendance of children. Only 70% of the children are brought to the repeated examination and only 30% of the parents follow the instructions of treatment with their children at home. In order to convince the parents to come to the repeated examination, medical personnel appeal to managers of the Centres of Family Doctors or vice-managers responsible for Mother and Child Health Protection, and they in turn, request family doctors to insist mothers to bring the child to the repeated examination.

The Follow up Centre has a fully functioning database, which not only registers the cases, but also performs case management function. It supports the specialists working with mothers and children. This database could be developed to connect the centre with the other four NGO’s which are functioning as EI centres for children of age 0 to 3.

Within the Centres of Family Doctors, specialists and family doctors offer services of examination, diagnosis, medical treatment and consultancy to children with disabilities and their parents.

In the Needs Assessment Report for the Development of a National Early Intervention System for Children with Disabilities in Moldova (issued by Open Society Mental Health Initiative in 2008) it was pointed out that it is necessary to develop district level recovery centres which should be accessible for more children to fit the demand, while as for now the demand is far greater than the supply.

Early Intervention practitioners highlight that in some cases the diagnosis for new born children is not set at time, because the malformations occur when the child is born but cannot be detected because of lack of medical equipment. Certain development problems are detected later because parents do not notice the health problems that their child has, or they do not contact their family doctor instantly after the detection. In addition, there is a lack of medical personnel in the state medical institutions (family doctors, paediatric-consultants, neuro-paediatricians, neonatologists, masseur nurses, kinesis-therapists, speech therapists, etc.). That could be contributed to the improvement of medical services offered to children, including children with disabilities from 0-6 years old. Another issue that family doctors permanently needs more training. Moreover, they should be involved in the capacity building system in general, which would include new (and time to time updated) methodologies and indicators for early detection based on International Classification of Diseases (ICD).

A very important issue related to early detection is the determination of the disability degree for children with disabilities by Medico Consultative Board at the Centres of Family Doctors. The MCB thoroughly examines the child and determines the severity degree of infirmity. However, the medical model of determination the level of disability is outdated. Therefore the evaluation team should involve such specialists as social workers and special pedagogues; they are necessary to ensure the set up and functioning of medico-social model.

European practices shows that beside the disability determination, the social status of the family should be evaluated as well. It is important to decide which package of social services should be provided according to the special needs of the child (and the family). These recommendations are obligatory for social services providers at LPA level. In this case the child and the family automatically enter the system of social protection which provides; not only social benefits, but also community based social services. Such practice is envisaged in the new Strategy regarding social inclusion of persons with disabilities in the Republic of Moldova, (2009-2012) (not approved by the Government yet).

3.4 Early intervention through a national perspective

State Early Intervention services (medical, social and educational) are being provided to children 0-6 with disabilities and at high risk, but only in the municipalities of Chisinau and Balti, as well as in Criuleni
district. There are approximately 200-300 children 0-3 years old and approximately 670-720 children of 4-6 years old who benefit from recovery services in the institutions of the Ministry of Health. The NGO sector includes in its system about 230 children 0-3 years old and 450 of 4-6 years old\(^4\).

These institutions deliver the following services: (1) medical and psychological consultations and support; (2) multidisciplinary assessment of physical, cognitive, communicational, social, emotional and adaptive developmental level of the child with special needs; (3) elaboration of individual rehabilitation programmes; (4) promotion of children’s functional performances, using individual courses of physical, occupational and speech therapies; (5) reframing of family’s understanding of EI strategies by information support and sharing the experience through the trainings, round-table discussions and seminars; (6) publishing informational leaflets, booklets and books.

MoH is responsible for the accreditation of NGO’s providing EI services. The department of Mother and Child Health could do the monitoring of quality, EI policy evaluation and planning functions. In this case, Ministry could become as the administrator of united database which connects all EI services providers.

Due to the involvement of NGOs, the vacuum of EI services is being filled, but only in Chisinau and some other municipalities. However, their activities could be more coordinated and efficient. Much better results could be achieved if NGOs would (a) divide between themselves the activities according to third specialization or severity level of the disability; (b) collaborate in preparation of unified methodologies for the determination of the disability and intervention therapy; (c) collaborate in organizing joint trainings or even (d) in publishing, etc.

Currently, there are only three Rehabilitation Centres functioning in the country. Two of them are only working with children age 3 - 18 years old and only the Centre in Chisinau works with children 0 - 18 years old. In the future, the Chisinau Rehabilitation Centre could develop into a research centre for creation of new methodologies, their development and adoption, as well as a training centre for high quality specialists and also maintaining its current practice. There are no EI services providers at the district (or local) level. This is especially important and relevant for the districts which are far away from Chisinau or other regional centres. According to the information gathered during the meetings and round-table discussions, there is a high need and demand to organize professional development trainings for family doctors and other specialists who are involved in EI activities. The practitioners of EI would like to get acquainted with standard methodologies which are applied in European Union countries. They also lack information about the newest methods of work with families, as well as therapeutic methods in the fields of speech therapy, children psychiatry, psychology, etc.

The financing for EI services is guaranteed by the regulation of the State Health Insurance. The activities of state institutions are being financed without any disorders, even those which are not specifically medical. The services provided by NGO’s are paid by State Health Insurance too. However, problems occur for example when to pay for the services of speech therapist, psychologist or social worker, which is part of the multidisciplinary work... Therefore, the standardised EI services package should be elaborated ensuring its permanent financing.

Another very important issue is the development of a database. Currently, the National Centre of Mother and Child Care is using a progressive database which allows improving the quality of EI services. However, this database should be developed to fit the needs of all system, not only of one centre.

### 3.5 Prevention through intervention, information dissemination and training

A very positive fact is that all stakeholders of the EI sector realize the real need of prevention; however, the prevention as a process is understood differently. The National Centre of Mother and Child Care and some other NGO’s could be emphasized due to their approach and their activities, as a very positive factor which

should be supported by the state institutions (e.g. MoH) and the experience of the Centre should be shared all over the country.

It is very difficult to distinguish whether the increasing number of children with psychological and socio-emotional problems is because of natural causes or because of parental awareness. There is increasing focus on the population ‘at risk’ in its broadest sense, as being a subject of EI. At first, children with disabilities should be provided with a proper assessment in order to receive EI support. To be perceived as ‘at risk’ is not enough to warrant receiving EI. Preventive action, addressed to the ‘at risk’ population is also one of the main tasks of other services. They need to either ensure systematic monitoring and follow-up of the child (mainly in the case of biological risk factors) or to take active care of the family (mainly concerning social risk factors). In many cases, efficient counselling of parents will make any further intervention unnecessary. Prevention does exist, however, not always in correspondence to international practice. There are three main levels of prevention and intervention (see the box below) which are functioning in Moldova. These three levels can be identified in a broader context, taking into account the ‘bio-psycho-social’ model of functioning and disability published by WHO (World Health Organisation, ICF, 2001). According to this approach, prevention in the field of EI cannot take into account only the health condition of a person; it should also take into account his/her social environment: it is only the efficient combination of action and intervention that ensures good results from any intervention addressed to young children.

<table>
<thead>
<tr>
<th>Primary prevention</th>
<th>aims to reduce the number of new cases of an identified condition or problem in the population (incidence).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary prevention</td>
<td>aims to reduce the number of existing cases of an identified problem by acting after the onset of the problem, but before it is fully developed (prevalence).</td>
</tr>
<tr>
<td>Tertiary prevention</td>
<td>aims to reduce the complications associated with an identified problem or condition, to limit or to reduce the effects of a disorder or disability.</td>
</tr>
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</table>

In this context, the lack of common policy is very obvious. This policy should consolidate and coordinate the efforts of MoH, MoE and MSPFC in the field of early child disability. The real picture of how these three sectors collaborate with each other is illustrated in Mapping of Early Intervention, Inclusive Education and Community Social Services development for the children with disabilities and their families in Moldova in (Annex 4). All three kinds of services exist only in Chisinau, Balti and Criuleni. Therefore, the assumptions of consolidation and coordination are still alive. In this context it is important to highlight that these assumptions in Criuvleni district became real actions and could become a good example for other districts.

4. Prevention of children with disabilities from discrimination and exclusion

4.1 Conceptual framework

For the introduction to this chapter some conceptual remarks are needed to better understand the situation of inclusive education in the country. Inclusive education could be considered as a pathway to attain social inclusion.

From a societal perspective, inclusive education is clearly and substantially linked to the discussion of the type of society to be attained, the kind of well-being desired for all citizens and the quality of democracy and social participation wished to be pursued. On a long-term basis, basic education in relation to social inclusion implies an understanding of it as of essential component of social policy and importance of civic participation. The Government of Moldova insufficiently appreciates this simple fact. It also implies that the government does not appreciate the fact that – including children with disabilities in the education system is absolutely

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5 Education, Poverty and Disability in Developing Countries. Jonson, T. and Wiman, R. 2001
cost-effective and beneficial in the matter of society welfare. A World Bank study (James Lynch, 1994) on special educational needs enumerates the following economic benefits from inclusive primary education:

- Reduction of social welfare costs and future dependence
- Increased potential productivity and wealth creation provided by education of those children with impairments and disadvantages;
- Reduction of number of residential institutions for disabled people;
- Increased government revenue from taxes paid, which can, in part, be used to recoup the costs of initial education;
- Reduction of administrative and other recurrent overheads associated with special and regular education;

4.2. “Education for all” dimension

The Republic of Moldova is attempting to broaden the approach of inclusive education and shift the focus from creating various educational opportunities for children with special needs to the creation of one school for all pupils. In the past few years there has been a separation between the integration and inclusion process, terms that used to be given the same meaning. Causes of exclusion are various, the most obvious ones are: inadequate perception of children with disabilities by society, lack of tolerance for differences, present structure of the educational system and inefficient methods of funding. This is exacerbated by a lack of policy implementation mechanisms, absence of educational and social services for children with disabilities and their families and no preparation of mainstream schools for accepting and supporting children with special educational needs.

During the last years the Government has been undertaken a series of measures regarding the accomplishment of the right to education of children with disabilities and of ensuring the access to general education. A set of strategic documents were adopted domestically, as well as the international engagements outlined the inclusive education at the first place. These include: Strategy and National Action Plan “Education for All (2004-2008)”, Strategy on Social Inclusion of Persons with Disabilities 2009-2012 (project phase), Inclusive Education Concept (draft under consideration at Ministry of Education), Education Code (draft), and the Convention on the Rights of Persons with Disabilities (signed but not ratified yet).

However, the Government does not outline a clear mechanism that would regulate the access of children with disabilities in the mainstream education. Documents described above show that all initiatives have been blocked at the stage of projects discussion (Governmental, Parliament level) and were not adopted. Primarily, this situation reveals the lack of decisive political will. Secondly, the presence of legal gaps in the field has further complicated the situation of persons with disabilities regarding the right to education.

4.2.1 Main features of inclusive education

A closer look into the inclusive education practice in Moldova would show that it has a little in common with other practice in Europe. In comparison, Inclusive Education implies coherent and articulated set of policies aiming for (1) a pertinent and relevant curriculum with a vision that facilitates dialogue among different levels of the educational system; (2) a vast repertoire of diverse and complementary pedagogical strategies (formal and non-formal schooling) that can respond to the specificities of each student by personalizing the educational provision; (3) available physical facilities and equipment aligned with the designed curriculum and its implementation; (4) strong teacher support in the classroom, seeing him/her as a co-developer of the curriculum and (5) engaging in dialogue with families and communities in order to understand their expectations and needs as well as to promote their active participation in school.

At the moment in Moldova, the main strategy planners and implementers are NGOs, such as the efforts of “Speranta” from Chisinau and "Woman and Child - Protection and support” Association from Criuleni (and some other partners).

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6 Regional Preparatory Workshop on Inclusive Education – Eastern and South Eastern Europe; Sinaia, Romania, 14-16 June 2007, UNESCO
The Day Care Centre „Speranta” is one of the promoters of IE of children with disabilities. The process of inclusion of children with disabilities in mainstream educational institutions (promoted by this Centre) can be set out as follows: 2000-2001 – the first child with disabilities was integrated in primary school; the first partner in the process of inclusion was School-kindergarten No. 120; 2006 – project „Educational inclusion of children with disabilities in Moldova” was implemented in partnership with DFID. The main goal of the project was social inclusion of children with disabilities, by raising school assistance of children and their awareness regarding the rights of children with disabilities; 2008 – establishment of Resource Centre for Inclusive Education „Inclusive ME”. Present – currently there are approximately 270 children with disabilities integrated in 80 mainstream educational institutions (see Annex 4). Day Care Centre “Speranta” is working towards creation and implementation of a model of inclusion for children in Moldova. Future – model of educational inclusion developed by Day Care Centre „Speranta” to be accepted and implemented at national level.

"Woman and Child - Protection and Support” Association from Criuleni implements an awareness activity at local level and as a result in the last 3 years there were no children placed in residential institutions. During the preceding year in Dubasari and Criuleni regions 22 children with special needs were integrated into school and an additional 45 children were provided with the assistance and home education facilities. Up to 12 children, who have not attended kindergarten at all, were integrated into the preschool institutions. Four children with disabilities from residential institutions were supported in their inclusion in the educational process. The most important is that the Association has a very effective collaboration with local authorities so that all services’ sustainability is assured. Moreover, at local level, public authority supported establishment and development of social inclusion services.

According to the data of Statistic Bureau 2008, there were about 11 800 disabled children in age of 7 to 18 in Moldova. It means that due to the efforts of these two organizations mentioned above, 2.7% of disabled children are integrated in to the schools providing inclusive education.

At the end of 2008 there were 1349 kindergartens operating in Moldova. 23.4% of them were located in urban areas and 76.6% respectively in rural areas. Number of children enrolled in preschool education increased by 3.2% (in comparison with 2007) and reached 123 900 at the end of 2008.7 Children with special needs are working in specialized groups within 33 kindergartens; most of them are children with speech disorders (61.9%). In 2008 such groups were attended by 2267 children or approximately 8.4% more than in 2004. These children have mild disability. Children with severe or medium level of mental disability, unfortunately, are not integrated to kindergartens at all.

The lack of a specific department in the Ministry of Education that deals specifically with inclusive education hinders the process of policy implementation. Currently there are one or two specialists responsible for special needs and residential institutions and they do not incorporate the wider concept of inclusive education that seeks to promote social justice.

The absolute majority (except 33 mentioned kindergartens and 80 secondary schools which accept and provide education to children with disabilities; see Annex 4, Annex 4.3) of educational institutions are not prepared to physically and methodologically integrate children with disabilities. Despite the school management’s willingness they are not able to integrate children with disabilities due to the non-existence of basic conditions and they lack of financing to change the situation. At the moment the centralized finance does not allow and encourage changes and further development. Therefore, it is the time to revise currently existing approaches either concerning financing or even school network optimization. It would become serious assumptions to enforce the development of IE all over the country.

The absence of alternative models of inclusive education leads to the segregation of children with special education needs. In this context there is a risk that the deinstitutionalization can acquire a negative shade through the isolation of children with special needs at home. Teachers are also unable to provide qualitative educational services for all the categories of children including those with special needs. Additionally, lack

7 The situation of the children in Moldova in 2008, National Bureau of Statistics, Nr. 02-11/68 din 29.05.2009
of collaboration between state and NGOs in addressing social and educational problems impedes the possibilities for advancing inclusive educational practices.

4.2.2 Special schools

The Salamanca Statement

The 1994 World Conference on Special Needs Education (UNESCO) produced a statement and framework for action which argues that regular schools with an inclusive orientation are “the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all; moreover, they provide an effective education to the majority of children and improve the efficiency and ultimately the cost-effectiveness of the entire education system.”

The majority of children with disabilities of school age are hosted in residential type education institutions which could be called special schools. Such schools host up to 68% of children with disabilities. Lately, there has been a decrease in the number of schools and children attending them (see Annex 5) due to international organizations and local authorities implemented active deinstitutionalization. This has increased the attention paid to the family and/or alternative measures of care, which enables the return of a child to his/her biological family, foster family or adoption. However, social inclusion of children with disabilities is still not the general rule. Attention should be paid to the concrete local condition and traditions as well as the financing and management of special schools which are centralized; all these schools are reliant on the Ministry of Education. However, only the institutions which are especially specialized and are related with blind, hearing and speech disability should be left depended on the Ministry. All other institutions should be gradually assigned to LPAs.

Many of the initiatives that have been discussed, especially those related to families and communities, are essential for the successful promotion of alternatives to institutional care for children with disabilities. These include the introduction of measures that reduce the pressure for children to be admitted to institutions in the first place, including the development of child-centred public services, accessible schools and the provision of local supports and services. These elements can be complemented by the development of support programmes for and by families and the establishment of community-based alternatives, with the active involvement of parents and community organizations.

A number of initiatives undertaken within the National Strategy for reform of residential care for children in the years 2007-2012 serve as successful examples, which can be implemented at national level. NGOs, such as Every Child and Keystone Human Services implement projects on deinstitutionalization policy of children with disabilities. One of their projects “Community for all – Moldova” focus on the development of normative legal framework for regulation of community services for people with disabilities and developing community services focusing on the needs of people with disabilities and families/caretakers The project team was able to develop a series of projects of normative acts to regulate such services, to reintegrate 22 children with mental disabilities into their families, to reintegrate15 boys with severe mental disabilities into their families, 7 children were prevented from abandonment and institutionalization, when parents were supported to keep their children in the family.

4.2.3 Resources and support

Despite the fact that inclusive education in secondary schools system is not developed yet, traditionally the trainings of work with children with special needs for pedagogues are being held. In State Pedagogical University „Ion Cringe” students can get specialization in this area at the faculty of Special Psycho Pedagogy and Psychology. Besides, at „Alecu Russo” University from Balti the specialization in working with children with special educational needs can be obtained too. Each year approximately 50 students graduate from both universities. Starting with 2008, the Institute of Educational Science (IES) introduced a

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8 The Salamanca Statement and Framework for Action on Special Needs Education. 1994
There are three levels of medico-psycho-pedagogical services in Moldova for children with mental or psychophysical disabilities. At the central level there is Republican Medical Psycho-Pedagogical Consultation which is responsible for screening, examination and medico-psycho-pedagogical diagnosis of children with mental disabilities and those with psycho-physical disabilities. This institution is subordinated to the Ministry of Education and operates according to the Regulation approved by Government Decision No. 42 on 24 of January, 1994. The total number of employees in the commission is 18 people (1 president, 1 secretary-advisor and 11 specialists, 5 staff). At the local level there are district consultations which are named according to local regulations as municipal Medical Psycho-Pedagogical Commissions. These commissions are responsible for screening, examination and complex diagnosis of children with mental disabilities, language impairment and psychical development restraint. Children after the diagnosis and detection of psycho-physical and/or mental disabilities are assigned (with parental consent) to special educational institutions. Children with hearing and visual impairments, neuropsychiatric diseases, severe mental disabilities, disorders of the locomotors system are referred to the Republican Medico-Psychological Consultation. Finally, at the school level there are Medical Psycho-Pedagogical Commissions which are working according to the recommendation of Consultation and are responsible for child placement in class.

However, it was found out that only 20% of Medical Psycho-Pedagogical Commissions (MPPC) is actually operating. According to the experts, current organization of activities of the MPPC at the structural-functional levels do not meet current trends in assistance and psychosocial support to children with special needs due to the lack of social assessment of the family and child. Medical aspect in evaluation of children with special educational needs do not lead to inclusive education.

The major problem with the MPPC is that most of them advocate for care and education of children with special needs in residential institutions, without proposing alternative plans. International experience strongly promotes coordination and monitoring of service of quality inclusive education, at central and local levels. The competence of the service at local level should cover the development of methodological materials as school books necessary for inclusive education programmes. It is impossible to implement inclusive education without adapted manuals, recommendations for individual programmes and other support materials. Another important component of operating area of this service should be relations with school. It has to be focused on the supporting school in inclusive education process; e.g. trainings for improving teachers’ qualifications. Finally, simultaneous work with families should be ensured as well.

4.3 Child rights protection

The existing system of children rights protection and common practice is not the factor which could properly represent the interests of children with disabilities. Currently, families raising a child with disability cannot expect that services represent their interests or (1) delivering EI services on time; (2) ensuring inclusive education to a child regarding the place of residency; (3) permitting social services to involve family into community life if the family has socio-economic difficulties.

Children Rights Protection Agency as a structural unit exists only in Chisinau, while other districts have only one specialist in each Department of Social Protection. In the context of indicated problems, the specialist, at best, is included in the work of the Commission which gives the recommendations about the institutionalisation of the child.
This year the position of Child Advocate was established by the Parliament of Moldova which should help improving the current situation. The United Nations Convention on the Rights of Persons with Disabilities indicates concrete fields where the interests of children with disabilities should be protected. In case the interests are protected, appeared precedent will encourage unification and integration of all efforts of different Ministries due to the protection of disabled children.

At the moment there are many discussions on how (in what conditions) the Government should sign and ratify the Convention on the Rights for Persons with Disabilities (CRPD). The Outline for Ratification of the Convention on the Rights of Persons with Disabilities & the Optional Protocol by the Republic of Moldova (2009) gives very reliable arguments. First, policy makers are concerned of the expenses which could appear implementing the articles outlined in the Convention. The main argument is the costs of ensuring accessibility. However, social and intellectual aspects of accessibility are cost neutral features. Therefore, proper planning and drafting of adaptation of current physical structures should not mean additional costs.

That is because Moldova has already ratified some core international treaties concerning human rights, what had already included the aspect of accessibility. Another very important argument is that the ratification of CRPD would create additional conditions to initiate and maintain significant reforms in the country. The principles contained in the CRPD, in particular inclusion and independent living, as well as the Convention’s paradigm, which focuses on the social aspects of exclusion, could be most beneficial in informing the debates around these reforms to ensure that the vision of highest social cohesion in Moldova can be achieved9.

Hopefully the Government of Moldova will realize that the ratification of CRPD is not only directly connected with positive changes in life of children with disabilities and their families, but also it will have significant positive influence to civic society development and respect for fundamental human rights.

### 4.4 Social protection

As it was mentioned above, the existing social welfare practice for children with disabilities is more oriented into the stationary? services. However, due to the efforts of local and international organizations, community based social services are being established and being developed. In the context of considered problems, this factor is very important, because early intervention and early intervention services will be effective in case they are supplied with services covering issues related with child and family social relationship and care. For example, today there are 30 Day Care Centres functioning for children and teenagers with special needs in Moldova; four of them deliver rehabilitation services and 680 children with disabilities are being provided services from these centres.

The fight against social exclusion should be mainstreamed in general policy by (a) making social services more responsive to the needs of society, and (b) developing appropriate coordination procedures and structures. This could be achieved by mobilising Public Authorities at all levels, by enhancing partnership and dialogue between all relevant public and the private bodies by taking into account the opinions expressed by social partners, social services providers, and in particular of children with disabilities suffering exclusion and organizations representing them. It is necessary to analyse and to disseminate good practice of those districts, towns and cities (Chisinău, Balti and Criuleni) were community based social services are being established on the backgrounds of collaboration between local governments and local communities. (See Annex 3; Annex 3.2). Early intervention services are evidently more effective in those districts which host Day Care Centres for children with disabilities, provide family consulting services and have developed network of home services. This supposes the possibility to establish multidisciplinary teams which deal with problems of Inclusive Education and Early Integration. It would ensure the mobility of services what is very important especially for people living in remote areas.

The development of community services network, has created possibilities of inclusion and integration of families into various activities dealing with their child social/pedagogical/psychological rehabilitation issues

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and in organizing effective prevention. Community based services support parents solving problems related with social adaption and social career?. Because of the development of these services, disabled children have the possibility to become clients of non residential social service centres, which also can employ the parents of these children. Foreign practice shows that these employees are very motivated and after getting proper qualification they are able to easily deal with their professional tasks as well as improved parenting skills. This kind of organization of social services stipulates more effective use of funds for problem solving of children with disabilities both, at LPA and CPA levels. Local governmental bodies could adopt a Model for Turning Institutions into Community-Based Support Systems. It is a model of social services provision for children with disabilities and their families. It should be adopted according to the local specifics (national traditions, level of development of institutional/administrative capacities and human recourses, financing capabilities and conditions). Experience shows that the transition from residential institutions to community based services is (was) an enormous challenge for CEE and CIS countries. Some find it hard to make the philosophical leap required, while others cite lack of funding and other resources. But all countries can take the important step of creating models, mechanisms and practices in their communities. For example, Hungary and Baltic states during 1990-1998, several institutes experimented buying small dwellings in their area and then relocating 10 to 12 residents into these homes – a process known as ‘fragmenting out’. This transitional tactic has also been used in the United Kingdom, where it is known as a ‘core and cluster’ approach.

As an exercise for this report, I would like to present a model for re-casting an institution into a family centre (see Model 1). While the model presents the re-envisioned centre as a single physical facility, it could, in fact, be spread out in different sites, to ensure that all parts are coordinated to act as an integrated system of support.

Model 1 A family centre for children with disabilities

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**COMMUNITY FAMILY CENTRE FOR CHILDREN WITH DISABILITIES**

**Half or Full Day Care**
- All ages, all disabilities. Area to be divided into smaller units based on activities and children’s choices.

**Fostering and Adoption Centre**
- Matching children with disabilities with local families, training for families and supporting and families would be encouraged to use the other activities available at the Centre.

**Full or Part Time Specialist schooling**
- To be integrated with local schools. Flexible education based on age and severity of disability.

**Further Education Preparation for Independent Living Leisure Facilities for Young People**
- Vocational training, qualifications, preparation for University. Integrated unit with young people in the community working alongside people with disabilities.

**Meeting Rooms**
- Confidential counseling for new parents. Self help groups for parents and young people.

**Short Term Holiday Care**
- All ages, all disabilities – organized in groups to support social mixing (not all children with the same disability). Holiday care to include excursions and physical and social activities. Respite from caring responsibilities for the parents and a holiday for the child are equally important.

**Interdisciplinary Offices**
- For education, social services, health, management, administration and publicity.

**Small Units for Independent Living**
- Conversion of part of the institution for 3 to 4 young people with disabilities per unit. Access to staff members in separate living accommodation.

**Access to Local Communities**
- Priority in developing all other services
- Regular transport to and from local areas (hourly).
Another aspect of social protection of children with disabilities is social benefits (financial aid) for their families. Children with disabilities benefit from following kinds of social payments: birth allowances, state social allowances, care allowance, nominative compensations, money compensations for transport, pecuniary aid from the Republican Fund and local funds for population’s support, social aid. According to the national legislation, the social allowance established for children with the first degree severity amounts to MDL 285.71, while for those of the second and third degree – MDL 242.61 monthly. Families raising a child with the first degree severity also benefit from a care allowance (to MDL 300 per month). Besides, children with disabilities also benefit from nominative compensations for the payment of public utilities accounting for 50%, according to the established standard norms. Local public authorities provide nominative compensations for travels in urban, suburban and international transport around MDL 30 a month (in Chisinau municipality – MDL 70 a month). Children with locomotor disabilities (including those with infantile cerebral palsy) benefit of money compensations for servicing in the transport amounting to MDL 400 a year.

Now Moldova has launched the process of efficiency enhancement of social assistance provided to categories of underprivileged people12, including persons with disabilities, who still remain the target of state social policies. This particular process needs coordination, efforts mobilization and streamlining of the existing resources. With a view to achieving the aim established by the Parliament of the Republic of Moldova, the Law on Social Aid No 133-XVI was adopted. This law aims to ensure a minimal guaranteed monthly income for the underprivileged families by providing social aid, established according to the assessment of the family’s global average monthly income and the need of aid.

During nine months in 2009, 16,469 families benefiting of social aid were registered; the current amount of social aid represents MDL 746.8. Financial resources appropriated for this purpose amount to MDL 12.3 million. According to the statistical data, around 1.8% of the country’s population is covered by the provisions of the aforementioned law (2.65% of the rural inhabitants and 0.52% of the urban inhabitants). However, the capability of local and central budgets to change this situation is very limited. Therefore the development of community based services becomes essential alternative which would increase social welfare of family throughout complex support integrating the community and developing the capabilities of family members to take care of themselves.

5. Monitoring and evaluation of prevention on children with disabilities and care system

In November 2000, the Special Rapporteur for Disability convened an expert seminar in Stockholm, in order to draft guidelines for identifying and reporting human rights violations against persons with disabilities. The seminar established five distinct areas that must be monitored, as follows13:

• National laws: these can appear to protect human rights but may come to be used in ways that create inequity and violate the human rights of persons with disabilities.
• Legal cases: these are just as important as the written laws of a country: regardless of what a law says, in reality what matters is how a law is interpreted and enforced.
• Government programmes, services and practices: these normally have the greatest impact on the daily lives of persons with disabilities and their families but it is often difficult to thoroughly review the effect of these programmes. The seminar recommended that special reporting manuals be made available to disability rights groups.
• Media representation of persons with disabilities: media events must be monitored to ensure they do not promote ideas and images that infringe upon the rights of persons with disabilities.
• Individual cases of abuse: documenting and reporting these cases raises awareness and support and makes it difficult for neglect and human rights violations to go unnoticed and unaddressed.

12 Despite the fact, that currently Laws regulating social system oftently define underprivileged groups, in the future process of developing system of targeted social assistance underprivileged groups should disappear
Monitoring and evaluation (M&E) as processes or as an organized institution/structure is not prominent in Moldova when it comes to disability issues. If M&E system is properly functioning it can have a positive influence no quality of services, accessibility, targeted provision, efficiency and other factors which ensure human rights and integration opportunities for children with disabilities.

According to traditional approach to social protection or health assistance, M&E systems basically compose of twelve functioning components. To answer the question of which components of M&E system acts in sectors of early intervention, inclusive education and child care sectors, the below matrix is presented.

<table>
<thead>
<tr>
<th>Component</th>
<th>Current situation</th>
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<tbody>
<tr>
<td>1. Organizational structures with M&amp;E functions</td>
<td>Organizational structures with M&amp;E functions do not exist in Moldova. The monitoring function is dedicated to the National Council for the Protection of Children’s Rights (which was established in 1998); however, in the Rules of Procedures of the Council this function is unclearly defined and monitoring is not being performed at all. In the Rules of Procedures there is an article (No. 5) which is called “Investigation and Monitoring”, but this article has nothing in common with monitoring or evaluation of social services. Moreover, the team of Human Rights Centre (established in 2008) includes a Children Advocate. Who is to monitor the rights and protection of all children? However, something similar to monitoring and evaluation of services delivery level are being done by Follow-Up services in Mother and Child Centre. During the process of Early Intervention development at national wide, similar scheme of monitoring (together with software application) should be adapted (see Annex 3).</td>
</tr>
<tr>
<td>2. Human capacity for M&amp;E</td>
<td>Only the specialists of Follow Up service are ready and have sufficient analytical capacity to use data and produce relevant reports. However, there are at the moment no such specialists who would be able to perform function of M&amp;E at national and sub-national level.</td>
</tr>
<tr>
<td>3. Partnerships to plan, coordinate and manage the M&amp;E system</td>
<td>The partnership among local and international stakeholders in the field of planning and managing the national M&amp;E system does not exist.</td>
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<td>4. National, sectoral M&amp;E plan</td>
<td>These analyzed questions cover three main sectors: Health, Education and Social Protection. None of these sectors have developed and regularly updated M&amp;E plans, which should include identified data needs, national standardized indicators, data collection procedures and tools and roles and responsibilities for implementation of it.</td>
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<tr>
<td>5. Annual, costed, national M&amp;E workplan</td>
<td>An annual, costed, national M&amp;E workplan does not exist. It should include specified and costed M&amp;E activities of all relevant stakeholders and identify sources of funding. This plan should be used for coordination and for assessing the progress of M&amp;E implementation throughout the year.</td>
</tr>
<tr>
<td>6. Advocacy, communication and culture for M&amp;E</td>
<td>Nonexistence of knowledge of and commitment to M&amp;E and the M&amp;E system among policy-makers, program managers, program staff and other stakeholders.</td>
</tr>
<tr>
<td>7. Routine program monitoring</td>
<td>Routine program monitoring timely and in a high-quality (valid, reliable and comprehensive) data is not being produced. However, some data is being produced by Statistic bureau; this data usually is used by the Ministries in annual reports.</td>
</tr>
<tr>
<td>8. Surveys and surveillance</td>
<td>Non-existence of timely, valid and reliable data from surveys and surveillance.</td>
</tr>
<tr>
<td>9. National and sub national databases</td>
<td>Non-existence of national and sub-national databases which would enable stakeholders to access relevant data for formulating policy and for managing and improving programs</td>
</tr>
<tr>
<td>10. Supportive supervision and data auditing</td>
<td>Data quality is not monitored. All produced data should be monitored if it is reliable and necessary.</td>
</tr>
<tr>
<td>11. Evaluation and research</td>
<td>Evaluation is not identified, questions are not researched and studies are not coordinated. This all should meet the identified needs and enhance the use of evaluation and research findings.</td>
</tr>
<tr>
<td>12. Data dissemination and auditing</td>
<td>Despite the fact, that mainly data is not being produced, it is not disseminated.</td>
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</table>

Collected data from the M&E system should be used to guide the formulation of policy and the planning and improvement of programmes.

However, it has to be admitted that M&E system is not established yet, and institutions which are responsible do not realize the real need of M&E. This should be changed as soon as possible and in a high quality according to international standards.

6. Conclusions and recommendations

The conclusion are generalized and integrated. The situation of children with disabilities will be set out according the following aspects: Availability, Proximity, Affordability, Interdisciplinary and Diversity and the recommendations are divided according to the particular sectors: health, education and social protection.

6.1 Conclusions

1. The existing EI policy measures do not ensure that EI reaches all children and families in need as early as possible. Partly this problem is solved by the National Centre of Mother and Child which can provide EI services during prenatal and postnatal period and providing Follow Up services. Due to the fact that Family Doctors Centres are not EI services and Family Doctors are not always able to detect at time the disability or risk of disability and therefore the availability of EI services for residents living in districts (especially remote ones) are limited.

2. The existing IE policy measures do not ensure that IE reaches all children according to their place of residency. Practice shows that only 2.7% of approximately 11 800 children with disabilities 7-18 years old are using IE services. Furthermore, 68% of these children are placed in residential educational institutions; physically and socially excluded from families and community.

3. The existing social services policy measures do not ensure that social services reach all children and families in need according to their place of residency. There is only 30 Day Care Centres for children with disabilities established in the country. Moreover, seven districts do not have any services provider at all; approximately 1800 children with disabilities live there. Policy measures do not support and are not able to ensure the coordination of education, social and health services at central, regional and local levels.

4. There is a lack of professional capacities in medical staff which are involved in EI detection, therapies and prevention. Doctors are applying outdated methodologies of detection, so that usually the problems of detection of neurological and psychical disorders occur. This problem is most relevant to the doctors working in remote districts.

5. The physical environment of schools does not fit the needs of children with disabilities. The lack of professionals involved in IE and the shortage of training methodologies and tools, makes schools not acceptable (and not available at the same) for children with disabilities and their families. This kind of situation force parents to choose residential institution.

6. Availability of information is a major problem. The information about EI services/provision should be extensive, timely, clear and precise and disseminated at local, regional and national levels to families and professionals of all services.

7. There is no monitoring and evaluation framework and structures in Moldova, which fit international community agreed concepts and standards. Monitoring and evaluation have a strategic role to play in informing policy making processes and have the aim to improve relevance, efficiency and effectiveness of policy reforms.

8. Institutions situated in Chisinau, Balti, Ciadur Lunga, Criuvelni and some other districts provide high quality services, due to the professional staff, up-to-date technologies and use of international standards,
because they (1) ensure and enhance personal development of children with disabilities, (2) strengthen family’s own competences, and (3) promote social inclusion of family and child. These actions are to be provided in the child’s natural setting, mostly at a local level, with a family-oriented and multidimensional teamwork approach. Professional staff is well aquitended and uses for daily operations International Classification of Functioning, Disability and Health, Children and Youth Version issued by WHO, 2007.

9. Despite some non-systematic difficulties, there are some NGOs (in all three sectors, health, education and social services) which are functioning at a high professional level and share practice of multidisciplinary work with family as well as other conceptually important methods for all country.

10. Taking in to account that EI provision and services should be available as close as possible (in the meaning of distance) to the families and should be focused to family: all three types of services (health, education, social protection) are being provided only in Chisinau, Balti and Criuleni.

11. The current situation does not ensure same quality of service for people due to the geographical differences (e.g. scattered, rural or remote areas).

12. In general, both, EI and IE provision and services are not reach by all families and young children in need of support, due to different socio-economical backgrounds and unequal access to the information. However, all services and provision are cost free for the families. Despite the fact that sometimes those services are not at the best quality, public funds still cover all costs related to EI and IE through public services, insurance companies, non-profit organisations, etc.

13. EI and IE services/provided by NGOs such as VOINICEL, SPERANTA (Criuleni and Chisinau), ASCODE involve professionals from various disciplines and different backgrounds. Co-operation with families as the main partners of the professionals is ensured, taking into account that: (1) Professionals initiate co-operation and have an open and respectful attitude towards the family, in order to understand their needs and expectations and avoid any conflict arising from different perspectives on needs and priorities, without imposing their point of view; (2) Professionals organise meetings in order to discuss the different points of view with parents and together set up an agreed written document, called an Individual Plan.

14. According to the activities of NGOs mentioned above could be stated that the team building approach exists. Despite their different backgrounds, corresponding to their disciplines, EI teams/professionals work in an inter-disciplinary way before and whilst carrying out the agreed tasks.

15. Inadequate co-ordination of health, education and social services sectors implies that these services are not involved in the process of early detection. So that, sometimes gaps or significant delays occur that affects (a) further intervention and (b) waiting lists (in a sense of overloaded services or teams). Furthermore, inadequate co-ordination of provision implies that services do not ensure continuity of the required support when children are moving from one institution to another. Families and children should be fully involved and supported.

16. The setting of preschools usually does not ensure a free place for child coming from EI services/provision because of insufficient number (only 33 all over the country) of such type institutions with inclusive education services.

17. EI and IE policy-makers dis-comunicate and this result in lack of discussions and common researches in this field. It should be taken into account that early intervention and inclusive education policies are the common responsibility of families, professionals and policy-makers at local, regional and national levels.
### 6.2 Recommendations

**Early Intervention**

<table>
<thead>
<tr>
<th>Recommendations according to the level of impact</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>On policy issues</strong></td>
<td></td>
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<tr>
<td>1. Development of National Program for Early Intervention.</td>
<td>The program should cover basic EI principles and the Government's declaration that EI should be the priority of Mother and Child health. The program should clearly identify all EI system segments and their fields, target groups and responsibilities. The program should clearly define inter-institutional relationships within the system and the mechanisms of quality evaluation and monitoring. The program should indicate all services which are included in the content of EI package and who funds it. The program should indicate what kind of law regulations have to be created or which have to be changed.</td>
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<tr>
<td><strong>On institutional capacities</strong></td>
<td></td>
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<tr>
<td>2. Establishment of Early Intervention Services at the Family Doctors Centres (Recommended EI Model is presented in Annex 2).</td>
<td>This service would be composed by a group of 4 to 5 specialists: paediatrician (leader); psychologist (part-time); social worker (part-time); speech therapist and kinesis-therapist. To successfully organize their activities, two surgery rooms are needed for individual therapy, as well as one spacious room for kinesis-therapy. It is important to ensure the mobility of this service in case of visiting families in the remote areas.</td>
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<tr>
<td>3. Development of Early Intervention Information System.</td>
<td>The data base which is currently functioning at the National Mother and Child Care Centre could be further developed. First of all, it should be able to register case management, evaluation, supervision, data on social status, etc. At the level of Ministry (MoH could be the administrator of the system) statistics should be aggregated and differently sectioned; demographically, according to the type and level of disability, according to gender and social status. It would allow better system administration, the analysis of needs and planning of the development.</td>
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</table>
4. Development of Early Intervention sectoral Monitoring and Evaluation structures and professional capacities with appropriate data base.

Ministry of Health is responsible for the accreditation of NGO’s providing EI services.
1) The department of Mother and Child Health could do the monitoring of quality, EI policy evaluation and planning functions. In this case, Ministry could become as the administrator of united database which connects all EI services providers.
2) Develop and regularly update M&E plans, including identified data needs, national standardized indicators, data collection procedures and tools and roles and responsibilities for implementation;
3) Develop databases that enable stakeholders to access relevant data for formulating policy and for managing and improving programs.
4) Ensure systematic monitoring and follow-up of the child (mainly in the case of biological risk factors) or/and to take active care of the family (mainly concerning social risk factors).

5. Development of standardised EI services package to ensure its permanent financing.

EI activities of state institutions are being financed without any disorders, even those activities which are not specifically medical. The services provided by NGO’s are paid by State Health Insurance too. However, problems occur for example when it is needed to pay for the services of speech therapist, psychologist or social worker, what are the parts of the multidisciplinary work. According to the State Health Insurance the following services have nothing in common with medical services.

On human capacities

6. Training courses on professional capacities building.

The following training modules should be elaborated and trainings provided:
1) The “Good practice” of Early Intervention in Europe;
2) The newest technologies and methods of disability detection (highlighting socio-medical model);
3) Early Intervention as multidisciplinary team work. Involvement of family and community; The National Centre of Mother and Child Care and some other NGO’s could be emphasized due to their prevention activities, as a very positive factor which should be supported by the state institutions (e.g. MoH) and these experiences should be shared all over the country.

7. Establishment of a working group for elaboration of law regulations.

This working group should elaborate three packages of law regulations:

First package of documents should include the methodology on evaluation of children with disabilities, corresponding to up-to-date standards. The methodology should be followed by trainings for Family Doctors and other specialists of this field how to apply this methodology in practice.
Second package of documents should include methodological recommendations (Practical Guidelines and Package of Operational Manuals according to the type of disability) on application of various EI methods for children with different disabilities.

Third package of documents should include methodological recommendation on work with families with children with disabilities; i.e. how to maintain positive psychological climate, how to train family members of various therapies and techniques, to teach them independently use their knowledge and skills at home.
**Inclusive Education**

<table>
<thead>
<tr>
<th>Recommendations according to the level of impact</th>
<th>Comments</th>
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</table>
| **On policy issues** | The following (or similar) articles should be incorporated to the Law:  
  - General provisions  
  - Structure of the Inclusive Education System  
  - Organization of Inclusive Education  
  - Pedagogical, Psychological, Social and Medical Assistance  
  - Training of Inclusive Education specialists  
  - Rights and obligations of persons with special needs, their parents (or the child’s guardians) and teachers  
  - Administration and funding of Inclusive Education |
| 1. Inclusion of regulations, which define Inclusive Education segment within the Education system, to the basic Law on Education. | Main principles of “student basket” calculation and functioning see Annex 6. |
| 2. Change of financing mechanisms of Education system in order to replace planned model with “student basket” financing concept. | |
| 3. Institutions which are especially specialized and are related with blind, hearing and speech disability should be left depended on the Ministry. All other institutions should be gradually assigned to LPAs. | |
| **On institutional capacities** | 1. The concrete outputs of the research should present (a) the locality of inclusive education services, (b) the number of children with disabilities which are in need of IE services, (c) types of disabilities.  
  2. Action plan should indicate realizable action programme, financing sources, technical specifications, deadlines and accountabilities. |
| 4. Carry out country wide research on determination of real need of Inclusive Education and preparation of action plan for implementation. | |
5. Central level. Reformation of National/Central MPPC into the National Centre for Special Needs Education and Psychology at the Institute of Educational Science.

NCSNEP should become the responsible institution under the IES for developing the system of special pedagogical and psychological support in Moldova. The possible (or similar) tasks of the Centre are:

1. to create the strategy of special pedagogical and psychological support system in Moldova;
2. to work on the development of special pedagogical and psychological support system;
3. to implement the system of provision of special educational materials.

The possible (or similar) functions of the Centre are:

- to coordinate the first (school) and the second level (LPA) of the special pedagogical and psychological support;
- to organize training programs for specialists of the municipal pedagogical psychological services and schools;
- to provide advice on assessment or supervision on difficult or problematic cases to psychologists, speech therapists and special pedagogues working in the municipal services;
- to construct and adapt psychological and achievement tests and make recommendations for their use in the municipal pedagogical psychological services and in the schools;
- to develop and redact the legislation acts that follow the implementation of the regulations on Inclusion Education in the frame of Law on Education;
- to cooperate with municipal pedagogical psychological services;
- to provide methodical support for the municipal pedagogical psychological services and schools.

The possible (or similar) structure of the Centre are:

- Administration;
- Special pedagogical section;
- Psychological section;
- Special educational training aids section;
- Methodologies of evaluation section.

6. District level. Delegation of particular functions of Inclusion Education to Specialist at LPA Department of Education.

The Inclusion Education Specialist should work only with Inclusion Education. This Specialist should be responsible for inclusive education within the district and for pedagogical psychological services at municipal level (including communication and coordination with schools, health and social services sectors). After the IE system will be developed and functioning, the separate agency could be established (4-5 specialists). This kind of structure should function as subdivision subordinated by Education Division at district level.
7. Development of Inclusive Education sectoral Monitoring and Evaluation structures and professional capacities with appropriate data base.

On human capacities

8. Preparation of training programme on Inclusive Education strategic, methodological and practical issues and implementation of the programme in all country.

9. Review of special pedagogues and psychopedagogues training programmes at the Universities and Pedagogical college level, and preparation of recommendations on it.

1) Develop and regularly update M&E plans, including identified data needs, national standardized indicators, data collection procedures and tools and roles and responsibilities for implementation;
2) Develop databases that enable stakeholders to access relevant data for formulating policy and for managing and improving programs

Training modules should be targeted as follows: first module - to Ministry and LPAs officials; second module - to ordinary schools teachers’ community; third module - to the specialists involved in IE area.

Universities and colleges should re-evaluate current situation regarding disability issues; the need of specialists should be evaluated quantitative and qualitative; if necessary, all curriculums should be harmonized to correspond international standards of education quality.

<table>
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<th>Social Protection</th>
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<td><strong>Recommendations according to the level of impact</strong></td>
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<tr>
<td><strong>On policy issues</strong></td>
</tr>
<tr>
<td>1. Renew Law on social integration of disabled people according to European standards.</td>
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<tr>
<td>2. Development and approval of framework regulations and minimal quality standards for various types of social services intended for families and children with disabilities.</td>
</tr>
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</table>
Assessment and Recommendations on Child Disability Prevention and Care System in Moldova

On institutional capacities

3. Reconsideration of Children Rights Protection Specialists’ functions.

4. Develop Children with Disabilities Social Care sectoral Monitoring and Evaluation structures and professional capacities with appropriate data base.

5. Piloting of the Community Based Social Services Infrastructure Development as a Model of a Family Centre for Children with Disabilities at LPA level.

On human capacities

6. Provision of trainings on capacity building of social workers at district and primaria levels on social work methods with families raising children with disabilities.

The functions of specialists should include more responsibilities and accountability protecting children rights. UN Convention on Disabled People Rights clearly states that restricted availability to EI, IE or to social services (in case of necessity) is gross violation of child’s and his/her family’s rights. Children Rights Protection Specialists have to be independent from LPAs. A significantly positive step would be more active and effective participation of specialists in the field of children rights protection.

1) Develop and regularly update M&E plans, including identified data needs, national standardized indicators, data collection procedures and tools and roles and responsibilities for implementation;
2) Develop databases that enable stakeholders to access relevant data for formulating policy and for managing and improving programs

The purpose of this piloting project is to establish Day Care Centres at LPA level providing open type services described in pages 30-31. It is a model of social services provision for children with disabilities and their families. It should be adopted according to the local specifics (national traditions, level of development of institutional/administrative capacities and human recourses, financing capabilities and conditions).

The following training modules should be elaborated and trainings provided:
1. Interaction process with children with disabilities and their families (including evaluation, planning, intervention, supervision and etc.);
2. Multidisciplinary team work on social inclusion issues;
3. Home care social services for the families raising children with disabilities.
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