Practical Guide

Access to services for persons with disabilities

Technical Resources Unit
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Practical Guide

Access to services for persons with disabilities

"To ensure the service offer in our sectors of activity is available, adapted and accessible[1]" represents one of Handicap International main action purpose.

The relevance and impact of our efforts depend in large part on our approach to our actions and our relationships with local actors.
This decision-making guide for Handicap International's programmes is based on a "systemic" vision of services, which includes the policy of a given country or sector (sector-based policies), practices (the service offering) and the lives of the individuals concerned.

This guide is divided into three sections. The first section sets out the basis for a common vision of the key determining factors for accessing services. We then develop the analytical tools to apply to the services sector according to the type and continuity of these services, the role of mainstream, specific and support services, key actors in service provision and access, and the link between improved access for users and the internal quality of the service. This global vision of the services system and its organisation, in parallel with a more detailed analysis of a given sector or service, can significantly improve our strategic intervention in the country concerned.
The second part sets out the planning stages to be followed at programme level, specifically the parameters for analysis and decision-making. In conformity with Handicap International's specific requirements, these stages ensure that projects implemented in the different disability service sectors are effective and relevant.
The third section explores the practical tools we can use in order to apply the techniques proposed in the practical guide (by completing pre-defined documents, gathering further information or performing in-depth studies on the subject in question). A glossary and comprehensive reference bibliography are provided at the end of the guide.

Our approach is pragmatic. Analyses highlight the strengths and weaknesses of the access system to ensure the continued relevance of our response. In reconstruction and development situations, the weaknesses of the system often require us to work on the structural aspects of the problem (legislation, budget availability, premises, service organisation, etc). If, on the other hand, the difficulty (incapacity or obstacle) is more individual in kind, we need to offer personalised support instead.

I hope you enjoy this guide!

Susan Girois
Director, Technical Resources Division
Handicap International

1. Handicap International's Scope of Activities, November 2009.

A

Why a new guide?

Most projects run by Handicap International as part of its programmes over the last 25 years have included the delivery of services to persons with disabilities. The range is extremely wide and includes education, prevention and health services, rehabilitation, personalised support, mediation and assistance to employment, leisure and sport services, vocational education, and more.
The level of intervention can also vary (local, national and regional), as can the supported actors and partners chosen within the framework of Handicap International's programmes.

The services sector has grown to such an extent that an analysis of its practices is now essential for organisational purposes. It helps us take a more structured approach, encourages strategic programming and allows us to take into consideration recent international developments. Handicap International is now confronted with the need to reconsider the question of access to services for persons with disabilities, often among the poorest and most disadvantaged members of the community, in response to the service provision issues, which have arisen over time.

Although there are numerous reference documents devoted to services (see the bibliography at the end of this document), they focus mainly on the process of service delivery rather than access or accessibility for certain marginalized groups.

B

Why is Handicap International focusing on "access to services"?

Despite considerable efforts, the commitments made by governments within the framework of the Millennium Development Goals are unlikely to be met. Hidden behind a veil of global statistics, the disparities between and within countries continue to grow. Access to health, education, housing and a decent living wage remains a major challenge for most people around the world. Women are particularly disadvantaged in this regard in many contexts.

Poverty is undoubtedly an aggravating factor in or the result of disability:
Poverty and low educational standards hinder the access to care and lead to health complications. They limit the social participation, which is an essential element to the inclusion of people with disabilities. They also restrict access to education and employment and lead to greater poverty and more severe disabilities.
By breaking this vicious circle, access to services can have a direct impact on improving a person's quality of life and enhancing their level of economic, social and cultural inclusion. It is therefore an essential component in the fight against poverty.

In addition to implementing services when appropriate, improving access to existing services offers an essential means of ensuring people's needs are taken into account in the immediate to long-term. Access to services for persons with disabilities is a central issue for most of Handicap International's projects and all of its programmes.

If we analyse these experiences, we note that a number of changes have occurred: In the 1990s, many service-based programmes focused on providing equipment and administrative support; within a few years, this was expanded to include human resources, vocational
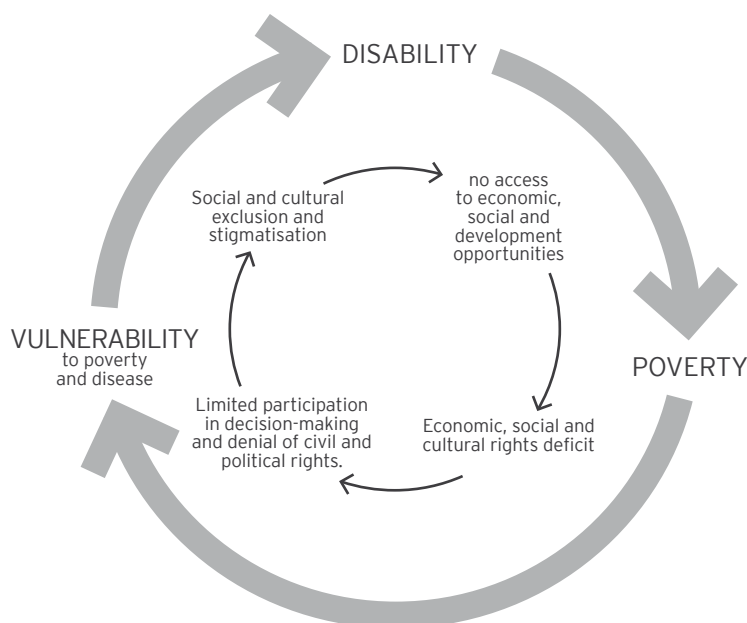
Figure 1
Poverty and disability – a vicious circle
Source: Department for International Development (DfID),
Disability, Poverty and Development, Issues Paper, Feb. 2000.

education and quality of services.
The underuse of services was still a
problem, however, and over the last few
years our teams have shifted their focus
toward increasing more widely the access
to services. Though not excluding direct
service provision support, they now take
into account additional elements like access
to information, financial access to services,
improvements to regulatory mechanisms, etc.

For several years, this issue has given rise
to a number of wide-ranging debates within
the association but also with our partners[2].
However, lesson-learning on this subject
remains extremely limited.

The following elements provided the starting
point for the approach taken in this guide:

a. In fulfilling Handicap International's
mandate, all programme teams regularly
witness examples of limited access to
services by persons with disabilities and
vulnerable populations. The categories
of persons more acutely affected by this
situation are women, children, minorities,
persons with certain types of disabilities, etc.

b. Working on the system of services (and
therefore including the access to services)
increases the chance that persons with
disabilities will be able to fully benefit from
it. Limiting action to the quality of service
provision without also working on access for
all does not necessarily help to improving
their living conditions.

c. Lastly, access to services issues
are equally relevant in emergency,
reconstruction and development contexts;
all teams therefore stand to gain from the
sharing of experiences.

2. The work performed for Handicap International by
Charlotte Axelsson in 2007; working documents on regulatory
mechanisms in South East Europe (Diana Chiriacescu, 2006),
a technical seminar organised by Handicap International in
Skopje (April 2007); guides and recommendations in the fields
covered by the Technical Resources Division (TRD); discussion
documents on access to social and medical/social services
for persons with disabilities (Franck Flachenberg, Audrey
Relandeau, Alice Jardin, Louis Bourgois) 2008.

C

Who commissioned this guide?
Who compiled it?
Who is it targeted at?
What working method was used?

In 2008, the Executive Committee commissioned a capitalisation document on our practices in this field in order to enhance the relevance and impact of pluri-annual programme programming. Under the supervision of the Technical Resources Division, a project team[3] was formed in January 2009 primarily to compile a general framework document for the association regarding the analysis and decision-making process used to implement operational frameworks on access to services for persons with disabilities.

How the guide was compiled
Based on the global and conceptual analysis developed by an internal discussion group[4] the team chose to provide teams with practical decision-making aids based on existing experiences and lesson learned wi. The project team benefited from the consistent support of the Knowledge Management Unit[5], which provided an extensive body of literature as basis for internal practices analysis and to shape the guide itself.

The document's key targets are:

— **Handicap International's programme teams and programme coordination teams** developing actions related to the access of persons with disabilities to social and medical/social services (desk officers, field programme directors, technical coordinators, project managers, project coordinators, field teams, etc). This framework will serve as a tool for decision-making, selection of methodologies and practical intervention soutions in a given country or action context.

— **The technical units of the Technical Resources Division** - the guide will provide them a systemic and coherent vision of projects related to access to services.

— **Handicap International's strategic policy unit.**

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3. Diana Chiriacescu, Maryvonne de Backer and Rozenn Botokro.
4. A discussion document on the access of persons with disabilities to social and medical/social services
(Franck Flachenberg, Audrey Relandeau, Alice Jardin, Louis Bourgois) 2008.
5. Anne-Marie Fombon, Catherine Clavel, Stéphanie Deygas, Nacera Kaifa, Catherine Dixon and Elodie Finel, with consistent help from Eric Delorme.

D

What approach has been used in this guide? How should it be used?

This document contains a set of questions and invites you to analyse your own experiences by helping you to identify those different aspects that need to be examined in greater detail or to explore further and by fostering the forming of links.

The guide begins each point with a set of questions and issues to consider. You are advised to answer each question individually then collectively. Each participant is encouraged to write down their answers before sharing their questions, ideas and opinions as a team and with their partners during discussion sessions before continuing to read the rest of the guide. This joint effort will enable everyone to objectively assess their context and intervention methods, and prepare them to make fresh contributions, enhance their skills and identify innovative ways of taking action.

E

Why certain expressions were chosen?

Person in a disabling situation?
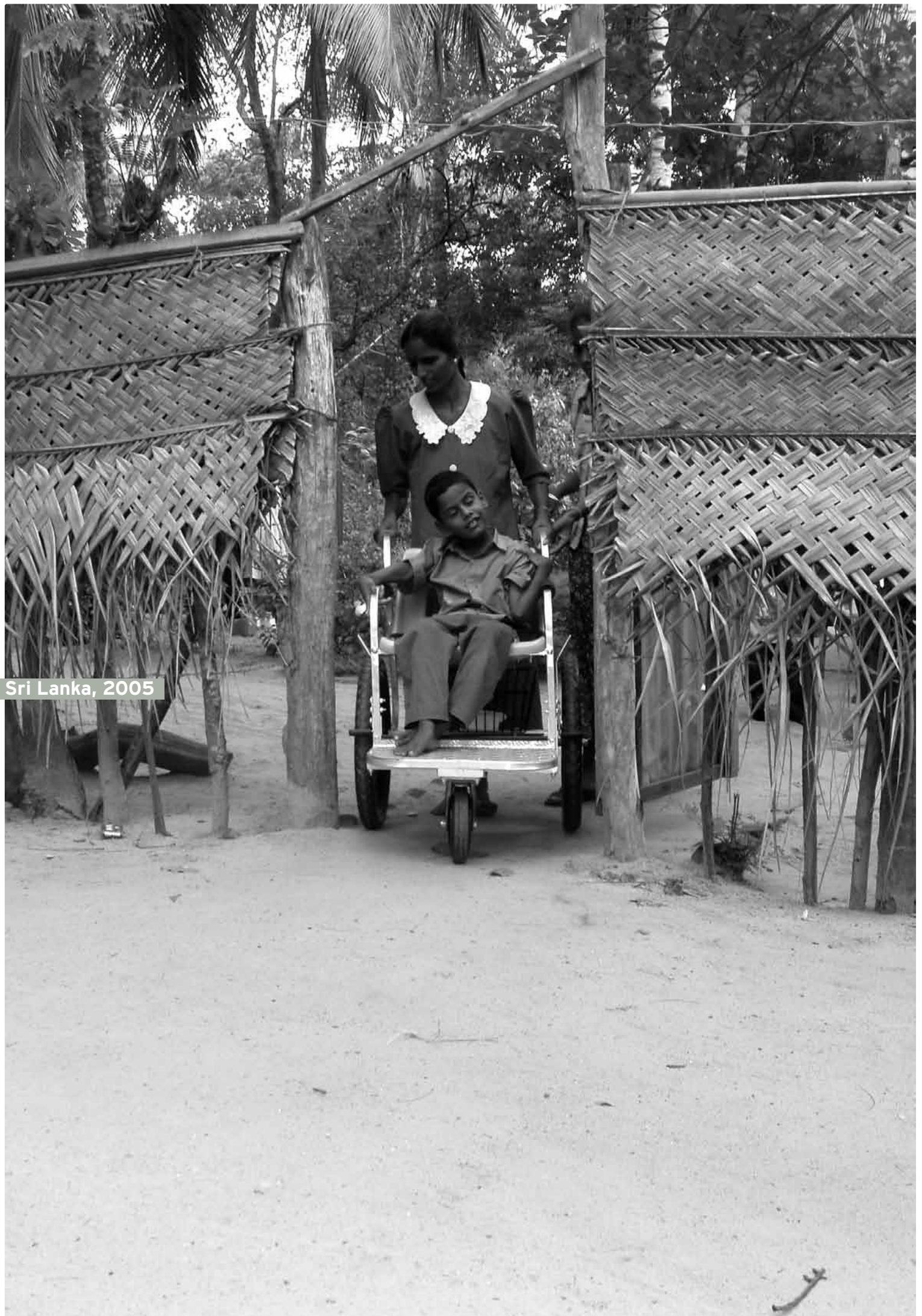**Person with a disability?**
Disabled person?

Using the United Nations Convention as our reference, we have chosen to use "personne handicapée" in French and "person with disabilities" in English.
A glossary at the end of the guide lists the main specific terminologies. Explanations will also be provided as we go along.

End

Sri Lanka, 2005

Principles and benchmarks

Services

You

What services have you supported
so far as part of your programme?
(List and explain with examples)

What sector do they belong to?
For what age and what type of users?
In rural or urban areas?

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A

Introduction: spectrum and continuity of services

**In order to achieve a common understanding of the services on which Handicap International wishes to have an impact, several the key concepts are listed below, in relation with the services sector for persons with disabilities:
Like any other member of society, persons with disabilities have the right to access a wide range of services close to their place of residence[6]:**

Although these services belong to very different domains, together they constitute a cycle or continuity that helps improving the living conditions of a person.
In figure no. 2, service examples are represented in the form of a circle of continuity.
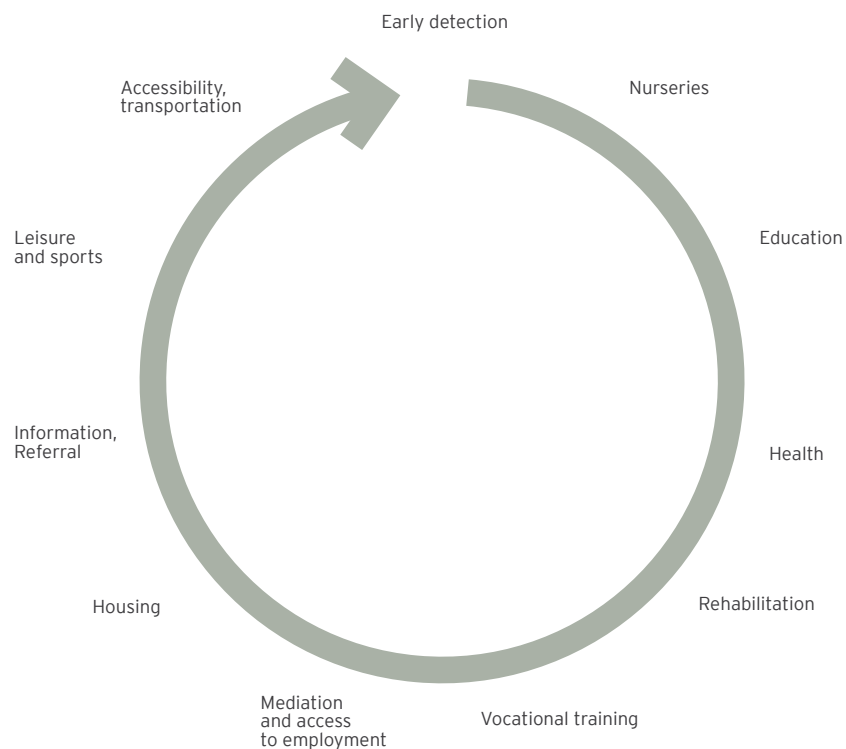
Figure 2
Spectrum of services

B

Spectrum of services

It is widely acknowledged that a person's social and economic participation is enhanced if these services are of a high quality and **provided on a continuous basis** during the various life cycles of a person with disabilities.
It is not enough for these services to simply exist. There must be a functional link between them and especially between those services intervening during a change in the life cycle or status of the person in question (e.g.: passage from childhood to adulthood, from school age to employment, etc.)
The continuous provision principle is highly important for persons with disabilities because it highlights their need for support services and assistance arrangements.

It is necessary to ensure a high level of continuity between:
- Education and rehabilitation;
- Education and vocational education;
- Rehabilitation and mediation for (or transition to) employment.
These links are required to ensure persons with disabilities will fully benefit from this range of services.

1. Support services[7]

One of the greatest needs of persons with disabilities in terms of access to services is the "support service".
Persons with disabilities may have additional needs for which their environment or mainstream services are not prepared. Support services compensate for this shortfall and help persons with disabilities taking part effectively in the daily social, cultural and economic activities. Support services include personal assistant schemes, in-home support for independent living, support teachers, mediation for employment, interpreters for sign language, etc.
This is why this services category plays a key role in their lives. Hence their central position in figure no.3: support services are essential levers for day-to-day life.

Below are examples of support services from each of the key service sectors.
- A support teacher ("school assistant"), providing educational support for children with disabilities.
- An employment mediator in a work environment.
- A professional sign language interpreter.
- A support service for accessing health, legal, educational services, etc.
- A personal assistant.
- An in-home daily care assistant.
- A social advisor or worker, etc.
The production and distribution of assistive technologies are also considered as support services in all sectors: housing, education, employment, vocational education, leisure, etc.

6. Articles 19, 23, 24, 25 et 26 of the UN Convention.
7. The term "support services" was mentioned officially for the first time in a document called "The Standard Rules on the Equalization of Opportunities for Persons with Disabilities", adopted by the United Nations in 1993. Rule number four of this key document in the field of disability is devoted to support services.

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Early detection

Accessibility,
transportation

Nurseries

Leisure, culture
and sports

Education

SUPPORT SERVICES

THE PERSON

SUPPORT SERVICES

Health

Information,
referral

Rehabilitation

Housing

Mediation
and access to
employment

Vocational training
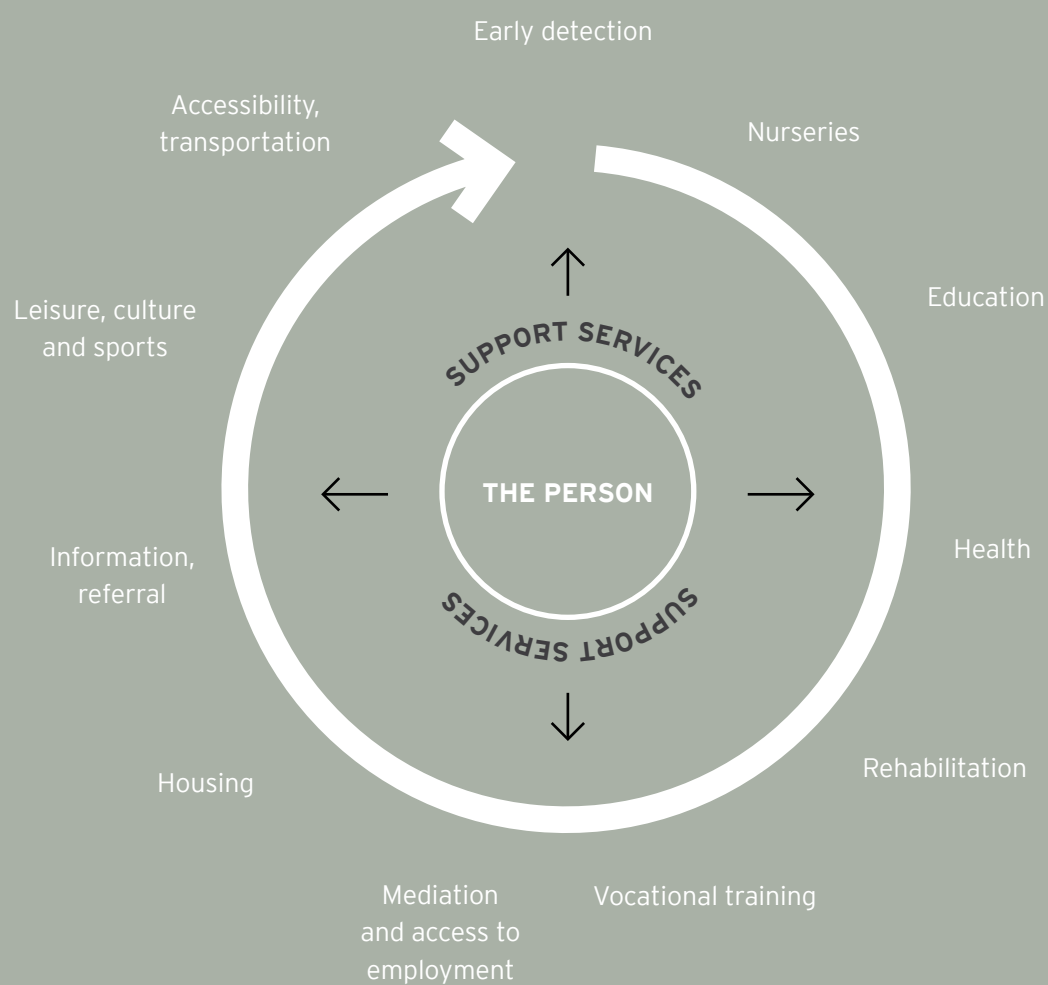
Figure 3
Support services –
a key role to play in the sector of services

2. Mainstream and specific services

Specific services are just as necessary as mainstream services in an inclusive society (the "house roof" in figure 4 below).

> For a society to be inclusive, it must ensure that its citizens have access to both general or mainstream services and more specific services, according to their needs and choices.

This systemic approach shows that, in order to meet certain needs, and more particularly for persons with multiple disabilities or highly dependent persons, society is committed to making specific services as accessible as mainstream services, with the needed links between them and with fully available support services (to ensure continuity of services)
From this point of view, the support services category can sometimes be considered as a separate and distinctive category of specific services.
However, its role remains highly precise because these services are not therapeutic but rather assist persons with disabilities in playing an active role in different areas of day-to-day life, allowing full access to mainstream services.
The functional rehabilitation process offers a good example.

This process falls into several categories:
- Mainstream services (including functional rehabilitation, physiotherapy, speech therapy, occupational therapy, etc.);
- Support services (assistive technologies, including mobility aids);
- Specific services (a rehabilitation centre offering a complete range of appropriate services, including functional rehabilitation, social support, assistive technologies, including mobility aids, etc.)

3. Basic services

We often talk about making access to "basic services" a priority during emergencies or in situations of extreme poverty.

Like other international actors, for Handicap International "basic services" include:
- Services essential to a person's survival (access to drinking water, basic foodstuffs, sanitation)

And in some contexts:
- Education;
- Primary health care;
- Road infrastructure;
- Basic safety measures [8].

8. Basic services and community facilities include the supply of drinking water, sanitation, waste management, social protection, transport and communications, energy supplies, health and emergency services, schools, public safety and the management of green spaces" (United Nations Habitat Programme, paragraph 84, mentioned in the document "International guidelines on access to basic services for all", http://www.un-habitat.org/downloads/docs/6243_65697_K0950030-F_HSP_GC_22_2_ADD6.pdf

AN INCLUSIVE COMMUNITY

=

REMOVING BARRIERS
(physical, information, attitudes, etc.)

+

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Mainstream services

• Education: preschool, school, university, continuing education, etc.
• Vocational training
• Childminder/ babysitting
• Day care centres
• Health
• Rehabilitation
 Employment mediation services
• Social support service (social work)
• Social housing
• Public transport
• Leisure, sport
• Information (resources centre, etc.)
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Support services

• Care assistants (personal assistants)
• Assistive technologies
• Sign language interpreters
• School support assistants
• Employment support and mediation
• Adapted transport
• Personalised budgets,
• In-home support, etc.

⟷

Specific services

• Early detection and intervention services
• Individual needs assessment
• Day care centres for persons with disabilities
• Rehabilitation centres
• Sheltered employment
• Sheltered homes, etc.

Figure 4
Typology of services in an inclusive community
(Outline developed by Handicap International's teams in South East Europe and the Middle East)

4. Social services and services with "a social function"


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           SOCIAL WELFARE SYSTEM

SOCIAL SECURITY                    SOCIAL SERVICES
Cash transfers, benefits,
     allowances
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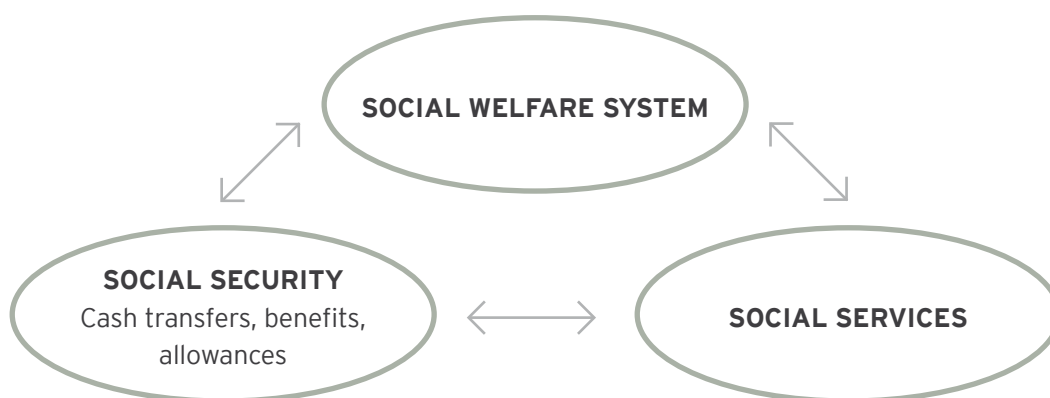
Figure 5
Two key components of the social
welfare system.

Out of all the services that are important for persons with disabilities, social services represent a distinctive category. Although there is no universally accepted definition of social services, their main role is to compensate for situations of vulnerability, deficit or poverty, whether temporary or permanent. For example, social support, in-home care for the elderly, social canteens, social or psychosocial assistance for large families, etc.
Social services are part of the national "social welfare" system. In countries in which such a system exists, it consists of two components:
- Social services;
- The cash benefits (allowances, pensions, financial indemnities) sometimes called "social security services".

Access to these two types of services is equally important for persons with disabilities, because they improve their quality of life and participation in society (the assignment of a personal assistant, transport vouchers, personalised budgets, etc.)

The current policy on persons with disabilities aims **to strike the right balance between disability related benefits and available social services**. In this way, the individual is able to exercise their rights and choices while benefiting from support appropriate to its particular needs.

In general, States **guarantee the access to social services for all of its citizens**. However, this does not necessarily mean that States ensure the direct provision of these services, which is often delegated to private service providers.
However, the State (local or national authorities) remains responsible and, as a result, must guarantee access of citizens to these services according to their needs. Some services such as education and health cannot be considered directly in the category of social services but they contribute to the social inclusion of citizens. They therefore belong to the category of "services with a social function"[9].

9. A formulation that appeared in the EU during debates on general interest services (2001–2006).

C

Summary

– Persons with disabilities generally need to access a wide spectrum of services in their community, from early detection and early intervention to education, vocational training, health and rehabilitation services, leisure, transport, etc.

– It is necessary to ensure the continuity of service provision (rehabilitation, health services, etc.)

– An inclusive society ensures that mainstream and specific services are also accessible to persons with disabilities.

– Support services allow persons with disabilities to access services and to take part in social and cultural activities, etc.

– In emergencies or in situations of extreme poverty, access to basic services is a priority.

– When we talk about a country's social policies, we're referring to two key aspects:
• the social security system
(or all financial support mechanisms for a country's citizens);
• and all social services and personal assistance services.
Access to these services is just as important for persons with disabilities.

– Education and health are considered to be "services with a social function".

Actors

A

You

In your country of intervention, which actors intervene (directly or indirectly) in providing services for persons with disabilities? Could you draw up a detailed list?

When you provide support or a service, which other actors intervene with you? Who are your direct partners or contacts?

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Introduction: range and interaction of actors

Below are the key concepts to be considered when developing a common understanding with the partners with whom you work:

Numerous actors play an important role in providing a service to persons with disabilities:

- Service providers;
- Donors/funding bodies;
- Media;
- Voluntary workers;
- The authorities;
- Professionals;
- NGOs and INGOs;
- Family, etc.

The empowerment of these actors and the good governance are essential to ensuring access to services.

Access to services for persons with disabilities depends heavily on effective interaction between three categories in particular.
This relationship should be analysed in all contexts, even in the poorest countries or unstable situations.
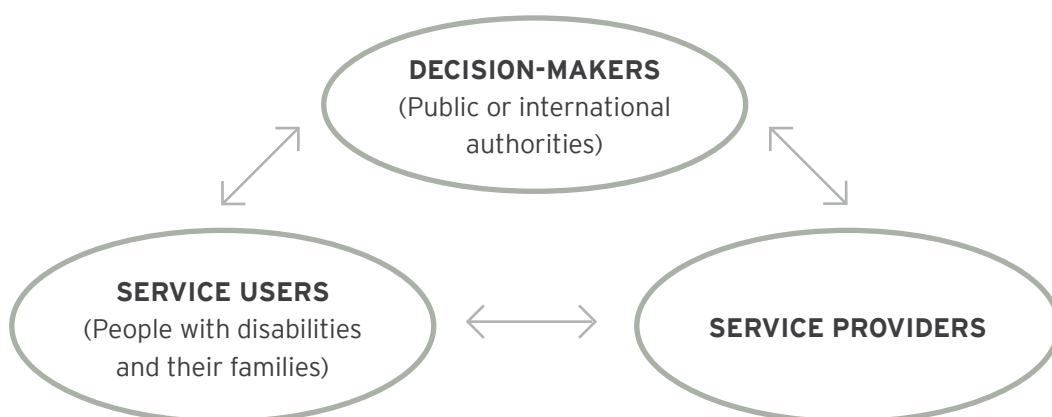
Figure 6
Key actors in providing services to persons with disabilities.

B

Roles and interaction of actors

During the analysis of a country's situation with regards to service provision, the interaction as well as the accountability mechanisms between these actors in an "ideal" system must be taken into account since it determines the conditions under which services are accessed.
It helps you to identify gaps/faults and to analyse the capacity and actual situation of each keyactors.

1. Users and their families

They are the first claimants for community services. They should succeed to successfully express their needs and specify their choices and priorities.
In a favourable context, users may successfully influence the policies pursued by the authorities and enforce their rights. For this to happen, they need the necessary information in order to be able to question the availability and quality of existing services. A firm involvement of users in the quality assurance approach to services is essential.

2. The authorities or decision-makers

The authorities of a country, region or territory are responsible for meeting the population's needs for social services and services with a social function. These services may be delivered by public service providers or delegated to private actors. Those authorities with the capacity and resources should also play a regulatory role. They define key guidelines and should provide the resources necessary to ensuring the availability of these services.
The authorities should also guarantee the level of quality of services. Audit and accreditation mechanisms ensure the appropriate control of these services.

When local or national public authorities are unable to adequately fulfil their role, the regulation of services is generally delegated to outside agencies or bodies (either local or international, such as NGOs, UN, etc).

3. Service providers

Service providers are in direct contact with users.
They supply the required information on their services to the authorities and must respect the quality standards and principles defined by a regulatory body (the State, local decision-maker, body delegated to regulate services, etc.)
User information is seldom regulated in most of the countries in which Handicap International intervenes. However, it remains part of the provider/user relationship. Ideally, service providers are made aware of their responsibilities towards users and the authorities.
In some cases, they can take part in call to tender processes and receive public or private funds.

There are three categories of formal service providers and one category of informal service providers in the medical/ social and social sector. This diversity represents a particular characteristic of social services[10]:
- Public service providers;
- Private (non-profit) organisations;
- Private (for profit) organisations;
- Then "informal": families, voluntary workers, neighbours, etc.(NB: when it comes to families, the majority of informal service providers are women) or "traditional" ('tradipractitioners', healers).

10. Munday, B., "European social services, characteristics and trends", in the papers given at the "General interest services in Europe today and tomorrow" international conference, ODSSE, Hamburg 2002.

C

Summary

Beyond their role as service providers, these practitioners can play several roles simultaneously:

— A humanitarian role for the most destitute? Poorest or most vulnerable people;
— A lobby role, aiming to support the interests of a certain profession, type of service, or category of users;
— A role in the resources mobilization role for specific causes or needs.

Service providers also play an important role in revealing social needs. In direct contact with the most vulnerable categories of the population whose needs are rarely taken into account, they can also develop a space for the sharing of knowledge and experience between people from different environments.

— **Access to services is closely linked to the responsibility of actors and good governance.**

— **Access to services is optimised when three types of actors (users, the authorities and service providers) form a relationship of collaboration and exchange and assume their roles in ensuring the transparency and the good management of demand and offer of services.**

— **These services can be delivered by public service providers or delegated to private (non-profit or for profit) service providers. In an ideal system, the authorities retain a regulatory role.**

Principles and benchmarks

21

Determining factors

You

What do you think are the main determining factors impacting access to services by persons with disabilities?
(List and explain with examples)

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A

By level

In order to achieve a common understanding of these determining factors, we provide below a number of lists issued from exchanges of practices performed by our field and head office teams, and statements made by persons with disabilities with regards to their access problems, based on studies and presentations made by Handicap International's partners and actors during a seminar on access to services in December 2009 in Amman and, lastly, reference documents.
Your own thoughts and experiences will help us expand these lists.

A good access of persons with disabilities to services is mainly determined by:

1. L'organisation systémique (macro)

Factors related to the organisation of the services system as a whole at national and local level:

The actual existence (availability) of services, adequate in number and variety;

Physical and geographical access to services by people with disabilities, which involves:
- A geographical distribution of services responsive to needs in rural and urban areas, throughout the territory;
- Environmental factors limiting access to services (climatic, etc.) are taken into account or measures are taken to remove them;
- The existence of and compliance with accessibility standards;
- The existence of outreach services;
- The existence of mobile teams, according to needs;
- The existence of accessible transport to and from these services;

The existence of widely distributed information on the services available and on what they can provide:
- Multiple formats to meet the needs of particular groups (in Braille, sign language, local languages, easy-to-read, images for illiterate persons, etc.);
- Media adapted to local communication methods and social life (theatre, group awareness-raising, communication in places regularly visited by girls and women, etc.)

The existence of motivated and trained professionals:
- Sufficient in number, possessing a range of complementary skills (in mainstream, specific and support services) underpinned by a global person-centred approach[11]. Gender-sensitive, for example. And mindsets conducive to service access.

An appropriate range of available assistive technologies

Affordable costs and financially accessible services

The existence of flexible procedures for accessing services:
- Non-bureaucratic, reflecting the actual needs of users
- Include users who change their region of residence[12];
- Procedures or services for guiding and referring people to services (Disability and Vulnerability Focal Points, disability centre, referral committees, etc.)

2. Internal organisation (micro)

The **service's internal operations** with the potential to facilitate or, conversely, if they do not exist, to diminish access of users:

The ability to listen, the information supply and the user welcoming procedures
- By the service staff (in local languages, for example)

The existence of adequate resources
- The service management, with operating continuity assured;
- Installation of appropriate and respectful sanitary facilities.

The "flexibility" of services (in terms of the responsiveness of services to user needs)
- Using a range of technologies and working methods which are responsive to a wide range of users and contexts (emergency, reconstruction and development),
- And based on regular adjustments to the changing needs of users
E.g. growing children, adults with disabilities whose in-home care needs are changing, pregnant women, etc.

The availability of information on prevention and treatment
- For the diseases in question (in the case of health services)
Access to accurate diagnoses
- E.g. for prescribing orthopaedic devices

Easy access within service's premises

A qualitative management
- Focusing first and foremost on the interests of users and the service's response to their real needs.

See diagram next page.

11. Global approach: taking into account the needs of the individual, their past, environment, needs, etc.
12. Rural exodus, displaced persons, refugees, etc.

AT SYSTEM/ MACRO LEVEL	AT SERVICES SYSTEM MICRO LEVEL
PLANNING	**PLANNING**
Activities:	Activities:
• Local needs analysis;	• Drawing up internal organisation instruments (manual ofprocedures, internal regulations, ethical charts, etc.);
• Elaboration of maps of needs and existing/required services;	• Assessment of the needs of users accessing directly the service, initial assessment;
• Drawing up user access procedures;	• Drawing up personalised intervention plans, etc;
• Tenders procedures;	• Planning the usersactivities targeted at users;
• Authorisation of services in compliance with the local needs and the minimum conditions and standards required;	• Calendars of internal assessment.
• Contracting and funding of service providers.	
IMPLEMENTATION OF ACTIVITIES	**IMPLEMENTATION OF ACTIVITIES**
Delivery of actual service.	• Actual delivery of services to users;
	• PDCA (Plan Do Check Act) cycle action inside the service provider organisation.
EVALUATION	**EVALUATION**
• External evaluations of existing services;	• Internal evaluation of service's quality;
• 'Benchmarking' actions at local or national level.	• Evaluation of personalised intervention plans, etc.
CORRECTIONS AND FOLLOW-UP	**CORRECTIONS AND FOLLOW-UP**
• Recommendations (corrective);	• On-going follow-up of the service;
• Renegotiations (contract and funding);	• Correction of errors or ineffective procedures within the service.
• Punitive actions, if necessary.	

The diagram below shows the service provision activities at the different levels and stages of organisation, in a quality insurance approach.

Determining factors

According to the European Commission's High-Level Group on disability, several principles contribute to rather than determine the quality of services for persons with disabilities[13]:

- Full respect of users' rights, their choices and interests;
- A people-centred approach all along the intervention;
- The continuity of care and interventions throughout the person's different life-cycle stages;
- The participation of users in the planning and evaluation of the service;
- Service delivery partnerships;
- A results-oriented service;
- Good governance of the service.

3. External organisation (users and populations)

Facilitators related to **the population's attitude to services or search for support** in general:

The proactive attitudes of users when initiating a request
- Users who identify and use appropriate services, partly because they have been made aware of their right to access services (combating Paolo Freire's concept of introjection[14])

A positive perception among the users groups of accessing social services for:
- Women;
- Ethnic minorities;
- Persons with various disabilities;
- Poor people, etc.
in order to reduce cultural and traditional barriers, linked to beliefs or local customs.

13. http://www.easpd.eu/LinkClick.aspx?fileticket=4D55703469 685630427A633D&tabid=3531&stats=false
14. Paulo Freire, Pédagogie des opprimés, La découverte/Mas-pero, 1983 See the glossary, la Transposition du Concept d'auto appréciation ou d'introjection de Paolo Freire au handicap.

B

Illustrations

1. Different surveys in Africa

As part of the national disability survey in Morocco performed in 2004, "people with disabilities were asked to define which, among the constraints and barriers they are faced with, raised the most significant problems and which major needs and expectations need to be met in order to resolve these problems."

Below are the main reasons that users considered as obstacles for accessing access services:

Insufficient financial means
83,2 %

Geographical distance
25,2 %

Negative image of health-care services
21,1 %

The services have insufficient means
17,6 %

Physical inaccessibility
7,9 %

Communication difficulties
4,6 %

Highly complicated administrative procedures
3,4 %

Lack of information
2,1 %

Other reasons
8,2 %

15. National Disability Survey in Morocco, Secretary of State in charge of the family, childhood and persons with disabilities, Kingdom of Morocco, with the support of the European Community, 2004.

Determining factors

A questionnaire on access to services was also used in 2010, in West Africa (DECISIPH 2009)[16].

A survey in Togo[17] performed in 2007 revealed that:
"The accessibility of the streets during the rainy season is an obstacle for more than three quarters of people interviewed. The negative impact of this environmental factor is mentioned by a very large majority of people with physical difficulties (over 83%) or vision problems (86.3%)."

A study in Zambia[18] revealed that:
"The major difficulties are public transport, accessible to only 65% of people, and the workplace, accessible for 68% of persons with disabilities. Around one third of persons with disabilities who use public transport or who work encounter barriers to accessing these services"

2. Afghanistan study

A Handicap International study in Afghanistan also revealed the types of problems encountered by users during visits to health services (based on a comparison between persons with and without disabilities)[19]:
- Lack of money;
- Lack of transportation;
- Lack of medication;
- No accompanying person;

- Lack of food;
- Lack of medical staff;
- Poor attitude of staff;
- Equipment supplied unusable.

Additional barriers revealed in studies by other NGOs:
- Fear of denunciation;
- No residency in a setting where proof of address is required to exercise rights.

3. Amman seminar questionnaire

A brief questionnaire, completed by the members of an international seminar organised by Handicap International in Amman, December 2009, listed the main barriers and facilitators to accessing services for people with disabilities, in the opinion of Handicap International's teams and our local partners. Here are the results:

The main barriers to accessing services in the community:
- Limited number or non-existence of services in rural, geographically remote or isolated areas;
- Difficulties for physically accessing the existing services; users need to travel long distances, sometimes in unsafe environments, especially for women and children;
- Limited access to existing services (physical, information, etc.);
- Financial aspects: high cost of services or assistive technologies and resources; other costs involved in gaining practical access to the nearest services (transport, accommodation, safety, etc.) by users; services are not a priority for poor families; generally limited budgets allocated to services for persons with disabilities;

16. ENQUETE SIPS - DECISIPH, Health, disabilities and social participation 2009, Handicap International.
17. Living conditions of persons with disabilities in Togo: survey of 30 communities in Togo, Survey report June 2007, Handicap International.
18. Living conditions among people with activity limitations in Zambia, a national representative study, SINTEF A262 Report, Septembre 2006.
19. Understanding the challenge ahead, Executive Summary Report, National Disability Survey in Afghanistan, Islamic Republic of Afghanistan and Handicap International, 2005, schéma p. 28.

20. 2003 report by the care access observatory of the France mission of Médecins du Monde, ORSMIP, published in 2004, special issue no.1.

- A lack of information on what the services offer and their usefulness; lack of knowledge of the rights of persons with disabilities, of the services to which they are entitled to, and of existing services; lack of interest in services in certain cases;
- The poor quality of the services; low level of expertise of professionals and practitioners;
- Inefficient service provision systems; excessive bureaucracy; corruption; lack of support services to facilitate access of users to outreach services;
- The lack of trained professionals in the different disability sectors; lack of a basic knowledge of disability in initial and on-going education of professionals;
- Negative attitudes of the public in general towards disability; the negative attitudes of service providers to persons with disabilities; cultural or religious prejudices with regards the demand for care services;
- Poor coordination between all actors involved in the case-management of persons with disabilities (individually or as a group via the associations that represent them, their families, professionals and the public authorities);
- Inadequate policies in the disability or services sectors; lack of political will to improve the disability services sector;
- Poor organisation of the service "demand": lack of proactive behaviour by users with regards to the identification of existing services; disabled people's organisations still weak or not coordinated, lack of collaboration between actors in performing effective advocacy work, etc.
- Insufficient civic involvement of local communities.

4. Field experiences collected at the seminar (what is being done so far)

Experience sharing
Handicap International has extensive experience of improving the access to services for persons with disabilities. The examples below provide an overview of the wide range of operations performed by the association around the world [21].
- Handicap International supports the creation of multidisciplinary diabetes care teams within local communities in the Philippines to improve **access to primary care** for people in poor regions.
- In Lebanon, Handicap International helps operate **Support and Guidance Centres**, which facilitate access for families to early detection services and therapeutic services dedicated to psychological disorders for Palestinian displaced persons living in refugee camps.
- In Nepal, the team of Handicap International works to ensure that physical rehabilitation services are **more accessible for people living in isolated areas**.

In the Balkans, Handicap International, present in the region for 20 years, has supported national actors in their efforts to apply **structural (more global) reforms related to its services** for persons with disabilities at national level; but also the creation of **practical and innovative services**:
• In Montenegro and Romania, based on pilot projects set up in day centres for children with disabilities, Handicap International supported the development of national service networks, in partnership with the local authorities and international agencies.
• In Macedonia, Handicap International supported the reform of the regulatory system for services for persons with disabilities.
• In Kosovo, Handicap International began by supplying emergency aid during the Balkans wars and subsequently continued to support local actors and helped to develop national and local strategies, in order to improve the access of persons with disabilities to outreach services.
In Mali, Rwanda and Togo, Handicap International has set up, in conjunction with local actors, equity funds to ensure financial coverage of the functional rehabilitation care for the poorest categories of population.

5. Cross-cutting document study (what still needs to be done)

From March to June 2009, the "services" project team has studied a significant number of documents related to Handicap International's actions in the access to services sector [22].

It revealed the variety of sectors in which Handicap International intervenes, in keeping with the association's wide field of activity sectors (see Scope of Activity, November 2009).

In identifying the areas for improvement, the following elements were identified:
Programmes rarely have an explicit global strategy for improving access to services. In some cases, there is an awareness of the need for a more systemic approach to services (and their access), despite the fact that the project approach is more widespread, with not always clear links between the different projects of the same programme.

The contexts and actors analysis used so far (mainly included in the programme review documents/programme operational frameworks) do not necessarily highlight priorities in terms of the choice of services to be supported or the actors to be targeted. In fact, the current grid for reviews analysis was not sufficiently detailed to highlight such priorities.

The types of partnership differ widely from one programme to another.
For multi-actors partnership initiatives, it's rare that decisions are made jointly with associations and disabled people's organisations. Moreover, the involvement of local actors in defining the local needs of services is not approached in the same way for all programmes. Although concerns exist and goals are mentioned, the methods do not always reflect intentions.

28

22. The documents were gathered and supplied by Handicap International's Methodology Unit and Resource Centre. They included programme reviews, lesson-learning documents, positioning documents (...) from the last ten years.

C

Summary

— **The identification of support or transitional measures (excluding the intervention during humanitarian emergencies) necessary to move from a period of direct service provision to a sustainable operating stage, which is sustainable outside the intervention of Handicap International, is often lacking.** Most of Handicap International's programmes do not anticipate the benefits of sustainable change in the services sector and, more generally, of the mechanism for sustainable improvement of access to services procedures.

— Lastly, **mechanisms for multiplying positive effects** (such as the training of trainers, multiplier cascade effects, the widespread distribution of lessons learned and successful experiences, etc.) are not planned or used regularly in all programmes, despite an obvious increase in the number of these choices over the last few years.

The determining factors that contribute to an improved access to services for people with disabilities are related to:
— **The organisation of the services system at local and national level (meaning how they are planned, funded, evaluated and continuously improved);**
— **The internal management of services;**
— **The attitude of users and the population towards these services.**

Factors determining access to services must be subject to a detailed analysis that takes into account the context of each respective country or region, and include gender issues. Handicap International's priorities for action will then be selected according to the analysed local context, but also according to internal skills and the length of Handicap International's intervention.

For example:
It would be difficult to imagine a complex support project to help a country's national authorities implement a large reform of the service system, if Handicap International's teams are present in that region, as part of an emergency response or over a very short period. In this case, the teams would rather be able to support the improvement existing services and make them more visible and effective in terms of their management and availability to users.

Development and influences

You

How did the latest international developments influenced the perspectives on access to services for persons with disabilities?

Do you know of (and do you use as part of your current practices) any international reference documents and their related programmes, which have an impact on the disability services sector? Which ones?

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A

Evolution towards fundamental rights

The "social model of disability" and the promotion of disability as a human rights issue have led to a reassessment of the balance between social welfare measures and access to care and support services. The harmonisation of these two types of intervention is now a key issue for social policy systems worldwide.

At a political level, these developments have led to political and legislative progress in terms of taking into account the prevention, health, education and employment services sector.

At a service level, these key guidelines have gradually encouraged professionals to:
- take into account people's needs as part a more holistic approach;
- prioritise the user's living environment as the main point of intervention;
- emphasise the individual's social support network, and the continuity of care and support measures;
- work in partnership to manage the increasingly complex situations [23].

23. Haelewyck, M.C., Qualité des services offerts aux personnes en situation de handicap: élaboration conjointe d'outils d'autoévaluation, in "Recherche et développement qualité en action sociale", under the direction of J.M Dutrénit, L'Harmattan, 2004.

B

Reference documents

The intervention targeting the development of services for persons with disabilities are currently based on two international reference documents compiled by the United Nations:

- **The Convention on the Rights of Persons with Disabilities (2006)** [24], [25]
- **The Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)** [26]

Other texts and framework documents are equally important:

- The Convention on the Rights of the Child, 1989;
- The Convention on the Elimination of all Forms of Discrimination against Women, 1979;
- The Universal Declaration of Human Rights, 1948;
- The international classification of functioning, disability and health (WHO 2001).

In the disability services sector, the disability analysis framework developed by Patrick Fougeyrollas and his colleagues also plays a particularly important role: the **Disability Creation Process** (DCP) [27].

Within Handicap International's programmes, the DCP has served as a basis for the reform of the systems used to evaluate the needs of persons with disabilities and has had a direct impact on procedures for guiding people towards services.
The DCP is also used in conjunction with rehabilitation and vocational education services for people with disabilities.

C

Summary

This initial section of the guide provided an overview of the key points for analysis in the disability services sector:

- **The spectrum and continuity of services;**

- **The role of mainstream, specific and support services;**

- **Key actors in the process of service provision;**

- **International developments that are currently impacting the service analysis frameworks for persons with disabilities.**

End of Principles & Benchmarks

24. http://www.un.org/disabilities/documents/convention/convoptprot-f.pdf
25. Dixon, C., The UN CRPD holds a central place for access to services for persons with disabilities, 2009, Handicap International.
26. http://www.un.org/esa/socdev/enable/dissrfr0.htm
27. Fougeyrollas P., Cloutier R., Bergeron H., Cote J., Saint-michel G., Quebec Disability Creation Process classification, Quebec, RIPPH, 1998.

Macedonia, 2006

Practical guide

Step 1
Data collection
and analysis

Introduction and applied methodology

A series of analyses are required to decide which types of intervention and actions will be most appropriate to improve the access to services by persons with disabilities:

Stage 1.A
A country context analysis;

Stage 1.B
An analysis of the situation of the actors involved in service provision: users, direct service providers and public authorities or regulatory agencies;

Stage 1.C
Analysis of Handicap International's programme in the respective country/territory/region: background, the organisation's priorities in the region, constraints, etc.

How to use this information?

An analysis of the context and key actors will aid decision-making during a given period targeting:
• The types of services in which Handicap International is going to invest: support, financial support, direct service provision/delivery, staff training, etc.;
• The types of actors that Handicap International is going to support;
• The choice of practical support to provide, that is, the practical actions taken by Handicap International's teams;
• The choice of intervention level: at the local level of a specific service and/or at a regional or national level in case of policies and reform of services system.

Overall methodology of these analyses

The methodology for this stage of the analysis starts with the collection of several types of data as a baseline for informed and reasoned decision-making.
This involves paying particular attention to gender issues at each stage. Otherwise, the data collected will not allow us to subsequently perform a "gender sensitive" analysis [28].
The following chapters include lists of related issues and questions. These questions are accompanied by corresponding checklist tools and recommendations of other possible data collection methods, as well as estimations of the time necessary for each analysis.

This tool does not replace the existing context analysis methodologies used during the development of multi-annual operational frameworks for programmes.

On the contrary, the analysis tools set out in this guide can be used to build on the "standard" analysis tools [29] used by Handicap International, based on a "systemic" approach to the access of services for persons with disabilities.

Here is a brief reminder of the components of the standard analysis generally performed by Handicap International's teams for a given programme:
• Observing the situation;
• Analysing existing problems;
• Programming goals and the intervention strategy;
• Drawing up the action plan;
• Evaluating programming and the programming of evaluations.

28. Gender and Development Resources: Toolbox to help integrating gender in Handicap International project. http://www.hiproweb.org/fileadmin/cdroms/CD_Genre/index.htm
29. Cf. References handbook, Handicap International, 2005, part I, chapter 1, pp. 70/71.

NEEDS observed by the professionals

Range of **PROBLEMS leading to a project**

DEMANDS expressed by the community

RESOURCES and local "know-how"
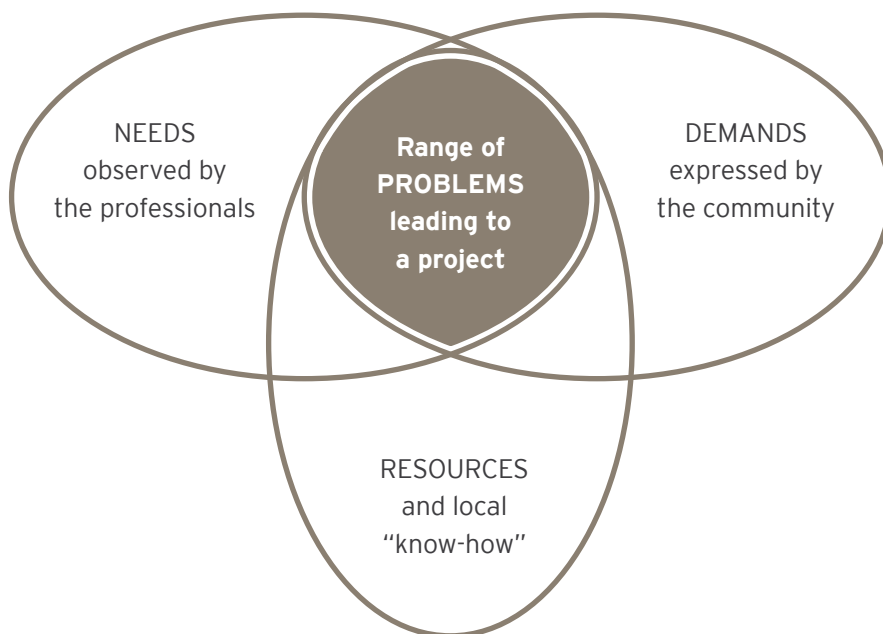
Which data collection methods should you select to complete stages 1A and 1B (context and actor analysis)?

───────

The variety of tools suggested for these stages (see the tool box) alone reveals the complexity of the data necessary for programming relevant interventions which are meant to improve access of persons with disabilities to services.

In order to optimise the analysis, you must ask yourself how much time is required and what resources you need.
Below are detailed information and advices on the type of data to collect and on the collection procedures themselves:

a. You may use a "two speed" data collection process, depending on the resources (human and material) available during the preparation stage of the strategy-programme:

➥ **A "general" data collection**: guides the programming of the intervention as a whole, without entering into details, but primarily targeting:
• the policies implemented,
• the existing range of services,
• the overall professional situation;
The estimated time necessary for this assessment, in general, is **between one and three months.**

➥ **An advanced data collection**: provides more nuanced information on the services situation and helps develop a clear, relevant and well-reasoned strategy for the programme. *The time necessary, according to the extent of the programme and the complexity of the countries involved, generally varies* **between six to twelve months.**

b. Obviously, the more detailed the analysis, the better the preparation and, consequently, effectiveness of the programme.

c. If the teams are not familiar with the specific concepts presented in the guide or the analysis tools, ask for **the support of the technical teams from the Technical Resources Division, the Emergency Response Division, or the Mines Division**. Resource persons will be available to help the teams in order to perform better the start-up analysis.

d. Involving national actors (persons with disabilities, or disabled people's organisations if they exist, service providers and/or representatives of the authorities) at the data collection and situation analysis stage is a key method, whenever possible.

e. The teams often have time restrictions, and it is necessary to find the most effective methods to **maximise data collection within a minimum amount of time**. Roundtables at national or local level, think tanks and work meetings organised on specific topics can help a lot. **Inviting different types of actors around a table** allows you not only to avoid distorted information but also to enhance the dynamic of discussions and testimonies.

f. Existing documents in the field are also important, from official data to reports compiled by NGOs, other organisations or international agencies. All are essential for clarifying the current service situation.

g. Some programmes use **mini projects** (such as "Competition for the best practices in the services sector for persons with disabilities" or "best practice sharing seminars", etc.) in order to identify innovative examples but also to collect "live" information on certain sectors of activity, their organisation, the professionals involved, etc.

h. Lastly, the best analyses are, obviously, performed **in the field** when teams spend time with key actors and informants (interviews, practical visits to services,

families, discussions with local authorities, etc.). This practical information on the current state of services is central and will optimise the decisions made by Handicap International at a later stage.

Important: **If resources are limited, this should not prevent the team from performing the context and actors analysis**. Each team can choose their own means of collecting data. More in-depth analyses can be scheduled and staggered over time at a later date.

The point of this stage is to obtain a range of decision-making parameters, reasoned and supported by data from the field, aiming at developing Handicap International's future intervention strategies in a given country/ territory/ region.

A

Analysis of context

This covers specific elements, on several levels:

— **The geopolitical background to the intervention;**

— **Official policies** relating to services for people with disabilities by sector (education, health, rehabilitation, employment support, social welfare, etc.);

— **The administrative context and general organisation of the services system** (level of decentralisation, funding, overall management of systems, regulatory mechanisms, participation of various actors in decision-making, etc.);

— **The current state of the services themselves:** spectrum, internal quality, accessibility, management capacity, continuous improvement strategies, innovation, etc.

1. Geopolitical context of the intervention

Specifying the context of Handicap International's interventions is the starting point for all planning exercises.

The type of crisis (emergency, chronic crisis, reconstruction or development) will determine various options when selecting interventions according to the sector and for a given period:
— **The post-crisis period**, leading to a more stable situation of growth and development, offers major opportunities for taking an even more systemic approach to access to services for persons with disabilities and other vulnerable groups, according to the stages set out in this guide.
— **Chronic crisis contexts** (extreme poverty, inability of states to meet their basic responsibilities, insecurity of teams, partners

and target populations) remain extremely difficult from the point of view of the tactics to adopt to ensure access to services for different groups. This guide does not contain specific tools for these situations. However, Handicap International is focusing resources on lesson-learning from experiences of these situations in order to better anticipate the factors which promote greater access to services for our beneficiaries.

The types of services that need to be restored restore in emergency contexts Two factors must be taken into account:
— **The choice of services to deliver** over the short-term: According to **the type of services**, basic services, essential to the survival of the individual, must generally be prioritised during emergency situations: access to food and water, sanitation, primary medical care and minimum law enforcement guarantees to ensure people's security.
— **The measures to put in place at the earliest opportunity in order to ensure continuity** between an emergency response and more long-term actions. According to Handicap International's intervention principles, from the very beginning if the project's planning, it is necessary to design an exit strategy, including any possible support or transition measures to be taken.

The impact of the duration of the intervention on a service-related strategy
— The duration of a Handicap International intervention in a given country plays a key role in the definition of mid- to long-term action strategies. A strategy that targets the reform of the services system cannot be developed when Handicap International is only present over the short-term. The sustainable introduction of new types of services on a large scale, the support for national policies in the services sector, the initial training and follow-up of professional, etc., altogether require Handicap International's stable presence in a country

over a well-defined period of more than 5 years.
‑ In a reconstruction or development
situation, an intervention at local and national
level requires a minimum presence of around 4
to 5 years to bring about lasting change.
‑ On the other hand, if Handicap
International only expects to have a
short-term presence (1 to 3 years), the
programme could support only targeted
services and apply measures to multiply
further their positive results. In this case, it
is particularly important to form alliances or
partnerships with actors who are expected
to remain in the country, territory or region
for longer periods, in order to transfer the
"multiplier" roles and the necessary skills by
providing these actors with intensive support.

Planned financial and human resources
‑ It is essential to know from the beginning
the type of professionals and/or trainers that
Handicap International is able to mobilise for
a given country, as part of its projects.

**Handicap International's mandate in an
emergency context:**
Handicap International provides a
multidisciplinary humanitarian response to
refugees and persons affected or displaced
by crisis, conflicts or disasters and, for
those caught up in these events, specialised
support to particularly vulnerable persons,
trauma victims and persons with disabilities,
by supporting the organisation of aid
efforts, the coordination and management
of camps, covering basic needs and
reconstruction [30], among other actions.
Our action is submitted to the principle
of "operational differentiation", which
enables us to adapt our operating method
to the context and the activity sectors
mobilized, with a very rapid response time.
As our emergency response unfolds, we
are careful to ensure support for initiatives
based on local solidarity actions and seize
opportunities that the aid supplied provides
in terms of sustainable improvements. [31]

2. Existing policies

Data to collect
↳ See Toolbox: 1.A.2

Here are three questions to be asked about
each document below.

The questions
• Do these policies exist in the different
service sectors?
• At what level (country/territory/region)
of intervention?
• In what form?

The documents
• The signature/ratification of the Convention
on the Rights of Persons with Disabilities
(CRPD) and its Optional Protocol;
• The key strategies and action plans in the
disability and/or services sector; the quality
of these documents and their synchronisation
with international reference documents
(examples: poverty reduction strategies;
action plans for respect and protection of
the rights of persons with disabilities, action
programme for women, etc.);
• Specific laws relating to the services sector
or the protection of the rights of persons with
disabilities; the quality of these documents
and their synchronisation with international
reference documents;
• Strategies and/or local action plans for
persons with disabilities (compliance with
Agenda 22, for example) [32];
• Existence of an allocated budget for
implementing these plans or laws;
• Officials to ensure their implementation.

Analysis: how to use this information?
It provides a sound basis for launching a
programme approach that aims to improve
access to services within the given context
and period.

30. Scope of Activities, Board Letter November 2009.
31. Principles of intervention, Board Letter 3 May 2010.
32. Agenda 22, Disability policy planning instructions for local
authorities, The Swedish Co-operative Body of Organisations of
Disabled People, 2001.

If these documents and officials in charge exist, it is possible to use their goals and principles as **levers for our own programmes**. If they do not yet exist, and even if their implementation is not a goal in itself for Handicap International's programmes, they form a key component of the context and allow us to base our actions on national or local dynamics, managed by or with the country's players. These policy elements above should, whatever the case, be considered by the programme, preferably at the beginning of the programming period.

3. The administrative context and systemic organisation

Data to collect
↳ See toolbox: 1.A.3

Here is a checklist to apply in relation to the administration and general organisation of the services system by sector:
• The agencies that manage or regulate service provision (e.g. local or government agencies, control offices, ministerial departments, accreditation office, etc.);
• The regulatory mechanisms for different categories of services;
• The different types of service funding (taxation, third-party payment, single-payer health system);
• The degree of decentralisation of the services and the route of decision holders within the services in general;[33]
• The overall coordination of these services.

Analysis: how to use this information?
It enables us to establish if the service sectors are adequately regulated at local and national level, and to identify negotiation officers/partners related to the sustainability of our interventions or investments.
It also allows us to identify any shortcomings or gaps in the service sector for persons with disabilities at different levels:
• Regulatory mechanisms not in place: to be developed;
• Uneven funding: to regulate;
• Agencies without resources or non-existent: provide them with technical support or create them in order to effectively fulfil their regulatory and/or funding role.

4. Existing services

Data to collect
↳ See toolbox: 1.A.4

• A mapping of existing services;
• The prevalence and characteristic of mainstream and specific services
– An essential step to ensuring the complementary nature of these two types of services;
• The situation of support services situation (typology, geographic distribution, coverage of rural and isolated areas, etc.)

Analysis: how to use this information?
It helps us to define the priority intervention areas by type of service.
When numerous types of services need support and improvement, the important question is: which services Handicap International is best able to support?
The reasoning must take the following aspects into account to optimise their interaction: actors, invention contexts and Handicap International's professional expertise.

33. The organisational complexity of the social or medical/ social sector is such that key decisions are often made at different management levels (service managers do not always initiate or fund the service). It is therefore particularly important to understand, on a case by case basis, the specific decision-making route. The correct analysis of this route will make positioning and decision-making easier.

5. Obstacles

Data to collect
↳ See toolbox: 1.A.5

The following checklist will help identifying the main barriers to accessing services for persons with disabilities, in relation to various service category:

• Services: existence, number and adequacy;
• Professionals: trained, available and motivated; [34]
• Barriers due to the cost of services;
• A lack of information on existing services including in accessible formats (Braille, etc. see section 1: determining factors);
• Barriers due to service guidance and referral procedures (referral);
• Barriers due to the "passivity" of users (lack of proactivity in search for appropriate services) or to "fatalism" about their situation (see Paolo Freire's introjection concept);
• The general public's negative view of disability or of certain categories of persons with disabilities;
• Cultural barriers;
• Physical and architectural barriers.

Analysis: how to use this information?
Once data on the main barriers has been collected, it is important to establish, in conjunction with those concerned (persons with disabilities), an order of priority or importance to remove these obstacles. These elements will guide the order of priority for Handicap International's intervention and will allow you to systematically, efficiently and sustainably contribute to the removal of these barriers.

6. Quality of services

Data to collect
↳ See toolbox: 1.A.6

• The adequacy between existing services and expressed and identified needs of persons with disabilities;
• The existence (or non-existence) of quality criteria [35];
• The organisation of control and accreditation procedures, related to the implementation of quality criteria; the quality of the initial and continuous training of professionals within the service;
• The way in which persons with disabilities and their families take part in the planning and evaluation of services;

Analysis: how to use this information?
There is a close link between the quality of services and their use by persons with disabilities. A quality-focused service will implicitly ensure better access for users to the respective service.
If this brief analysis of the quality assurance mechanisms will highlights gaps in this area, the improvement if service's quality should clearly be one of the programme's choices of intervention, if possible, during the given programming period.

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34. The demotivation of professionals in a service is a barrier to accessing services. As the guidelines for the call for proposals, EuropeAid/129196/C/ACT/Multi, Good health for all, Dec. 2010, confirms: "Qualitative aspects of the HR crisis include [...] the extreme demotivation of health personnel".

35. In the bibliography, you will find additional documents on service quality and quality principles and standards.

7. Practices currently used or developed in the field

It is strongly advised to identify similar experiences and good practices examples related to access to services, in the region of intervention.

It seems "optional" because, if poorly executed, it may be useless or even badly interpreted by those from whom the data is being collected.

This does not involve judging the actions of others, but rather including them in the context analysis in order to ensure that a programme takes into account all possible experience and lesson learned during an intervention. It forms an integral part of a quality approach and, as such, should benefit from the support of a technical resource worker. It provides a precious source of information in learning about and understanding the local context.

The examination and analysis of the lessons learned and any innovative experience will enhance the relevance and effectiveness of the interventions made over a given period. The "innovative" actors can also become further resource persons, team trainers and partners of Handicap International's programme.

B

Analysis of the actors

The analysis of the actors intervening in the services sector focuses on the characteristics and capacities of each type of key actor in the service provision field:
- **The users** (persons with disabilities and their families or representatives),
- **Service providers** (public or private)
- **The authorities or decision-makers** (or agencies replacing public authorities in certain cases, in their role as regulators of the services system)
- **Other organisations** (international and national) with significant roles in the sector
- **Donors**.

1. Types of service providers and their intervention sectors

Data to collect
↳ See toolbox: 1.B.1

Use the checklist to identify the different types of service providers at local and/ or national level and their respective intervention sectors.
• Public service providers
• Private service providers
  – Non-profit organisations (local and international organisations);
  – For profit organisations;
  – Informal service providers (families, volunteers, mutual aid networks, etc.)

Analysis: how to use this information?
It can inform the choice of partners or actors requiring specific support.
It also allows us to check if different types of exchange networks or platforms are capable of strengthening the coordination between these service providers in order to improve the access of people with disabilities to services.

2. Trained professionals

Data to collect
↳ See toolbox: 1.B.2

• Trained professionals in the services sector
by category
  > The quality of their training:
  − Techniques and approaches;
  − Initial, continuous and managerial training;
  > Their employability
  > Support the takeover of their duties;
• Associations, unions and/or professional
organisations by category;
• Recognised national vocational education
agencies/institutes.

Analysis: how to use this information?
It serves as a guide for orienting Handicap
International's investment in training and
potential partnerships with different training
institutes and professional associations,
in order to strengthen the professional
networks already in place.

3. Public authorities and/or decision-makers

Data to collect
↳ See toolbox: 1.B.3

• Their ability to regulate the services
system and existing regulatory mechanisms,
if appropriate;
• Their presence of national or local
authorities as service providers (meaning
with both a regulatory and service provider
role);
• The specific nature of governance at
local and central level (management,
decentralisation, financial transparency,
communication, level of bureaucracy and
resources).

Analysis: how to use this information?
It will help to determine:
• The necessary investment towards
developing the capacities of the public
authorities;
• Whether these authorities can become
reliable partners in the programme's mid
to long-term actions;
• The intervention levels (bearing in mind
that optimised operations and transparency
facilitate the multiplier effects of our actions).

4. Users

Data to collect
↳ See toolbox: 1.B.4

• Existing statistical data on: their number,
geographical breakdown, gender, age,
the group to which they belong, etc.
• Their current use of general, specific
or support services;
• Their role in choosing services and planning
interventions, especially with regards
to personalised services;
• Recommended: to collect gender-
specific data.

Analysis: how to use this information?
It reveals need and gaps in this sector from a
user's perspective, which enables us to:
• Invest in further developing the capacities
of users;
• Improve their access to information and
knowledge of existing services;
• Increase their active participation in service
provision and its sustainability.

5. Other actors

Data to collect
↳ See toolbox: 1.B.5

The checklist below makes sure that all other key actors involved in service provision are equally considered by our programmes: international NGOs, international agencies (UN), interstate bilateral cooperation, etc.
• Which actors?
• Which intervention sectors (sector of activity, direct provision of services, regulation on behalf of the State, advocacy, etc.)?
• What relationships exist between international solidarity organisations and the local authorities that regulate their presence in the country?

Analysis: how to use this information?
This is a particularly important element for making decisions of cooperation or complementarities in conjunction with these actors.
The effectiveness of investments also depends on coordinating action with similar actors/interventions to ensure effective coverage of needs and services of an appropriate quality.

6. Donors

Data to collect
↳ See toolbox: 1.B.6

The data below should be taken into consideration in your funding body policy: opportunities and limitations
• What are the funding opportunities for ''services'' projects for the given period?
• What are the donors' strategies?
• Does the services sector and/or disability feature among the funding priorities?
• If not, can we perform advocacy work to urge them to reconsider them as priorities?

Analysis: how to use this information?
This information will help us estimate the required extent of Handicap International's presence in the region, by allowing us to analyse the feasibility of the different types of intervention in a given sector over a certain period, for example.
It can also more simply help us determine the duration of the investment in the services.
It determines the potential alliances to form with international organisations.

C

Analysis of programme relevance

This analysis improves the programme's capacity to intervene on services sectors in a in a "systemic" way.

- Does the programme have a history of access to services improvement projects?
- What advances have been made in achieving the programme team's goals within the multi-annual operational framework?
- What connections exist between various projects targeting the services sector (education, health, functional rehabilitation)? Do they have a common and consistent methodology for implementing the strategy of the programme as a whole?
- What are Handicap International's institutional choices in general?
- What are Handicap International's ethical limitations? At what level of the programme do they appear? (see the organisation's policy papers)

Important

Access to services should be seen as a programme goal and not anymore a set of projects.
A programme approach is preferable to a project approach. Making access to services a programme goal ensures that all projects are applied in a country/territory/region in a consistent and synergetic manner over a given period.

End of step 1.

Step 2
Decision-making

A

Choice of approach(es)

1. Focus on a service (micro) or on the services system (macro)

Explanation
The main question is whether one programme should focus its action on a specified service or on the entire service system? There are good reasons to choose either alternative, depending on the context and the service(s) in question, but how do we make sure that in both case a the "systemic" vision exists in every situation?

Two types of action coexist in Handicap International's current practices:
- Intervention in relation to national actors at central level (governments, national platforms for disabled persons or professionals, etc.) to introduce, reform or enhance a type (or category) of service as a whole.
> The multiplier effects and impact of an approach at system level is obvious.
- Supporting a specific service provider, in a determined area.
> In this case, the intervention focuses on the needs of the most disadvantaged groups who are often located close to and dependent on a single service.
The most common approach, in this regard, consists in firstly supporting a "pilot" service, before capitalising on it and using the lessons learned as part of a wider system, with multiplier effects.

Examples of the programmed development of a pilot project into an expanded services system:
• **Introduction of functional rehabilitation and orthoprosthetic services in Albania, with qualification-based training at national level.**
• **The introduction of a system of day care centres for children and young adults in Montenegro (shift from a local**

(practical) system to a national system of day centres).
• **Orthopaedic-fitting services in Kenya - progression towards wide coverage of the population concerned.**

Analytical elements to use
In general, **the analysis of existing policies** will quickly provide us with direction in this type of decision.
⌐ Flawed services policies (inadequate resources and legislative frameworks, extremely weak regulatory mechanisms, etc.)
> It is therefore important to call on national actors as part of a "systemic" approach to improve these frameworks, within the limits of Handicap International's mandate and expertise.
⌐ Even if a service meets local needs or a special situation, it might be confronted at some point with a lack of sustainability and a structuring framework at system level.
> It is recommended, in pilot actions, to plan for a multiplication phase and to support the improvement of the services sector at large.

Another element to take into account: **the actual duration Handicap International's presence** in the country/territory/region.
⌐ A short-term presence (1 to 3 years) is not enough to support the services system at large.
⌐ A more long-term presence gives us a bigger space to have an impact on the services system (at least 3 to 5 years).
> We should not forget that enhancing the modernisation of the services system (or of certain sectors) is fundamentally a political process, performed in conjunction with capacity development for actors, the priorities decided at local level (decentralisation) or central level, participatory decision processes, etc. The implementation of these elements takes time. Respecting the time and pace of national actors is a key requirement for Handicap International.

2. Mono or multi-sector approach

Explanation
⌐ Mono-sector approach: focuses on one sector of intervention (e.g. health, education, employment) and then anticipates the multiplication of services at local and national level.
> A multi-sector approach can then be further implemented. It benefits from Handicap International's recognition and legitimacy in this sector with service actors in general.
⌐ Multi-sector approach: support of a set of services or sectors, meant to improve the general access of persons with disabilities to these services at large.
(E.g. by targeting the general regulatory mechanisms for these services, the Disability and Vulnerability Focal Points, Inclusive Local Development, Community-Based Rehabilitation, etc.).
> Some sectors can then be identified with a mono-sector focus that benefits from the mobilization of actors in a given territory.

Analytical elements to use
In general:
⌐ Analysis of the spectrum of existing services
⌐ Analysis of professionals
⌐ And Handicap International's key competence and skills, as specified in the organisation's "Scope of activities", in November 2009.

B

Intervention level

1. Determine the level of intervention and further planning

It is necessary to prioritise the level of intervention of the Handicap International's programme for a given period (local/national/regional) and specify in advance the planned multiplier mechanisms in order to maximise their impact on the living conditions of persons with disabilities.

Explanation
↳ See toolbox: Technical Sheet F.2

➥ It is important to define if these actions will be performed:
> Locally
(village, municipality, region of a country)
> Centrally (national)
The answer to this question will influence the choice of partners, the multiplication of its effects and the resources mobilized. The decision may be linked, if appropriate, to the previous analysis (A-choice of approaches) on supporting a service or an entire system.

↳ See toolbox: 2.A.

Analytical elements to use
In general, this choice is based on three main elements:
➥ The analysis of existing policies and of the administrative organisation of services at several levels (decentralisation, funding, regulation, etc.); this information identifies structural framework failings (gaps) and needs at different levels;
➥ *The duration of Handicap International's presence and available resources.*

When choosing between an immediate response to local needs versus acting centrally in support of a system of services, in order to promote an improved access to services for persons with disabilities, it is important to maximise the impact of

Handicap International's intervention.
> If resources are limited, the second option may be the most effective.
> A decision must be taken at programme level once the following elements have been established: context, actors, relevance of the period, but also a long-term vision of the situation.

➥ The presence of other international actors and their specific skills.
> Handicap International's intervenes initially at a local and service level, close to the populations, groups and persons concerned.
> Support to national authorities is often provided at the request of national actors and other international solidarity organisations, as well as Handicap International's partners in the country.
> Handicap International's interventions have a greater impact if performed in synergy with the interventions of other international actors, which have a mandate to support States in the governance process.

2. Examples of intervention by levels

See Figure 7.

Intervention at national level

- Support for national authorities in implementing the sector-based reforms of a services system;
- Support for deinstitutionalization;
- Introduction of new services at national level;
- Introduction or modernisation of regulatory mechanisms (funding, accreditation, evaluation, etc.);
- Training of professionals (initial, continuous, managerial);
- Awareness;
- Advocacy for access to services;
- Support drafting legislation in the field of services for persons with disabilities.

Intervention at local or regional level (community/region)

- Support for local authorities to promote better governance of the services system;
- Community planning; inclusive development, continuous training of professionals;
- Multiplication of pilot services:
- Improvement of mechanisms for evaluating the needs of users and their referral towards services;
- Supporting disabled people's organisations;
- Local advocacy.

Intervention at the level of a single service

- Support to a targeted service or to persons with disabilities themselves: direct provision (by Handicap International or a partner) of a service;
- Improving the internal quality of a service;
- Management support, evaluation, strengthening the links between the service providers and the users;
- Capacity development within the service;
- Designing a multiplier strategy for the service;
- Partnerships and multi-actors cooperation;
- Community awareness and involvement of local authorities and advocacy leaders.

Figure 7
Types of possible projects at different intervention levels, regardless of the service sector chosen.

C

Intervention methods

The following stage is designed to clarify the way in which the Handicap International programme will provide practical support for service provision. The following elements need to be decided and supported by arguments:

1. Which sectors?

According to the range of existing services in the country, you should ask the following questions:
• Does Handicap International have specific, recognised skills in this sector?
• Does Handicap International have resources available over the given period to support local actors in the sectors concerned, and then to monitor the practical development of the service or sector?
> Ensuring available internal expertise, "Handicap International's Scope of Activities" (November 2009).

The activity sectors within Handicap International's scope of activities[36]:
| Health
| Prevention
| Rehabilitation
| Economic inclusion
| Social inclusion
| Education
| Local development
| Accessibility
| Disaster preparation and risk reduction
| Demining and mine risk education
| Camp coordination and management
| Basic needs
| Reconstruction

2. Which services?

Once the sector has been chosen, you need to determine if the intervention aims to improve access to users within the framework of mainstream or specific services. You need to ask the following questions:
• What is the added value of each option (mainstream or specific), in the country context?
• If you choose to act in both areas, how do you ensure the functional link and a continuity of quality between the two types of services, in order to promote inclusive practices?

3. Which actors?

Deciding which national actors will be provided with support by the programme over the long-term.

Generally, the response of Handicap International's programme to this question depends on:
• The duration of the presence of the programme–It is possible to intervene in support of local and national actors when the association maximises the duration of its presence.
• Change agents[37] identified at programme intervention level:
> Identifying these actors from the very beginning makes a major contribution to the decision-making process.
> Investing in their capacity development and training, and providing them with professional support could lead to greater multiplier effects at a later stage;

37. By change agents, we mean people or groups who can make a significant contribution to the long-term improvement of a services sector, or which can positively influence their peers, in order to change mentalities and practices in the disability sector. They are people who promote listening, the sharing of expertise, continuous improvement, group work, etc.

36. November 2009.

• The resources available to Handicap International programme
>The choice of actors is obviously influenced by this factor. The training or capacity development can be considered on a larger scale, if available funds or there is a plan for obtaining them.

In terms of the nature of service providers, Handicap International is carefully monitoring the expansion of for profit private service providers in the social and medical/social sector, paying particular attention to the ethics and the quality aspects. Providing support to these actors is rarely a priority.

4. What intervention method?

Prioritising the type of support, expertise and resources required for the intervention.

⌐ Support of local provider or direct service provision?
There are numerous contexts in which the services necessary for persons with disabilities do not currently exist or where local expertise is extremely limited.

• **Support**: You therefore need to coordinate your activities with actors involved at local, national and international level, while paying particular attention to the contributions of local actors. Try in particular to develop the capacities of national service providers.
• Handicap International as the **direct service provider**: a programme where it happens is not necessarily part of an emergency response (the most frequent setting). However, it should still form part of a larger effort to strengthen local expertise. This choice has a significant weight on the programming actions of Handicap International's over the long-term and must target sustainable access to this service for persons with disabilities.

⌐ Who should you support?

• **Support for services:**
> Support to improve internal procedures (access to services, management, follow-up and evaluation);
> Management and improvement of the quality of services, etc.

• **Support for professionals:**
> Training in technical skills and developing attitudes [38] to promote access to quality services.
> Support through training expertise (training needs analysis (initial, on-going), engineering, education and evaluation);
> Performing supervision on a regular basis (follow-up, post-training or support for professional inclusion if training in a new profession);
> Identify, once the training project has been set up, recognition mechanisms (diploma or certification from training institutes and responsible ministry, etc.)

Example:
Rehabilitation services in West Africa with a progression of support:
– From professionals (initial training, promotion of professions, support for professional inclusion, continuous education) towards;
– Services themselves, in order to constantly increase the number of users accessing these services.

38. For example: welcoming users, availability, listening, respect for the user's expectations, openness and user self-esteem (in order not to turn the other person into the passive subject of your expertise), gender awareness, respect for the user's customs and lifestyle, etc. (lots of ideas were gathered during a training course on the "links between training and access to services").

D

Identifying partners

↳ **Support for advocacy**
↳ See toolbox: Technical Sheet F.1

The programme must also decide if it will be involved over the given period in advocacy actions to improve access to services for persons with disabilities, or to support actors involved in an advocacy process.

• **Either by supporting** national **actors** and/or by supporting representative organisations
• **Or directly**: the Handicap International programme can develop advocacy actions in relation to governments, organisations or international agencies.

The aim of these advocacy actions must be directly linked to the entire range of programme's interventions.
The idea is to create synergies with all types of actions and enhance the dynamic of change.

A key stage: understanding how to identify national partners with which the programme will work on the ground and potential alliances and international partners.

One of Handicap International's key roles must be to perform a detailed evaluation of the presence in the country of other actors (public or private) involved in providing services to people with disabilities. Before any decision is taken on launching new "service projects", you need to consider **two key questions related to the realistic programming of actions:**

• Is Handicap International the best positioned to intervene in these types of services?
• If yes, which partnership and alliances will best ensure the sustainability and quality of its actions?

Priority is always given to partnerships with disabled people's organisations (DPOs) and service users [39], and to ensuring that women are well represented. The methodology document compiled by Stefanie Ziegler at Handicap International is an important benchmark for this type of decision-making (see bibliographic references).

Example:
Partnership with the Amicale Marocaine des Handicapés (AMH) in order to facilitate the access to functional rehabilitation and orthopaedic-fitting specific services

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39. When the context and nature of the activities allow, Handicap International chooses to officialise partnerships through agreements setting out common goals, how to implement them, and the roles and contributions of their partners (intervention principles).

E

Evaluation methods

Choose at the start of the programming stage:
• the means and methods of evaluating the effectiveness of the programme in relation with services;
• reliable, accurate performance indicators adapted to realities in the field and the services sector.

This stage must also define the preliminary analyses that the programme needs to perform at the beginning of the period in order to check the initial state of these indicators and provide a baseline reference for further evaluations.

End of the practical guide.
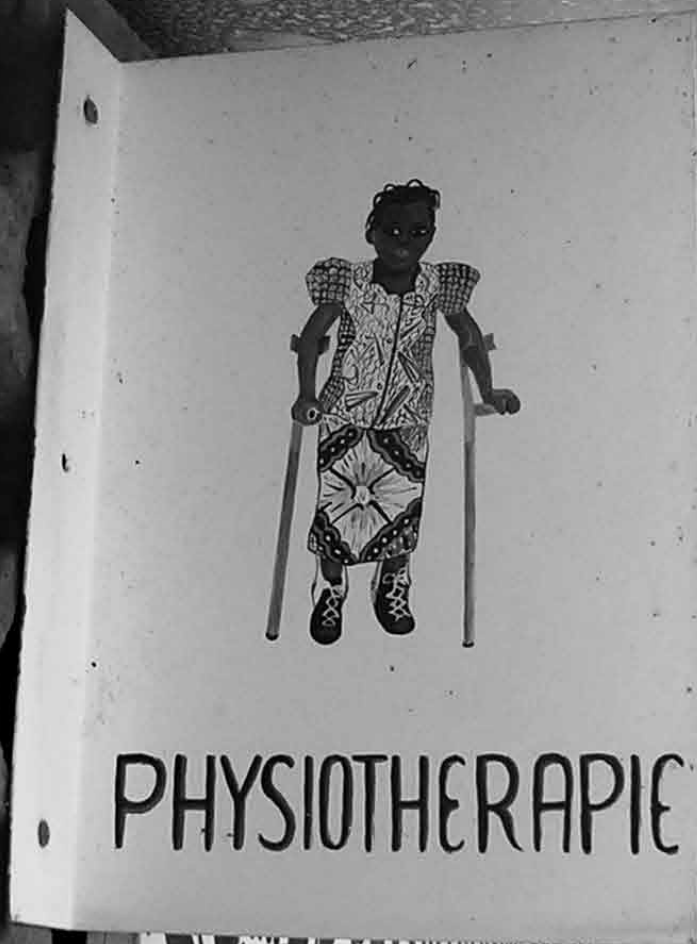
PHYSIOTHERAPIE

Togo, Afagna, 2007

Toolbox

Practical guide tools

Data collection and analysis

Decision-making

40. Preliminary observation: some questions will be repeated
in different tables. The information is not superfluous however,
because the application of the questionnaires depends on the
local context. Teams can decided whether or not some tables
are to be completed.

1.A.1 Short analysis of the capacity and willingness of countries to manage and improve the services system

To what extent are the key actors willing to and capable of improving access to services for persons with disabilities?
Try to outline the position of each type of actor (decision-makers, service providers, users) in this axis-based system.

Table adapted from the DFID working document "Approaches to Improving the Delivery of Social Services in Difficult Environments" (Berry, Forder, Sultan, Moreno-Torres, 2004).

Capacity →

← **Willingness**

WILLINGNESS AND CAPACITY
☐ Decision-makers
☐ Service providers
☐ Persons with disabilities

NO WILLINGNESS BUT EXISTING CAPACITIES
☐ Decision-makers
☐ Service providers
☐ Persons with disabilities

WILLINGNESS BUT LIMITED CAPACITIES
☐ Decision-makers
☐ Service providers
☐ Persons with disabilities

NO WILLINGNESS, NO CAPACITY
☐ Decision-makers
☐ Service providers
☐ Persons with disabilities

Toolbox

1.A.2 Checklist of existing policy-related documents

No	ASPECT TO CHECK	∨	Comments
Legal framework: UNCRPD, national strategies, action plans, laws, implementation orders, action plans			
1. CRPD	Have the United Nations Convention on the Rights of Persons with Disabilities and the Optional Protocol been signed?	☐	
2.	Have the Convention and Protocol been ratified?	☐	
3. Stratégies	Does the country have a strategy or a national action plan in the poverty reduction field?	☐	
4.	Does the country have a strategy or national action plan on disability issues? (E.g.: "strategy for promoting and protecting the rights of persons with disabilities"- NB: It is also important to mention if these strategic documents have corresponding budgets, as well as clearly defined managers) Check also the definition(s)of disability used in various legislation - in brief.	☐	
5. Laws, decrees	If they exist, is this strategy in the disability sector accompanied by specific legislative documents (laws, implementation orders, etc.)	☐	
6. Sector-based strategies	Does the country have a strategy or specific national action plan in the following sectors: ☐ Social services? ☐ Education? ☐ Inclusive education? ☐ Employment? ☐ Employment of people with disabilities? ☐ Health? Mental health? ☐ Gender equality/ethnic minorities/children/the elderly? ☐ Social welfare in general? ☐ Assistive technologies? ☐ Other significant sector for access to quality services for persons with disabilities?		

No	ASPECT TO CHECK	✓	Comments
7. Sector-based laws	If they exist, are these strategies accompanied by corresponding legal texts? ☐ Social services? ☐ Education? ☐ Inclusive education? ☐ Employment? ☐ Employment of people with disabilities? ☐ Health? Mental health? ☐ Social welfare? ☐ Social assistance/social work? ☐ Gender equality? ☐ Assistive technologies? ☐ Sign language interpreters? ☐ Professional education in the social sector? ☐ Other significant aspect for access to quality services for persons with disabilities?		
8. Conformity with UN documents	Are the strategies, actions plans and/or laws in conformory with international documents and principles in the disabilitysector? (e.g. the CRPD, the Convention on the Rights of the Child, etc.)	☐	

Implementation of the legislative framework

No	ASPECT TO CHECK	✓	Comments
9.	Is the legal framework implemented and respected? Are theresufficient resources for their implementation? Are there complaint procedures, which are known and used?	☐	

Local strategies

No	ASPECT TO CHECK	✓	Comments
10.	Does the practice of community planning exist in the respective country? And community disability action plans (or similar initiatives)? Is the planning process (in the field of disability and social services) rather centralised or decentralised? Up to which level of decentralization?	☐	
11.	Do community disability action plans exist (or similar)?	☐	

1.A.3 Analysis of administrative context for services at local and national level (by sector)

How to use this information?

It enables us to establish if the service sectors are regulated at local and national level, and where to find negotiation partners for the aspects linked to the sustainability of our interventions or investments. According to the context, these partners could be present at local, regional (district, department) or national level. We can also identify shortcomings in the services sector for persons with disabilities: either services are not regulated (but should be), or are underfunded, or agencies require technical support to effectively fulfil their regulatory and funding role.

There are two possibilities for data collection:

a. Achieve a general overview ("services for persons with disabilities") – In this case, what is important is to get a general view on the regulatory mechanisms and the management of (and responsibilities for) these services, at different levels. All additional details will be obtained later on. Or:
b. Establish an analysis sector and then analyse the administrative context of this sector in detail. Ideally, you should be able to start with a general analysis of this administrative context and advance to detailed sector-based analyses, as and when possible during Handicap International's presence in this country.

Sectors of interest for Handicap International:

1 Early diagnostic and intervention in the disability sector
2 Education:
   Primary education
   Secondary education
   Education – other types

3 Other forms of education, including lifelong learning
4 Economic inclusion/employment
5 Health:
   Mental health
6 Rehabilitation
   Rehabilitation – physiotherapy, speech therapy, occupational therapy, etc.
   Assistive technologies, including mobility aids
7 Social assistance/social work
8 Personal assistants
9 Social security measures for persons with disabilities (benefits)
10 Adapted transport
11 Leisure and sport
   Add to the list, if necessary.

This analysis, called the "administrative organisation of the services system", will focus on the following aspects in particular:
• **the key actors in the decision-making process and the centralised/decentralised** nature of decision-making, in order to target actors who play the most important role in the accessibility of services for persons with disabilities and aspects related to its quality;
• **the different types of funding for the service;**
• **the other regulatory procedures** governing the service (if they exist);
• **the agencies responsible for regulating** services or service provision, and their regulation in practical terms;
• the way in which the activities of professionals are regulated.

41. Once again, we can either analyse the services system as a whole (if we have the team resources and knowledge to gain such a global vision), or (first of all) the services by sector, in order to subsequently build up a global view of service organisation.
42. Understand international NGOs, local NGOs.

Analysis of the decision-making process within the services sector[41]

Place a cross in the relevant box or note additional details in these boxes, if necessary

KEY ACTOR	Who decides to set up the service?	Who decides to modernise it?	Who hires the staff?	Who gives official authorisation to the service?	Who manages the service?	Who assesses the service?	Who establishes eligibility criteria for the service users?	Who funds the service?
Public authorities at national level – ministries, national bodies or agencies etc	☐	☐	☐	☐	☐	☐	☐	☐
Local public authorities (specify)	☐	☐	☐	☐	☐	☐	☐	☐
Civil society organisations (non-profit)[42]	☐	☐	☐	☐	☐	☐	☐	☐
Private organisations (profit-making)	☐	☐	☐	☐	☐	☐	☐	☐
Faith-based organisations	☐	☐	☐	☐	☐	☐	☐	☐
User organisations	☐	☐	☐	☐	☐	☐	☐	☐
Users (disabled persons and their families)	☐	☐	☐	☐	☐	☐	☐	☐
Others (specify) E.g.: UN, World Bank, ICRC, donors, etc.	☐	☐	☐	☐	☐	☐	☐	☐

Table 2. Analysis of service funding mechanisms
Indicate with a cross if the funding mechanism exists or not. The list can be completed by field teams.

	Education		Support for inclusive education		Primary health		Rehabilitation services		Assistive technologies		Vocational training		Supported employment		Support for independent living		Leisure/sport		In-home assistance		Others	
Payment made by users	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Private donations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Indirecting funding	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
In kind support	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dedicated funds	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Subsidies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Funding per project	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Public procurement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
State budget allocation calculated per cost unit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
State budget overall allocation per year	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Type of service provider	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private

SECTOR

Also check the names of these mechanisms and rename if necessary.

More details on the different funding mechanisms listed in the table 2

State budget (under the form of a global envelope or allocation per year)
This is a global amount covering the annual costs of a service. Usually this amount (presented by the service provider under the form of a provisional budget) is negotiated with the authorities (in charge of funding) at the end of the previous year.

State budget (under the form of an envelope based on unit costs)
This is a global envelope given to the service provider, based this time on unit costs, for example: cost per day per user, or cost per month per user, or cost per activity per month/year, etc.

Public procurement and contracting of services
These procedures are usually taking place after public call for offers, in the field of social services. Service providers are contracted to deliver services, following a specific demand formulated by public authorities and regulated through a contract. The contract contains quality requirements, detailed unit costs, monitoring and evaluation procedures, conditions for reporting and installments etc. The funding is made by service or by activity/department, and usually by cycles of 1 to 3 years.

Funding per project (grants)
In this case, the service delivery is associated with a project-type activity. The provider submits a project to donors (which could be public or private), describing an activity of limited duration. The donor is not committing to continue the funding after the end of the project.

Subsidies
Fixed funding, which is given to service providers under the form of monthly or annual financial aids, and using different calculation methods or unit costs. This funding mechanism usually diminishes significantly the level of responsibility of public authorities in the sector of disability and provides rather modest funding for providers or for persons with disabilities themselves.

Dedicated (or specific funds)
In some countries, social services (or sometimes services for persons with disabilities particularly) are funded through specific instruments called ''special funds''. They are managed by central authorities or delegated to specific agencies. The name of these funds is different from a country to another, but most commonly they are called ''social funds'', or ''equity funds''. The source of money is usually World Bank or international organizations, and they are available on a limited duration.

Support in kind
In this case, service providers receive in kind support from authorities, for the daily activities (e.g. transportation means, premises and infrastructure, utilities coverage, etc.)

Indirect financial support
It consists in different forms of supporting service providers, not through direct funding, but through measures that reduce the financial burden of these providers, for example: exemption of taxes, re-direction of a certain percentage of revenue taxes (collected locally or nationally) towards service providers, utilities free of charge, etc.

Table 3. Regulatory mechanisms
This analysis can only be performed by sector.

TYPE OF REGULATORY MECHANISM	√	What agency is responsible for this mechanism? Centrally or locally?	Comments
Needs assessment and referral to services			
> At macro/local level			
Evaluation of local needs	☐		
Map of needs (territorial outlines)	☐		
Maps of existing services	☐		
Data and statistics collection procedures, at local and national level	☐		
> At the level of persons with disabilities (micro)			
Evaluation of individual needs	☐		
Orientation and referral towards services	☐		
Service provider authorisation/accreditation mechanisms			
Accreditation/licensing or authorization of the service provider	☐		
Service quality standards (including accessibility norms)	☐		
Follow-up and evaluation of services for persons with disabilities			
Monitoring procedures	☐		
Evaluation procedures	☐		

Table 4. The role of various of actors in the regulatory process

	√	Comments
Users		
Are there organizations or umbrella organizations/bodies of persons with disabilities? (e.g. a National Council of Persons with Disabilities)	☐	
Are these organisations active in demanding services? How?	☐	
Are there mechanisms for persons with disabilities to formulate and send their demands to local or national authorities?	☐	
Are the opinions and demands of disabled people's organisations taken into account by (a) decision-makers and (b) service providers? How?	☐	
Service providers		
Are there organizations or platforms of service providers?	☐	
Are there professional organizations or platforms, at local or national level (e.g.associations of social workers, of community workers, of psychologists, physiotherapists, etc.)?	☐	
Are service providers required to comply with internal regulations (manuals of procedures, quality procedures, complaints procedures, staff procedures, etc.)	☐	
Decision-makers		
Do the decision makers have different mechanisms for registering the demands from the users of services (and also their complaints or improvement recommendations)?	☐	
Do they have planning or prioritization procedures, in relation with the continuous improvement of services needed by persons with disabilities? (e.g. local action plans, the presence of persons with disabilities in decision making bodies, etc.)		

Table 5. Regulation of professional activities in different service sectors for persons with disabilities

TO CHECK	✓	Comments
Education professionals		
Are there professional standards or references for this intervention sector?	☐	
Do professionals in this sector benefit from initial official (or qualification-based) training in this country?	☐	
Do professionals in this sector benefit from continuous training in this country?	☐ Compulsory ☐ Optional	
Is there an official procedure for the regular evaluation of professionals in this sector? Who is responsible for it? How often is it performed?	☐	
Is there legislation devoted to professional activities in this sector?	☐	
Health professionals		
Are there professional standards for this intervention sector?	☐	
Do professionals in this sector benefit from initial official (or qualification-based) training in this country?	☐	
Do professionals in this sector benefit from continuous training in this country?	☐ Compulsory ☐ Optional	
Is there an official procedure for the regular evaluation of professionals in this sector? Who is responsible for it? How often is it performed?	☐	
Is there legislation devoted to professional activities in this sector?	☐	

TO CHECK	✓	Comments
Rehabilitation professionals		
Are there professional standards for this intervention sector?	☐	
Do professionals in this sector benefit from initial official (or qualification-based) training in this country?	☐	
Do professionals in this sector benefit from continuous training in this country?	☐	☐ Compulsory ☐ Optional
Is there an official procedure for the regular evaluation of professionals in this sector? Who is responsible for it? How often is it performed?	☐	
Is there legislation devoted to professional activities in this sector?	☐	
Social workers and professionals from the support services (personal assistants, counsellors, etc.)		
Are there professional standards for this intervention sector?	☐	
Do professionals in this sector benefit from official initial training in the respective country?	☐	
Do professionals in this sector benefit from continuous training in the respective country?	☐	☐ Compulsory ☐ Optional
Is there an official procedure for the regular evaluation of professionals in this sector? Who is responsible for it? How often is it performed?	☐	
Is there legislation devoted to professional activities in this sector?	☐	
Others		
…	☐	

1.A.4 Analysis of the overall spectrum of existing services for persons with disabilities at local and national level

How to use this information?

It will help you (in addition to other criteria such as facilitators in the sector, intervention contexts, and available professionals from Handicap International) to define the precise field for priority interventions by type of services. In contexts in which the services in need of support or enhancement are extremely numerous, the corroboration of all of this information may help in deciding on one or two priority sectors.

TYPE OF SERVICE	Exist?	Accessible?	In sufficient numbers? Evaluate. Reasoning.
Early detection and intervention services for persons with disabilities			
Early evaluation of risk/or disability	☐	☐	☐
Referral services for persons with disabilities	☐	☐	☐
Early intervention service for children at risk/children with dis.	☐	☐	☐
Crèches (nurseries)	☐	☐	☐
Information services or Resource Centres for persons with disabilities (including disability and vulnerability focal points)	☐	☐	☐
Education and development			
Kindergartens	☐	☐	☐
Other preschool services (toy library, play groups, etc.)	☐	☐	☐
Children's clubs (playgrounds, holiday centres, etc.)	☐	☐	☐
Day-care services	☐	☐	☐
Inclusive schools	☐	☐	☐
Specialist schools per type of disability	☐	☐	☐
Special classes in mainstream schools	☐	☐	☐
Housing and residential services for children with disabilities			
Residential services for children with disabilities	☐	☐	☐
Family like settings for children/group homes	☐	☐	☐
Foster families or foster homes	☐	☐	☐

TYPE OF SERVICE	Exist?	Accessible?	In sufficient numbers? Evaluate. Reasoning.
Adult care and independent living services			
Day centres for young people and adults	☐	☐	☐
Residential establishments or services for persons with disabilities	☐	☐	☐
In-home care and support services	☐	☐	☐
Sheltered accommodation for adults with disabilities	☐	☐	☐
Support services for independent living	☐	☐	☐
Respite care services			
Temporary accommodation services– for adults and children	☐	☐	☐
Adaptation of living and working settings			
Home adaptation services	☐	☐	☐
Adaptation of schools or of workplaces for persons with dis.	☐	☐	☐
Other services related to the adaptation of living and working settings	☐	☐	☐
Rehabilitation and functional rehabilitation			
Speech therapy	☐	☐	☐
Physiotherapy	☐	☐	☐
Occupational therapy	☐	☐	☐
Orthoprosthetics	☐	☐	☐
Psychological support and counselling			
Psychological therapies	☐	☐	☐
Counselling	☐	☐	☐
Support groups	☐	☐	☐

1.A.4   Continuation

TYPE OF SERVICE	Exist?	Accessible?	In sufficient numbers? Evaluate. Reasoning.
Social assistance/social work			
Personalised social support	☐	☐	☐
Health-related services			
Prevention services	☐	☐	☐
Primary medical care	☐	☐	☐
Specialist health services	☐	☐	☐
Others	☐	☐	☐
Employment of persons with disabilities services			
Vocational training	☐	☐	☐
Evaluation of the professional abilities of persons with disabilities and mediation services (job placement, job coaching)	☐	☐	☐
Supported employment	☐	☐	☐
Sheltered employment	☐	☐	☐
Other support services			
Sign language interpreting services	☐	☐	☐
Writing services and Braille printing	☐	☐	☐
Transport and support services related to adapted transport	☐	☐	☐
Daily assistance services	☐	☐	☐
Assistive technologies	☐	☐	☐
Technical mobility aids	☐	☐	☐
Other support services or equipment	☐	☐	☐
Training services for using support services or equipment	☐	☐	☐
Leisure and sport services	☐	☐	☐

Analysis of the overall accessibility of services for persons with disabilities, at local or national levels

How to use this information?

It helps us identify the main obstacles encountered by persons with disabilities in effectively accessing services. These elements can help us prioritise interventions or support with the aim of eliminating obstacles over the long-term. You may add to the list of accessibility factors.

TYPE OF SERVICE

Type of service	Is there a sufficient number of services?	Are the services physically accessible to people with disabilities?	Are the services accessible to persons with mental health problems?	Are the services accessible to persons with an intellectual impairment?	Are the services accessible to persons with sensorial problems?	Are users proactive enough in their search for the services they need?	Are the referral procedures effective and of good quality?	Are the services affordable?	Do public attitudes towards disability have a negative impact on access to services for people with disabilities?
Others	☐	☐	☐	☐	☐	☐	☐	☐	☐
Leisure and sport services	☐	☐	☐	☐	☐	☐	☐	☐	☐
Economic inclusion services	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vocational training	☐	☐	☐	☐	☐	☐	☐	☐	☐
Assistive technologies	☐	☐	☐	☐	☐	☐	☐	☐	☐
Functional rehabilitation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Health	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prevention	☐	☐	☐	☐	☐	☐	☐	☐	☐
Education	☐	☐	☐	☐	☐	☐	☐	☐	☐

1.A.6   Quality checklist for the disability services sector

How to use this information?
It gives us succinct information on the quality management of the different types of services and the support that Handicap International can potentially provide to improve it.
NB: if the internal quality of services is good, this has a major impact on inhancing the access of users to these services.

TYPE OF SERVICE	Are there minimal performance conditions (minimum quality criteria) for these services at national level?	Are there service provider authorisation procedures to ensure compliance with minimum quality conditions?	Does legislation include requirements related to the service quality provisions?	Do services operate according to a people-centred approach?	Do users take part in decision-making, within the services?	Do service providers have internal quality management procedures?	Are managers trained in quality management?
Others	☐	☐	☐	☐	☐	☐	☐
Leisure and sport services	☐	☐	☐	☐	☐	☐	☐
Economic inclusion services	☐	☐	☐	☐	☐	☐	☐
Vocational training	☐	☐	☐	☐	☐	☐	☐
Assistive technologies	☐	☐	☐	☐	☐	☐	☐
Functional rehabilitation	☐	☐	☐	☐	☐	☐	☐
Health	☐	☐	☐	☐	☐	☐	☐
Prevention	☐	☐	☐	☐	☐	☐	☐
Education	☐	☐	☐	☐	☐	☐	☐

1.B.1   Service providers by sector and by type

How to use this information?

It can inform the choice of our partners or those actors requiring specific support from Handicap International. It allows us to check if different types of networks or platforms can be developed among these service providers in order to continuously improve the quality of the services delivered. The previous files helped us clarifying the different types of service providers existing in the country, within services for people with disabilities (public, private, not-for-profit and profit-making)

The following file will help with drawing up a practical list of service providers operating in a given space (neighbourhood, city, region or, in the case of rare services, a country). Each cell below should indicate the actual names (or number) of these service providers in order to draw up a concrete map or an organisation chart that's as exhaustive as possible. This is not possible unless the information on these services is sufficiently accessible to Handicap International or its partners.

TYPE OF SERVICE	Education	Prevention	Health	Functional rehabilitation	Assistive technologies	Vocational training	Economic inclusion services	Leisure and sport services	Others
Public services									
Services managed by NGOs									
Services managed by profit-making private companies									
Services managed by families and voluntary workers									

1.B.2   Existence of professionals, by sector

PROFESSION	Do these professionals exist? Any remarks	Do professional associations or organisations exist in this sector?
Social assistants/social workers	☐	
Psychologists/counsellors	☐	
Psychotherapists	☐	
Sociologists	☐	
Educators	☐	
Specialist educators	☐	
Special education teachers	☐	
General practitioners	☐	
Specialist doctors	☐	
Nurses	☐	
Speech therapists	☐	
Physiotherapists	☐	
Occupational therapists	☐	
Orthoprosthetic technicians	☐	
Personal assistants	☐	
Foster families	☐	
Employment mediators	☐	
Sign language interpreters	☐	
Community-based rehabilitation agents	☐	
Community agents	☐	
Wheelchair technologists	☐	
Wheelchair technicians	☐	
……		

1.B.3   The role of the public authorities in service provision

How to use this information?

It tells us if Handicap International can support the capacity development of the public authorities and if these authorities are likely to become reliable medium- to short-term partners. In addition to the previous data, it will help us decide on Handicap International's level of intervention (local or national, support for practical services or a services system) because the smooth operation and transparency of the public authorities facilitates the multiplier effects of Handicap International's actions. The table also tells us if the authorities combine a service provider role with a regulatory role. This dual role often reduces transparency and service quality. If the public authorities do not fulfil their regulatory role in the services sector, use this space to describe who performs this role, if this "substitute" exists. What other decision-maker exists? What are their responsibilities? Do the public authorities officially delegate the regulatory responsibilities in question?

TYPE OF SERVICE	Do the public authorities meet their responsibilities for ensuring the population has access to these services?		Do the public authorities fund these services?		Do the public authorities manage directly these services?		Do the public authorities control and evaluate these services?	
	Local authorities	National authorities	**Local authorities**	National authorities	**Local authorities**	National authorities	**Local authorities**	National authorities
Others	☐	☐	☐	☐	☐	☐	☐	☐
Leisure and sport services	☐	☐	☐	☐	☐	☐	☐	☐
Economic inclusion services	☐	☐	☐	☐	☐	☐	☐	☐
Vocational training	☐	☐	☐	☐	☐	☐	☐	☐
Assistive technologies	☐	☐	☐	☐	☐	☐	☐	☐
Functional rehabilitation	☐	☐	☐	☐	☐	☐	☐	☐
Health	☐	☐	☐	☐	☐	☐	☐	☐
Prevention	☐	☐	☐	☐	☐	☐	☐	☐
Education	☐	☐	☐	☐	☐	☐	☐	☐

Toolbox

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1.B.4 The role of users in service provision

Why is this information useful?

It tells us if Handicap International can support the users capacity development, their knowledge and their active participation in service provision. This information is particularly important within the framework of advocacy projects and "critical mass" choices that can improve the effectiveness of advocacy actions. It also tells us if users provide a financial contribution to access these services.

TYPE OF SERVICE	Do users intervene in the planning of these services? Yes/no? How?	Do users intervene or contribute to the management of these services? Yes/no? How?	Do users intervene in the evaluation of these services? Yes/no? How? How often?	Do users contribute to the funding of these services? Yes/no? How?
Education	☐	☐	☐	☐
Prevention	☐	☐	☐	☐
Health	☐	☐	☐	☐
Functional rehabilitation	☐	☐	☐	☐
Assistive technologies	☐	☐	☐	☐
Vocational training	☐	☐	☐	☐
Economic inclusion services	☐	☐	☐	☐
Leisure and sport services	☐	☐	☐	☐
Others	☐	☐	☐	☐

Do user organisations exist? Are they active in formulating requests for services? Are their requests taken into account by the authorities and by service providers?

1.B.5   Other actors related to the services sector for persons with disabilities, their role and intervention methods

How to use this information?
This is a particularly important element for Handicap International when making decisions related to cooperation with NGOs and IOs.

The effectiveness of Handicap International's investments also depends on not duplicating similar interventions, unless they are inadequate or of poor quality.

TYPE OF SERVICE	Which other actors intervene in this sector at country level?	What role do the following actors play? • Direct service providers; • Government consultants; • Local authority consultants; • Partners for local NGOs; • Others.	Presence high (+++)/medium (++)/weak(+)
Education			
Prevention			
Health			
Functional rehabilitation			
Assistive technologies			
Vocational training			
Economic inclusion services			
Leisure and sport services			
Others			

1.B.6

Donors. Donors' policies.
Opportunities and challenges

List the donors that contribute
to the funding of services for people with
disabilities. Describe the opportunities and
challenges related to their funding.

Add the possible opportunities and
challenges for Handicap International and its
own funding bodies in the context.

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2.A

Short route and long route of responsibility in service provision

DECISION-MAKERS

USERS → **SERVICE PROVIDERS**

Figure 8
Relationships of responsibility between actors in the provision of services (World Bank, 2004 [43]).

We talk about three categories of essential actors within the social and medical/social service provision framework.
• **Service users** (people with disabilities and their families)
• **Service providers** (schools, functional rehabilitation centres, employment agencies, personal assistants, social workers, etc.)
• **Decision-makers** or responsible organisations with policies in the services sector (usually public authorities, but also independent organisations who play a regulatory role in situations in which the State is unable to meet its responsibilities).

Other actors intervene throughout the provision period: the local community, media, donors, etc. However, it is mainly between these three main categories that relationships of responsibility exist and lead to service regulation.

During a business transaction, the user receives a service from the service provider for which they can be held responsible because it is paid to do so. If the users are not satisfied, they are entitled to demand a new service or, in the event of illegal behaviour, to request that legal action is taken against the service provider.

This is what we call the **"short route of responsibility"** [44]. The service provider has a direct responsibility towards the user. Because the services (education, health, social services, etc.) provided as part of our projects are often free of charges, the service provider's direct responsibility towards the user is not so strong anymore. States has rightfully decided that these services should be therefore exempt from market rules and rely on the regulatory role of governments, which set up social services. This is an example of what we call a "long route of responsibility": users (as citizens) influence decision-makers, who at their turn influence service providers.
If the decision-makers neither control nor regulate these services, users are rapidly denied access to community resources and services and fall back into poverty and exclusion.

43. World Bank, Making Services Work for Poor People, World Development Report 2004, p. 6.
44. Idem, p. 6.
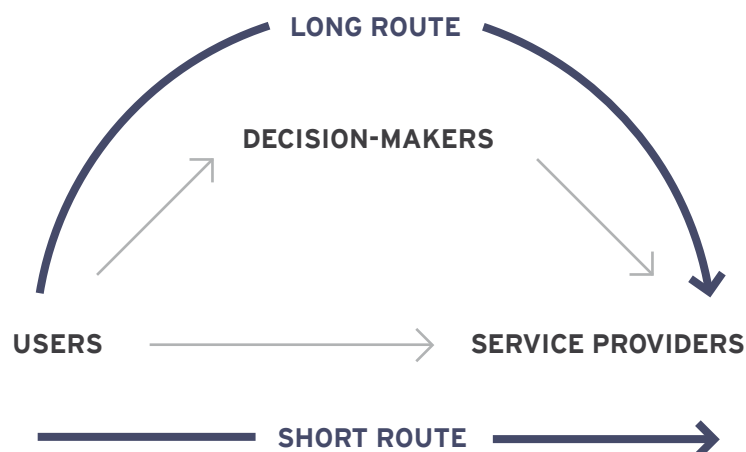
Figure 9
Short route and long route to make service
providers aware of their responsibilities
towards users.

Organisations such as Handicap International can provide consistent support to all of these actors in order to ensure the good understanding and awareness of responsibilities within this route as well as increasing the visibility each actor in the process.

Improving access to quality services for users (persons with disabilities) requires, among other actions, the strengthening of the lines of responsibility between actors.

Handicap International must perform an in-depth analysis of the capacities and/ or willingness of decision-makers, the capacities of existing service providers and professionals in the field and the capacities of persons with disabilities to express their needs and defend their rights before determining the nature of its interventions. Handicap International **can work with each of these three groups**, according to the indentified demands, capacities, needs and institutional frameworks.

2.B

Different types of support provided by Handicap International, by type of actor

We will start by looking at the type of support necessary in general with regards to each category of actors:

2.B.1 Support for users
Handicap international supports the implementation of projects to encourage the participation of users in all services provided within the community.

Users have a key role to play in each stage of service provision: from planning a personalised intervention to the evaluation of the service provided. A quality service ensures that users are actively present and that the opinions of persons with disabilities are taken into account by teams within the service sector.

The users of social services are rarely seen as "clients" and rather as "beneficiaries". This undermines their active role and participation. In order to make this active participation possible, service providers must develop specific tools and procedures within the service: consultation, evaluation, registering of complaints, regular communication between professionals and users, ethical codes, etc.

Handicap International can support service providers in developing these procedures, as well as the users in enhancing their positions and capacities.
As far as service providers are concerned, the support that Handicap International provides to enhance the participation of users is relatively "conventional" and consists above all of management and quality management procedures and methods. These procedures can be adapted to each context, even in countries where the services system is very weak.

User support is divided into three levels, from an extremely restricted intervention to planning long-term support:

• Support for a highly-restricted group of users within a specific service
When Handicap International provides technical support for the development of a local service or a limited number of local services, users can then play an active role in service provision:
– By forming part (directly or indirectly) of the management structures;
– By taking part in developing a personalised intervention plan;
– By taking part in the service evaluation (internal and external) processes;

• Support for users living in a community (village, municipality or region)
In this case, several types of projects can be implemented to improve the participation of users and their access to services. Here are a few examples:
– Evaluation of local needs in the social services sector and community planning. (E.g. projects to develop "local action plans"; towns and disability, etc.);
– Projects to form "local initiative groups in the disability sector" (committees, coalitions, local platforms) with an important role to play in planning all local measures for persons with disabilities. These groups may include the authorities, but it is essential to ensure the active participation of persons with disabilities and to build their capacities for expression, planning and action;
– Service accessibility projects within the community, in which the participation of persons with disabilities is enhanced (identification of accessibility priorities and practical projects, technical support for professionals, etc.);
– Projects to develop new services at local level, or the modernisation of existing services. In this case, persons with

disabilities must be included in initiative groups and partnership structures devoted to these projects.

• **Support for users at national level.**
The existence of a dense, active association network representing the interests of all persons with disabilities is generally an essential condition for the smooth operation of the services system.
At this level, Handicap International's action is based on capacity building and advocacy projects, with an emphasis on actions targeted at the services sector:
– Participation of persons with disabilities in the development and follow-up of national action plans for the disability sector;
– Advocacy for the signing and ratification of the UN convention on the Rights of Persons with Disabilities, as well as the effective implementation of articles 19 to 26 (devoted specifically to the services sector);
– Advocacy for the development of new services (call to action, conceptual studies on innovative services, etc.)
– Participation of persons with disabilities in action plans to modernise existing services;
– Inclusion of persons with disabilities and their representative groups (disabled people's organisations, national coalitions, parents' unions, etc.) in deinstitutionalization at national level, in countries where this process has been launched;
– Participation of persons with disabilities in all follow-up processes for national policies in the disability sector and/or services sector (follow-up of their application, their budgetary allocations, their annual and pluri-annual planning).

2.B.2 Support for service providers
Handicap International supports the implementation of projects that aim to improve the quality of services for persons with disabilities and capacity development for service providers in implementing and

managing well these services.
Until now, this type of intervention was Handicap International's key activity sector. Benefiting from solid technical expertise in certain sectors (prevention and health, functional rehabilitation, assistive devices, accessibility of services for persons with disabilities, vocational training, etc.), Handicap International has provided continuous technical support to service providers, in each country in which it has intervened.

This support can be organised at several levels:
• **Support for a particular service or a limited group of service providers**
In this particular case, the support is limited to a particular (technical) sector of service providers: education, functional rehabilitation, employment, etc. Projects in this category are performed with the support of the technical resources division and aim at improving the quality of these services.
This type of intervention can also support the management of a service and build managerial capacities.
At this level of Handicap International's intervention, the need for expertise is particularly important: both specific technical expertise in the sector in question, and expertise in the management and quality control sector.

• **Support for a group of service providers at local level (community or region)**
In this case, the projects are targeted especially at:
– Expertise and professional exchange networks, at local level;
– Continuous education of professionals; capacity building;
– Community planning and the participation of service providers in this process;
– The organisation of service providers into platforms and local coalitions;

- Supporting the development of public/ private partnerships;
- Supporting the development inclusive services within existing community services.

• **Support for service providers at national level**
These projects relate in general to:
- The development of national platforms (umbrella) of service providers, formal and informal (aiming at fostering the exchange of expertise, or advocacy activities in the services sector)
- The improvement of professional training mechanisms, at national level;
- The strengthening of professional associations in one sector or another (for example, psychologist associations, physiotherapists associations or associations of social workers, etc.)
- Support for the development of occupational standards as well as benchmarks criteria at national level.

2.B.3 Support for states and decision-makers
Handicap International supports the development of a national regulation system that aims to guarantee the access of persons with disabilities to quality services and the development of the capacities of actors at national level.
Handicap International's support is based on the core principle that States remain responsible for ensuring the access of their citizens (including persons with disabilities) to basic services and social services.
When a request for support is received from these levels, Handicap International must initially evaluate the added value of its possible intervention, compared with other bodies with a more conventional positioning with regards to supporting States (World Bank, bilateral cooperation agencies, OECD, etc.)

If the evaluation shows that Handicap International can provide added value, then the projects most often performed at this level are as follows:
- Qualification-based training projects at State level, initial or continuous, training of professionals (Handicap International's core expertise is physical rehabilitation, P&O and assistive technologies); these projects are very often run in partnership with training bodies (GRAVIR, ISPO, etc.);
- Supporting the development of an official regulatory system, to ensure the provision of available, accessible and transparent services that respect the principles of quality and choice.
The mechanisms most often targeted are: the accreditation of service providers; development of gatekeeping mechanisms (evaluation of needs and referral of users towards services); the development of national quality criteria; monitoring and evaluation of services and provider; setting up a national data collection system in the services sector for persons with disabilities.
The mechanisms implemented as part of these projects must be defined in partnership with the local or national authorities, persons with disabilities and their representatives. They must be professionally operated and evaluated to take into account the different levels of organisation in society and all participants in the triangular diagram. If the government implements national strategies in the fields of social services and disability, a poverty reduction process or other reforms in the social development sector, Handicap International must combine its efforts with those of public actors in order to avoid duplication and to ensure that authorities in question are aware of their responsibilities.
- Handicap International supports national or local authorities to implement national or local action plans in aid of persons with disabilities and social services. Agenda 22 can be easily adapted for use by Handicap International and its partners. Based on

The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, it comprises an entire section on social services. To the extent that all evaluations proposed by Handicap International must include local authorities and public and private service provision actors, Agenda 22 [46] or a modified version of this document can serve as a benchmark for the local community and Handicap International. The procedures and methods implemented must be used and then integrated into the day-to-day operations of local authorities and their general framework for evaluating the needs of citizens.
– Support for structural reforms in the services sector (modernisation of legislation, national strategies, etc.);
– Support for the process of deinstitutionalization;
– Support for the development of national systems of community-based services (development of new services with multiplier effects);
– Support for the inclusion of disability in social development programmes and other national policies - fight against poverty, employment, etc.

2.C

Support for actors in different intervention contexts

Experience has shown that each intervention context requires a specific approach.

In emergency situations, it is very unlikely that the association can intervene in support of the State, other than through the distribution of emergency aid following a disaster. Handicap International therefore transforms itself into a service provider (by offering victims or displaced persons basic services, such as primary medical care, emergency functional rehabilitation, assistive technologies, food aid, survival packs, etc.)
Within this framework, we must not lose sight of our responsibilities to users. However deprived these target populations, respect for their rights and interests remains a priority. The existence of clear ethical codes, and the respect of quality standards for emergency activities, forms the basis of the short route of responsibility.

See figure 10.

In reconstruction and development contexts, we can consider all the support forms mentioned above, since there is room for manoeuvre, targeting both the short and long route of responsibility:
Handicap International can help improve access to quality services for persons with disabilities by supporting users, service providers and decision-makers, and by strengthening relations of responsibility existing between these actors.
In these contexts, several different types of situations are possible with regards to the capacity of the State (or decision-makers) to assume their responsibilities. DFID working document "Approaches to Improving the Delivery of Social Services in Difficult Environments".

See figure 11.

45. Developed by the Swedish Co-operative Body of Organisations of Disabled People, Agenda 22 is a tool to help local structures implement disability policies. Visit the following website to learn more: http://www.hso.se/start.asp?sida=7053. The English version and Serb, Albanian, Macedonian and Arab translations of Agenda 22 are available in the first report of the HI-SEE disability observatory initiative and in the analysis of Handicap International Middle East's facilitators.

USERS ⟶ SERVICE PROVIDERS

SHORT ROUTE ⟶

10

LONG ROUTE

DECISION-MAKERS

USERS ⟶ SERVICE PROVIDERS

SHORT ROUTE ⟶
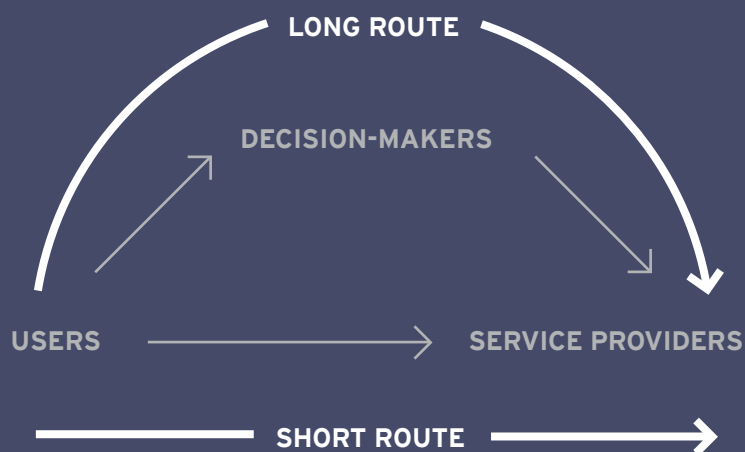
11

46. First considered by Handicap International in 2006-2007, using an analytical framework initially put forward by DFID. Summary provided in a discussion document on access to services, Handicap International, December 2008 + Berry C., Forder A., Sultan S. and Moreno-Torres M., 2004. Approaches to Improving the Delivery of Social Services in Difficult Environments. PRDE Working Paper 3. UK: DFID.

47. Berry C., Forder A., Sultan S. and Moreno-Torres M., 2004. Approaches to Improving the Delivery of Social Services in Difficult Environments. PRDE Working Paper 3. UK: DFID.

Case 1. Willingness but limited capacity

This category includes countries whose authorities find it difficult to mobilize the necessary resources to implement social reforms and poverty reduction policies for the following reasons: inadequate fiscal capacities, weak (but legitimate) government, shortage of adequate statistics and information on disability, lack of trained staff, etc. Their institutions are, however, aware of the poverty reduction issue or motivated by outside agencies (accession to the EU, for example). This category includes for example countries such as Albania, Kosovo and Lebanon (before the current period of instability), but also some countries in post-conflict situations in which international aid always has a strong presence (Afghanistan and Sierra Leone, for example).

Case 2. Capacity exists but limited willingness

This category includes countries with a good administrative capacity and territorial control, but which remain deaf to the needs of vulnerable and disadvantaged groups. Some use resources, which could otherwise be devoted to poverty reduction and exclusion to face external threats, real or imagined (North Korea, for example). This category includes countries such as Jordan, Russia and Algeria.

Case 3. Willingness but limited capacity

This category includes countries which are not recognised or which are involved in territorial disputes. They are characterised by a limited administrative capacity in terms of the development and implementation of policies and generally remain deaf to the needs of certain groups. This category includes countries such as Southern Sudan, Somalia and Iraq (countries involved in conflicts).

Case 4. Willingness and capacity

This category includes countries, which are generally considered to be "good examples" by the World Bank and international cooperation. They benefit from a government presence, and a high level of territorial control, as well as a satisfactory fiscal and monetary policy. Their administrative capacity allows public institutions to intervene, to a certain extent, in aid of development. This category includes countries such as Romania, Croatia, Bulgaria and certain Latin American countries.

Each case requires an analysis of the possible support to be provided by Handicap International within this triangular diagram. For example, in case 1, Handicap International will prioritise support for decision-makers, in parallel with support provided to other actors, in order to gradually build the regulatory capacity of these decision-makers, in the services sector. If Handicap International is not well positioned to work at national level, it will perform advocacy work to achieve this, targeted at the best placed actors (WHO, World Bank, UNICEF, etc.). In the 4th example, Handicap International will decide to position itself in particular (and sometimes only) in support of users, with particular attention given to not replacing one of the actors involved in service provision.

Technical sheets

F.1

Advocacy at international level in the service access sector

Handicap International may be called upon, as an international NGO, to defend its vision of services in campaigns and other actions, mainly targeting donors, States or international organisations.

Handicap International can therefore perform different forms of advocacy in international networks. **The implementation of the articles contained in the United Nations convention on the Rights of Persons with Disabilities** (articles 19 to 26 being the most significant for the social services sector).

Financial accessibility of services. Advocacy in favour of the financial accessibility of services (or free of charge services) is a response coherent with Handicap International's project and programme findings, and for the following reasons:

- This advocacy is part of a series of claims made by civil society and which aims to rebalance funding flows between North and South, particularly via a substantial increase in public development aid and, as part of this, the share devoted to social services;

- The participation of Handicap International in campaigns on these issues ensures persons with disabilities are taken into account in the actions performed by these civil society movements;

- These campaigns will raise awareness of the need for donors to commit themselves over the long-term, beyond crisis situations, in terms of supporting services;

- Lastly, these campaigns often target international donors so that social budgets are spared in structural adjustment plans.

The commitment of resources to promote better access to services can also be the subject of specific advocacy actions, targeted in particular at:

- Putting pressure on countries to respect the 0.7% of GDP commitment for development aid and the cancellation of the debt of developing countries;

- Improving the efficiency of aid and the harmonisation of the practices and the efforts of donors so that at least 20% of development aid is dedicated to essential services;

- Promoting the financial involvement of donors over the long-term;

- Ensuring the follow-up of public expenditure and the application of commitments made by States in terms of service implementation;

- Fighting against policies and practices that weaken the services system or give rise to greater exclusion. Liberalisation and privatization policies, the weakening of social budgets, the brain/skills drain and intellectual property rights are other subjects on which Handicap International may be involved alone or collectively.

F.2

The Different Levels Of Intervention In The Services Sector [48]

POLICY LEVEL
ACTORS

Handicap International's projects at policy level, in partnership with the public authorities

• Support drawing up disability policies based on a social approach.
> Kosovo 2000–2001
Almost total substitution in the development of policies on physical rehabilitation).

• Support drawing up inclusive sector-based policies
> Transport policies
E.g.: Handicap International Belgium in Cambodia for a road safety policy 2004–2008.

• Support creating occupational standards [49] for new professionals (often physiotherapists, occupational therapists, etc.), training curricula, mechanisms to support professional inclusion and the promotion of professions.
> Training of speech therapists in Togo for French-speaking Sub-Saharan Africa; defining orthoprosthetic benchmarks (ISPO 2)
> Indonesia (underway)
> Training of medical (physical) rehabilitation specialists in Albania
> Training of orthoprosthetic technicians (ISPO 2) in the Balkans

• Technical support for public authorities for specific projects, such as the development or support of national surveys as a basis for enlightened decision-making.
> National survey in Afghanistan in 2005 (national disability survey + development of an education unit to duplicate this project).
> National survey in Morocco (2004)

• Handicap International's projects at a policy level, in partnership with service providers
Training of service providers and professionals in the institutional environment, policies and legislative frameworks, etc.
> Burkina Faso CAPAS project, support for public health management school.
> Montenegro (2004–2008)
Development of the community-based services network.
> Balkan countries (2007–2009)
Development of quality criteria for social services in several.

• Handicap International's projects at policy level, in partnership with users/ persons with disabilities
Support/training of disabled people's organisations to help develop, implement and follow-up public policies.
> Balkans 2004–2008, SHARE SEE then SSEO projects on access to services.
> Madagascar 1998–2003, SAPESH project.

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48. Source: F. Flechenberg, A.Relandau, L.Bourgois, A.Jardin, Discussion document on "Handicap International and access to medical/social services by persons with disabilities", Oct. 2008.

49. An occupational standard (fr. Referential des competences) has been developed as a detailed inventory of skills and abilities required to exercise a profession.

F.2

Continuation

Handicap International is developing its intervention at all levels and in relation to all actors.

A rapid analysis of the projects developed by Handicap International puts into perspective the different intervention modes developed by our programmes, according to the actors present and the different levels of intervention.

SYSTEM LEVEL

ACTORS

• **Handicap international's projects at system level, in partnership with public authorities**
– Support developing and coordinating a system of services (regulatory, contracting system, etc.)
Kosovo 1999 – 2000
– Advocacy actions to implement a regulatory system by States
Balkans 2004 – 2009
– Support defining and implementing a sustainability strategy in the functional rehabilitation sector
E.g.: Sierra Léone et Libéria (underway),
Cambodia 2008 – 2011
Montenegro 2008 – 2009
Reform of the system for accessing education services (gate-keeping)
Macedonia 2008 – 2009
global reform of the regulatory system for social services (preparation of the regulatory framework+implementation mechanisms)

• **Handicap International's projects at systemic level, in partnership with service providers**
– Training of service providers in complying with/implementing a system
Cape Verde 2003 – 2013
Rehabilitation project.
– Coordinating the referral system between service providers.
Burkina Faso 2003 – 2013
Rehabilitation project.

• **Handicap International's projects at system level, in partnership with users/ persons with disabilities.**
– Supporting disabled people's organisations perform advocacy actions on access to services.
Balkans 2005 – 2009
SSEEO project
(social services for equal opportunities)
– Support for the system of direct evaluation of services by users.
Middle East 2008 – 2012
Regional project.

• **Handicap International's cross-cutting projects at systemic level:**
– Implementation or enhancement of the referral system, particularly in complex environments.
Sri Lanka 2006 – 2008
both inside and outside the conflict zone.
– Supporting the implementation of local inclusive policies founded on new inter-actor collaboration methods.
Morocco – Souss Massadra
ILD project.

F.2

Continuation

This analysis shows that Handicap International is capable of intervening at every level and with different actors in varied geographical contexts.

ACTORS

• Handicap International's projects at services level, in partnership with the public authorities
- Supporting providers of public services.
- Training of public sector professionals in charge of direct service provision.
- Supporting the restoration of private medial/social service facilities by public authorities.

> Sri Lanka 2008 – 2011
- Gradual transfer of the Batticaloa physical rehabilitation centre to the ministry for health and technical support for the setting up of fitting centres within public hospitals.
> Mali 2004 – 2009
- Projets PASORF et PIDERF, Rehabilitation projects.

• Handicap International's projects at services level, in partnership with service providers
- Direct provision of medical/social services (substitution), mostly for specialist services and/or of basic services through pre-existing structures.
> Cambodia, para/quadriplegic centre
> Kosovo, 1999, Pristina rehabilitation centre, during the first year.
- Supply of outreach services, generally in conflict situations.
> Palestine. Handicap International's outreach team in association with a public hospital.
- Organisation of peripatetic fitting tours
> Togo, Sénégal, Mali
- Supply of services by Handicap International via partners.

> Serbia 2000 – 2004
- Distribution of mobility aids/hygiene packs via hospitals and clinics.
> Chechnya 2001 – 2007
- Capacity-building for service providers (e.g. organisational capacities; support implementing establishment projects, etc.)
- Supporting innovative initiatives and practices:
> Algeria since 2004:
Support for socialising spaces.
> Russia (Pskov) support for independent accommodation services.
- Technical support/Training of professionals in practice improvements.
- Etc.

• Handicap International's projects at services level, in partnership with users/ persons with disabilities
- Reception of persons with disabilities and guidance towards existing services
> Maroc, Local Information and Guidance Centre project.
- Support for persons with disabilities in monitoring and evaluation actions for community-scale services.

F.3

Financial access of persons with disabilities and vulnerable persons to services in difficult contexts

Financial access to services forms part of Handicap International's 2010 – 2015 strategy.

Financial access to services: the rights and responsibilities of states

Article 19 of the Convention on the Rights of Persons with Disabilities states that "States Parties to this Convention […] shall take effective and appropriate measures […] to ensure that persons with disabilities have access to a range of services; […] community services and facilities for the general population are available on an equal basis to persons with disabilities."
Article 24 refers to "quality and free primary education and secondary education on an equal basis with others in the communities in which they live". Article 25 on health stipulates that "States Parties: provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons." Lastly, article 28 stipulates that "States Parties recognize the right of persons with disabilities to social protection […] including measures to ensure: […] access to social protection programmes and poverty reduction programmes; […] access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care."

These articles introduce the notion of free-of-charge access to primary school and health services. It should be noted that an alternative to free-of-charge services is envisaged for health services, under the form of "affordable costs". We would also emphasise that the quality and range of services offered are therefore associated with the existence of free-of-charge or affordable care. This represents a major challenge for the States in question! How can we, as an international solidarity organisation, support States in meeting these responsibilities regarding the rights of persons with disabilities?

R. Botokro for Handicap International

Cost of services and pricing

The initial stage of the financial analysis focuses on the cost of services.
Firstly, it is important to differentiate between costs and pricing. Calculating the actual costs entailed in producing a service, in a more or less precise manner, according to a chosen calculation technique, is a form of accounting. Pricing, which can be fairly sophisticated, is a price policy adapted to the user. It involves making a choice, justified by a set of reasons, regarding the cost of a service that the beneficiary will have to pay to access that service. Calculating costs is a technical procedure; pricing is policy-based. It is unusual or cunter-productive to use mathematical tools and accountants to calculate costs. There is no direct link between pricing and cost calculation.
A service or a State may decide to set a base price with variants according to the categories of age (children and the elderly), income (poor people) or social status (widow/er, etc). A free access policy, an exemption card and care vouchers are all pricing mechanisms, as is a percentage discount applied under certain circumstances.
All services have a cost. Who is going to pay this cost and how will the services be funded?

Financing of services

Most of the time, services and even public services have a diverse range of funding sources. A number of organisations may co-fund a service, including the State, users, bilateral or multilateral cooperation, local or

international NGOs, religious organisations and private companies.

Various funding methods are outlined in this toolbox: See 1.A.3; table 2.

It is not harmful to have multiple sources of funding. On the contrary, the more scarce they are, the more dependent the service becomes. The larger in number they are, the more independent they become. Encouraging our partners to diversify their sources of funding and helping them manage these sources are therefore excellent ways of helping them achieve a desirable level of independence.

It is possible to think of service funding like a basket in which you look at all the fruit inside, identify what they are and count them. Calculating costs enables us to establish the dimensions of the basket. We can, for example, define a desirable dimension for a determined number and quality of services (or fruit). We will then identify who can put which fruit in the basket and how many of them. It is not up to the user to provide everything, and at any rate, they are unable to do so! That's why, in many public rehabilitation services in West Africa, this analysis will allow us to establish that the State funds salaries, water and electricity and owns the land and buildings used by the service. It will also reveal the share covered by users and that paid by NGOs or other funders. Our partners are often very surprised by the results of this analysis because they do not have a realistic vision of the number of their partners and the share of funding covered by each of them. The notion of a service budget co-funded by various actors should be used both to identify the existing situation and to plan for the future.

After exploring how services are funded, that is, from the supply side, let's look at how financial access to services can be considered from the demand side, that is, from the point of view of users.

Demand side: free-of-charge versus fees-for-service

At first sight, there are two main "payment" methods: free-of-charge and fees-for-service.

In low-income countries, the Bamako Initiative backed "cost recovery" for basic health services to give them greater independence and settled up local management committees. The Bamako Initiative received widespread support from funding bodies until the last decade, despite the fact that a more in-depth analysis reveals that, beyond receiving clear political support, most technical decisions were not necessarily based on the fees-for-service model. Thus, the French Cooperation Agency, supported by the French Ministry for Foreign Affairs, preferred to fund prepayment methods, such as health insurance and premiums, than the payment itself.

The fees-for-service system generates resources to:
- Improve quality (existence of consumables and equipment)
- Increase salaries
- Cover operating costs

It often gives rise to positive results if it is associated with the subsequent follow-up of quality levels. However, after applying this model, we frequently noted a drop in the number of people using a service, an increase in access obstacles, and a level of household debt that sometimes led to bankruptcy.

The results of the research and advocacy performed by certain NGOs subsequently brought about a shift in opinion in favour of free services. Many international organisations now broadly recommend that certain services with a core social element, and which form part of a person's basic rights, should be totally free, including health care (basic care, including rehabilitation care) and schooling. In fact, the less expensive a service, the more

F.3

Continuation

accessible it becomes to everyone, including to the disadvantaged. The UN Convention cited above reflects this approach.

There is now a broad consensus in favour of free basic care for children aged under 5, pregnant women and breastfeeding women among many actors in the health sector; it was also recommended in the WHO's 2010 annual report. This movement has been spurred by efforts to achieve the Millennium Development Goals (MDGs). Because resources are rare, energies and skills are currently focused around this strong consensus. This is an element that should be taken into account in the development of projects relating to maternal and child health and early detection within Handicap International.

There is no consensus on universally free of charge services, that is, for all care services. For example, the current option preferred by the French Cooperation Agency is to promote the implementation of national health funding plans that include health coverage systems in which free services have a role to play. Following the G8 Meeting in 2007, Germany, France and Switzerland set up the "P4H" project with the World Bank, the WHO and the ILO. A new project in support of the UEMOA (West African Economic and Monetary Union) to help define a funding policy for health services for interested States began in 2011. Free services are therefore increasingly seen as a public policy tool for universal health coverage, towards which all States are moving. Other tools include compulsory health insurance and voluntary health insurance, such as insurance premiums. However, what approach should we take to payment exemption for users? Are free of charge services used by more people, and accessible to and used by everyone? Research has revealed the major impact that free of charge services have on the number of people who use these services over the short- to mid-term, and often without a

drop in care quality. Some research has also shown that "interventions aimed at ensuring exemption from payment for care and the subsidising of a service by a third-party fee payer [...] benefit all categories of the population without increasing inequalities in access to health care [50].

Aiming towards fairness

Free of charge services are not, however, more fair, or are not adequate to ensure everyone enjoys fair access to services. Among the possible reasons for difficulties accessing services are:

— The cost for the user of a healthcare or rehabilitation service is higher than the cost of the care itself. In Burkina Faso, it is estimated that at least 60% of costs for childbirth are non-medical. Transport, accommodation, food, childcare, and work delegation are some of the many indirect costs of providing care.

— The level of information and awareness, that is, socio-cultural barriers

— Geographical remoteness, the lack of support services, physical and communication barriers, the attitude of users and their entourage, etc.

Handicap International, which works in aid of the most vulnerable populations and persons with disabilities, should strive towards achieving fairness in financial access to services. This value provides a framework for the choices we make in terms of financial access to services. Handicap International's beneficiaries have specific needs, which need careful consideration and understanding, as well as those of rehabilitation services, to which a large proportion of our actions are devoted.

50. Ridde, V. and Queille L. (2010) L'exemption de paiement: un pas vers l'accès universel aux soins de santé, Expériences pilotes au Burkina Faso, 44p. Publication downloadable from the websites of the Université de Montréal and the HELP and Terres des Hommes NGOs.

Specific nature of handicap international's beneficiaries and of rehabilitation

From the point of view of:

- Beneficiaries and service users: there is a close link between poverty and disability, and a proven risk of a need for certain care services; they are discriminated against, poorly informed, suffer from a low level of literacy and little or no formal job security, self-depreciation, etc.
- Service providers: costly, long-term care, a variety of service providers: public and private; mainstream services: hospitals; specific services: centres; support services: assistive device workshops, etc.
- Public authorities: poorly informed, prejudiced, other priorities, etc.

Searching for solutions

Given these considerations and the methods of financing access to health services for persons with disabilities and vulnerable persons in difficult situations, and more particularly rehabilitation services, we believe that:

- Exemptions and free of charge services have demonstrated their limits, are not fair or efficient;
- Health insurance and premiums are not suited to costly care for which we are sure they are going to be required;
- Rehabilitation Equity Funds (REF), based on the principle of health equity funds, are a suggested form of payment that appears to be adapted to persons with disabilities and vulnerable persons experiencing difficulties and to rehabilitation care. By proposing a third-party payment system, which injects funds into the services system, they combine affordable costs for the user, an increase in services and funding received for services with continuous quality and enable States to fulfil their function of ensuring the right to services for everyone [51].

Basis for action

- In-depth analysis of the context;
- Work at a regional and district level before moving to the national level;
- Identify action-oriented research projects in partnership with universities or consultants;
- Calculate costs;
- Support service pricing policies;
- Inform and train actors in service funding;
- Ensure the inclusion of functional rehabilitation in national health development programmes and in national poverty reduction strategies or other public policies;
- Develop partnerships with existing health mutual insurance companies within our intervention areas for mainstream health services for persons with disabilities and vulnerable persons;
- Promote the emergence of Rehabilitation Equity Funds within an action-oriented research framework or direct existing solidarity funds towards rehabilitation;
- Develop contacts with insurance actors to cover specific expenses.

51. Improving access to rehabilitation care for the poorest; Evaluation of the 3 Equity Funds set up by Handicap International in Rwanda, Mali et Togo, B. Gerbier, R. Botokro, Handicap International, 2009, available in French and English

F.4

Regulatory mechanisms

Based on the experiences of the Balkans programme, a working paper was produced by Handicap International in 2006 explaining the role of regulatory mechanisms in service provision for persons with disabilities. It was also discussed and expanded in the regional report "Shifting the Paradigm in Social Service Provision: Making Quality Services Accessible for People with Disabilities in South East Europe".

Regulatory mechanisms are processes and procedures meant to control, coordinate and improve services. Generally, they are developed at national level and implemented locally.
A good regulatory framework leads to significant improvements in the access of users to services identified as necessary.
The diagram opposite presents a typical example of a regulatory framework in Europe. Regulatory mechanisms are the same everywhere:
- Assessment needs;
- Referral procedures;
- Accreditation of service providers and services;
- Contractualization;
- Funding procedures for these services;
- Follow-up and evaluation procedures;
- Collection of data and statistical analyses (at local and/or national level);
- And internal regulatory procedures established within services themselves.

What is different from a country to another is rather the way in which these procedures are organised in practical terms and their allocation to different regulatory agents (public authorities, delegated agencies, etc.)

Types of frames:

Grey frames represent Service regulation mechanism

Decision frame

Procedure and process frame

Evaluation frame

The continuous lines represent ordinary situation. The dashed lines represent exceptional situations.

*
Internal mechanisms of regulation are all instruments and procedures elaborated within an organisation, from the management, to guarantee efficiency and continuity: financial procedures, self-evaluation, internal regulation, ethic charts, etc. They must also be linked to existing standards in the services sector.

**
Results or added values from the intervention toward the user can be:
- The user satisfaction
- An improvement in functioning, or socially
- A technical aid
- An improvement in education a training level
- The acquisition of new skills
- A better involvement in social life
- An improvement of living conditions, etc.

52. Ensuring the Access of People with Disabilities to Social Services: the need for regulatory mechanisms in South East Europe, Chiriacescu D., Handicap International, 2006, www.disabilitymonitor-see.org, (pages 32 – 43).
53. Chiriacescu D., Disability Monitor Initiative, Handicap International, Sarajevo, 2008, www.disabilitymonitor-see.org

```
                    ┌─────────────────────────────────┐
                    │  Analysis of needs, at local level │
                    │             (macro)              │
                    └─────────────────────────────────┘
                                    │
                                    ▼
        ∅  ◄───  No  ◄───  ◇ If the service ◇
                            ◇  is needed  ◇
                                    │
                                    ▼ Yes
                    ┌─────────────────────────────────┐
                    │     Application registration     │
                    └─────────────────────────────────┘
                                    │
                                    ▼
                    (  Assessment of application  )
                    (  (against quality standards) )
                                    │
    Adjustments                     ▼
                            ◇ If application ◇
                            ◇   accepted    ◇
                      No                │
                                        ▼ Yes
                    ┌─────────────────────────────────┐
                    │      Licensing/Authorisation     │
                    └─────────────────────────────────┘
                                    │
                                    ▼
                    ┌─────────────────────────────────┐
                    │       Contracting/Funding        │
                    └─────────────────────────────────┘
                                    │
                                    ▼
    ┌ · · · · · · · · · · · · · · · · · · · · · · · · · · · ┐
    · ┌──────────────────────┐                              ·
    · │ Users entry in the service │                         ·
    · └──────────────────────┘      ↗↘                       ·         ┌──────────────┐
    ·         │                ↗↘  ┌────────────────────┐     ·         │ Individual needs │
    · ┌──────────────────────┐ ◄──►│ Internal regulatory │  ◄──────────│   assessment   │
    · │ Direct service provision │   │   mechanisms *      │     ·         │     (micro)    │
    · └──────────────────────┘      └────────────────────┘     ·         │  and referral  │
    ·         │                ↗↘                              ·         └──────────────┘
    · ┌──────────────────────┐         Concrete service        ·
    · │      Users exit      │            provision             ·
    · │         +            │                                  ·
    · │ Added values (résults)** │                              ·
    · └──────────────────────┘                                 ·
    └ · · · · · · · · · · · · · · · · · · · · · · · · · · · ┘
                                    │
                                    ▼
                    ┌─────────────────────────────────┐
                    │     Monitoring of the service    │
                    └─────────────────────────────────┘
                                    │
                                    ▼
                    (     Evaluation of the service     )
                                    │
    Adjustments                     ▼
                            ◇ If evaluation OK ◇
                      No                        Yes
```

Analysis of needs, at local level (macro)

If the service is needed — No → ∅ — Yes

Application registration

Assessment of application (against quality standards)

Adjustments

If application accepted — No — Yes

Licensing/Authorisation

Contracting/Funding

Users entry in the service

Direct service provision

Users exit
+
Added values (résults)**

Internal regulatory mechanisms*

Concrete service provision

Individual needs assessment (micro) and referral

Monitoring of the service

Evaluation of the service

Adjustments

If evaluation OK — No — Yes

A|z

Glossary

Assistive technologies
Assistive technologies are all tools (non human) designed to help a person to perform everyday activities: mobility aids (wheelchair, walking stick, tricycle, etc), positioning aids (special chairs, standers, etc.), prostheses, orthoses and orthopaedic shoes, daily living aids (responsive covers, shower seats, handles, etc.), visual aids (large print books, white canes, Braille, computer screens, etc.), hearing devices (amplified telephones, visual systems, hearing aids, etc.), communication aids (communication board, etc.), cognitive aids (lists, diaries, etc.) [54]. Human aid refers to anyone who helps a person perform his or her life habits (parents, friends, medical staff, etc.). Adjustments: any modification to a person's surroundings to facilitate the performance of life habits: access ramp, widened door, etc.

Contracting of social services
Process used by public authorities to draw up a contract with service providers (public or private) in order to supply services for which the State remains the guarantor.

Decentralisation
Process of transferring responsibilities, capacities and resources from the central State authorities (government, central agencies) to local authorities and decision-makers (mainly at municipal level).

Deinstitutionalisation
The change of service provision framework for persons with disabilities: from high-capacity residential institutions towards services integrated into local communities, focusing on individual needs.

Service regulatory mechanisms
Regulatory mechanisms are processes and procedures for the control, coordination and improvement of services. Generally, they are developed at national level and implemented locally. A good regulatory framework leads to significant improvements in the access of users to services identified as necessary.

Community level services
Service delivered at the level of the local community and organised in partnership with (or by) members of the community, with the participation of users in prioritising needs, and the planning and the evaluation of services.

Self-appreciation or introjection of views on disability
Some persons with disabilities become fatalistic. But how is it possible to improve your life if you "run yourself down"? According to Paolo Freire, self-depreciation results from the "introjection" of other people's judgements by a person with disabilities.

Social services for persons with disabilities
Services (specific and mainstream), which contribute to the enforcement of basic social rights and equal opportunities for persons with disabilities.

Welfare mix
A service provision model for persons with disabilities that takes into account the plurality of service providers (public, private, non-profit and profit-making) as well as the policies and mechanisms that ensure the smooth functioning of this plurality of services providers.

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54. Within this classification, see Community-based rehabilitation, BR Guidelines, WHO, UNESCO, ILO, IDDC, 2010, pages 60, 61 and 62 of the "Health component" booklet.

Reference bibliography

For additional information on handicap international's experience in the disability services sector

➥ *Practical guide to setting up a Local Information and Guidance Centre (LIGC), Modelling of a LIGC experience in Salé (Morocco)*, July 2007
Eric Plantier-Royon, technical advisor,
Inclusive local development,
Available in English and French.

➥ *The Right to Live in the Community: Making it Happen for People with Intellectual Disabilities in Bosnia and Herzegovina, Montenegro, Serbia and Kosovo*,
Adams L. Disability Monitor Initiative,
Handicap International, Sarajevo, 2008,
www.disabilitymonitor-see.org

➥ *Bonnes pratiques pour l'insertion économique des personnes en situation de handicap dans les pays en développement. Mécanismes de financement pour l'auto-emploi.* Handicap International, 2006.
Lyon: Handicap International.
Available in English, French and Spanish.
French version:
http://www.handicap-international.fr/
uploads/media/bonnespratiques.pdf
English version:
http://www.hiproweb.org/uploads/tx_
hidrtdocs/GoodPracticesEcoInclusion.pdf

➥ *Executive summary report national disability survey in Afghanistan*,
Handicap International, Islamic Republic of Afghanistan, 2005.

➥ *Comment améliorer l'accès aux soins de réadaptation pour les plus pauvres ? Evaluation de 3 Fonds d'Equité mis en œuvre par Handicap International au Rwanda, Mali et Togo*, B. Gerbier, R. Botokro, Handicap International, 2009, langue française et anglaise.

More reading on section 1.2. Of the guide (common vision of access to services)

➥ *Handicap International et l'accès des personnes en situation de handicap aux services sociaux - document de discussion*,
Franck Flachenberg, Audrey Relandeau, Alice Jardin, Louis Bourgois, Handicap International, October 2008.

➥ *Garantir l'accès des personnes handicapees a des services sociaux de qualite dans les pays en developpement a revenu intermediaire*, Charlotte Axelsson.
Document de travail. Handicap International, 2007.

➥ *Conditions de vie des personnes en situation de handicap au Togo: enquête dans 30 communautés du Togo*, Rapport d'étude June 2007, Handicap International.

➥ *Enquête SIPS – DECISIPH, Santé, Incapacités et Participation Sociale*, 2009, Handicap International.

➥ *Enquête Nationale sur le Handicap au Maroc*, Secrétariat d'État chargé de la famille, de l'enfance, des personnes handicapées, Kingdom of Morocco with the support of the European Commission, 2004.

➥ *Living conditions among people with activity limitations in Zambia*, a national representative study, SINTEF A262 Report, September 2006.

➥ *Classification québécoise: processus de production du handicap*, Fougeyrollas P. et AL., 1998. Quebec: RIPPH/SCCIDIH.

➥ *Rapport 2003 de l'observatoire de l'accès aux soins de la mission France de Médecins du Monde*, ORSMIP, published in 2004, special issue no 1.

➥ *Taking a Step Forward: Views from Stakeholders on Disability Policies and Services in Egypt, Jordan and Lebanon*. Working Paper. AXELSSON C. AND SHARKAWY G., 2006. Amman: Handicap International Middle East Regional Office.

➥ *Comprendre les approches communautaires du handicap dans le développement (CAHD).* Handicap International, 2001. France: Handicap International and CBM. http://www.handicap-international.fr/ bibliographie-handicap/4PolitiqueHandicap/ niveau_local_communautaire/rbc_cahd/ CAHDFr.doc

➥ *Beyond De-institutionalization: the Unsteady Transition towards an Enabling Society in South East Europe.* Adams L., Axelsson C., Granier P. - Disability Monitor Initiative Handicap International, 2004. Belgrade: Handicap International South-East Europe Regional Office, www.disabilitymonitor-see.org

➥ Shifting the Paradigm in Social Service Provision: Making Quality Services Accessible for People with Disabilities in South East Europe Chiriacescu D., Disability Monitor Initiative, Handicap International, Sarajevo, 2008, www.disabilitymonitor-see.org

➥ *Ensuring the Access of People with Disabilities to Social Services: the need for regulatory mechanisms in South East Europe*, Chiriacescu D., Handicap International, 2006, www.disabilitymonitor-see.org

➥ *Free Movement of People with Disabilities – an inaccessible right?* Adams L., Sestranetz R., Disability Monitor Initiative, Handicap International, Sarajevo, 2008, www.disabilitymonitor-see.org

➥ *Guide méthodologique "Comment réaliser un diagnostic local participatif sur la situation des personnes handicapées et leur degré de participation citoyenne"* Eric Plantier-Royon RT Développement local inclusif, available in French and English.

➥ *Capacity Development and Partnership. Overview and Methodology. Guide for the staff of Handicap International*, Stefanie Ziegler, Handicap International, Munich, Germany, 2008.

➥ *Actualisation des champs d'actions de Handicap International* - November 2009, Lyon: Handicap International.

➥ *Rethinking Care from the Perspective of Disabled People*. Conference Report and Recommendations, Colin Barnes, WHO, June 2001.

➥ Paulo Freire, *Pédagogie des opprimés*, La découverte/Maspero, 1983.

➥ *Agenda 22, Disability policy planning instructions for local authorities*, The Swedish Co-operative Body of Organisations of Disabled People, 2001.

➥ *Impact des soins de réadaptation sur l'insertion sociale des personnes handicapées au Togo: enquête auprès de 30 personnes amputées de membre inférieur*, Y. Tublu, R. Botokro F. Flachenberg, C. Mésenge, Handicap International, 2009, langue française et anglaise.

➥ *Community-based-rehabilitation*, CBR Guidelines, WHO, UNESCO, ILO, IDDC, 2010,

➥ *Approaches to Improving the Delivery of Social Services in Difficult Environments*, Berry C., Forder A., Sultan S., and Moreno-Torres M., Document de travail. UK DFID, 2004.

Reference bibliography

Works on service quality

➥ *La qualité dans les services sociaux – positioning document*; European Commission – Disability High Level group http://ec.europa.eu/employment_social/index/final_mainstreaming_en.pdf

➥ *Memorandum on a European Quality Principles Framework EQFP*. Communication. EASPD, December 2006. Brussels: EASPD (European Association for Service providers for persons with disabilities) (www.easpd.eu)

➥ *Promoting person-centered care at front line*; http://www.jrf.org.uk/knowledge/findings/socialcare/pdf/0296.pdf

➥ *User's involvement in social services* – Final report of the activity carried on in 2003 – 2004 (Council of Europe). Brian Munday, 2004 www.coe.int/t/dg3/socialpolicies/socialrights/source/2004finalSocServ_en.doc

➥ *Quality of social and health services - the Social NGOs' recommendations to EU decision makers* – Position paper adopted by the Social Platform Steering Group, 6 June 2008. http://cms.horus.be/files/99907/MediaArchive/Policies/Services_of_General_Interest/08-06-26%20Final%20common%20position%20on%20quality%20social%20and%20health%20services.pdf

➥ *Improving Standards of Child Protection Services – A Concept Paper*, Bilson A. and Gotestam R., 2003. Florence: UNICEF Innocenti Centre and World Bank.

➥ *Projet d'établissement des structures a caractère médicalisé, éducatif et/ou social de la région Maghreb*, Handicap International, 2007. Cahier thématique n°5, March 2007, Maroc: Handicap International Morocco/Tunisia.

Delivery of services in difficult environments

➥ *Approaches to Improving the Delivery of Social Services in Difficult Environments* Berry C., Forder A., Sultan S. and Moreno-Torres, M., 2004. PRDE Working Paper 3, UK: DFID.

➥ *Access to disaster services: Social work interventions for vulnerable populations* (fr. Accès aux services sociaux en cas de désastre: Interventions sociales pour des populations vulnérables), Zakour Michael J. (1); Harrell Evelyn B. (2) - Journal of social service research, ISSN 0148-8376, 2003.

➥ *Dans l'intérêt du public: santé, éducation, eau et assainissement pour tous*, OXFAM AND WATERAID, 2006. Oxford: Oxfam International. http://www.oxfam.org/fr/files/bp_public_interest_full/download

➥ *Accès aux services pour les personnes handicapées dans les contextes difficiles: compléments au séminaire tenu à Amman (Jordan)* – December 2009 (English title: Access to services for persons with disabilities in challenging environments: Supplement to the seminar held in Amman (Jordan) in December 2009. Lyon: Handicap International, 201075 p.

Other external reference documents

~ *Disability, Poverty and Development.* Department for International Development (DFID), 2000. UK: DFID. http://www.dfid.gov.uk/pubs/files/disability.pdf

~ *World Development Report. Making Basic Services Work for Poor People.* World Bank, 2004. Washington: Oxford University Press.

~ *Deinstitutionalisation and community living. Outcomes and costs: Report of a European Study* (coord. By Jim Mansell) www.ec.europa.eu/employment_social/index/vol1_summary_final_en.pdf

~ *Disability mainstreaming in the new streamlined European social protection and inclusion processes*, Disability High Level Group, discussion paper http://ec.europa.eu/employment_social/index/good_practis_en.pdf

~ *First Report of the Disability High Level Group (EU) on the Implementation of the UN Convention*, May 2008 http://ec.europa.eu/employment_social/index/political_note_accessible_en.pdf

~ *Literature Review of Non-State Providers of Basic Services*, Moran D. AND Batley R, 2004.. International Development Department. School of Public Policy. UK: University of Birmingham.

~ *A Note on Disability Issues in the Middle East and North Africa*. World Bank, 2005. Human Development Department Middle East and North Africa Region: World Bank. http://www.urban.org/UploadedPDF/410871_ContractingwithNGOs.pdf

~ *World Development Report. Gender Equality and Development*, World Bank, 2006. Washington: Banque mondiale. http://siteresources.worldbank.org/INTTUNISIAINFRENCH/Resources/WDR2006overview-fr.pdf
Joint position paper on CBR 2004, World Health Organisation (WHO), 2004. Geneva: WHO. http://www.ilo.org/public/english/employment/skills/download/jointpaper.pdf

~ Study on Social and Health Services of General Interest in the European Union, Huber M., Maucher M., Sak B., European Commission, Dg Employment, Social Affairs And Equal Opportunities.

End of the toolbox.

**Access to services for persons
with disabilities**

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"To ensure the service offer in our sectors
of activity is available, adapted and
accessible" represents one of Handicap
International main action purpose.
This decision-making guide for programmes
is based on a "systemic" vision of services,
which includes the policy of a given country
or sector, practices and the lives of the
individuals concerned.

This guide is divided into three sections:
- Principles & Benchmarks set out the basis
for a common vision of the key determining
factors for accessing services.
An overview of the elements of analysis for
the service sector for people with disabilities
is then developed.
- The Practical Guide part sets out
the planning stages to be followed at
programme level. These stages help defining
the analytical and decision parameters
effective and relevant projects.
- The Toolbox offers practical tools and
sheets to implement the various techniques
proposed in the guide.

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