In countries of the CEE/CIS region, well over a million children live in institutions. Many of these children were abandoned at birth and a large proportion of them have disabilities. In fact, disability is one of the most frequent causes of abandonment. Institutionalisation deprives children of a family environment and most often, especially in the case of very young children, has a very negative impact on their development. The General Comment No. 7 on the UN Convention on the Rights of the Child states that “young children should never be institutionalized solely on the grounds of disability. It is a priority to ensure that they have equal opportunities to participate fully in education and community life, including by the removal of barriers that impede the realisation of their rights.”

This study takes an in-depth look at how Belarus is moving along the path of providing inclusive, child-centred and family-focused services to address the needs and rights of children with developmental delays and disabilities. In many cases, Early Childhood Intervention (ECI) services, which arguably need to be expanded to cover more and more children, are working to make early diagnoses and remediate existing or emerging delays and disabilities in conjunction with and respecting the rights of parents and children. The study discusses the “defectological” tradition, extant in most countries of the CEE/CIS region, which although evolving and changing, tends to focus on “correcting deficiencies.” Modern, scientific approaches, the study emphasises, characterise the children as capable of learning and focusing on their competencies.

Two very talented and experienced child development and special needs professionals, Dr. Emily Vargas-Barón and Prof. Ulf Janson were responsible for conducting this study. They were assisted in their endeavours by Natalia Mufel, a Belarusian psychologist, working with UNICEF. Together the team visited examples of different services for special needs children in Belarus, conducted interviews, made observations, and profiled the services based on criteria such as parental participation, interdisciplinarity, and flexibility. The authors make a number of important recommendations towards aligning services even more closely with child rights principles. They also provide a set of practical guidelines that can assist other countries in the region to re-examine and transform their services for children with special needs.

It is hoped that this informative document will benefit health, education and welfare professionals and decision makers, and that its rich insights will help spur the necessary changes that will lead to better protecting the dignity and rights of children with special needs and their families.
UNICEF
Regional Office for CEE/CIS

Emily Vargas-Barón & Ulf Janson
with Natalia Mufel

EARLY CHILDHOOD INTERVENTION,
SPECIAL EDUCATION AND INCLUSION:
A FOCUS ON BELARUS

Minsk
«Altiora – Live Colours»
2009
The Project
This study reviews early childhood intervention (ECI), special education and inclusive education programmes in Belarus. Upon the request of UNICEF’s Regional Office for CEE/CIS, it presents key programme concepts and information, identifies lessons learned, offers recommendations, and presents general Guidelines for ECI and Special Education Systems for the consideration of other countries in the region and the world.

The Authors

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Vulnerable children require early childhood development (ECD) services to help them achieve their potential. However, ECD programmes in many world areas aimed at serving vulnerable children tend to be short in duration and they have general contents that are more appropriate for typically developing children. Abundant research has shown that effective services for vulnerable, high-risk, developmentally delayed or disabled children should be more intensive, enriched and longer in duration.

Providing intensive and enriched services for vulnerable young children is sometimes considered to be overly expensive. After significant experience, we believe this to be untrue. New types of Early Childhood Intervention (ECI) programmes for vulnerable children can be designed with varying levels of intensity and richer curricula, learning materials and methods. In addition, better community outreach and child assessment systems are needed to identify children with high-risk status, developmental delays, malnutrition or disabilities. Improved and expanded pre- and in-service staff training and combined supervisory, monitoring and evaluation systems are required to support programme development over time.

As we shall show in this study, investments in ECI, special education and rehabilitation services are less costly than institutionalising children, and in addition, they are far more humane, effective, child-centred and family-focused.

Because most countries in the CEE/CIS region have large health and education systems, we believe they are poised to develop ECI, special education and inclusive preschool services. To enter this next stage of programme development for young children, we encourage readers to review the initial Guidelines for Early Childhood Intervention that are presented in Part V. We look forward to receiving your comments on these suggestions.

Because this review deals with many complex and sensitive issues, UNICEF felt it was appropriate to create a two-person study team that united our experiences with ECD and ECI systems in Europe, Russia, Eastern Europe, the United States and Latin America. With respect to study methodology, we conducted an extensive desk review of many studies and documents, systematic observations of programme services in action wherever possible, and probing interviews of many parents, programme directors and personnel. We crosschecked information extensively with a variety of sources to ensure the greatest accuracy possible. UNICEF personnel, and most especially Natalia Mufel, provided extensive information about the evolving ECI system in Belarus.

On a personal level, it was very rewarding to work together and share ideas. We hope our readers will agree.

Emily Vargas-Barón
and Ulf Janson
Early Childhood Intervention, Special Education and Inclusion: A Focus on Belarus describes and analyses a variety of programmes for vulnerable children with developmental delays and disabilities.

This study documents the evolution of services for Early Childhood Intervention (ECI), special education, and rehabilitation for Belarusian children with special needs from birth to six or eight years of age. It includes definitions of key terms, including: developmental delays and disabilities; ECI services; special education; defectology; and “child-centred,” “family-focused,” and inclusive services. It reviews the nature of services before the introduction of child-centred and family focused approaches in recent years, and it identifies some of the triggers that prompted the modernisation of services as well as drivers that sustain programme quality and continuous service improvement. The study focuses on these programmes’ normative, institutional and juridical status; structure and organisation; general service coverage; and programme contents and approaches. In addition, the study provides some lessons learned, recommendations for the CEE/CIS region, and guidelines for ECI services.

Quandaries regarding prevailing global, regional and national rates of developmental delay and disability are also discussed. The current status of services for vulnerable children in the CEE/CIS region is also reviewed, along with trends for moving from placement in state care institutions to providing child-centred and family focused services for special needs children and their parents.

In section II.3, a Continuum of Early Childhood Services is advanced as a conceptual framework regarding ways countries can provide universal support for families with young children as well as more intensive and enriched services for children with risk status, developmental delays, malnutrition, chronic ill health or disabilities.

To assess the wide variety of services for vulnerable children in Belarus, the authors created a heuristic device: “Continua regarding Conceptual Approaches to ECI” that is presented in Section II.6. In Part III, these continua were used to assess prevailing special health, medical and education services for young children in Belarus. These assessments revealed that a wide range of approaches is still used and further evaluation research is required to assess programme outcomes.

In Part III, Chart III.1 Services for Special Needs Children in Belarus presents a schematic overview of Belarus’ large and impressive system of health, medical and education services. It then describes and analyses the country’s main programmes for children with special needs, including:

- Polyclinic-based Early Childhood Intervention Centres;
- Child and Adolescent Psychoneurological Dispensaries;
- Medical Rehabilitation Centres;
- Infant Homes;
- Development Centres of the Ministry of Education;
- A wide range of preschools for children with special needs; and
- Family services of the Belarusian Association of Assistance to Children and Young People with Disabilities.

In Part IV, a series of triggers and drivers of the ECI and Special Education System are identified. Major lessons learned gleaned from this review of Belarusian services for young children with special needs include:

1. Strong policy support, a legal basis for the ECI system, and inter-sectoral agreements and guidelines promote the development of sustainable, culturally appropriate, comprehensive and continuous ECI services.
2. Former defectological systems, concepts and methodologies should be revised to ensure an effective special education and health system can be developed.

3. Service eligibility criteria should remain broad.

4. Outreach services are essential to identify and serve all special needs children.

5. Inter-agency early identification, assessment, case management, tracking and follow-up systems are needed to ensure children are not “lost” in the system.

6. Individualised family and child service plans should include the informed consent and active participation of parents in all programme activities.

7. Comprehensive centre- and home-based ECI services should feature the full range of service intensities plus child care and respite care, as needed.

8. Year-round ECI services are essential given continuous child and family support needs.

9. Belarusian parent education, counselling and support services have proven to be effective and highly used by the parents of special needs children.

10. Parent involvement in ECI services and centres is correlated with client satisfaction.

11. ECI’s Interdisciplinary Teams helped to achieve well-integrated services.

12. Guidelines are needed to manage ECI learning resources.

13. Careful planning for the transition of children and parents from ECI services to inclusive preschools and primary schools is essential.

14. Flexible approaches should be used for pre- and in-service personnel training.

15. Inter-agency coordination roles and Commission meetings should be revised to ensure, among other matters, that parents are able to decide on the futures of their children.

16. The cost of institutionalising children with developmental delays and disabilities far exceeds the cost of providing preventive and supportive child-centred and family-based services for families with special needs children. The costs related to infant homes and orphanages should be progressively shifted to the ECI and Special Education System along with the provision of high-quality parent education and support services to ensure children will be well cared for and nurtured. Care must also be taken to ensure the transition is well programmed to provide quality care in residential environments as children are gradually transitioned to new foster homes or are adopted.

17. In addition to current institutional monitoring requirements, ECI services should design and implement results-based programme evaluation systems in order to assess programme outcomes.

18. Strategies for ECI programme advocacy are needed.

19. In addition to public sector services, it is essential to provide support for NGOs, universities, professional associations and other civil society organisations.

20. Basic research is needed on child status, ECI systems and policy impacts.

In addition, recommendations are provided for regional training, exchange and networking in order to promote the development of ECI services, special education programmes, and inclusive preschools in other countries.

In Part V, Guidelines for Establishing ECI Services are offered to help other countries design rights-based, child-centred, and family-focused ECI services. These Guidelines include core concepts and basic principles, structures and ranges of services, processes and methodologies for establishing effective ECI services. The authors welcome comments on these Guidelines.
PART I: 

Introduction
I.1 Early Childhood Intervention: an essential part of all early childhood systems

Programmes for early childhood intervention (ECI), special education and inclusive education should be an essential part of all national early childhood systems. Every society has many vulnerable children with special needs. These needs may be due to poor birth outcomes, war, poverty, famine, insufficient nurturing care, an impoverished learning environment, poorly formed early relationships, disease, chronic ill health, biological or chemical contamination, child neglect, family genetics, domestic abuse, or the institutionalisation of “social orphans”\(^1\) and disabled children. Such vulnerable children require intensive ECI services that provide individualised attention to meet their special needs.

Brain research has demonstrated that it is imperative to provide supportive services for pregnant women and young children from birth to age three. During this period, approximately 80% of the brain is developed (Shonkoff and Phillips 2000). Most countries focus early childhood services for children from birth to age three narrowly on primary health care, and only begin to invest in preschool education at age three or four. The critical period of pregnancy to age three has been given relatively less attention. To date, most countries have not established comprehensive early childhood systems for parent education, early stimulation\(^2\), and integrated services to meet an array of child development needs, from high-risk and mild conditions to severe malnutrition, developmental delays or disabilities.

The incidence of developmental delays and disabilities throughout the world is only beginning to be discovered. For example, in the highly developed country of Chile, a nationwide assessment of infant and child development revealed high levels of developmental delay in young children, especially among families living in poverty. For infants from one to 23 months of age, delays varied in municipalities from 23% to 40%. For children from 24 months to four years of age, delays varied from 28% to 46% (Molina 2006). In response to these alarming figures, Chile currently is placing a major emphasis upon developing ECI services and inclusive preschool and school education.

A series of studies on the rate of return on investment in ECD revealed that returns range from US $2 to $17 per dollar invested (Heckman et al 2000 – 2006). Economists and national planners find these research findings most compelling. As a result of these and other studies, on October 25, 2007, leading international economists participating in the Consulta de San Jose, identified ECD as the first and most effective investment among 29 priority areas for improving public spending and policies in Latin America and the Caribbean. According to the outcome document:

*Top priority was given to Early Childhood Development programs. These are interventions that improve the physical, intellectual and social development of children early in their life. The interventions range from growth monitoring, day care services,

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1 Social orphans are children who are in state care and without parental care, but who have at least one living parent.

2 Parents and caregivers conduct early childhood stimulation and development activities, beginning at birth, to optimize infants and children’s perceptual, physical, mental, language, and social and affective development. In this study, infant stimulation is used to cover the full range of infant and child development activities. It includes nurturing relationships, strong mother/child bonding, and the promotion of positive socio-emotional development.
preschool activities, improved hygiene and health services to parenting skills. Besides improving children’s welfare directly, the panel concluded these programs create further benefits for family members, releasing women and older siblings to work outside the home or to further their own education. Evidence shows that the benefits are substantially higher than the costs.3

I.2 Objectives, limitations and scope of the study

The UNICEF Regional Office of CEE/CIS established the following study objectives:

1. To document the evolution of centres for ECI, development training and rehabilitation for young Belarusian children from zero to six or eight years of age with special needs, including: the nature of services before the introduction of “child and family friendly” approaches; triggers that prompted the modernisation of services; and drivers that sustain quality and continuous service improvement.

2. To characterise and assess ECI systems and services in Belarus with regard to: normative, institutional and juridical status; structure and organisation; general service coverage; and contents and approaches.

3. To develop general guidelines for the establishment of effective, rights-based, child-centred, and family-focused ECI services in the CEE/CIS region.

Although these objectives were attained, this study has some limitations. We had very limited time for field work. Programme directors were universally present during our relatively short visits to each centre; in some sites professional personnel were on vacation, limiting opportunities to observe child, parental and professional interactions. Most materials were available in Belarusian or Russian, and key documents had to be translated for us. Several technical terms and types of specialists were substantially different from those used in other countries. As a result, some terms have been translated using rough equivalents in English.

3 See website for additional information: http://www.iadb.org/res/consultaSanJose/files/outcome_eng.pdf
PART II:

Definitions, Conceptual Approaches and Context
In 2007, UNICEF established new programme guidance regarding Children with Disabilities: Ending Discrimination and Promoting Participation, Development and Inclusion. This guidance provides a framework for ensuring all children will be given an opportunity to develop their potential. It states:

“Programming can incorporate attention to the issues raised by childhood disability in different ways across the life cycle. In the early years, early detection and intervention, as well as family support come to the fore. Early intervention is critical and holds tremendous potential for success. It requires high awareness among health professionals, parents, teachers as well as other professionals working with children. Family- and community-based early intervention services should be linked up with early learning programmes and pre-schools, which meet the needs of children with disabilities and facilitate their smooth transition to school.” (p. 7)

“Efforts to incorporate attention to children with disabilities in UNICEF health and nutrition programming should focus on improving strategies for early detection, referral and intervention and promoting equal access to health services.” … “As seen in numerous community-based rehabilitation (CBR) programmes, early screening and simple community-based interventions by front-line workers have shown to be an effective tool for improving the lives and functioning of persons with a disability... However, early screening and diagnosis must be linked to the provision of timely and appropriate support and advice to families, combined with the design and orientation of a corresponding intervention plan for more complex problems and for developmental delays. Efforts should focus on building the capacity of health workers and others in the community to provide advice and assistance to parents, as well as to refer children with more complex disability appropriately.” (p. 9)

Part II addresses definitions and conceptual approaches used to assess and identify children with developmental delays, malnutrition and disabilities, and to provide child-centred and family-focused services. It also discusses global, regional and Belarusian rates of vulnerable children as well as reviews programme approaches developed in CEE/CIS countries. Part II also presents a general continuum of early childhood services and discusses issues regarding defectology, special education and inclusion.
Definitions and conceptual approaches are essential to understanding the fields of ECI, special education and inclusive education. The status of children targeted by these programmes is a complex topic. They include children at high risk of developing delays or disabilities, children that have developmental delays, and children with disabilities.

**II.1.1 Child status**

Children who are at risk of developing delays and disabilities include those with poor birth outcomes, biological or genetic risks, or whose parents live in poverty, have low levels of formal education, or suffer from domestic violence, substance abuse, violent conflicts, famine, diseases, poor sanitation or other negative situations.

A child is considered to have a developmental delay when he or she is assessed to have atypical behaviour or does not meet expected normal development for actual or adjusted age in one or more of the following areas: perceptual, fine or gross motor, social or emotional, adaptive, language and communication, or cognitive development. A delay is measured by using validated developmental assessments. The delay may be mild, moderate or severe. Poor birth outcomes, inadequate stimulation and nurturing care from birth onward, organic problems, psychological and familial situations, or environmental factors can cause delays.

A child is considered to be disabled if he or she has a physical, health, sensory, psychological, intellectual or mental health condition or impairment that restricts functioning in one or more areas, such as physical movement, cognitive and sensory functions, self-care, memory, self-control, learning, or relating to others. Many national and international typologies of disabilities list impairments by type.

Children develop in a holistic manner and evolve dynamically over time in response to their environments. Because of this, both typically developing children and those with developmental delays or disabilities require balanced support in all areas of development, including perceptual, fine and gross motor, language, cognitive and social/emotional development as well as health and nutrition in order to achieve their innate potential. To achieve balanced development, early childhood programmes use integrated approaches that include basic services for preventive health care, nutrition, early nurturing, stimulation and child development activities, home and community sanitation, and in cases of special need, juridical protection and protective services.

**II.1.2 Special education needs**

Special education can be defined as educational and social services provided by preschools, schools and other educational organisations to children usually between the ages of two and one-half or three years of age to 18 to 21 years of age. ECI services usually begin before special education services are provided but in some countries, ECI programmes are included within special education services, as is the case in Belarus.

The OECD classification of children with special education needs is as follows: Cross-national category “A/Disabilities”: Students with disabilities or impairments are viewed in medical terms as organic disorders attributable to organic pathologies (e.g. in relation to sensory, motor or neurological defects). The educational need is considered to arise primarily from problems attributable to these disabilities.

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4 Holistic development refers to integrated and balanced development in all areas, including physical, social, emotional, language and cognitive development.
Cross-national category “B/Difficulties”: Students have behavioural or emotional disorders, or specific difficulties in learning. The educational need is considered to arise primarily from problems in the interaction between the student and the educational context. In the survey of special educational needs provision among member countries for school year 2000/2001, “mild mental handicap” was changed from category B to category A. (OECD 2005, pp. 14 and 26)

Cross-national category “C/Disadvantages”: Students have disadvantages arising primarily from socio-economic, cultural and/or linguistic factors. The educational need is to compensate for the disadvantages attributable to these factors.

Although widely used, the OECD classification for children with special needs focuses on disability rather than ability. It does not include learning opportunities from the removal of barriers or achievements that can result from giving each child positive support for attaining his or her potential. The early childhood intervention approach, presented next, stands in stark contrast to this classification’s focus on disability.

II.1.3 Early childhood intervention

Michael Guralnick defines early childhood intervention “…as a system designed to support family patterns of interaction that best promote child development” (2001). From the parents’ point of view, Texas ECI services are described as follows: “Children grow and learn, or develop, a lot during their first three years. Although each child is special and grows and learns at his or her own pace, some children need extra help. This extra help is called early childhood intervention.” (Texas ECI Handbook 2006.) Shiela Wolfendale asserts that an ECI programme has several goals: “Firstly, it is provided to support families to support their children’s development. Secondly, it is to promote children’s development in key domains such as communication or mobility. Thirdly, it is to promote children’s coping confidence, and finally it is to prevent the emergence of future problems.” (1997).

ECI programmes include an array of balanced activities with infants and young children to encourage their development in different domains through a variety of methods: physical, language and occupational therapies; special education and inclusive services; medical, nursing and nutritional services; and parent education and support services, including referrals and protective services, if required. They seek to identify high-risk, developmentally delayed, and disabled children at or soon after birth or the onset of special needs. They also identify delays that appear later due to situations such as poverty, lack of early nurturing and stimulation, malnutrition, chronic ill health, war, loss of parents, neglect, abuse, child labour, and so forth. By focusing on children’s environments, ECI services help remove barriers to development in terms of social and educational conditions as well as environmental adaptation and the provision of technical aids.

An additional ECI definition describes the range of potential programme services and impacts. For example, Shonkoff and Meisels state:

“Early childhood intervention consists of multidisciplinary services provided to children from birth to 5 years of age to promote child health and well-being, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning. These goals are accomplished by providing individualized developmental, educational and therapeutic services for children in conjunction with mutually planned support for their families.” (2000, pp. xvii-xviii)

ECI services usually begin at or shortly after birth, and depending upon need, should continue until developmental goals are achieved and consolidated, the child enters preschool or school, and/or reaches six to eight years of age. The length of time ECI services are provided varies from country to country: from birth to three years of age, or from birth to school entry or five to eight years of age. In countries with strong inclusive preschool education programmes, ECI services often focus mainly on the critically important period of birth to three years of age. Where they exist, ECI services are usually provided to both parents/families and to children. For this reason, ECI services are universally family-focused and feature parent empowerment, education and support. When ECI, special education and inclusive services are joined together, inclusive services may continue until they reach 18 years of age.

In essence, ECI programmes provide a system of early childhood services and support for:

1) vulnerable children at high risk for developmental delays or with confirmed developmental delays or disabilities, and
2) their parents and families.

The primary goal of ECI programmes is to support parents in helping their children to use their competencies to achieve their full developmental potential and attain expected levels of development, to the extent possible.
II.2

CHILDREN WITH DEVELOPMENTAL DELAYS OR DISABILITIES

II.2.1 Global rates of developmental delay and disability

The global rate of developmental delay and disability is not known. Some estimate there may be 150 million children with disabilities alone worldwide, indicating a prevalence rate of only 1.3%, which must be a vast undercount (Committee on the Rights of the Child 2006). The World Bank estimated that 40 million of 115 million out-of-school children have disabilities, including those with moderate disabilities, and at least 25% of the world population is affected by disabilities. (World Bank 2003) The numbers of children, who are at risk of developmental delays or disabilities or are already affected by them, vary greatly from country to country depending upon: poverty rates; basic health care; birth outcomes; parental educational and economic levels and other circumstances. Many more children are affected by developmental delays than originally thought, as demonstrated by the Chilean national study of Dr. Helia Molina, noted above. However, many national planners believe that only a small percentage of children are affected by delays, such as from 4% to 5%. This belief has been used as an excuse for neglecting to budget adequate funds for essential health and education services for children with developmental delays or disabilities.

Regrettably, few countries have reliable counts of children with high-risk status, delays and disabilities. Starting Strong II

Efforts to improve equitable access target primarily two categories of children: children with special needs due to physical, mental or sensory disabilities; and children with additional learning needs derived from family dysfunction, socio-economic disadvantage, or from ethnic, cultural or linguistic factors. In practice, many children in need of special or additional educational support have accumulated both physical and socio-cultural at-risk factors. Early childhood services are particularly important for such children, and contribute strongly to their health, social and cognitive development, as well as to the social inclusion of their families and their future participation in society. Moreover, these services fulfil an early screening function in detecting special needs which, if identified sufficiently early, can be treated more effectively, including the provision of support to families.” (Bennett 2006, p. 92).

In Starting Strong II, OECD’s Education Directorate presents the following statistics for OECD member countries using the categories presented earlier regarding the frequency of varying levels of risk, delay or impairment:

**Category A/Disabilities:** These are conditions that affect students from all social classes and occupations, generally around 5% of any OECD population.

**Category B/Difficulties:** These learning disabilities are often temporary in nature, and afflict a small percentage – around 1% – of any population.

**Category C/Disadvantages:** This is a large group in many countries ranging from 15% to 25% of children in any given urban population.” (Paraphrased from Bennett 2006, pp. 97 – 98)

5 The OECD member states are: Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States.

6 For Category C, due to a relative lack of adequate health and education services, the rates of developmental delay and disability in rural areas of OECD nations tend to be higher.
Adding these rates together, from 21% to 31% of young children in OECD countries are affected by/or at risk of developmental delays or disabilities, a figure not totally dissimilar to Molina’s findings in Chile. This high level of need for ECI services has enormous implications for educational achievement, social service costs, and national productivity.

National coverage of special and inclusive education services that are enriched, more intensive, and longer in duration has been attained only in Australia, Europe, New Zealand, North America and a few countries of Latin America. These realities make the achievements of Belarus, a country in transition, all the more striking. Similar to many industrialised countries, Belarus has developed a large ECI and Special Education system.

II.2.2 Services for children with special needs in CEE/CIS region

Before the founding of the Soviet Union, Russia had developed a wide variety of preschools. (For a rich discussion, see Taratukhina et al 2007.) However, after the October Revolution, private or otherwise independent preschools were ended or transferred to People’s Commissariat of Education. Thereafter, State-funded programmes provided centre-based care for newborns and young children: 1) to enable mothers to work after two months of rest after childbirth; and 2) to form children into citizens devoted to collectivist approaches wherein individual creativity and initiative were not fostered (Zafeirakou 2006).

As noted by Taratukhina, “…the Soviet system was quite effective in dealing with the tasks set by the State. It was: stable; without competition; not arbitrary; settled and in keeping with Russian habits and mentality; a prop of the existing social system; the same for all 15 component republics of the USSR; centralized; without right of initiative or independent decision making; easy to manage from above because of its uniformity. From the mid-1980s (the beginning of perestroika) there was a gradual transfer from a unitary denationalized education system to a democratic, multiple and ethnically orientated education system. Russia saw the revival and qualitative improvement of national schools and the restoration of humanist traditions in education. (p. 6)

In some parts of the Soviet Union, nursery care was less available; however, young children were usually placed in preschools in order to release mothers to work outside the home. Infants and young children who were considered to have a “defect” or other disability were sent away to institutions and they rarely were able to leave them during their lifetimes. Defectology was developed as a discipline for identifying and caring for these children (See Section II.4). Parent education was not provided, and State responsibility for child rearing was emphasised while families were given a lesser role as helpers of State institutions. All of these circumstances led to a situation where many present-day families do not esteem parenting and lack basic parenting skills.

At the start of transition, several CEE/CIS countries experienced major economic and social dislocations and highly diverse approaches to ECD arose, depending upon historical, institutional, cultural, religious and economic circumstances. However, a few general statements may be made about the region as a whole. Poverty indices rose sharply and in many countries, health, educational and social services were severely curtailed, leading in most but not all countries, to a rapid deterioration in primary health care, preschool education, and many other social services upon which most families had become dependent. In addition, with privatisation, where national and/or local governments did not mandate the maintenance of preschool services, coverage tended to decline precipitously. Since 2000, many of these countries are recovering economically, and they are rebuilding and reforming their services for young children and their families. In general in the region, programmes for early childhood tend to have low coverage and be directed and managed by the public sector. In some cases there is collaboration with civil society organisations, such as the Step by Step NGOs established by the Soros Foundation Network, International Baby Food Action Network (IBFAN), and others. Increasingly, NGOs, universities, institutes and private initiatives are playing key roles in ECD in many of the countries. Residual pre-transition programmes and newly developed ones tend to be clustered in urban centres. Most CEE/CIS countries are experiencing serious challenges in reaching rural areas and excluded ethnic and linguistic groups. The decentralisation of governmental
services has revealed a lack of capacity at municipal and community levels for comprehensive ECD planning, including for ECI services. In general, as countries have not formulated ECD policies, plans, legislation, standards, evaluation, quality assurance and accountability systems. Only a few countries have developed incipient ECI systems. In this, Belarus is leading the way through the establishment of its large, varied and quite integrated ECI and special education system.

In CEE/CIS countries, until recently infancy to three was considered mainly the responsibility of parents and health care systems. There is growing acknowledgement of the need to develop comprehensive ECD systems for parents and children starting from the prenatal period. With respect to children over three years of age, in Central Asia, preschool education declined after the fall of the Soviet Union; however by 2004, the preschool gross enrolment rate had risen to 27%. In Central and Eastern Europe, gross preschool enrolments also dropped but had recovered by 2004 with an average gross enrolment rate of 57% in the region, with great variation among the countries. However, children from the poorest backgrounds who stand to benefit most from ECD services tend to be most likely to be excluded from preschools. “Many children from ethnic minority groups are mislabelled as ‘developmentally delayed’ and lack access to essential services.” (Sammon 2001, p. 9) Better family income, majority status, urban residency, higher maternal education levels, birth registration, and the presence of an immunisation record, are associated with the likelihood of preschool attendance in the region. (UNESCO 2006, pp. 3-6) In South East Europe, services for children from birth to three and for preschool education tend to be severely limited, especially for rural and excluded groups. (Zafeirakou 2006) A growing emphasis on social equity is leading to new ECD initiatives, and to interest in developing ECI services in countries such as Bosnia and Herzegovina and Albania.

Countries of the CEE/CIS region use different definitions of disability, and systems for identifying children are not well developed in most countries. UNICEF’s Innocenti Centre estimated that there had been a threefold increase in children with disabilities between the start of the transition and 2005. Specifically, the figure rose from 500,000 children at the time of transition to 1.5 million children officially designated to have disabilities in 27 countries. (UNICEF 2005 p. 2) This increase may not be real since it is surmised that countries have become more adept in recent years at identifying and reporting disability.

In the former Soviet Union, most children with disabilities were institutionalised. They were never seen, and if they were, they became the object of discrimination (Sammon 2001). Furthermore, when children with disabilities entered preschools, they tended to be isolated and received a poorer quality of education and were unable to form social ties. When segregated into institutions, they rarely were able to rejoin society during their lifetimes. The 2005 General Comment Number 7 on the UN Convention on the Rights of the Child states, “Early childhood is the period during which disabilities are usually identified and the impact on children’s well-being and development recognized. Young children should never be institutionalized solely on the grounds of disability. It is a priority to ensure that they have equal opportunities to participate fully in education and community life, including by the removal of barriers that impede the realisation of their rights. Young disabled children are entitled to appropriate specialist assistance, including support for their parents (or other caregivers). Disabled children should at all times be treated with dignity and in ways that encourage their self-reliance." UNICEF estimates that about 1.5 million children in the CEE/CIS region live in institutions and other out-of-home care arrangements, and of them, at least 317,000 had disabilities. These institutionalised children tend to be either disabled or among the most vulnerable, and in most countries of the region, they usually lack access to ECD services and quality preschool opportunities. Jonsson and Wiman estimate that in Eastern Europe, 60% of all children placed in institutions are disabled (2001, p. 9). The study by UNICEF’s Innocenti Centre found that in the CEE/CIS, children with disabilities have an 18% chance of becoming institutionalised. Other typically developing children have only a 0.39% chance of becoming institutionalised. Overall, they estimate that a child with disabilities in CEE/CIS is 46 times more likely to be placed in an institution (UNICEF 2005).
A study in the Russia Federation revealed that many children continue to be placed in institutions because their communities lack essential supportive services. They stated, “The health, education, and social services necessary to permit children to remain in the community with their own family or with substitute families are lacking. … The near exclusive reliance on institutional care for children who require support contributes to the disabilities of children. Research in child development and the experience of other countries around the world has demonstrated that children experience developmental delays and potentially irreversible psychological damage by growing up in a congregate environment. This is particularly true in the earliest stages of child development (birth to age four), in which the child learns to make psychological attachment to parents (or substitute parents). Even in a well-staffed institution, a child rarely gets the amount of attention he or she would receive from his or her own parents. Consequently, institutionalisation precludes the kind of individual attachments that every child needs” (Rosenthal et al 1999). Indeed UNICEF found that most children with disabilities in the region come from poverty-stricken families. (UNICEF 2005, p. 2)

With support from international organisations including UNICEF, the World Bank, and the Open Society Institute, among others, countries in the region are working to de-institutionalise children, and especially those with disabilities. (Tobis 2000). For example, in the Former Yugoslav Republic of Macedonia, the Ministry of Labour and Social Policy (MOLSP) is developing new policies and alternative care options such as community-based services and day care centres. They are training personnel, reuniting children with their families or placing them with carefully screened, selected and trained foster families and developing small group homes where necessary (UNICEF 2007). In general, countries of the region are looking for alternative, positive options to institutionalising children with disabilities and other social orphans, and they are trying to go beyond the provision of welfare payments and disability pensions for children. (UNICEF 2005)

Fortunately, the CEE/CIS region has significant strengths upon which to build its ECD and ECI services. Most of the countries have retained strong institutions of higher education and technical institutes that continue to prepare health, education and other professionals. Populations tend to have higher levels of formal education than many other world regions. The public health system has been weakened but it is still intact in most CEE/CIS countries, and usually it has retained some home visiting and polyclinic primary health care services that could be improved and expanded to provide many ECI services. Although the number of preschools initially declined, curricula and methods have been largely revised, and preschool services are being expanded in most countries. Options for avoiding institutionalisation are under consideration and new parent support services are being instituted in several countries. Vivid interest has been expressed in expanding inclusive education and some inclusive preschools and schools are being developed. Countries are beginning to consider developing ECD policies and plans, and in many countries, they are taking an integrated and comprehensive view of the early childhood field, including the provision of ECI and inclusive services.

II.2.3 Delay and disability in Belarus

Definitions of developmental delay and disability in Belarus differ from those generally used by OECD countries. The Ministry of Education (MOE) reports that of the nearly 2 million children from birth to 18 years of age, 125,981 children (6.3% of all children) are affected by disabilities, and of them, approximately 30,000 children (1.5% of all children) are considered to be severely delayed or disabled.

Of the 125,981 children from birth to age 18 reported to have disabilities, the following statistics are provided by the MOE:

- Number of children identified to have delays and disabilities, from birth to three years of age: 6,740
- Number of children, four to five years of age: 33,943
- Total children birth to six years of age: 40,683

The total number of children from infancy to six years of age was reported to be 632,913 for 2006, with 40,683 identified to have a disability, yielding a disability rate of 6.4% of the children less than six years of age. This disability rate is virtually identical to that of the general population of children from birth to 18 years of age.

Poverty, family problems, stigma, and a lack of information and community-based options lead parents to seek help from institutions.

In addition to highly detrimental effects of institutionalisation on child development, institutional care is far more costly than community ECI programmes, inclusive preschools, and parenting services.
This disability rate is slightly higher than the general rate of 5% for OECD countries.

Of concern is the major difference between the numbers of children identified to have disabilities from birth to three years of age (6,740), in contrast to those who are from four to six years of age (33,943). Greatly expanded attention needs to be given to home and community outreach to identify all of the infants and toddlers who are high-risk, delayed or disabled. The MOE states that, in collaboration with the Ministry of Health (MOH), it serves virtually all identified children.

With respect to the types of disabilities found in Belarus, the MOE reports the following:
- 74.5% have speech/language delays
- 14.4% have “difficulties learning”
- 13.8% have cognitive delays
- 11.0% have physical disabilities
- 5.0% have problems with eyesight or blindness
- 1.6% have auditory challenges
- 2.6% have motor delays

This list totals 125%, indicating that some children have more than one type of disability. However, usually higher rates of multiple disabilities are encountered, so these figures may be a large undercount. Also the proportion of speech/language delays seems to be extraordinarily large and cognitive delays quite low, for they often go hand in hand. Physical disabilities also seem to be low. Although the MOE has made a major effort to identify such children, additional work is needed to identify and categorise disability.

According to the 2005 Multiple Indicator Cluster Surveys (MICS) for Belarus, 3.8% of children are born at or below 2,500 grams. This rate is low but all of these fragile children need special care to prevent long-term delays or disabilities. Because of universal health service coverage, it should be fairly easy to ensure all such children are promptly identified and referred for ECI services. Malnutrition is rarely found in Belarus, and the MICS identified less than 1% of children with malnutrition.

Before transition, most children with disabilities were separated from their families, placed in Infant Homes, and later transferred to orphanages. Today in Belarus, about 33,000 children are orphans or denied parental care. Many of them have disabilities and do not have contact to a stable family. They remain “invisible children” who are rarely seen in everyday life. These children with disabilities receive more developmental services than before but they lack loving, stable parents. It was reported that many infants become social orphans especially because of the high 68% divorce rate. In 2006, there were 73,000 marriages but over 30,000 divorces. In Belarus there are over 355,000 single parent families, and only 12,000 of these are father-headed families. Because of the high divorce rate and related social issues such as substance abuse, family violence, and child abandonment, new family therapy programmes are being developed throughout Belarus.

In addition to family therapy, Belarus is expanding its ECI and rehabilitative services, experimenting with special education and inclusive approaches in crèches and preschools, and has developed a country-wide parenting education effort that is nested within all health, medical and education services that work with the parents of young children. The strong and supportive Positive Parenting Programme (PPP) that was developed with support from UNICEF serves all programmes for young children in Belarus (Vargas-Barón 2006). To strengthen the PPP, the “Successful Childhood Development Centre” was officially inaugurated in 2007 with strong official support. This resource centre for the parenting programmes is located in the Belarusian State University. A post-graduate university programme is also envisaged to prepare early interventionists and upgrade other specialists. In addition to general parenting resources for specialists and parents of typically developing children at low risk of developmental delays, several books and booklets for parents of children with high-risk status, developmental delays or disabilities, have been developed, field-tested, produced and distributed.

7 A variety of assessment and screening instruments are used. A standardised system has not been established.
ECI services represent the most intensive pole on a continuum of national-level early childhood services. The following matrix refers especially to services for children from birth to 36 months of age. For children with high-risk status at birth or potential developmental delays or disabilities, it is essential that they enter ECI types of services soon after birth. Other children are identified after birth, and they should be assessed and served as soon as possible in order to avoid the occurrence of serious delays. Many children with developmental delays that begin services at the most intensive end of the continuum move to moderately intensive services within 9 to 12 months, and some will attain “normalcy” and then consolidate their gains through participating in the least intensive services listed at the right end of the continuum.

### Chart II.1: Continuum of Early Childhood Services

<table>
<thead>
<tr>
<th>Service Aspects</th>
<th>Most intensive</th>
<th>Moderately intensive</th>
<th>Least intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td>ECI + parent education &amp; support</td>
<td>Focused ECI/ECD services + parent education &amp; support</td>
<td>ECD services + parent education &amp; support, as needed</td>
</tr>
<tr>
<td><strong>Level of risk</strong></td>
<td>High risk of developmental delay</td>
<td>Moderate risk of delay</td>
<td>Low or no risk of delay</td>
</tr>
<tr>
<td><strong>Degree of delay</strong></td>
<td>Very high risk of delay, incipient to severely delayed</td>
<td>Improved, mild delay, or only at risk of delay</td>
<td>No delay or low to no risk of delay</td>
</tr>
<tr>
<td><strong>Degree of disability</strong></td>
<td>Disabled or at high risk of disability</td>
<td>Mild or no disability</td>
<td>No disability risk</td>
</tr>
<tr>
<td><strong>Nutritional status</strong></td>
<td>Moderate to severe malnutrition</td>
<td>Mild malnutrition, consolidating gains</td>
<td>Normal nutrition</td>
</tr>
<tr>
<td><strong>Health status</strong></td>
<td>Severe or chronic disease or illness</td>
<td>Improved health but still at risk</td>
<td>Preventive &amp; basic health status &amp; care</td>
</tr>
<tr>
<td><strong>Assessments</strong></td>
<td>Intensive, frequent child &amp; family assessments</td>
<td>Regular, less frequent child &amp; family assessments</td>
<td>Annual child &amp; family assessments</td>
</tr>
<tr>
<td><strong>Service locations</strong></td>
<td>Home &amp; centre-based services</td>
<td>Centre-based, with fewer home visits</td>
<td>Centre-based services only</td>
</tr>
<tr>
<td><strong>Service frequency</strong></td>
<td>Frequent visits or sessions (daily to weekly)</td>
<td>Less frequent (biweekly, monthly)</td>
<td>Sessions upon request, usually centre-based</td>
</tr>
<tr>
<td><strong>Service duration</strong></td>
<td>Continuous services of long duration</td>
<td>Duration dependent on need &amp; improvement</td>
<td>Shorter, episodic &amp; upon request</td>
</tr>
<tr>
<td><strong>Length of sessions</strong></td>
<td>Longer (1 to 2 hours+)</td>
<td>Moderate (45 minutes to 1 hour)</td>
<td>Short, vary with parental request</td>
</tr>
<tr>
<td><strong>Service providers</strong></td>
<td>Early interventionists, therapists, nurses, physicians</td>
<td>Early interventionists, supervision from therapists, others</td>
<td>Early childhood home visitors &amp; parent educators, others</td>
</tr>
<tr>
<td><strong>Roles of para-professionals</strong></td>
<td>Assistants, home visitors, supervised by specialists</td>
<td>Assistants, home visitors, supervised by specialists</td>
<td>Supervised assistants &amp; parent educators</td>
</tr>
</tbody>
</table>

*WHO standards for nutrition will be followed.*
Within the framework of intensive early childhood services, during the 1920s, the field of defectology, with Vygotsky’s8 as its pioneer, was established in the Soviet Union as a special discipline dealing with impairments, disabilities and developmental delays. Although Vygotsky was a precursor of modern special needs education, his early writings on defectology were not followed. Later on, in its treatment applications, defectology developed into a correctional and socially segregating system. Children with delays or disabilities were closeted away, and few rejoined society and their families (Rosenthal et al 1999).

To grasp the specific character of the defectological orientation, in comparison to the normative orientation underlying the ECI perspective, it is important to pay attention to conceptions held regarding the child, service objectives, and key principles for the organisation and provision of services.

In its conception of the child, defectology is oriented to deficits, rather than competencies. Assessment is considered to be solely a diagnostic procedure aiming at identifying deviances from what is assumed to be normal. The cause of a special need, as well as eligibility for support, is thought of as a “pathology,” in terms of physical, mental, sometimes also moral development, and the child is consequently conceived of as an “invalid.” This can be contrasted with the never ending, and sometimes ridiculed, discourse about the “correct” way of terming a situation where the individual child has a need for special support in development, health, learning, social participation or whatever. While the ambition, reflected in this discourse, is to identify and understand disabling or restrictive circumstances and barriers, and concentrate efforts on removing them, the defectological perspective frequently uses the term ‘invalid’ to characterise the child. It also employs other diagnostic and nosological labels, which in the ECI-perspective of today, are considered to be degrading, like “oligophren,” “moron” and so on.

The deficit approach is logically related to the orientation of goals for service provision and intervention, which is summarised in the term “correction.” Diagnosis points to what is wrong, deviant from normality, and the consequent next step is to attempt to correct this deviance. Correction is considered to be a matter of treatment, training, therapy or compensation, and it is believed that highly experienced and skilled professionals are required to accomplish this treatment. Since this is considered to be the case, laypersons are not generally seen as resources or as horizontally related partners in intervention and support. Parents are – at the most – receivers of prescriptions of regimes. Other children are seldom seen as potential resources within the treatment plan. Inclusion, if at all considered, is consequently judged from the perspective of treatment and training: if it leads to comparable correction outcomes it might be seen as an option. (In the case of preschool and school inclusion, such an outcome, however, is rarely considered, because special support is, with few exceptions, not given within the mainstream school context.).

Defectological service provision is organised as a highly specialised service, and it is usually centre or institution bound. Identification of needs was, in the early years, a task for regular medical health controls.

When “disorders” considered as severe⁹ were identified, the defectological system routinely advised parents to place the child in residential care. For preschool enrolment, children with disorders, disabilities or needs for special support were assessed by multi-professional committees or commissions (in Russian Federation Pedagogical-Medical-Psychological Committees, PMPK, in Belarus Medical, Pedagogical and Psychological Commissions), which then proposed placement. For children with previously diagnosed “defects,” this recommendation would mostly result in enrolment in a special preschool or sometimes in a special group, integrated in regular preschool premises, but segregated from typically developing peers.¹⁰

In comparison, the ECI-perspective conceives of the child as having many competencies and as capable of learning. The goal for support and intervention is to minimise activity limitations by relying on these developmental resources, the child’s parental attachment, and the home environment as the basis for optimal development and learning. In the case of preschool and later educational environments, socio-cultural diversity rather than the dichotomy between normality and deviance is the major perspective regarding the child, with the main goal being participation, not only in learning and cognitive achievement, but also in the preschool’s social arenas. Consequently, preschool provisions are more inclusive than self-containing.

It should be added, that defectology in its present form and as it is used in many CIS countries, is not always put fully into practice as described above. Sometimes it is used just to designate certain professions (‘defectologists’), like special education teachers, speech therapists, and others. However, different opinions between professionals or between professionals and parents in questions of preschool choice, nonetheless may lead to explicit conflicts between the orientations, as described above (Janson & Zinchenko, in preparation). In such cases, the proponents of defectology tend to take stances that are rather characteristic of the original medical defectological approach.

It should be noted that there is not a big difference in principle between the deficit, correction, and profession-centred position of Russian defectology and the diagnosis, treatment and programme centred position of much medical and paramedical habilitation and rehabilitation, for example in Western Europe. It should also be remembered that, while defectology¹¹ played an important role in handling the extremely difficult post-war and post-revolution periods in the Soviet Union, with millions of children abandoned, undernourished, disabled or otherwise severely disadvantaged (Knox and Stevens 1993), segregation and institutionalisation of children with disabilities was a widespread practice also in the industrialised world until the 1960s and 1970s and even later. Inclusion is a new phenomenon in many countries, and not only in transition countries.

The term “defectology” continues to be used in the Belarusian special education community, often to refer to special education and therapy for children with disabilities, although rarely so in relation to comprehensive inclusion in preschools and schools. Officials and practitioners that were visited mentioned several reasons for this usage:

- Some say that the term continues to be used simply out of habit.
- The course of studies for defectology is part of the approved curriculum of Pedagogical universities, and the diploma for a defectologist as well as the advanced degrees of defectology have been officially established in Belarus.

¹⁹ In the case of the Russian Federation, in a draft Law on special education of 1999, ‘severe disorders’ are defined as: “physical or psychic disorder expressed to such extent that education corresponding to state educational standards (including the specialized ones) is not available and educational abilities are limited to acquiring basic knowledge about the world, basic self-servicing and labour skills, as well as basic professional skills” (Zinchenko, 2007). ‘Disorder’ is obviously treated as an educational-administrative concept.

¹⁰ Russian federal law acknowledges eight different types of ‘educational establishments’, for persons with speech disorders, hearing disorders, eyesight disorders, psychic disorders, orthopedic disorders, complex disorders, ‘willpower’ disorders, and chronic somatic and infectious diseases. Establishments can also be set up for “joint training of people with different physical and (or) psychic disorders, provided this does not hinder successful mastering [of] educational programs and there are no medical counter-indications for such training”. (Zinchenko 2007, p. 14).

¹¹ As a term, ‘defectology’ was actually introduced to Russia already before World War I, in 1912, borrowed from contemporary German curative pedagogy (Knox & Stevens 1993).
• A series of other terms for special education activities dealing, for example, with mental retardation (oligofreno-therapist), vision, hearing, and speech therapy continue to be grouped under the term defectology.
• The MOE continues to use the term officially as a formal professional designation, and it remunerates specialists labelled as defectologists according to official salary scales.
• Retirement pay is calculated on the basis of a defectologist’s seniority and technical status, thus making it extraordinarily difficult to change this designation.
• The positions and seniority of defectologists are officially established in Development Centres and other educational establishments.
• Some defectologists are proud of their field, and they are reluctant to abandon what they consider to be their status and role in the field of education.
• They tend not to view their role in an inclusive system of services, and this is an area for in-service training.
• One of the strengths of the Belarusian system is that it is highly formalised and sustainable; however, as a result it is difficult to make fundamental changes except from the top echelons of ministries, the Council of Ministers, or Executive Committees of cities or regions.

It could be predicted that slowly the entire Belarusian system using the term “defectology” will shift to another term along the lines of “early childhood intervention” or “special education” or “special pedagogy”. Indeed, in Belarus the MOE department dealing with special needs children is now called the “Special Education Department” and efforts are underway to change the title “defectologist” to “special pedagogue.” This change is also occurring in other transition countries.

However, it will be important to ensure that specialists who were formerly called defectologists learn new skills and knowledge in order to avoid some of the continuing pitfalls of the defectological approach. It would be beneficial to consider enabling some additional training in the EU, North America or Australia for Belarusian specialists in the fields of early intervention, special education, and physical, occupational and speech therapy. Belarus should build on the strengths of its evolving system while integrating into it new functional knowledge, methods and approaches used by ECI programmes in many other countries.
UNICEF’s guidelines for inclusion state:

“…inclusion is not about inserting persons with disabilities into existing structures; it is about transforming systems to be inclusive of everyone. Inclusive communities put into place measures to support all children at home, at school and in their communities. Where barriers exist, inclusive communities transform the way they are organized to meet the needs of all children.” (UNICEF 2007)

Inclusion, as a concept for a person’s membership and active participation in a certain social arena, and acceptance by the other actors in that arena, may of course be valued and strived for in a variety of contexts. The most obvious case is preschool and primary education. Inclusive education is generally motivated both normatively, as a matter of basic human and civil rights, and in terms of positive impact on development, learning, social participation and well-being. Representative normative expressions are given in international documents such as the Salamanca Statement of 1994, the Dakar Protocol of 2000, United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol (United Nations 2006), UNICEF’s Programme Guidance on children with disabilities, and UNESCO’s Flagship on Education for All (UNESCO, 2004). The latter specifies goals and strategies for achieving inclusion of persons with disabilities.

While the right to inclusion in the educational system is a valid argument by virtue of its value base, its positive impact is an empirical question. The promotion of inclusive education is valid if it can be demonstrated that inclusive education actually is preferable to segregated and self-contained classrooms in terms of positive impacts on children. The developmental and social significance of peer relations in general is well established in developmental and social psychological research. Peer interaction promotes cognitive, communicative, and social competencies in unique ways, increases capacity for emotional behaviour control, and contributes to empathic and socio-cognitive understanding already at the preschool age (Odom, McConnell & McEvoy, 1992). The question may be posed: Is this also the case in groups of functionally different children? Extensive empirical research demonstrates that this is the case, not unambiguously and for everyone, but only under certain favourable circumstances.

While children with developmental delays, disabilities and special needs in inclusive preschools tend to have fewer friends and be less socially integrated than typically developing children, they demonstrate more developed social and communicative skills and bigger social networks than comparable children who have been placed in segregated settings (Guralnick 1999, 2001, 2005, Odom & al. 2002, 2004). Parents find that inclusion in preschool settings contributes to improved peer- and friendship relations. Children develop more accepting attitude towards differences. Typically developing preschool children adapt their cognitive and communicative registers to the capacities of their functionally different peers (Guralnick, ibid.). According to qualitative studies of the communicative patterns in interaction, negative attitudes towards, and evaluations of, peers with disabilities are related to perceived
disturbances in activity, rather than to children as such (Ytterhus 2000, Janson 2001, 2007). Access to physical, social and symbolical properties of preschool and play premises (Janson, 2001), and promotion of peer related social competence (Guralnick 2001, McConnell 2002, Odom & al. 2004), is vital to promote togetherness in spite of differences. Environmental arrangements, group friendship building, teacher-led as well as peer-mediated interventions (peer buddy programmes), and direct child-specific support are possible strategies to obtain this goal (McConnell 2002, Odom & al. 2002, 2004). While focusing strengths and competencies in such interventions, teachers must be aware of the kinds of physical and social barriers caused by certain types of functional differences. A condition for inclusion and social participation in preschool learning and peer communities is the teacher’s values, attitudes and competencies, which should actively reflect such awareness, and in the case of peer interaction, also trust children’s ability to solve social challenges, and respect the need for peer independence in designing their own activities (Corsaro 2005, Janson, 2007).

In summary: preschool inclusion is an internationally embraced programme approach, with a strong ethical, humanistic and equalitarian value base. Inclusion is also, in general, in accordance with what behavioural and educational science demonstrates as positive conditions for promoting development, learning and social participation. In the specific case of developmental and functional differences, however, research and practice also point to potential barriers to achieving such goals. Barriers can be removed, through overcoming challenges for inclusive education, including:

- Understanding how barriers to participation are created in the interplay between environmental conditions (perceptually, physically and socially) and specific differences or disabilities;
- Providing in-service training and special educational support to inclusive preschool personnel;
- Encouraging preschool and school teachers and leaders to build strong community relations for promoting inclusion throughout the community;
- Adapting physical environments, educational materials, toys and play equipment;
- Planning activities, individually and for groups, to provide special support within the context of general and collective preschool activities;
- Cooperating closely with parents of special needs children in order to learn about each child’s strengths, abilities, interests, and personality;
- Communicating and cooperating with all other parents to create a positive social atmosphere and a demystified attitude toward functional differences;
- Cooperating with early intervention specialists (occupational therapists, physiotherapists, psychologists, special educators, speech and language therapists) to adapt the physical environment, create optimal activity conditions, and select and construct education and play equipment, and
- Building co-responsibility among preschool personnel for all children rather than assigning a specific child as a “task” for only one staff member.

To achieve such changes, inclusive education must be seen as a concern for individual preschools, parents and children and as a challenge for the whole socio-cultural ecosystem, of which preschool and school is but a part (Guralnick, 2005, Odom & al, 2002) as well as for society at large (UNESCO, 2004)\(^{14}\).

A fully inclusive system, meaning that all children, independent of type and degree of delay, disability or need of special support, are members in the same preschool or school classrooms and share the same social activities and learning opportunities, is still an exception. Almost all countries that advocate inclusive education in principle also provide specialised education according to certain guidelines (for instance severe multiple disabilities) and for certain groups (for instance deaf and hearing impaired using sign language, children with autism spectrum disorders). Conditions for inclusion in Russia are discussed by Iarskaia-Smirnova (2001/2002), Starikova (2003/2004), Zinchenko (2007), and Janson & Zinchenko (in prep.), in Ukraine by Sofy, Svarnik & Trohanis (2006).
Full inclusion can also be supplemented with part-time inclusion, so called “cluster inclusion;” “reversed inclusion” (a small group of typically developing children is included) or “social inclusion,” where functionally different groups share the same general location, but not the educational programme, and contacts are at best limited to recreational and leisure activities.\footnote{For a comprehensive discussion of inclusive programs, see Guralnick 2001.}
Given the many traditions and conceptual approaches to ECI in various world areas, currently a perfect ECI system does not exist. However, over the last 35 years, much has been learned about how to design, implement, and evaluate ECI services. Child-centred and family-focused systems work best. Such systems help parents to value their children highly and empower them to advocate for their children at all stages of their development (Shonkoff and Meisels 2000; Guralnick 2005; European Agency for Development in Special Needs 2005; Odom et al 2003).

Substantial experience exists in bringing sustainable ECI services to scale in countries. Many “common sense” approaches to programme development appear to be logical but in reality they are “blind alleys.” On a case-by-case basis, national ECI programmes can be helped to avoid them.

Based on their experience in studying ECI and other ECD systems as well as on-site structured observations in Belarus, the authors identified a series of continua regarding conceptual approaches to ECI. The following criteria were used in later sections to provide a profile of each major type of programme in Belarus serving children with disabilities or developmental delays. Systems for serving children with special needs and their families were found to vary greatly with respect to the following continua.
Continua regarding Conceptual Approaches to ECI

Overall rating of participation

| Participatory approach | Provider-recipient approach |

Parent involvement

| Parents’ rights emphasised | Specialist opinion sole criterion |
| Parents involved in assessments | Specialists assess alone |
| Parents actively help design IFSPs | Parents’ role defined by specialist |

Socio-culturally appropriate services

| Centrally planned and imposed services |

Child and family strengths

| Focus on child & family assets | Focus on deficit, delay and risk |
| Maximise child’s competencies | Correct child’s deviances |
| Individualised Family Service Plan | Child record, set routines |

Interdisciplinary approaches

| Medical/education services integrated | Medical/education services separated |
| Interdisciplinary assessments | Multidisciplinary or single disciplinary assessment |
| Tracking system & shared database | Separate agency records only |

Service flexibility

| Home/community outreach for child identification | Centre-based child identification only |
| Home services regular part of services | Centre-based services only rigid service access |

In Part III, these continua are used as heuristic devices to profile and compare varying types of services for ECI, special education and inclusive education in Belarus. Other continua could be added, but these fit Belarusian programmes. Programme ratings on the continua, expressed as numerical scores, are presented at the end of most of the programme descriptions. The rating on each continuum varies between 0 and 100. The higher the rating on the left pole, the closer the programme is to meeting “ideal” ECI service provision. These ratings are admittedly notional but they are based structured field observations and interviews.
The Belarusian Support System for Families with Special Needs Children

PART III:
PART III:

The Belarusian Support System for Families with Special Needs Children
Belarus is a signatory to most key international conventions and declarations regarding children with disabilities and other vulnerabilities. As of this writing, Belarus had not yet signed the *United Nations Convention on the Rights of Persons with Disabilities* and its *Optional Protocol* (United Nations 2006) that provides important safeguards for young children with disabilities including the right to remain with their families, receive early intervention services, and be given opportunities for inclusive education.

Since transition, ECD leaders of Belarus have significantly reformed and updated health and education structures, and created new programmes based on international research and programme results. Many inter-agency agreements and protocols have been established to promote coordination between education, health and family therapy services. Services have been largely decentralised to respond to child and family needs at the community level.

Belarus has a large system for vulnerable children, including ECI, special education and inclusive education services. This focus of this document is on services for children with developmental delays or disabilities or a high risk of disability. It does not attempt to review all forms of child care provided in Belarus.

Three main programme approaches for serving high-risk, developmentally delayed or disabled children are guided by three leading ministries: MOE, MOH and to a lesser extent, the MOLSP. *Chart III.1 Services for Special Needs Children in Belarus* presents a schematic overview of this large and impressive system.

The varied services of the MOE and the MOH will be described below in detail because they are the principal players in the system. MOLSP only plays a support role. It directs 156 Family Support Centres, including 9 in Minsk and 147 in the rest of the country. The Family Support Centres do not play a “gate-keeping” role with respect to ECI services in Polyclinics or to MOE’s Development Centres for children with special needs. Rather, they receive referrals from the ECI and Development Centres.

In 2006, the Family Support Centres served 23,600 children with special needs from birth to 18 years of age and their parents. In 2006, MOLSP also managed 9 boarding schools that served 1,135 children with severe delays from birth to 18 years of age. They receive referrals from MOH and MOE centres for protective services, including family therapy, counselling, parent education and support. Their specialists coordinate with MOE and MOH programmes for young children, provide advice on curricula, train personnel, and give monitoring information and feedback on programme services.

In addition, the Ministry of Finance (MOF) plays a key role in supporting the ECI and Special Education System of the MOH, MOE, and the MOLSP and also participates in inter-institutional coordination. The MOF provides their annual budgets, and these ministries follow the same principles for financing children’s services. General core budgets are provided for administrative expenses, and additional grants are given for costs such as professional salaries, food, supplies and equipment, depending upon the number of children served. In addition to having a strong legal basis, the full involvement of the MOF as well as MOE, MOH and MOLSP directors and planning offices has helped ensure the sustainability and expansion

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17  Statistics are unavailable for services rendered to children less than six years of age.
to scale of programmes for high risk, developmentally delayed and disabled children in Belarus.

A strong system for central guidance and coordination has been combined with decentralised services. This system has been developed during the past eight years in Belarus and it continues to evolve as a long-term process. Ministries guide their regional directorates that in turn supervise Executive Committees that establish programmes for cities, sub-regions and communities. In the case of Minsk, the ministries supervise Municipal Executive Committees for Education, Health or Social Protection that are composed of local leaders, appropriate professionals, and other authorities. Executive Committees control the budgets of each municipality or region as well as all programme budgets, expected service levels, and supplies including food for children. **This partially decentralised approach requires continuous attention with respect to participation and quality.**

One computer system unites all government bodies, providing a common database for programme management. In addition, a computer-based “Atlas System” enables programmes to access pertinent governmental regulations, institutional plans, meeting and training schedules, and other information. These unified systems permit quick programme monitoring and accountability; however, they do not include systems for making quantitative or qualitative evaluations or tracking children over time. All programmes visited lacked internal evaluation systems, control groups, and longitudinal impact studies. Pre- and post-assessments are conducted to serve individual children and parents; however, results for cohorts of children have not been compiled and analysed. A system for assessing programme outcomes is urgently required for purposes of improving local planning to meet evolving needs and to ensure service quality.

The three ministries constitute a “system” because detailed inter-agency agreements, regulations and guidelines have been developed to permit cross-sectoral coordination and collaboration. Many inter-sectoral regulations have been developed, and more are anticipated. Several of these agreements (listed in Annex II), are available in a separate
CD ROM. They include official laws, resolutions and agreements that enable the MOE and MOH to work together to:
- identify children with high-risk status, developmental delays and disabilities;
- refer children and parents to appropriate services;
- establish a recording keeping and tracking system for children and their parents;
- keep children with developmental delays and disabilities united with parents;
- help parents to promote their children's development;
- provide health, educational and protective services to support families;
- and strengthen families that face multiple stresses pertaining to dealing with a child with special needs plus poverty, substance abuse, and restricted living conditions.

Some programmes follow current interagency agreements and procedures carefully while others are still learning about them. This rapidly evolving system is developing additional guidance to meet emerging needs and upgrade services. Most of all, monitoring and supervisory services are required at the local level to ensure positive laws and guidance are followed and revised when needed.
In 2006 in Belarus, there were 632,913 children less than six years of age, and because of the widespread coverage of health services, virtually all of them received primary health care as well as special health services, as needed. The country’s Polyclinics are natural points of entry for identifying and serving special needs children. However, they do not identify all of the children, and due to an unwillingness to accept their child’s status and to social stigma related to having a child with a disability, some parents are reluctant to use rehabilitation services.

**Health intervention services** in Belarus for children with at-risk situations, developmental delays and disabilities vary from **ECI Centres** with **Interdisciplinary Teams (IT)** to “Dispensaries” and “Cabinets” with groups of health and education professionals. These health services currently vary with respect to form, content, methods, availability, and types of specialists. Health services use a wide range of mainly medically based assessments, often feature ITs, and work with parents to prepare **Individualised Family Service Plans (IFSPs)**. They focus on the holistic, balanced development of the child, and usually provide continuous, year-round and longer-term services for children and parents. Wherever specialists have been trained to conduct interdisciplinary assessments and plans, services tend to be more balanced and participatory, and less dependent upon solely expert approaches.

**Medical Rehabilitation Centres** use a medical model to serve children with one or more disabilities. Physicians are the main, and often the sole arbiter of a child’s service plan. This ‘corrective approach’ wherein nurses and therapists work under the guidance of a medical doctor, has the strength of ensuring good medical oversight, especially in cases where surgery, corrective therapies and psychiatric interventions are essential. However, in Centres where ITs and other types of specialists and assessments are not used, the full range of a child’s needs for holistic, balanced development may be overlooked. In medical services, parents tend to become onlookers rather than active participants in their children’s services. Physicians often regret that when children return home after costly treatments, they tend to fall back in their development. However, physicians often lack the skills to guide parent education and support activities, and with the exception of a few visiting nurses, home visits for follow-up activities are not conducted. Referrals to ECI or MOE programmes may be made, but parents may not use them unless follow-up outreach is conducted to help transition them to new services.

**Educational services** for children with at-risk status, developmental delays and disabilities are varied in Belarus. Increasingly they are being brought into the conceptual and methodological framework of the MOE’s Correction and Development Training and Rehabilitation Centres, hereinafter referred to as “Development Centres.” They have a wide range of “defectologists,” other special educators and some health specialists who work in the Centres, preschools and schools. Education services use many types of assessments and a variant form of IT that emphasises several areas of ‘defectology’ as well as health specialisations. They collaborate closely with parents and provide parent education and support. **Individual Development Plans (IDP)** or **Individual Education Plans (IEP)**, and **Individualised Transition Plans (ITP)** are prepared with the presence or active participation of parents. Educational services follow the vacation schedule of the school system, and they do not provide services during long vacation periods. Staff loading is low but time at task is also low, leading to fluctuating levels of services for children. As a result, children needing year-round developmental services often fall back in their development during vacation periods or they migrate to health services.
where they can gain the continuous attention they require. These services are evolving as regulations are established and training and professional meetings take place.

Services that are mainly health or medical services attached to the MOH include:
- Polyclinic-based ECI Centres;
- Child and Adolescent Psycho-neurological Dispensaries or Departments;
- Medical Rehabilitation Centres and Rehabilitation Departments in Polyclinics;
- Infant Homes.

Mainly education services are attached to the MOE, and include:
- Development Centres;
- Preschools and Child Care Centres for Special Needs Children; and
- Inclusive Preschools that serve a small number of children with special needs.

Some families are enrolled in MOH and MOE services as well as MOLSP services. Various agreements state that parents are at liberty to select the services they prefer; however some entities occasionally do not encourage freedom of selection. Partly for this reason, many parents seek help from the Belarusian Association of Assistance to Children and Young People with Disabilities, hereafter referred to as the “Belarusian Association,” that plays key outreach, referral, counselling, and support roles.

Before presenting services for young children in Belarus, it is important to point out that no single classification system for disability is used throughout the country. Several classification systems are used, depending upon the methodological orientation of the group. Some groups did not use a classification system but rather depended mainly upon a battery of assessments and clinical observations. These assessments and observations varied greatly. One ECI centre applied over 50 normed and validated instruments that had been developed in a wide variety of countries. Some of the assessments were for general development (Portage, H.E.L.P, Bayley Scales, etc.) and others were for special language, physical or socio-emotional assessments. A medical rehabilitation centre used a variety of tests, examinations and clinical observations, depending upon the training, knowledge and skills of the specialists. No attempt was made to evaluate the quality or accuracy of these approaches or to assess them in relation to prevailing practices in EU countries. This will be a very important (and challenging) topic for future research and development work in Belarus.

<table>
<thead>
<tr>
<th>Concerned Line Ministry</th>
<th>Type of Service</th>
<th>Name of Centre</th>
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</table>
| Health                  | Polyclinic-based Early Childhood Intervention Centres | • ECI Centre at Polyclinic 19, Minsk  
• Polyclinic ECI Centre, Kobrin |
| Health                  | Child and Adolescent Psycho-neurological Dispensaries | • Psycho-neurological Dispensary, Minsk |
| Health                  | Medical Rehabilitation Centres | • Medical Rehabilitation Centre, Minsk  
• Medical Rehabilitation Centre, Brest’s “Tonus Centre” |
| Education               | Development Centres | • Development Centre, Minsk  
• Development Centre, Kobrin’s Alpha Centre  
• Development Centre, Brest |
III.3

POLYCLINIC-BASED EARLY CHILDHOOD INTERVENTION CENTRES

The ECI target group is children from birth to three years of age and their families. From their initiation in 2002, a total of 17 ECI Centres had been developed as of July 2007,\textsuperscript{18} with plans to increase the number to 29 by the end of 2008. In 2006, ECI centres and groups served approximately 2,700 children with high-risk status, developmental delays or disabilities. The planned expansion should enable an additional coverage of some 2,000 children in 2008, for an annual coverage of approximately 4,700 children. Annually, upon the request of parents and medical personnel in polyclinics, more children are assessed than are actually enrolled in services. Those that fit programme criteria for risk, delays or disabilities are enrolled or they are referred to other services, such as the MOE’s Development Centres. Plans for additional expansion of ECI centres are currently underway but they were unavailable at the time of this study.

ECI Centres feature inter-disciplinary teamwork for child-centred and family-focused programming, using a mixed health and education approach. They are based on ECI experiences in Russia, Europe and the Americas. ECI centres provide outpatient services to children with or at risk for developmental delays, disabilities and related special health needs. Children are served at parents’ request or they are identified and seamlessly referred to ECI services by Polyclinic physicians. In addition, neighbourhood parents who appreciate ECI services refer other parents to the Centre.

Generally, services were designed in accordance with ECI principles, as outlined in Sections II.1.3 and II.6. They include early nurturing and stimulation activities, health monitoring, medical treatment, special therapies, developmental and family support, and parent education. ECI programmes try to combine centre-based services with home visits to help ensure full parental involvement. Home and community outreach is seen as an essential part of identifying children at risk or in need of special support. Programmes emphasise parents’ rights, adapt to family needs and requests, and focus on parent involvement and empowerment. ITs are always used, and ideally include medical, health, psychological and special education competencies. Due to personnel limitations in some centres, such principles are realised to a varying degree; however, this rapidly expanding system promises to provide the full range of disciplines soon in all Centres.

The ECI Centres also work in tandem with MOE Development Centres, often taking children requiring health care services. However, many children with language delays or other non-medical needs including mild conditions are also served by ECI Centres. Normally, at the age of three, ECI services participate in preparing for the child’s transition to MOE Development Centres, specialised preschools or preschool groups, or ordinary inclusive preschool programmes, depending on the parent’s wishes and the needs of the child. However, if needed and increasingly upon parent’s request, some children continue to receive ECI services until they enter school or up to six years of age. Three Polyclinic-based ECI Centres were visited in Minsk, Kobrin and Brest. Two of these are discussed below.

III.3.1 ECI Centre at Polyclinic 19, Minsk

Initiated in 2002, this centre is a pioneer in implementing a holistic, family-oriented, and interdisciplinary ECI paradigm in Belarus. The St. Petersburg Early Intervention Institute intensively trained this ECI team. During the first half of 2007, with a technical staff of five persons (one physician/physical therapist, two child psychologists, two speech therapists),

\textsuperscript{18} Three ECI groups have been initiated in Minsk Polyclinics. In addition, a total of 14 ECI Centres or Groups have been established in Polyclinics outside of Minsk.
240 children received medical services, infant and child development activities and therapies, including children placed in short- or long-term programmes. Of these children, 82 “graduated” with ITPs that stipulated continued monitoring and short-term programmes of support and developmental activities, placement in MOE Development Centres, preschools and/or Medical Rehabilitation Centres.

In addition to full ECI services, upon the request of Polyclinic physicians, MOE Development Centres, and parents, this small team assessed 182 newly referred children less than three years of age, identifying 113 as having high social or developmental activities, placement in short- or long-term programmes. Of these children, 82 “graduated” with ITPs and/or Medical Rehabilitation Centres. MOE Development Centres, preschools and/or parents. They conducted multiple assessments of 183 children and prepared 82 ITPs and participated in 21 group sessions for children and/or parents. They conducted multiple assessments of 183 children and prepared 82 ITPs and participated in 21 group sessions for children and/or parents. They conducted multiple assessments of 183 children and prepared 82 ITPs and participated in 21 group sessions for children and/or parents. 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They conducted multiple assessments of 183 children and prepared 82 ITPs and participated in 21 group sessions for 82 instances of service per specialist per week. Averaging each instance of service at 2.5 hours, the amount of services per specialist per week.

ECI Centre specialists spend considerable time assisting with children’s transition to preschools or other service programmes and with follow-up reviews. Based on a detailed analysis of each child’s competencies, achievements, and other needs, in cooperation with parents, centre specialists prepare an IFSP and participate in sessions with Medical, Pedagogical and Psychological Commissions to help identify the child’s best service options while protecting family interests. They noted how hard they work to ensure that parents will be able to make the final decision regarding the placement of their children.

ECI specialists noted that increasingly children with multiple needs are being admitted to regular preschools and those specialised for children with disabilities. As Belarusian preschools gain more experience in developing inclusive preschool groups, ECI specialists are asked to help preschools understand each child’s needs. They work with parents, special educators and preschool teachers to help them exchange ideas and assist children with delays or disabilities adjourn to the preschool as well as assist other children and parents to accept and interact positively with the child. However, they noted that children with severe disabilities still are rarely accepted into regular preschools or kindergartens. Anticipating rejection, parents of such children are not encouraged to try to place their children in those schools. Indeed, some parents of children with severe disabilities noted their concerns regarding how the care, and support to help them deal with issues they are facing. They learn about child development skills such as how to promote speech development, select and use learning toys appropriately, nourish the child well, and help their child become well integrated into society. They are taught their rights and responsibilities, sign releases for assessments, and control all services they receive. Parents listed parental support as well as technical guidance for maximising the development of their children as important reasons for wanting to participate in both individualised services and the Centre’s Parents’ Club. Individualised services always include both parents and children during a home or centre session. Group services include group activities for children and Parent Club meetings for the adults but all day child care is not provided as in Development Centres.

Each child and family enrolled in ECI services has an IFSP profiling the child’s status, child and family objectives, developmental programme, next steps to be undertaken, centre and parental responsibilities, and parental observations and consent. Children with significant developmental challenges are assessed each three to six months, and then in collaboration with parents, the IT revises the IFSP. The members of the IT emphasise the child’s positive capacities, their respect for parental rights, and they empower parents to develop the IFSP in a positive manner. Parents receive counselling regarding expected child development stages, guidance on child development, and many others.

19 During the first semester of 2007, the ECI Centre’s five professionals provided 1,273 primary sessions and participated in 21 group sessions for children and/or parents. They conducted multiple assessments of 183 children and prepared 82 transitions. This yields a total of approximately 1,559 instances of service or an average of 13 instances of service per staff member per week, although in reality it would have been more because ITs were used, resulting in up to twice the amount of services per specialist per week. Averaging each instance of service at 2.5 hours, each professional would have dedicated in excess of 33 hours of direct services per week leaving little time for session preparation and reporting, in-service training, or training other professionals.

20 The unique PPP materials are available for use in Russian and English. (Vargas-Barón 2006)

21 Assessments used include medical examinations, Child Development Inventory (CDI), Kent Infant Development Scale (KID), Bayley Scales of Infant Development, and many others.
comparison of their children's abilities with typically developing children might be hard for their children. Increasingly, parents reported that children with Down syndrome (DS) routinely enter regular preschools, so progress is being made. (In some rural areas, Medical, Pedagogical and Psychological Commissions are bypassed because specialised preschools are unavailable. Such children are simply placed in regular rural preschools with support from special educators.)

Monitoring and evaluation at the ECI Centre is based on child and family records, assessments, IFSPs, service reports, and videos. Pre-post questionnaires have been used to ask parents about their expectations, experiences and perceptions of results. These questionnaires or a variant of this effort could provide a basis for internal programme evaluation, but their specialists’ heavy case loads and lack of time has stood in the way of a more systematic analysis and use of these data. This high level of services has also resulted in decreased number of home visits, which they consider to be essential to providing good ECI services. Given their heavy workload, this team, which should play a central role in pre- and in-service training of new ECI professionals, needs to be expanded. To expand the coverage of ECI services and meet expectations for personnel training, additional competencies are required in the fields of neurology, paediatrics, special education, social pedagogy, physical therapy, and massage.

The ECI Team participates in weekly in-service sessions in Minsk’s main Child and Adolescent Psycho-neurological Dispensary to exchange ideas with other ECI centres and Dispensary specialists, and six inter-sectoral workshops are also held each year. The team also participated in a major ECI Conference that was held in 2006 for Belarusian ECI specialists and invitees from Georgia, Kazakhstan, Russia, Norway, United Kingdom and Sweden.

III.3.2 Polyclinic ECI Centre, Kobrin

The ECI Centre of Kobrin, a small town near Brest, is located in a Polyclinic with a catchment area with some 20,000 children from birth to 18 years of age. Approximately 900 children are born there each year, and the ECI Centre assesses all of them. Neonates receive home visits and a medical card, and are examined for post-natal risk using a survey instrument. The ECI centre annually serves an average of 450 children from birth to three years of age, providing physical therapy, neurological and orthopaedic services. Paediatricians, neonatologists and a maternity home refer newborns to the Centre. Frequent problems encountered include: poor birth outcomes; heart and digestive problems; neurological problems; illnesses or diseases; and orthopaedic issues such as scoliosis. Social risks include: single mother; maternal alcohol abuse or smoking; non-compliant mother; or child neglect or abuse. The Polyclinic has a “school” for young parents, including fathers, where they present videos, counsel parents, and teach them about infant and child care.

The ECI team prepares an “Observation Plan,” with frequent home visits during the initial phase, and subsequently on a case-by-case basis. In addition to physical risk, delay and disability assessments, social risk is assessed. Personnel include a physiotherapist, rehabilitologist, neurologist, and psychologist. Close cooperation has been established with the MOE “Alpha” Development Centre in Kobrin, which sends psychologists, psychiatrists, defectologists or speech therapists to help create ITs to conduct IFSPs and ITPs. In addition to ECI personnel, the Polyclinic’s medical specialists may be involved. Children identified with low birth weight, impairments or other factors are offered treatment. Children with severe or multiple disabilities are referred to Brest’s Medical Rehabilitation Centre or Polyclinics. Should parents disagree with specialists, they are encouraged to seek a second opinion in any Belarusian regional centre; however, it was reported that this rarely happens. Most children remain in Kobrin and receive services at the ECI Centre in collaboration with the local Development Centre. These Centres supplement each other’s services and coordinate closely.

As in Minsk, parental participation in ECI is considered vital. Parental presence at assessments, results reviews, and IFSPs is compulsory. IFSPs include sections on: physical rehabilitation; feeding and nutrition; child care; structuring the child’s day; pedagogy; psychology; and positive emotional family development. Emphasis is given to positive parent-child attachment and parent education and support. ECI specialists use demonstration and practice to train parents about how to work with their child. Parents are asked to do certain tasks each week with their
child. Once the child has an IFSP, parents are offered continuous services until he or she reaches three years of age, after which the child may be placed in a specialised, inclusive or regular preschool. The Centre seeks to involve fathers and preserve families, and respite care is often recommended. If there are pervasive family problems such as substance abuse, mental illness or violence, the family is referred to MOLSP family therapy centres. In the absence of improvement, parents may lose their parental rights and the child can be placed in an infant home or an orphanage; however, during the preceding six month period, fewer than 1% of children in ECI services had been placed in an infant home or orphanage, demonstrating the ECI Centre’s success in preserving family units.

**General ratings for ECI Centres**

Based on their observations and review of documents, the authors rated the ECI Centres in Minsk and Brest using the instrument called: *Continua regarding Conceptual Approaches to ECI* (See Section II.6). The rating on each continuum varies from 0 and 100, with 100 representing the attainment of “ideal” ECI services. These rankings are not intended to be exact but rather to provide a general profile of programme services. The Minsk and Kobrin ECI Centres were ranked as follows:

<table>
<thead>
<tr>
<th>Participatory approach, overall rating</th>
<th>ECI/Minsk</th>
<th>ECI/Kobrin</th>
<th>Combined Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents’ rights emphasised</td>
<td>95</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>Parents involved in assessments</td>
<td>80</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Parents actively help design IFSPs</td>
<td>95</td>
<td>55</td>
<td>75*</td>
</tr>
<tr>
<td>Socio-culturally appropriate services</td>
<td>80</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Focus on child &amp; family assets</td>
<td>95</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>Maximise child’s competencies</td>
<td>85</td>
<td>65</td>
<td>75*</td>
</tr>
<tr>
<td>Individualised family service plan</td>
<td>85</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Medical/education services combined</td>
<td>90</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>Interdisciplinary assessments</td>
<td>90</td>
<td>70</td>
<td>80*</td>
</tr>
<tr>
<td>Tracking system and shared database</td>
<td>65</td>
<td>85</td>
<td>75*</td>
</tr>
<tr>
<td>Home/community outreach for child identification</td>
<td>65</td>
<td>85</td>
<td>75*</td>
</tr>
<tr>
<td>Home services regular part of provisions</td>
<td>60</td>
<td>70</td>
<td>65*</td>
</tr>
</tbody>
</table>

* Substantial difference in rating between the two centres.

**Comment and summary statement**

The ECI centres had well-functioning although somewhat different ECI programmes. In general, they adhered to ECI principles presented in Part II. High ratings of an overall participatory approach reflect an involvement of parents and a general holistic approach. They consider the child and its development as part of the whole family situation, focusing on assets and competencies rather than deficits and correction. They emphasise parents’ rights and empowerment not only rhetorically, but also in practice, with a strong emphasis on involving parents in assessments, IFSP preparation, child development activities, and programme service provision. The ITs seek to achieve inter-disciplinarity in methodologies as well as in roles in spite of their small staff sizes. To a certain degree, the centres are successful in adopting an integrated “bio-psycho-social-pedagogical perspective.” The Kobrin Centre tends to have a more pronounced medical model with a stronger focus on children’s “problems” than the Minsk Centre; however, its close collaboration with the MOE Development Centre enables it to supplement its mainly health services. In general, these two ECI Centres, one serving a rural and small town population and the other a large metropolitan city, have developed: well-established competencies in accord with international standards; a strong *esprit de corps* with high ambition to provide excellent services; and well-developed cooperation with medical and educational programmes. The Minsk Centre constitutes a paradigmatic example of how well functioning,
culturally competent, and participatory
ECI services can be metamorphosed out
of a basically defectological tradition.
The Kobrin Centre demonstrates that
rural and small town ECI Centres can
be cost-effective by networking local
health, medical and education resources
in function of children's and families'
needs and by successfully linking them
with larger services in cities. Centre
personnel recognise the importance
of disseminating ECI competencies
nationwide and internationally. However,
their heavy workload makes it difficult
for them to find time to provide training
services.
Outpatient psychological and psychiatric services are provided through Child and Adolescent Psycho-neurological Dispensaries or Departments (hereinafter referred to as Psycho-neurological Dispensaries). One Psycho-neurological Dispensary in Minsk and six regional Dispensaries serve children from birth to 18 years of age and their parents.

III.4.1 Psycho-neurological Dispensary, Minsk

During 2006, the Minsk Dispensary served approximately 2,500 children from the city as well as referrals from other cities. It also supervises specialists in all psychological “cabinets” (units) in Minsk’s Polyclinics, and several of them receive young children and their parents. Over half of the programme participants are self-referred, and Polyclinics; MOE Development Centres; preschools; and the Belarusian Association refer children. Personnel include: psycho-neurologists; psychotherapists; psychologists; and in a neighbouring department, neurologists; neuro-pathologists; and rehabilitologists.

The Dispensary provides assessments, development plans, individualised and group treatment, counselling, day care and respite care for children with developmental delays, autism, and hyperactivity. Entirely centre-based, the Dispensary does not provide home visits or community outreach services. The Dispensary provides support for the ECI Centres of Minsk, conducts mutual referrals, and prepares assessment reports on children for Medical, Pedagogical and Psychological Commission meetings. For the national expansion of ECI services, the Dispensary is prepared to help with training workshops, on-the-job training opportunities, and a regular exchange of experiences. An Action Plan is under development for: identifying additional specialists; designing pre- and in-service training; establishing interdisciplinary teams; and equipping more facilities with learning toys and educational materials.

<table>
<thead>
<tr>
<th>Table 3. Ratings of the Psycho-neurological Dispensary, Minsk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participatory approach, overall rating</td>
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<tr>
<td>Parents' rights emphasised</td>
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<tr>
<td>Parents involved in assessments</td>
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<tr>
<td>Parents actively help design IFSPs</td>
</tr>
<tr>
<td>Socio-culturally appropriate services</td>
</tr>
<tr>
<td>Focus on child &amp; family assets</td>
</tr>
<tr>
<td>Maximise child’s competencies</td>
</tr>
<tr>
<td>Individualised family service plan</td>
</tr>
<tr>
<td>Medical/education services combined</td>
</tr>
<tr>
<td>Interdisciplinary assessments</td>
</tr>
<tr>
<td>Tracking system and shared database</td>
</tr>
<tr>
<td>Home/community outreach for child identification</td>
</tr>
<tr>
<td>Home services regular part of provisions</td>
</tr>
</tbody>
</table>

*Comment and summary statement*

The Dispensary provides specialised centre-based services, with half of their patients referred from other services. It is less participatory than the ECI centres but this does not mean that Dispensaries are opposed to the participatory ECI model. On the contrary, the importance
of expanding services for early childhood and of providing a child-centred and family-focused approach is emphasised. However, much of the Belarusian approach to early intervention is still mainly expert-driven, and Dispensaries take a mainly disciplinary approach rather than providing fully inter-disciplinary services. Although greater community outreach and family support are needed, no system for paraprofessional home visitors has been developed as yet. The social workers and experienced volunteers of the Belarusian Association are increasingly filling this need (See Section III.9).
Medical Rehabilitation Centres focus on serving children with severe delays or disabilities. They are located in each region, except for one, for a total of 11 Centres. Belarus’ Medical Rehabilitation Centres in Minsk and Brest were visited. These large Centres include hospital and out-patient services for children from birth to 18 years of age and their parents, and they receive referrals from Maternity Homes, Polyclinics, ECI Centres, MOE Development Centres, and other services.

**III.5.1 Medical Rehabilitation Centre, Minsk**

This Medical Rehabilitation Centre was founded in 1981 as the first of its type in Belarus. The Centre has a wide array of medical and some educational specialists. In 2006, the Centre served 1,955 children from birth to eighteen years of age, and counselled an addition 500 children. Approximately 665 (34%) children were less than three years of age, and an additional 17% were less than seven years of age. ECI Centres, Dispensaries and MOE Centres provide concurrent services for some children. The Centre receives children only through referrals because it lacks outreach services. This concerns the Centre director because children with minimal signs of a problem at birth may later develop delays or disabilities. Also, problems may be identified at a Polyclinic but parents may decide not to take their child to the Centre for assessment. Due to denial, social stigma or family pressure, some resist taking their child to the Centre for hospitalisation and/or intensive treatment; however, if provided counselling, most parents will enrol their children. The Centre provides prenatal care and education for women with high-risk pregnancies, including: ultrasound examinations; amniocentesis; genetic counselling; and parenting programmes. Of the 1,955 children served in 2006, 781 received 24-hour services; 1175 received day care services; and most of them also received outpatient services.

The Medical Rehabilitation Centre emphasises the importance of parent rights and consent for services but it has not developed a system for ensuring informed consent. The Centre often refers children to MOE Development Centres and ECI Centres and continues to provide them services, as needed. It tracks children to see if recommended assessments and services have been provided. The Centre’s short-term, acute and intensive care improves child development but when children do not receive continuous and balanced developmental activities, they may fall back in their development. To ensure continuous services, close collaboration is required between Medical Rehabilitation Centres and colleagues in all other children’s services. Parents observed rarely took part in sessions, interacted with their child, or learned developmental activities. Although mothers often were present in treatment rooms, fathers tended to wait outside. The Centre’s principles of “rehabilitation” are to start when the child is very young; prevent later delays by treating mild delays quickly; and emphasise preventive medicine as more humane, efficient, and less costly. “Early selection” calls for identification and intervention from the earliest age possible.

**III.5.2 Medical Rehabilitation Centre, Brest’s “Tonus Centre”**

The Brest Regional Medical Rehabilitation Centre, called the “Tonus” Centre, was
founded in 1996 as a non-governmental organisation (NGO) called the “Association of Disabled People.” In 1998, Tonus became a MOH Medical Rehabilitation Centre. It employs 80 professionals, and is considered to be the largest and best equipped Medical Rehabilitation Centre in Belarus.24

During 2006, Tonus served 733 children from birth to three years of age, and can serve from 110 to 120 children a day, providing from two to eight hours of services a day. Some 40% of the children served live in Brest; 30% in the Brest region, and 30% from other Belarusian regions. It also functions as a demonstration centre for students attending Brest University. The director stated that in 2006, of 14,782 infants born in the Brest region, only 1,816 (12.3%) were considered to be “healthy.” A total of 12,595 (85.2%) infants were considered to be at risk due to “pathological development, prenatal infections, post-natal conditions or social risks of the family.” This is the largest at-risk statistic the authors have seen in a developed country. These numbers may be used to argue for expanding rehabilitation services. However, the labelling of children as “at risk” of developmental delays or disabilities may have negative impacts, especially if the situations could be resolved through other less intensive and expensive services. It also suggests that the criteria and standards used to pronounce a child “healthy” may need to be revisited. Ultimately, in 2006, 1,057 children from birth to 14 years of age were identified to have a significant developmental delay or disability that qualified for intensive rehabilitation services. Upon entry, the director, a neurologist and a paediatrician examine each child, and other specialists also assess children, depending upon their needs.

Parents observe but do not participate in their children’s assessments and they do not help to prepare service plans. Parents are informed of their rights verbally and through wall posters, and handouts. In 2006, 437 children were taken away from their families, and 614 parents lost parental rights. In addition to sending the children to Infant Homes or orphanages, a few children are adopted, placed in foster homes, and others enter MOE boarding schools for special needs children. It was stated that a few parents who have not lost their parental rights may be able to regain their children at a later date.

The International Academy of Rehabilitation and Development of Munich initially trained 28 Tonus specialists in Brest during a period of one and one-half years. Recently, Tonus has begun to look outward. Initially, Tonus trained Belarusian specialists from all over Belarus. In recent years, they have been asked to concentrate on the Brest region to expand services, perfect their service approach, and secure results. During the

Table 4. Ratings of the Medical Rehabilitation Centres

<table>
<thead>
<tr>
<th>Table 4. Ratings of the Medical Rehabilitation Centres</th>
<th>MRC/Minsk</th>
<th>MRC/Brest</th>
<th>Combined Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participatory approach, overall rating</td>
<td>50</td>
<td>30</td>
<td>40*</td>
</tr>
<tr>
<td>Parents’ rights emphasised</td>
<td>65</td>
<td>45</td>
<td>55*</td>
</tr>
<tr>
<td>Parents involved in assessments</td>
<td>45</td>
<td>25</td>
<td>35*</td>
</tr>
<tr>
<td>Parents actively help design IFSPs</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Socio-culturally appropriate services</td>
<td>65</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Focus on child &amp; family assets</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Maximise child’s competencies</td>
<td>70</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Individualised family service plan</td>
<td>70</td>
<td>50</td>
<td>60*</td>
</tr>
<tr>
<td>Medical/education services combined</td>
<td>60</td>
<td>40</td>
<td>50*</td>
</tr>
<tr>
<td>Interdisciplinary assessments</td>
<td>70</td>
<td>50</td>
<td>60*</td>
</tr>
<tr>
<td>Tracking system and shared database</td>
<td>70</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Home/community outreach for child identification</td>
<td>30</td>
<td>50</td>
<td>40*</td>
</tr>
<tr>
<td>Home services regular part of provisions</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

* Substantial difference in rating between the two centres.
past three years, the Centre has trained 86 specialists in the region, and it has helped to open medical rehabilitation cabinets in Polyclinics in Kobrin, Brest and Baranovichi. In collaboration with Brest State University, Tonus has prepared a curriculum for training early intervention specialists that currently is being reviewed by the MOE. Also, Tonus specialists have developed many educational materials and methods, currently available only in Russian. Tonus has made a major effort to involve MOE institutions in its services, including holding a conference and developing a joint programme of inter-sectoral cooperation for children from zero to three years of age. Tonus published and distributed a set of materials with the goal of assisting MOH and MOE specialists to identify children with delays or disabilities. As a result, a joint Steering Committee for collaboration in the Brest region was established to expand and improve services for children and parents throughout the region. Given Tonus’ significantly different approach, it is recommended that an in-depth technical review be made of their clinical and therapeutic methodologies, curricula, educational and training materials, and assessment tools.

Comment and summary statement

Significant differences were found between the Minsk and Tonus Medical Rehabilitation Centre. Both take a predominantly medical approach; however, they are making efforts to collaborate more closely with MOE and ECI services. As yet, neither service has adopted ECI approaches of parental participation, empowerment and involvement in guiding planning and service provision. Also, considerably more work is needed to achieve full inter-disciplinarity. It is highly likely that these Centres will remain strong medical rehabilitation models that will complement ECI services of the MOH and MOE.
The Correction and Development Training and Rehabilitation Centres, hereinafter called the “Development Centres,” provide integrated special education for children that have developmental delays or disabilities. They complement MOE’s Special Preschool Services that include a wide array of support and education services for children with disabilities, either separately or with typically developing children. Development Centres in Minsk, Kobrin and Brest were visited and will be described below.

In 2002, MOE specialists proposed a new organisational and methodological approach for serving children with special needs, and with strong Parliamentary support, the legal basis for Development Centres was established. An updated law on Special Education was approved in 2004, with further addenda in 2005 and 2006 (See Annex II). The current Presidential Programme for Children contains a sub-programme for children with disabilities and a safety programme to help prevent disability that is included in the Demographic Safety Programme (2007 – 2010). Since 2002, the number of Centres has grown rapidly to a total of 142 Centres, with 9 in Minsk and 133 in other regions.

Development Centres serve children from birth to 18 years of age; however only some of them offer ECI services for children from birth to three and up to six years of age. Centre coverage in 2006/2007 was 6,378 children, of whom 1,307 (21%) were from birth to two years of age and 1,981 (31%) were from three to five years of age. With the help of Development Centres, the MOE manages a national database of children that tracks children with developmental delays and disabilities when they move from one community to another or from service to service. Representatives of the MOE and MOH agree coordination and cross-referencing of children and families has improved, but all feel more coordination is needed to meet the goals of inter-agency agreements.

Because the Centres were founded recently, they are conducting intensive training to permit rapid growth. Understandably, service quality varies. The Centres were established to revise and up-date defectological services inherited from the Soviet Union. The MOE is making a major methodological shift from focusing on disability to emphasising child-centred and family-focused ECI services. The Centres contain health and medical elements but they seek to collaborate closely with MOH’s ECI and medical rehabilitation programmes to provide a full range of ECI services.

Development Centres provide a wide array of developmental activities through home visits and centre-based services, child care, and parent education and counselling. They monitor each child from entry and services to transition and enrolment in preschool or schools, as appropriate. At first they work to strengthen the parents’ emotional bonding to the child. Then they conduct diagnostic assessments and form ITs that may include a psychologist, defectologist, teachers, and as needed, a social worker, nurse and a representative of a district centre. IDPs, called “Individual Programmes of Care, Education and Development,” are prepared by ITs. They are reviewed and updated each three to six months, depending upon child status and needs. At present, professionals prepare the IDP, and it usually includes a diagnosis and activities to be accomplished with the child and the parents. They state they give priority to parents’ expressed needs and interests, even though parents do not write in the IDP or sign it. Parents are free to accept the IDP or not, and their rights are explained to them. No set format has been established for an IDP, but generally it includes assessment results, developmental goals, activities and expected results in: health; nutrition; social and emotional
development; learning play; cognitive development; language development; gross and fine motor development; self-care; and general development.

Because parents are important to child development, specialists work with them at least once a week, either in the home or Centre. Parents participate in services in a variety of ways: belonging to Parents’ Groups; attending parenting sessions, and participating in assessments, home visits, and the preparation of IDPs or IEPs. Each Centre has a Medical, Pedagogical and Psychological Commission. Centre specialists prepare reports for Commission meetings and provide technical support for preschool and primary school teachers of children with delays and disabilities. In contrast to continuous MOH services, children receive services during a 10-month period, with a two-month break for vacation.

The MOE supervises the Centres, and the National Institute of Education’s (NIE) Special Education Department gives them technical support, as do the Post-Graduate Academy of Education, Pedagogical Universities in seven regions, and the Psychology Department of the Belarusian State University. The Centre’s ECI services are based in part on programmes and materials developed by the St. Petersburg Early Intervention Institute. In addition, Germany, Ireland, Sweden, the United Kingdom and the United States have provided training. Several types of in-service training are available to Development Centres specialists: joint training through seminars and workshops; cross-training among Centres; and special conferences. In addition, informal “unions” of local professionals meet on a regular basis. They discuss cases, developmental methods and regulations. Joint training activities foster case management and coordination.

III.6.1 Development Centre, Minsk

Minsk’s main Development Centre was established in 2004 as a demonstration, training and resource centre for the city and the country. It is a spacious facility with well-equipped rooms for training workshops, demonstrations, assessments, individual work with parents and children, and group activities for children. Its rooms are filled with developmentally appropriate learning materials, toys, books and equipment. Centre specialists use national regulations to select children for services but they specialise in serving children with multiple challenges in order to be able to offer in-service training opportunities for specialists in other institutions. Children are identified through referrals from educational and health establishments, parental self-referral and other parents. The Centre also uses radio and newspapers as venues for reaching parents. Few fathers participate in services but personnel stated they are witnessing a positive trend in this regard. Centre specialists use the Portage Project system of following the child’s lead in developmental activities, and they provide psychological support to mothers, fathers and the entire family. A monetary allowance is also given to parents to help avoid child abandonment due to costs involved in rearing a child with disabilities. Child development activities are free of charge. The Centre has a Toy Lending Library and distributes many books and handouts for parents and professionals on child development that come from Belarus, Russia and other countries. The Belarusian Association helps secure books, organise Parents’ Clubs including one for parents of DS children, and conduct home outreach and peer parent support activities.

To promote innovation, help preschools and schools maximise children’s development, and support children and families, Centre specialists are preparing: new curricula and syllabuses for preschools; guidance for handling

25 The Centre has a room for auditory and visual development including computers and talking manuals for visually impaired children; a gymnastics and breathing room; several diagnostic rooms for mothers and children with one-way mirrors for group observations of assessments and learning sequences; music rooms including marionettes; a sensory development room; a self-care room for occupational therapy; a creative crafts workshop with art and sand therapy; a garden room with animals; rooms for medical assessments and examinations; rooms for physiotherapy; a swimming pool and a room for hydrotherapy; ergo-therapy and exercise rooms; a room for vitamin drinks, juices and herbal teas; a well-organised and colourful library filled with hundreds of books; and a room for storing children’s records and over 60 standardised assessment kits.

26 Centre personnel include: defectologists, teacher-psychologists, neurologists, rehabilitation physiotherapist, massage nurse, nurse therapist, ergo-therapist, and a hydro-therapist.
children’s emotional problems; and manuals for a wide variety of specialists. Some Centre specialists are encouraged to develop special projects or pursue advanced degrees at the *Magistratura* or Ph.D. levels. Some are interested in conducting evaluation research but lack the time.

Because the Minsk Development Centre is a training, resource and demonstration centre for the country, its personnel have exceedingly small child caseloads. Currently, on-site services are provided for only 18 children less than three years of age. In addition, they serve approximately 50 children less than three years of age who visit the centre for consultations. In specialists’ weekly Plans of Activities, they usually allocate their time as follows: 60% direct services with children and parents; 20% diagnostic work with children and participation in Commission meetings; and 20% conducting training activities and counselling professionals. The director and most specialists are certified as official trainers and often serve as trainers of trainers as well as mentors. They have an annual schedule of 32 methodological workshops and 60 workshops for the Council of Directors, specialists from the Belarusian Association, and district training specialists. They also hold national training workshops including roundtables of Centre directors.

In addition to on-site training, specialists present workshops and demonstrations in special education preschools, inclusive preschools and regular preschools with special education support staff in Minsk and the regions. To ensure quality, each Centre specialist receives frequent in-service training. The director and two vice-directors of the Centre provide monthly training for their specialists. Furthermore, their own work with children is observed, and once a week they mentor each Centre specialist.

### III.6.2 Development Centre, Kobrin’s Alpha Centre

As noted in the section regarding Kobrin’s ECI Centre (See Section III.3.2), close collaboration has been established between MOH and MOE institutions. This partnership provides an exemplary model for inter-institutional partnerships in other countries at regional levels. Similar to the ‘Tonus Centre’ in Brest, Kobrin’s Development Centre began in 1998 as a Belarusian NGO called “the Alpha Centre.” At first, it served eight young children with disabilities who were judged to be unable to go to ordinary preschools. The centre director quickly realised that a greater range of specialists was needed to serve the children. When it became impossible to attract external funding, the Centre converted to a Development Centre of the MOE in 2003.

Alpha Centre has defectologists, speech therapists, a psychiatrist, a massage therapist, a recuperative medical trainer, psychologists and nurses. Because it has some medically trained specialists, the Centre is able to provide daily on-site services for some children with medical needs but it lacks the full range of medical specialties that are required for some children, hence the referrals to the local ECI services and to Tonus in Brest. Paraprofessionals participate in Centre activities. Secondary school students play with children, take them on field trips, and arrange for a summer camp. Alpha specialists have found this to be beneficial for the children as well as for the students. The Centre seeks to serve town and rural families with at-risk, developmentally delayed and disabled children, providing both ‘defectological’ and physical training. Children with multiple or severe delays or disabilities are referred to Tonus for short-to medium-term services, and then Alpha follows up according to IDP provisions for each child. Because Kobrin’s Polyclinic lacks a neurologist and some other medical specialties, approximately 50% of the children served by Alpha have gone to Tonus in Brest at one point or another for intensive medical rehabilitation or psychological services.

Kobrin’s Polyclinic, ECI Centre, community members, and parents refer children to Alpha Centre. In July 2007, it provided full-day services for 36 children with multiple developmental needs, from infancy onward. Approximately six to eight hours are devoted to developmental work. Services are provided all year round, with a shorter summer break than in Minsk. Their major goal is to integrate special needs children into society and to ensure they go to kindergarten and school, if possible. As children transition to preschool or school, Alpha defectologists and psychologists work with school colleagues and assist them with developmentally appropriate activities. Some other children receive brief services from Alpha, such as speech therapy. Children with multiple disabilities deemed to be beyond the capacity for care and education in a school setting receive continuing services at Alpha.
specialists conduct joint assessments and planning sessions with ECI centre personnel in the Polyclinic in order to maximise the use of their resources and avoid unnecessary duplication of services. They work with parents alone, in groups, and with their children because they believe family harmony is essential for maximising child development. They demonstrate activities for parents to do with their children in their homes and in the Centre. They use the Belarusian Association to conduct home outreach to invite parents to join their Parents’ Club. The Centre benefits from strong parental and community support.

A Kobrin database is maintained that links the Alpha Centre, the Polyclinic, and the ECI Centre. All children with a risk, delay or disability are registered in the database, and it is updated twice a year. The Kobrin community is dedicated to identifying, assessing, serving, tracking and following-up all children in their database.

**III.6.3 Development Centre, Brest**

The Brest Development Centre, also called the “Veda Development Centre,” is also closely related to the local Polyclinic, ECI services and Tonus Medical Rehabilitation Centre. Veda receives referrals from those centres, parents, and preschools and assesses over 1,000 children annually. When children are assessed, parents are involved and asked about their interest in receiving services from the Veda Centre. After assessment, it was reported that the Centre’s Commission reviews the child and prescribes a course of psychological and pedagogical rehabilitation but not medical rehabilitation. However, physical exercises and massages are provided, and a psychiatrist and paediatrician are on site to assist, as needed. This Development Centre, like others of its type, is a mainly educational service with some health and medical aspects in order to provide comprehensive and balanced services. Children with significant physical delays or disabilities are served by Tonus. The Veda Centre has specialised defectologists, teachers, psychologists, a paediatrician, and a massage specialist-physiotherapist. The Centre receives referrals from Tonus, and some children are served jointly.

In July 2007, the Centre’s database currently had 2,118 children in active services. Five preschool groups with 76 children are provided for those with serious disabilities. Fifty percent of these children are relatively immobile. Like Tonus, many children served in the Veda Centre receive short-term, intensive services rather than continuous services as found in Minsk and Kobrin. Usually longer-term, continuous services are required to ensure children do not fall back in their development between service periods.

The Veda Centre promotes parent participation through holding monthly Parents’ Clubs and providing individual counselling and peer support groups. Professionals train parents in how to communicate with their children, and Centre specialists focus on father/child interaction; however, it was reported that over half of the children lack fathers. Parents are included in Commission meetings wherein specialists discuss assessment results and parental activities to improve their children’s development.

### Table 5. Ratings of Development Centres

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<tr>
<th>Combined Rating</th>
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<tr>
<td>Participatory approach, overall rating</td>
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<tr>
<td>Parents’ rights emphasised</td>
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<tr>
<td>Parents involved in assessments</td>
</tr>
<tr>
<td>Parents actively help design IFSPs</td>
</tr>
<tr>
<td>Socio-culturally appropriate services</td>
</tr>
<tr>
<td>Focus on child &amp; family assets</td>
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<tr>
<td>Maximise child’s competencies</td>
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<tr>
<td>Individualised family service plan</td>
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<tr>
<td>Medical/education services combined</td>
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<tr>
<td>Interdisciplinary assessments</td>
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<tr>
<td>Tracking system and shared database</td>
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<tr>
<td>Home/community outreach for child identification</td>
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<td>Home services regular part of provisions</td>
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They hold meetings with parents later in the year to summarise intervention results and assess the type and frequency of services. Few home visits are made because their regulatory framework does not permit them, and they feel parents prefer to visit specialists in their centres. It proved difficult to rate the Development Centres on all dimensions due to visits made during the centres’ vacation period. Therefore only a combined general rating is offered to illustrate key differences from health programmes reviewed above.

**Comment and summary statement**

In general, the MOE’s Development Centres are not as child-centred and family-focused as ECI Centres in Polyclinics. Although the Minsk and Kobrin Development Centres are judged to have similar profiles with respect to ECI services and participatory practices, the Brest Development Centre more medically oriented, reflecting its close relation to the Tonus Medical Rehabilitation Centre. With additional personnel training, Developmental Centres could achieve essential ECI goals as child-centred and family-focused services. The Minsk Centre would be an excellent site for in-service training and mentoring activities. Kobrin’s Centre, that coordinates with the ECI Centre and Polyclinic, has achieved a high degree of interdisciplinarity and parent involvement in its inclusive services. Its valuable inter-institutional database tracking system might serve as a model for MOE and MOH tracking and follow up in all regions of the country.
Infant Homes, although outside of the realm of this study, play a role in the system for at-risk, delayed and disabled children from birth to school entry. In addition, an Infant Hospital for severely disabled children not expected to survive beyond a few weeks or months provides loving care and gentle perceptual and physical stimulation.

Infant Homes are managed by the MOH, and they represent remnants of the outdated approach to disability developed during the former Soviet Union. The Homes represent a mainly medical approach for caring for orphans or “social orphans,” and especially for children with disabilities or developmental delays that are “taken by the State.”

Many but not all agencies and specialists of Belarus are making a major effort to reduce national dependency upon Infant Homes. Prevention of children from falling in the category of orphans is reported to be a national priority, as may be noted in the Law entitled “On Social Protection Guarantees for Orphans and Children without Parental Care, as well as Persons Categorised as Orphans and Children without Parental Care” (December 2005) and a recent 2007 Ordinance # 18 “On Additional Measures for the State Protection of Children in Disadvantaged Families.” These documents seek to strengthen the rights of children in at-risk families. They affirm the responsibility of parents for nurturing and rearing their children, and commit the government to provide special support for at-risk families and children. Due to this new national priority, care alternatives for orphaned children have changed considerably.

As of 2005, 68% of newly orphaned children had been placed in different forms of family-based care versus only 56% in 2004. An evaluation of a programme for family preservation noted, “In recent years the Republic of Belarus has passed a number of laws, and developed State programmes to support families in caring for their children. As a consequence, in the period 2001 – 2005 the number of children placed in orphanages decreased by 150% while the number of children placed in various forms of family care increased by 130%” (Sivuha 2007). This increase is mainly connected with the rise in the number of foster families. As of January 2007 there were 3,231 foster families in Belarus.

Deprivation of parental rights has been the main cause of children becoming “social orphans,” and it has been increasingly associated with parental neglect and substance abuse. As of January 2006, overall there were 32,878 orphans and children without parental care in Belarus. Of them, 16,451 children (50%) had been placed in substitute families (adoption, guardianship, foster care, family type homes). Some 11,582 (35.2%) orphans had been placed in public residential institutions, and another 4,845 children (14.7%) were living in public educational facilities that provide vocational training.

The distribution of children’s placements is presented in Figure 1. There is a clear trend of a reduced proportion of children placed into orphanages, and an increase in the proportion of children placed into foster families, small group family homes and children's villages. Adoption remains quite low.

As of 2006 six Infant Homes in Belarus still served 822 young children with disabilities. Through special arrangements, nearby ECI services are beginning to help the children in two Infant Homes. In the near future, ECI services will be made available for the other Infant Homes.

By giving additional emphasis to prenatal education, health and nutrition care, and avoiding high-risk behaviours, Belarus
is working to prevent serious anomalies and low-birth weight infants. In addition, significant efforts have been made to provide family outreach, counselling and focused social communications. An evaluation revealed that these initiatives are meeting with considerable success (Sivuha 2007). By expanding ECI services throughout Belarus, it is likely that dependency upon Infant Homes will be minimised rapidly.
Belarus provides a variety of options for inclusive education:

- individual children are included in regular preschools and preschool programmes with the provision of special support to varying degrees;
- special groups are integrated part of the time in regular programmes;
- special groups are physically present but not functionally or educationally integrated in regular preschools;
- special preschools serve only children with delays and disabilities; and
- residential institutions.

The choice, in principle, is free for the parent, but the Medical, Pedagogical and Psychological Commissions that assess children with special needs still have a strong influence on placement decisions. Although one author previously had visited preschools, they were not visited for this study principally because preschools were closed for vacation. Nonetheless it is important to review the options parents face with respect to preschool education.

It is important to note that in contrast to several other countries in the region, Belarus has achieved a high level of access to educational facilities for children with disabilities. Problems of quality of services and adequacy of training for providers remain, but programme coverage is adequate and includes children with disabilities - including those in Chernobyl - and most children in rural areas.

To encourage women to have children, improve maternal-child bonding, and reduce child abandonment, Belarus provides generous maternal leave and supplementary income for up to three years after birth. For this reason, few women send their children to preschool before the age of two and one-half. However, many take advantage of mother’s days at local preschools where they receive parent education and learn about developmentally appropriate play, their children engage in social play with other toddlers, and they participate in peer support “Mothers Clubs.” (Vargas-Barón 2006).

Due to increased Government investment in preschool education, Belarus has developed one of the most extensive preschool systems of all of the transition countries. As of 2004, Belarus was investing 0.8% of GNP in preschool education (UNESCO 2006). Overall preschool enrolment increased from 60.1% in 1995 to 79.3% in 2003 (Agranovitch 2006), and now is officially stated to be 82%. At the present time, 100 percent of children of five years of age, including those with disabilities, can access preschool services. All children who begin primary education complete it, and the country has 100% youth and adult literacy. Few private preschools exist in Belarus due to a lack of government support for private education. It is also difficult to assess the general quality of preschools because no comparative studies have been conducted on them. However, observations of a few select preschools conducted by one of the authors revealed an outstanding level of developmentally appropriate educational activities and rich parent education and support services (Vargas-Barón 2006).

If requested, regular preschools will receive children from birth onward, but usually preschool begins at age two and one-half or three years, and continues to age six. Preschool services for children and families with special needs range from a several hours a day to 24-hour services (UNESCO 2006). For working mothers, infant care ranges from a few hours to 24 hours for one to six days a week. Official preschool education begins at three years of age, and 104% of children were enrolled in preschool in 2004, indicating that some underage and overage children are also found in the preschools (UNESCO 2006). Pupil teacher
ratios are established at six children to one teacher. UNESCO reports that only 64% of the teachers have completed expected pedagogical training; however, according to official statistics, 45.2% of preschool teachers have completed pedagogical university education and 53% have received a pedagogical college education. Preschool education is free of charge; however, parents are requested to pay for about 60% of meal costs. A major effort has been made to increase preschool coverage in rural areas. In 2004, only 45% of rural preschool age children could access a preschool (Republic of Belarus, 2004). Today, coverage is close to 60% in rural areas, especially because a flexible form of family and community preschool groups has been instituted.

In line with the education system’s basic principles, MOE leaders have made a major effort to include children with developmental delays and disabilities in preschools in appropriate ways. They are dealing with parental expectations as well as long-standing social norms regarding educational quality and expectations that children with disabilities will be closeted away in special institutions. However, as in other countries throughout the world, this situation is changing rapidly. Increasingly parents are observing that inclusive classrooms are rewarding for both typically developing and disabled children.

Parents of children with special needs have, in reality, several different options for preschool education. With respect to children considered by local Medical, Pedagogical and Psychological Commissions and their parents to be able to benefit from preschool services, in theory children may enter separate, inclusive or regular preschools. In actuality, not all options are available in all locales and not all Commissions allow parents to have the final say on the placement of some children.

The following types of preschool arrangements exist for children with special needs in Belarus:

**Special preschool children’s homes** are orphanages that serve children who leave infant homes or are abandoned during their preschool years. There are six orphanages serving 401 children, for an average of 67 children per orphanage.

**Special boarding schools** are provided for older school children with disabilities. They may maintain some contact with their families. A total of 62 boarding schools under the MOE serve 7,598 children, for an average of 123 children per boarding school.

**Special preschools** mainly serve children with severe disabilities or profound mental retardation. They are not integrated or inclusive. There are 10 special preschools in Minsk and 37 in regions, totalling 47 preschools. Special Preschools serve 4,062 children less than six years of age, for an average of 86 children per preschool.

**Special groups** of children with disabilities are placed in preschools but they attend separate classes. They are the predominant form of education for such children in the Belarusian education system. There are 428 special groups in preschools in Minsk and 846 special groups in preschools outside of Minsk for a total of 1,274 special groups in 532 preschools [13% of all preschools in 2003, (Ministry of Education 2004)] in the country. They serve 16,112 preschool age children with special needs [4.5% of all children enrolled in preschools in 2003 (ibid)], averaging 30 such children per preschool admitting special groups.

**Integrated groups** are beginning to be developed in Belarus enabling preschool-age children with disabilities to be included in some regular classes as well as separate classes. They are closer to what is called “inclusive” preschool education in other countries but still not quite there. There are 27 preschools with integrated groups in preschools in Minsk and 180 in regions, for a total of 207 integrated groups in preschools. These preschools serve a total of 729 special needs children under six, averaging fewer than four children per group.

**Regular preschools (and preschool points)** where children with special needs are served through receiving special education support are also quite close to inclusive services. They include placing preschool-age children with disabilities with typically developing children in 859 preschools in Belarus. Special educators (often called points of specialised support) are expected to work closely with Development Centres and ECI Centres to provide developmentally appropriate guidance to children, parents and teachers. In 2006, 859 preschools received special education support to serve 22,894 children with delays or
disabilities, for an average of 27 children per regular preschool.

These arrangements provide preschool education for a total of 44,198 children less than six years of age with special needs, which exceeds the total number of children officially reported to have special needs (40,683 children). In addition, some 6,378 children are given preschool type services in Development Centres. This situation may be explained in part due to double counts and to the retention of some overage children in preschool services due to parental preference and Commission decisions.
The Belarusian Association of Assistance to Children and Young People with Disabilities, referred to as the “Belarusian Association,” was established in 1991. It is one of the few – if not the only – NGOs devoted to supporting families with children with disabilities. Its main goal is to create equal opportunities for children and youth with disabilities to participate in all aspects of society (Belarusian Association 2007). The Belarusian Association provides psychological, social and legal support to families. They conduct advocacy services; provide information; prepare, print and distribute booklets, books and other educational materials for parents and professionals; and conduct conferences, workshops and seminars. They give young people with disabilities training for employment as well as leisure time activities for them and their parents.

In 1991, the Belarusian Association served 9 parent groups, and by 2007, with support from MOE, MOH, MOLSP, UNICEF and others, it provides information, referrals and other support for over 4,000 families whose children have mental or physical disabilities. It supports 64 community-based member organisations: 9 in Minsk and 55 regional organisations. Currently, its paid personnel include a full-time director, two full-time social workers, a computer technician/publications specialist, a part-time psychologist, and a part-time music therapist. Volunteers play critically important outreach and family support roles for ECI Centres, Medical Rehabilitation Centres, Development Centres and Family Support Centres. They identify children needing services, help parents to access appropriate programmes, provide developmentally appropriate toys, videos and booklets, offer parent education classes, and assist parents to transition their children from MOH or MOE services to preschools and schools. Working with the Foster Educators Association, they also identify potential foster parents to provide respite and foster care. Without this extensive corps of trained and experienced volunteers, the Association would be unable to achieve its goals. It needs additional specialists to provide more training, supervision, specialised outreach, and home visits for the over 4,000 families served, and to expand services to more families throughout Belarus.

The Belarusian Association's innovative programme, “Families for All Children,” proposed and launched a system to prevent the abandonment of infants with “psychophysical disorders of mild and moderate degrees” through placement with families (Ibid, 2007). Services begin in Maternity Hospitals, where the Association's social workers talk with the parents of newborns with disabilities. There is a continuing tendency among hospital personnel to encourage parents to relinquish disabled children to Infant Homes, signalling the need for fundamental awareness raising and attitude change for several years to come. Social workers make home visits and provide timely psychological, legal, medical and technical support to parents and relatives, especially in rural areas with few services. They help parents bond with their child, be aware of their rights, learn about the positive results of infant nurturing and stimulation activities, and assist them to freely consider their options. They encourage parents not to place their child in an Infant Home, inform them about available MOH, MOE and MOLSP services, and provide support during the period between disability identification and entry into MOH or MOE services. Their volunteers, who are parents of children with disabilities, give new parents valuable peer support. They and social workers help parents register the child, arrange for child care, and set up short-term foster care or respite care, as may be needed. Subsequently, they monitor the family, provide parent education, and ensure parents can access...
needed services. During 2006, *Families for All Children* served 89 families with 90 children. The Belarusian Association reports that as a result of this programme, potential abandonment was prevented in 11% of cases, and in an additional 18% of the cases, problems were temporarily solved.
PART IV: Lessons from Belarus and Recommendations
The triggers that have promoted conceptual and structural changes and the development of the innovative ECI and Special Education System of Belarus include: 1) the high priority placed on children and families, and 2) strong governmental support for child and family development. Social values as well as response to evidence-based research are key in all countries to improving child status, and positive Belarusian social values support the preparation of many specialists who help ensure all Belarusian children will have opportunities to develop their abilities to the fullest. The existence of strong university and post-graduate training programmes has unquestionably aided system development.

Belarus inherited an extensive infrastructure of health, medical and educational services from the Soviet Union. The country could have allowed this system to disintegrate, as was the case in some other CEE/CIS countries. Instead, it was maintained and reformed in important ways. Existing children’s services were linked with MOH, MOE or MOLSP structures, and then thoroughly revised their conceptual frameworks, contents, and methods to resemble peer services in St. Petersburg, Western Europe and the Americas. They retained key features linked to Belarusian culture in all programmes: good nutrition and health; art, reading and creativity; learning toys including traditional marionettes and puppets; environmental protection and nature; sports, music, dance, and theatre.

Openness to change is striking and should be maintained and expanded. Belarus has much to give other countries and receive from them. In the reorientation of the existing system for children and families with special needs, collaboration with UNICEF and the Early Intervention Institute of St. Petersburg has been very important. Centre directors uniformly spoke of their willingness to innovate, and this capacity is reflected in many new curricula, books, educational materials, media and learning tools that Belarusian specialists have developed to make their services culturally competent and attractive.

Another key trigger has been high parental demand and use of services as well as the support of the Belarusian Association for family outreach and support. Offering services is not the same as access. Even though more needs to be done to increase access for young children less than three years of age, it is clear that many parents use, approve and benefit from current services. The use of increasingly child-centred and family-focused services undoubtedly is part of the reason for service demand growth. It is also revealing that parents often make educational toys and decorations for the centres and they consider the centres to be “home away from home” for them and their children.

A series of drivers serve to maintain the strength of the Belarusian ECI and Special Education System in terms of continuing financing, improving quality, and ensuring sustainability. This national system embraces all children of the country, and it is based on a robust foundation of legislation and inter-agency agreements. The Ministry of Finance and Parliament continue to provide strong budgetary support for the programmes, and they have increased key programme budgets over time. Specific ministers, deputy ministers, and departmental directors have also played important roles in fields under the responsibility of MOE, MOF, MOH, and MOLSP. City and Regional Executive Committees for Health and Education composed of local policy makers and leading professionals in ECI fields have strongly supported the system.

MOH and MOE leaders seek to comply with international normative instruments, and especially the CRC and most of their services comply with its requirements. Belarus has made a major effort to achieve
child rights. Several national policies and plans state they are working to comply fully with this and other international normative instruments developed to safeguard the children's rights. From legal and technical points of view, investment in children in Belarus is quite secure. However, were the economic situation of Belarus to suffer, it would be essential to protect these services. To date, they have been sheltered from fluctuations in the country's productivity and balance of trade. Because the MOH and MOE have experienced fairly steady budget increases during recent years, it can be hoped that children's budgets will be increased to consolidate the services and serve thousands more of the country's vulnerable children and families.

Another driver is the national capacity to prepare standards, regulations and guidelines for improving and coordinating programme services. This can be a two-edged sword because over-formalisation can lead to inflexible and restrictive guidance, as has occurred in ECI programmes of some countries. A strongly formalised system, in combination with highly specialised professional practitioners, may act as an obstacle to the flexibility and openness necessary in a child and family orientation. But such conditions could also be helpful when trying to change increasingly inflexible routines, founded in habitual thinking rather than in critical analyses of outcomes. A case in point could be the Medical, Pedagogical and Psychological Commissions with their heavy influence on transition and preschool placements after the initial period of ECI services. On the one hand, these Commissions represent solid and traditional authority, especially in the eyes of medical and educational bodies; authorities which can be very hard for parents to influence regarding their views on preschool placement. On the other hand, the Commissions' role could be of significant importance, should they act as advocates for a non-defectological, flexible and inclusive view on the preschool's role for children in need of special support. Belarus' current regulations demonstrate the strong capacity of their systems to innovate. Clarity of definitions, roles, responsibilities, protocols and procedures combined with child-centred and family-focused services will help achieve improved system quality and expansion over time.

Periodic official in-service training sessions plus frequent informal meetings to exchange ideas and experiences have created a continuous "learning organisation" approach within the ECI and Special Education System. This valuable capacity will help revise the System flexibly over time. The System provides many opportunities for teamwork and has resulted in building strong inter-personal and inter-institutional relationships and coordination. Teamwork is a major reason for believing long-term sustainability will be achieved. Professionals who learn to work together and with parents are the backbone that maintains the System. Their knowledge, experiences, shared responsibility and achievements will sustain the ECI and Special Education System in the future.
In addition to identifying main triggers and drivers, 20 major lessons learned are presented below regarding programme contexts, inputs, processes and outputs. These lessons and recommendations may help other countries consider their options as they design their ECD and ECI systems.

1. **Develop and maintain strong policy support and legal basis for ECI system.**
Belarus has established strong policy support and a firm legal basis for its ECI and Special Education System. The country currently lacks a unifying ECD Policy but were it to exist, a major strategy would be devoted to this system and its programmes. The Early Childhood Education Plan, Health Policy for ECD, Child Protection Policy and the National Plan of Action for Children's Rights (2004 – 2010), and the President’s Programme for the Children of Belarus (2006 – 2010) all support the ECI programmes. The Government has made amendments to policies and included ECD issues as a part of the National Children’s Programme, and created an ECD Council that promotes ECD regulations as well as a National Commission on Children’s Rights. Although Belarus lacks an Education for All (EFA) Plan, the country has virtually attained EFA. In addition to having achieved 100% literacy and 100% primary school completion, it has also attained universal preschool coverage for all five year-old children and preschool education is provided for the vast majority of children from three to four years of age, which is far more than is found in many industrialised countries. The Millennium Development Goals statement of Belarus has had a positive impact on ECD. The National Development Plan does not mention ECI, but it does mention disability. In addition, several policy statements, agreements and standards have been developed to ensure the quality of ECI services for vulnerable children and their families (See Annex II). Because the system is highly decentralised, these documents provide guidance regarding roles and responsibilities at all levels: national, regional, and municipal. However, these documents cannot substitute for a national ECD Policy. To ensure system sustainability, it would be advisable to review all existing policy statements in education, health and social protection, harmonise them, and establish a consolidated ECD Policy that would embrace all advancements made to date.

2. **Revise the former defectological system, concepts and methodologies to create a special education system in fact as well as name.**
Belarus has been successful in developing MOH ECI Centres that meet most of the basic ECI concepts and participatory and inter-disciplinary methodologies. Other medical and education services for children with high-risk status, developmental delays and disabilities still have some distance to go to achieve this goal. They have maintained expert-driven and disciplinary approaches that are less participatory. It is recommended that Belarus also move slowly from the label and approaches of defectology to an ECI and special education approach, with attention to retaining the strengths of the current system while discarding the correctional approach to child development.

3. **Criteria for service eligibility should remain broad.**
One of the strengths of the Belarusian system is that the criteria for serving high-risk, developmentally delayed, and disabled children are very broad. Some countries have made the mistake of defining eligibility very narrowly, thereby precluding the early identification and treatment of developmental delays before children become more involved, much more costly to treat, and have less successful outcomes. Belarusian health services are sensitive to the needs of high-risk children. They understand that early intervention and health prevention services are essential during the prenatal
and birth to three periods. Broad service criteria for ECI should be maintained.

4. Outreach services should be improved and expanded.
More attention needs to be given to home and community outreach because according to statistics provided by the MOE, many high-risk, developmentally delayed and disabled children ages zero to three currently go unidentified by health and education services. Most such children are identified when they go to preschool or health practitioners refer them after the age of three. However, most centre-based service providers in Belarus resist conducting community outreach and home visits to identify children, with the exception of visiting nurses and volunteers or social workers of the Belarusian Association. The Association’s programme should be expanded.

5. An inter-agency early identification, tracking and follow-up system is needed.
Services for early identification, regular screening and assessments are needed. MOE’s database for children and families appears to work well at city, regional and national levels; however, it is not connected with MOH services and records. It would be advisable to combine these systems to ensure each child is tracked, served well over time, and does not become “lost in the system.” At a general level, all statistics are collected from ministries and collated by the Ministry of Statistics and Analysis, but this system should be separate from a confidential tracking system that would unite MOH Polyclinics, ECI Centres, Dispensaries, Medical Rehabilitation Hospitals, Infant Homes, MOE Development Centres, and all preschools.

6. Ensure individualised plans are developed in a participatory and consistent manner with informed parental consent.
ECI Centres of Polyclinics are skilled in developing IFSPs with parents participating in all aspects of IFSP preparation. Medical Rehabilitation Centres and most Development Centres prepare similar but different IDPs or IEPs, and most do not include parents in IDP or IEP preparation. Rather, specialists tell them the results of assessments along with their professional recommendations for services. Although parents need good professional advice, they should feel they are participating in assessments, planning and decision-making. Based on intimate knowledge of their children, parents can make invaluable observations and provide essential inputs into these processes. Often the wide array of planning approaches confuses parents, and they begin to expect to play subsidiary roles to the professionals. ECI Centres seek to empower parents and help them assume overall responsibility for orchestrating the services they and their child will receive. Other centres treat parents kindly, but basically disempower them in their roles as parents.

Parents should give written consent to programme enrolment and participate actively as members of Inter-disciplinary Teams, and in all assessments, individualised planning sessions, and services. To ensure IFSPs, IDPs and IEPs and ITPs pay consistent attention to the holistic and integrated needs of each child, it would be advisable to establish a unified approach to child development, including common definitions, the same or similar validated assessments, a similar comprehensive IFSP for each type of ECI service, and a common service reporting form. The IFSP and ITP forms should include all developmental areas, inter-disciplinary assessment results, a service plan, spaces for parental observations and comments, and the duration and frequency of services from all points of service (e.g., MOE, MOH, MOLSP or others). Because parents rarely sign and add their comments to these documents, for reasons of empowerment and parental and child rights, it is advisable to explain the reasons they should do so. ECI services have procedures to ensure family privacy, and limited access should be provided to individual child and family data. Safeguards should be put into place with respect to both written and electronic records, and parents should state who may see their records.

7. Develop comprehensive centre- and home-based ECI services.
Community-based, comprehensive and culturally competent home visiting and centre-based ECI and ECD services should be provided for the full range of service intensities, as outlined in Section II, plus supportive day and evening child care and respite care, as needed. A wide array of centre-based services for ECI is provided in Belarus. Individual clinic visits for therapies are usually principally but not solely provided by Medical Rehabilitation Centres and Psychoneurological Dispensaries. Family visits are made to ECI Centres in Polyclinics or
to Development Centres wherein parents work with their child and the specialist, and also learn how to do developmental activities at home after the visit to the clinic. **Inter-disciplinary arena assessments** are mainly conducted in ECI Centres and some Development Centres. Group activities for children are mainly found in ECI Centres and Development Centres. Group activities for children with their parents are provided in Development Centres and ECI Centres. Group activities for parents include parent education classes in all MOH and MOE ECI programmes, and peer gatherings (Mother’s Clubs, Father’s Clubs, Parents’ Clubs) in the Belarusian Association, ECI Centres, and Development Centres. Centre-based activities are favoured generally in Belarus and appear to be easier to provide. They enable parents to meet, establish friendships, and support one another and the Centre. This camaraderie often has a therapeutic affect. Group sessions can represent a way to overcome the social isolation that affects so many parents with disabled children.

Several programmes use home visits to provide core services. Home visits are especially effective in achieving improved child development more rapidly because parents who learn activities in their homes have a higher likelihood of doing them regularly. Visiting nurses of Polyclinics conduct home visits, as do specialists of ECI Centres in Minsk and Kobrin, and the Minsk and Kobrin Development Centres. The Medical Rehabilitation Centres of Minsk and Brest and the Development Centre of Brest do not conduct home visits. ECI and Development Centres also make visits to preschools to support teachers, children and families. In contrast, specialists of Psycho-neurological Dispensaries, Medical Rehabilitation Centres, and the Brest Development Centre stated that they prefer to wait for parents to come to them. This is typical of centre-based services where specialists are not trained to make effective home visits and their status comes mainly or solely from playing professional roles in Centres rather than from making home visits.

**8. Develop year-round ECI services.**
Children with developmental delays and disabilities require year-round services yet MOE Development Centres follow the academic schedule and many families take vacation breaks. However vacation breaks of two or more months can lead to children falling back in development. A system of flexible vacations, special camps, and substitute services is needed to avoid these developmental losses.

**9. Develop linked parent education, counselling and support services.**
Belarus provides extensive parent education and support services for all ECI and ECD programmes that are highly praised by parents. Specialists of ECI Centres and various universities have prepared educational materials for parents of children with developmental delays and disabilities. In addition, the parent clubs, and parent education seminars and classes are attracting many parents who find them rewarding. For parents needing additional support, the Belarusian Association provides peer counselling and social work assistance. MOLSP Family Support Centres work in close collaboration with all of the MOH and MOE ECI services providing counselling, family therapy and referrals to essential social services for families with difficult family situations. A similar array of services should be developed over time in other countries in the region.

**10. Enable strong parent involvement in programme services.**
Parents are most involved in MOH ECI Centres and the MOE Development Centres, and they expressed the strongest satisfaction with these services. They emphasised that the support they had been given had made a major difference in their ability to accept their child’s situation and work well with him or her. They appreciated the respect, support and guidance they received. The other programmes reviewed are mainly expert-driven, and parents are considered to be patients rather than participants. ECI programmes where they exist are increasingly focusing on parent involvement and satisfaction as a path to maximising child development. Belarus is slowly improving parent involvement and satisfaction in its ECI and Special Education services. The Belarusian Association’s “Families for All Children” should be greatly expanded to reach more parents through direct services and advocacy messages. The Association is in the vanguard of creating a change in attitude and behaviours regarding children with disabilities in Belarus.

**11. Develop Interdisciplinary Teams to achieve integrated services.**
Interdisciplinary Teams are used in ECI Centres, and to a somewhat lesser extent
in MOE Development Centres. The latter require the presence of additional specialised medical personnel due to the requirements of multiple needs children, and Centres such as the Alpha in Kobrin and Veda in Brest have achieved this through partnering with nearby Polyclinics or Medical Rehabilitation Centres. In a way, this is the ideal situation for certain children and their parents who become well known to specialists in both centres. Joint IFSPs can be prepared and include relevant services from each programme. Referrals to regional services can also be considered. True interdisciplinarity is difficult to achieve. With the exception of the ECI Centres, most specialists in other centres still conduct assessments alone with the child and sometimes with the parent looking on. Specialists report results to the IFSP, IDP or IEP group and for the child’s review by a local Commission including parents. Arena assessments, with the participation of several specialists and the parents together, are rarely found outside of the ECI Centres, and considerable training is required on how to conduct them. Because children require integrated development services, it is insufficient to focus only on the area of delay or disability. A balanced, holistic and integrated approach was found in ECI Centres, and to a lesser degree in the MOE Development Centres. Because medical services focus mainly on the child’s delay or disability, they should routinely also refer children to ECI Centres.

12. Develop guidelines for managing learning resources.
Guidelines for Toy Lending Libraries should be established to ensure parents have easy and open access to the developmental toys they need, with an emphasis on toy safety, appropriate use in the home, and cleaning between uses. Some Centres manage these matters quite well while others need additional training and guidance.

13. Promote effective transitions to inclusive preschool and primary school services.
A great deal of work is needed to clarify specialists’ and parents’ roles in transition from ECI services to inclusive preschools or schools. ECI programmes in several countries begin to work with parents on transition processes from soon after their children enter the programme. Parents become less psychologically dependent upon the ECI programme, are increasingly informed about their options, and are empowered to make good decisions. Specialists require additional training to help parents prepare for transition and drafting ITPs. Guidance will be needed to ensure parents are prepared to make decisions regarding preschool options and can help their children to transition well. More work is needed on follow-up and support for children and families as the children enter regular, inclusive or separated preschool services. These transitions are often more important than the quality of the programmes themselves because a poor transition to an appropriate preschool or school can easily end in poor outcomes for the child and parents.

14. Consider new approaches for pre- and in-service training.
Professional preparation is fairly uniform across specialisations in the fields of education and health. Each five years they are required to take post-diploma training course. This system for continuously upgrading professional knowledge is most beneficial considering the major organisational and methodological changes that have occurred in recent years. The amount of in-service training in both MOE and MOH centres is striking. Specialists are keenly interested in learning new skills. Openness to change was expressed in each centre visited, along with an eagerness to share local knowledge and achievements. The centres have created their own in-service training opportunities through reaching out to the St. Petersburg Early Intervention Institute, and to universities and programmes in Germany, Ireland, Sweden, United Kingdom, and the United States. Now that many structural, communications and coordination matters are well advanced in Belarus, areas for future international and regional training and exchange could include topics related to: curricula; assessment tools and methods; therapeutic methodologies; and

28 At Pedagogical Universities, five years of training is required for all “defectologists” (special educators) to receive a Professional Diploma that will enable them to work in Development Centres, preschools and schools. Graduate degrees that are required for supervisory roles include the Magistratura (roughly a Master of Science degree) representing two years of additional study, and the Ph.D. that is an especially but not exclusively research-oriented degree, and requires an additional three to five years of study. For medical professionals in all developmental areas, six years of university study are required, including one year of internship and two years of residency. They too may seek a Magistratura and a Ph.D. with comparable dedications of time to study.
programme evaluation and monitoring. Health, medical and educational specialists expressed interest in learning about internationally accepted clinical methods for improving child and family development. All specialists need training in interdisciplinarity. Consideration should be given to establishing a new profession of integrated ECI specialists, often called on “Early Interventionists.” To promote rapid ECI growth, additional specialists will be needed in the ECI Centre of Polyclinic #19 to meet growing service demand, ensure quality is maintained, revitalise home visits, and secure release time for training professionals of other ECI Centres. To ensure comprehensive outreach services, more trained volunteers and aides are needed. To provide home visits in countries lacking certain specialisations, they may want to train and supervise community ECI home visitors who will be supervised by early interventionists, therapists and special educators.

15. Improve inter-agency coordination roles and Commission meetings.
The new agreements of the Belarusian ECI and Special Education System describe its vertical coordination rules. However, some of them have not been placed fully in force, and others appear to require modification. Directors and specialists seem to be willing to consider changes in these regulations. A surprising amount of important horizontal coordination exists between ministries, cities, regions and programmes, and should be maintained and expanded to ensure the ECI system becomes a continuous learning community. Internal programme coordination appears to be strikingly effective. Specialists appear to keep complete child and family records; however, many of these records could be simplified and computerised over time. Each programme has a set of internal committees that permit a clear delineation of personnel roles and responsibilities. However, systemic difficulties were observed regarding Medical, Pedagogical and Psychological Commissions in several locales. It appears that they should be reviewed with respect to their purpose, roles and responsibilities as well as the roles of participating parents, specialists and agencies. Attention should also be given to: the duration of the meetings; balance of specialists participating; contents and methods of the meetings; the roles of parents and parent empowerment during and after the meetings; meeting follow-up; and links to child and parent tracking and service provision.

16. Progressively shift costs from infant homes and other orphanages to the ECI and Special Education System.
It was impossible to secure complete costs for programmes. Cost figures are unavailable for ECI Centres and Dispensaries or Cabinets because their expenses are nested within the general budgets of Polyclinics but they must be much less costly than Medical Rehabilitation Services. They may resemble the costs of Development Centres where the cost per child per month of services is reported to be from US $78 to $156 per month or $936 to $1,872 per year, with the cost varying by the type and location of the Centre. In the Minsk Medical Rehabilitation Centre, the daily cost of a “bed” per child is US $23 or US $460 per month. The Tonus Centre’s cost per day per child was stated to be approximately US $21.7 or $434 per month. These services are intensive and last from a few weeks to two to three months per child.

The monthly cost of services in six Infant Homes is from US $443 to US $561 per month per child, or an annual cost per child from US $5,316 to US $6,732. MOH ECI and MOE Development Centre services, when provided, would add more costs. With a total of 822 children served, the total annual cost of serving these children in Infant Homes must be in excess of from US $4,369,752 to US $5,533,704. These high costs (about five times the $1 million dollar annual operating budget of a Medical Rehabilitation Centre) could gradually be shifted to ECI services with high-quality parent education and support services that would help parents keep their children at home.

As budgets are progressively shifted from orphanages to ECI and related services for parent education and support, care must be taken to ensure the transition is well programmed to provide quality care in residential environments as children are gradually transitioned to new foster homes or are adopted. At the same time, personnel need to be continuously trained as they take on new roles and responsibilities.

17. Design and implement a results-based programme evaluation system.
The MOE and MOH have institutional monitoring systems that include quantitative measures regarding family
circumstances, childbirth outcomes, child status, types and instances of services, and so forth. However, internal evaluation systems have not yet been designed for services of the ECI and Special Education System. It appears that the existence of many regulations and effective monitoring systems has led administrators to believe that quality assurance is in place and evaluation is unnecessary. When asked about programme results in terms of child, family and community outcomes, directors were uniformly unable to provide them. Belarus’ ECI system is valuable but it needs both internal and external evaluations with rigorous research designs to demonstrate its results. An easy-to-use evaluation system should be designed with instruments (interviews, observations, surveys, etc.) that utilise, to the extent possible, existing child and family assessments and supervisory and monitoring systems. Personnel should be trained in data collection, analysis, and interpretation. ECI programmes in other countries usually allocate from 5% to 12% of their annual budgets to monitoring and evaluation.

18. Develop strategies for programme advocacy.
The services of the ECI and Special Education System should expand their joint work to conduct family outreach, prepare educational materials, and provide social communications through the radio, television and newspapers. Many reported that although progress is slow, family outreach, counselling and public education services are helping to build positive public opinion regarding: the potential of children with disabilities; the importance of reducing the number of social orphans and community support for keeping children at home; and the provision of services that support families who have children with special needs.

19. Provide support for NGOs with the ECI and Special Education System.
In most countries of the world, NGOs play essential roles in ECD and ECI programmes. Many of them provide high-quality programme services, and they usually lead the way in programme innovation and materials development. Many NGOs are linked to universities and institutes for research and programme improvement. In most countries, these NGOs receive funding from national, regional and municipal governments. They have to present regular programme and financial reports, and therefore, they tend to be highly accountable. However, in Belarus, many NGOs have been closed, have been unable to secure national and international funding or have merged with public sector programmes, as has been the case with two institutions in this study, the Alpha and Tonus Centres that began as NGOs.

Within the ECI/Special Education system, the Belarusian Association of Assistance to Children and Young People with Disabilities is one of the few NGOs successful in securing both national and international support. It plays a series of essential roles, including: home outreach services; family preservation services; peer support activities for parents; training workshops; and information dissemination. The Association has the strong support of the MOH and MOE, and MOLSP who count on its services. Its 4,000 members and 64 member groups are spread throughout Belarus. Its programmes fulfil essential functions, such as “Families for All Children” that is helping to reduce the incidence of social orphans.

20. Develop research studies on the ECI and Special Education System.
The Belarusian State University conducted a useful situation analysis on the status of children and women in 2004 but additional studies are needed, including:
- Rigorous assessments to identify the prevalence of developmental delays for specific age bands;
- Identification of chronic health problems and disabilities among infants and young children;
- Cohort-based experimental outcome studies that would measure programme impacts in relation to randomized control groups;
- Case studies using a qualitative, life-world and narrative perspective would explore family experiences in programme participation, needs assessments, and service provision;
- Detailed reviews of existing human, institutional, financial and training resources for children;
- Analyses of the impacts of policies, plans, laws, standards and guidelines on ECI programmes;
- Special studies on promoting parent involvement and the use of non-professionals for programme outreach and support;
- Research on experimental therapeutic approaches used in medical rehabilitation to ensure
that they are sound and technically acceptable for use with fragile children; and

- Studies on programmes that apply a systems ecological perspective to demonstrate how individual, programme and community outcomes are dependent on organisational factors of the entire service system, including resources, legislation, general beliefs, and cultural norms.

By participating in a wide array of research studies and learning from their results, ECD and ECI specialists’ should improve their knowledge and hone their skills over time.
The Belarus ECI and Special Education System could help other Russian-speaking countries to learn about and develop comprehensive services for vulnerable children. Many lessons can also be learned from the positive policy environment Belarus has developed to maintain, expand and improve the system. Although these programmes are still working to improve inter-agency and inter-sectoral coordination, significant progress has been made. In fact, few other countries in the world have achieved this level of coordination, exchange and cooperative training.

With respect to ECI services, on conceptual and methodological levels significantly more training needs to be provided. The Minsk ECI Centre in Polyclinic 19 offers outstanding child-centred and family-focused services; however, it needs to expand its staff to achieve fully balanced Interdisciplinary Teams, and the Centre’s specialists are extremely taxed with on-going services and need additional support to prepare train programmes for specialists who will work in new ECI Centres throughout Belarus.

Given this situation, we recommend the following steps be taken:

1. **Design a national and international training programme.** Build a close collaboration with the St. Petersburg Early Intervention Institute and key Belarusian institutions to design, prepare and hold national and regional training sessions for countries that decide to develop ECI services.

2. **Develop training manuals and materials.** Before training begins, general and specialised training manuals should be prepared, field-tested, revised and produced for each national programme regarding topics such as:
   a. Conceptual approaches for fully child-centred and family-focused services;
   b. National programme development, planning and inter-agency coordination;
   c. ECI curricula and methods for all essential areas, e.g.: health; nutrition; early nurturing and stimulation activities; rehabilitation; protective services; and parent education and support;
   d. Educational materials available for all types of professionals and parents, including learning toys, computers as learning tools, and toy lending libraries;
   e. Interdisciplinary Teams and methodologies;
   f. Child and family assessment instruments, methods and utilisation;
   g. Formats and methods for preparing and utilising IFSPs, ITPs, IDPs and IEPs;
   h. Guidance and methods for providing home visits and centre-based services;
   i. Programme monitoring and evaluation instruments, systems and databases and systems for continuous programme planning and revision;
   j. NGO roles and responsibilities in conducting and supporting ECI services;
   k. Financial planning, budgeting, accountability, and quality assurance; and
   l. Communications media usage to build programme advocacy.

3. **Provide training programmes.** Selected partner countries could be invited to send teams of specialists to training programmes in Belarus, with a
focus on the ECI programmes of Minsk and Kobrin.

4. **Hold training workshops in St. Petersburg.** Selected training workshops also should be conducted at the St. Petersburg Institute. The Institute’s experienced specialists are highly skilled trainers. They consider the provision of training services for other programmes and countries to be a part of their core mission.

5. **Follow-up supervision, monitoring, and evaluation.** Initial and continuous training for ECI services is essential, but to ensure that new programmes in other countries will be designed for sustainability and will go to scale, follow-up supervision, monitoring and external evaluation will be required.

6. **Exchanges.** The best way to learn concepts is to participate in teaching them, including the exchange of studies and educational materials. Programmes for the “training of trainers” and networking will be needed in each country until stable organisation structures are established.

In addition, it would be important to plan ahead and anticipate the development of inter-site exchange with Russian and Belarusian specialists visiting other Russian-speaking countries and vice versa. It is generally agreed that the best form of in-service training is inter-site exchange visits. As national focal points for ECI services are developed in other countries, it will be essential to develop a horizontal network uniting new ECI programmes and existing ones to create a continuous learning community.

As a result of these regional ECI training and programme development activities, it is expected that regional resource networks of professionals and parents will be established, grow and thrive. This new generation of leaders will inspire others to continue this work to help ALL children achieve their potential. It will also be important to establish professional linkages between this new network and the International Society on Early Intervention (ISEI), the European Agency for Development in Special Needs Education, the Consultative Group for Early Childhood Care and Development, the International Step by Step Association (ISSA), and other international groups.
PART V:

Guidelines for Establishing ECI Services
This section provides general guidelines regarding core concepts, structures, processes, and methodologies for establishing effective ECI services that are rights-based, child-centred, and family-focused. The bibliography at the end of this document provides helpful resources for specialists in countries that plan to develop ECI systems and programmes.

The conceptual and methodological Guidelines for ECI services, presented below, feature an integrated educational, social, health and nutritional approach, in contrast to a mainly medical or rehabilitation approach. Rather than considering children with high-risk status, developmental delays or disabilities as having deficits, defects or illnesses, this approach emphasises their competencies, strengths and developmental potential. ECI programmes seek to overcome functional limitations, if present, and they maximise children’s development and their participation in home and community activities, with an eye to helping them achieve long-term independence and opportunities to contribute to society. Children with illnesses or other medical or nutritional conditions should, of course, receive appropriate health and rehabilitative services. The ECI approach embraces such rehabilitation services as a part, but only a part, of children’s Individualised Family Service Plan.

To implement ECI programmes, an ecological and community-based approach should be taken wherein a range of community services for education, health, and protection work in concert to ensure maximum support for children and families. Communities should take leadership in ensuring all children’s services are well coordinated and share the goals of: maintaining children in nurturing homes; identifying each child with special needs or high-risk circumstances early; providing continuous and intensive ECI services; and collaborating to ensure parents are continuously trained and supported to help their children to achieve their potential. Where services are lacking, communities and public, civil society and private programmes should join together with parents to develop new services in accordance with parents’ evolving needs.

The following Guidelines do not constitute a detailed programme design. Rather, their goal is to help colleagues in many countries consider the ECI approach, outline policy strategies, and prepare an ECI Plan of Action.

National Ministries of Finance and Planning should be involved from the outset. Early childhood leaders and planners from all levels should consider their options in light of the human resource and institutional realities they face. Each country is profoundly different, and child development and parent programmes must be well knit into national cultures. Countries should be encouraged to provide rights-based services and achieve national development goals through increasing their investments in children and families.
Ultimately, early childhood planners should seek to serve ALL of the children and parents in their countries. On the path to universal services, research results have shown that it is essential to reach the most vulnerable children on a priority basis. Research on brain development, developmental delays and disabilities have demonstrated that early intervention for infants and toddlers (from conception and birth to three years of age) is the most important period for ensuring good child development. Therefore, throughout the world, ECI programmes begin with early intervention services for children from birth to age three. Services are provided in homes and in centres, and always with the active participation of parents. This early period is usually complemented or followed by inclusive preschool education, from approximately age three until school entry. ECI services should continue until the child enters inclusive preschool or primary education services. In some cases, children with multiple or severe disabilities will need the continuing assistance of special education teachers and therapists to complement school activities.

**V.2.1 Basic principles**

1. ECI services are a child and human right.
2. ECI services should be designed from the outset to go to scale in each country.
3. They should be comprehensive, coordinated, inter-disciplinary, multi-sectoral/multi-agency, culturally competent, and fully equitable.
4. ECI services should be conducted with parents and preschool educators in order to maximise child development through consistent nurturing care and activities at home, and in centres and preschools.
5. Involving parents also reduces future costs by reducing the need for special education services, extensive health care, protective services, welfare services, and long-term residential care.
6. All ECI services should be consistently child-centred and family-focused.
7. ECI services must develop formal systems of coordination with all collaborating educational, health, nutritional, social and protective services in order to ensure child-centred and family-focused services will become permanent.
8. Options and trade-offs for programme services should be carefully considered with regard to: mapping and targeting vulnerable populations of children and parents; cost-effectiveness; and maximising service coverage and quality.
9. The following attributes of quality ECI services are emphasised: availability, proximity, affordability and diversity. (See European Agency for Development in Special Needs Education 2005)

**V.2.2 Range of services**

ECI programmes often contain a wide range of services, for example:

- Comprehensive Infant and child assessments conducted by an Inter-disciplinary Team (minimum of quarterly during the first two years).
- Early nurturing and child development services, including all developmental areas using a rich curriculum and interactive demonstration and practice methods.
- Psychological support for parents and family members, from identification onward, with family counselling as needed.
- Parent education and support, both individualised and in small peer groups.
• Individualised family and child service plans prepared by parents as a part of the Interdisciplinary Team.
• Referrals and active support for securing essential health, medical, rehabilitation, nutritional, social and protective services, as needed.
• Play groups for children and parents under three years of age.
• Inclusive preschools for children two and one-half or three years of age and older.
• Transition programmes for parents, children, teachers and other school staff to prepare for entry into inclusive primary schools.
• Respite care for children to enable parents to work, relax or take a vacation.
• Financial support for parents living in poverty to help them keep the child at home and cover additional care expenses a child with special needs requires.
• Support groups for siblings and other family members (grandparents, etc.).
• Short-term foster parents, carefully selected and trained, as needed.
• For working parents, extended day care including developmentally appropriate activities, feeding and other services.
• Adaptive equipment and toys for developmentally appropriate play.
• Special equipment for transportation and help with transport, as needed.
• Centre-based community education activities to help develop shared attitudes regarding ECI, special education and inclusive preschool and school services.
The following Guidelines provide an overview of key elements of an ECI system.

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<th>Main Activities</th>
<th>Guidance</th>
<th>Comments</th>
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<tr>
<td><strong>Strategic Planning</strong></td>
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<tr>
<td>Develop the conceptual framework for an ECI programme.</td>
<td>Establish the normative basis for a rights-based ECI Programme.</td>
<td>Consult widely, nationally and internationally to ensure programme norms fit child and family needs. Use CRC and other international covenants and declarations as a basis for national commitment.</td>
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<td>Develop policy support.</td>
<td>Insert the ECI approach into current ECD policies. If the country lacks policy, structure a process for developing one.</td>
<td>Place ECI services in an ECD policy, an Education, Health Plan or Protective Services Policy or Plan.</td>
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<td>Establish ECI programme’s legal basis, national standards and guidelines to ensure sustainability and scale. Local programmes can set more detailed standards and guidelines meeting expectations but enabling culturally competent services.</td>
<td>Place ECI services in national laws or a Children’s Code with enough specificity to allow the system of justice to rule on key issues for children and families, as needed. Ensure that standards include a process for oversight, review and accountability.</td>
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<td>Develop a National ECI Technical Council or Committee.</td>
<td>Attach National ECI Technical Committee to a National ECD Council and sectoral bodies. Specify roles, responsibilities vis a vis public agencies, NGOs, ECI programmes, and communities.</td>
<td>Include representatives of all key public sector, civil society and private sector agencies, parents of typically developing and high-risk, delayed and disabled children, and community leaders.</td>
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<td>Establish provincial and municipal and/or community ECI Committees.</td>
<td>Coordinate and network provincial, municipal and/or community committees with all other child and family services.</td>
<td>Ensure both vertical (top/down and bottom/up) and horizontal coordination at each level: national, provincial and municipal/community.</td>
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<td>Structure annual planning processes for ECI services at each level.</td>
<td>Link annual planning to evaluation, monitoring, feedback and budgetary processes.</td>
<td>Clear rules for roles and responsibilities at each level should be developed and monitored frequently to ensure programme compliance and accountability.</td>
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<p>| <strong>Initial Design Activities</strong>                         |                                                                           |                                                                                                                                                        |
| Conduct a baseline Situation Analysis and correlated studies. | Include in Situation Analysis: * Identify prevailing child and family needs in all areas; * Survey institutional, human, financial and training resources for ECI services; * Analyse relevant policies, plans, codes, laws, standards, guidelines, etc. | Conduct studies before designing the ECI services. Use baseline data for evaluation and monitoring and for the long-term longitudinal analysis of programme cohorts. |</p>
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<tr>
<th>Define and establish criteria and guidelines regarding the types of children and parents that should be targeted for priority attention through ECI services within the country’s array of ECD services.</th>
<th>Prepare a flexible but clear definition that ensures all vulnerable children, including high-risk and developmentally delayed children and their parents, will eligible to be served.</th>
<th>Definition includes children: *At biological or socio-economic risk of delay; *Assessed to have a mild, moderate or severe delay; *Assessed with one or more developmental disabilities; *Diagnosed to have a chronic illness or disease; *Diagnosed as malnourished.</th>
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<td>State service coverage goals in terms of populations and geography.</td>
<td>Specify clearly the populations, types of families and children who should be served. Identify and map rates of children with high-risk status, developmental delays (all levels) and disabilities.</td>
<td>To achieve social equity, it is essential that under-served populations be given special attention for receiving ECI services. Ensure service goals are consistent with the results of the mapping process.</td>
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<tr>
<td>Design ECI programme to be fully culturally competent.</td>
<td>Ensure ECI services fit the culture and its positive child rearing ideals. National programmes should ensure the language of the home is used. To the extent possible, specialists and community educators should belong to the community or culture. Materials should be easy for parents to read and use.</td>
<td>When ECI programmes are not culturally competent, it is essential to develop a strategic plan for ensuring all of the essential elements are put into place over time.</td>
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<td>Design a comprehensive tracking and follow-up system.</td>
<td>Ensure all children will be identified, assessed and tracked.</td>
<td>Computer-based databases for child and family tracking as well as program monitoring and evaluation should be prepared.</td>
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**Programme Organisation and Inter-institutional Relationships**

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<tr>
<th>Decide upon the best administrative and sectoral home(s) for ECI services.</th>
<th>Consider the institutional location with strongest political and policy support for the ECI programme. Sometimes, as in Belarus, two homes are selected. Both the education and health sectors lead ECI services, with strong support from protective services.</th>
<th>Often the education sector is selected to ensure a seamless transition from initial zero to three ECI services to inclusive preschools and primary schools. Sometimes the health sector is selected because it has essential therapists, physicians and primary health care services. The institutional home should have strong linkages with education, health, nutrition, protective, justice and sanitation services.</th>
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<tr>
<td>Develop a system for the lead agency to ensure quality service provision.</td>
<td>*Use health system resources *Use educational system resources *Provide direct services from the lead agency as well as contract services from NGOs, private providers and others.</td>
<td>Different countries will emphasise a health, education or social service base but in each case, other agencies should participate and coordinate their services as seamlessly as possible.</td>
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<tr>
<td>Select local service providers with care and ensure they are located close to the families they will serve.</td>
<td>Structure ECI services to be located close to families and to other social services families use to promote close coordination.</td>
<td>Families encounter difficulties in travelling far to access services. A combination of home-based and centre-based services may be needed. Competition between services should be avoided and coordination emphasised.</td>
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<tr>
<td>Develop partnerships with NGOs to ensure all available services are mobilised to support ECI services.</td>
<td>Create partnerships at local, regional and national levels because it is rarely possible for one service centre to include all basic ECI services.</td>
<td>Some ECI-related services fear partnerships but systems that have developed them have found that their services grow and develop better.</td>
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<tr>
<td>Decide upon the financing system(s).</td>
<td>Seek support from national, regional and municipal governments, cooperatives, insurance systems, non-profit organisations, parents and others. Consider establishing taxes on payrolls, property, extractive industries, businesses, and others.</td>
<td>Options regarding parents: 1. A sliding scale is used, based on family income and assets with free services for families living in poverty. 2. Free services are provided for all parents. 3. Parents volunteer to work for the programme.</td>
</tr>
</tbody>
</table>
Develop a system of inter-agency agreements. Establish formal inter-agency agreements at all levels. Each community should develop agreements to ensure comprehensive services are provided.

Training Activities

Develop a national Training and Resource Centre or system for developing and supporting ECI services. Locate it in the lead agency or another agreed upon agency. Roles: To ensure programme quality through training and resource development: assessments; contents; materials; methods; media; monitoring and evaluation.

Establish standards for pre-service training. Develop national standards for professional training as well as training early interventionists, and the pre-service training of community paraprofessionals and other support staff.

Develop standards and guidelines for educational and health contents, including: curricula, educational materials and manuals, and media for the programme. Ensure programme standards, guidelines, curricula, manuals and media are designed, field-tested, revised, implemented, and continuously evaluated by programme parents and personnel.

Establish schedules for regular in-service training and re-certification. *Ensure all programme personnel receive a minimum of 100 - 200 hours annually of formal in-service training. * Encourage the development of a re-certification programme with on-site mentoring each two to four years. Given rapid developments in the field re-certification is essential. *Combine regular less formal in-service meetings with reviews of family and child situations, monitoring, supervision, and other functional activities.

Develop a system of incentives, including training opportunities, to ensure staff retention and motivation. Provide a personnel scale or ladder for upward mobility and salary incentives commensurate with performance.

Programme Implementation

Conduct comprehensive programme outreach, information and advocacy services to inform all families and identify, enrol and ensure consistent services are provided at the appropriate level of intensity. Early identification is essential. Ensure children who are identified to be low in birth weight, victims of domestic abuse, social violence (war), substance abuse, etc. will be assessed and addressed by the ECI programme.

In some countries, training is distributed among university, sectoral training systems or inter-sectoral collaborations. However, to ensure coordination, it is advisable to have one main centre, if possible.

In some countries, training is distributed among university, sectoral training systems or inter-sectoral collaborations. However, to ensure coordination, it is advisable to have one main centre, if possible.

Encourage all relevant disciplines to include coursework on ECI concepts, activities and methods. Prepare ECI early interventionists with training in several disciplines. Training for paraprofessionals should give credits that can be used later for professional training.

Curricula and educational materials should be enriched and developmentally appropriate. Programme manuals should cover all programme processes and training activities. Handouts and booklets for parents need appropriate visuals for parents with limited reading skills.

Training should include topics such as: management of inter-disciplinary teams; refresher seminars and mentoring in special fields; assessments; child-centred contents and methods; transition programmes; methods for enabling parent involvement and support; recent research results on child development and neuroscience; new curricula, materials and methods; coordination methods; and problem-solving approaches.

In addition, community support and provision of awards for programme personnel is a strong incentive to expand and improve services over time.

Develop community outreach and advocacy plans. Consider using visiting nurses, community educators, school personnel, home visitors or social workers. Give attention to rural and urban poor, and ethnic and linguistic minorities.
| Provide comprehensive services, ensure a range of specialists is available to supervise and provide services, and use trained paraprofessionals to expand service coverage. | Personnel should include:  
* Family and parent educators  
* Early interventionists  
* Physical therapists  
* Speech/language therapists  
* Audiologists  
* Occupational therapists  
* Special educators  
* Psychologists  
* Social workers  
* Special child care specialists for day-long ECI programmes  
* Preschool educators trained in inclusion  
* Programme evaluators | Emphasise providing services essential to avoiding residential placement of children. Promote parent leadership and family empowerment. Ensure the full range of therapists is available to train and supervise early interventionists and paraprofessional home visitors to reduce costs, expand coverage and maximise programme impact. |
| Develop Inter-disciplinary Teams (IT). | Empowered parents and the main disciplines should be represented on each IT for each child and family, with a focus on the areas of greatest child or family need. | Co-responsibility and planning with parents is a hallmark of a well-functioning ECI programme. ITs usually have early interventionists and from 4 to 8 disciplines, depending upon need and availability. |
| Establish and reinforce child and family rights and responsibilities, as well as confidentiality. | Educate parents about their rights and responsibilities at the outset and during each phase of programme services. Ensure all programme documents are confidential and establish programme rules regarding confidentiality. | Place large reminder posters on walls for parents about child and family rights and confidentiality. Provide handouts and parents’ booklets on their rights, roles and responsibilities. |
| Conduct initial and frequent continuing child assessments. | Ensure parents actively participate in all assessments and state their observations. | Schedule assessments at the beginning and according to a regular schedule to meet each child and family’s needs. |
| Prepare Individualised Family Service Plans (IFSP) for each child with the participation of parents and Interdisciplinary Teams. | Develop a flexible form and methods for planning and drafting IFSPs. Ensure that parents have co-responsibility and the lead in decision-making in all aspects of programme activities including the development of each IFSP. | Ensure the IFSP includes assessment results, parent observations, a review of child and family competencies, strengths and needs, service priorities, goals and objectives, activities for each area of developmental to ensure balanced development and attention to special needs. |
| Implement the comprehensive tracking and follow-up system. | Track all children identified for assessments to ensure they receive appropriate services and outcomes are evaluated. | Computer-based databases for child and family tracking are essential. Continued vigilance is necessary to assess high-risk yet typically developing children. |
| Provide ECI services of the appropriate intensity and duration. | Identify children whose developmental goals require intensive services (daily/weekly) and ensure services until assessments reveal they may move to less intensive (biweekly/monthly) services. Once gains are consolidated, services may be reduced with continuing parent education and support. | The complete process of identification, interdisciplinary assessment, IFSP preparation and goal setting, programme activities and continuous regular reassessment should be viewed within the continuum of services from intensive to less intensive and occasional services. |
| Ensure that each child who needs continuing services has a seamless transition between ECI services and preschool or school services. | Design continuous services from infancy to preschool or school entry to ensure services for children who continue to have high-risk status, delays or disabilities. | Policy advocacy may be required to ensure programme services are continuous, guaranteed, well financed and appropriate for each child and family. |
| Prepare transition plans and plans for continuing special education services in inclusive preschools and schools. | Prepare, in collaboration with inclusive preschools and schools, formats and methods for drafting Individualised Transition Plans (ITPs) and Individualised Education Plans (IEPs) for transitioning to inclusive preschools and later inclusive schools. | With parents and representatives of inclusive preschools and schools, develop ITPs and IEPs and also encourage preschool and primary school teachers and resource personnel to visit the child and parents in the ECI programme and their home. |
### Programme Evaluation and Monitoring

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combine supervision with monitoring and in-service training.</td>
<td>Ensure supervisors monitor performance and provide in-service training for teachers of preschools and schools.</td>
<td>By combining supervision, monitoring and in-service training, efficiency is improved and costs are minimised.</td>
</tr>
<tr>
<td>Implement continuous internal and external evaluation systems.</td>
<td>Conduct both internal and external evaluations. Non-programme personnel should conduct external evaluations.</td>
<td>Parents should participate in evaluation activities including: programme inputs, processes, outputs and outcomes.</td>
</tr>
<tr>
<td>Develop a database for continuous programme feedback and planning.</td>
<td>Ensure continuous analysis of data to provide feedback to annual programme and financial planning.</td>
<td>Develop programme and community boards trained to use monitoring and evaluation reports for planning.</td>
</tr>
<tr>
<td>Implement a system of programme management and continuous parental and community oversight.</td>
<td>Ensure parents, boards and community representatives are involved in programme management and oversight.</td>
<td>Establish regular annual schedules for managerial reviews and oversight activities.</td>
</tr>
</tbody>
</table>

On the basis of these Guidelines, ECD leaders and specialists from public, civil society and private institutions should draft a National Strategic Plan of Action. (See Vargas-Barón 2005 for general guidance for preparing ECD Policies and Strategic Plans.)

Questions and comments are welcomed regarding these guidelines for structuring comprehensive ECI systems linked to all other early childhood services. Nations of the CEE/CIS region are poised to develop ECI systems, and once implemented, they will benefit millions of young children and parents.


Granthem-McGregor, Sally, Yin Bun Cheung, Paul Glewwe, Linda Richter, Barbara Strupp, and the International Child Development


Janson, Ulf & Zinchenko, Irina (in prep.). Implementation of inclusive preschool education - experiences from and evaluation of six Russian Kindergartens. Report from TACIS project “Joining Efforts to Create Inclusive Kindergartens”


Autism and Developmental Disorders, 32, 351-372.


Zafeirakou, Aigli (2006). Providing Access to Education and Care for all Young Children 0 to 7: Early Childhood Care and Education in South East Europe: Progress, Challenges, New Orientations. Alexandroupolis, Greece: UNESCO.


## ANNEX I

**LIST OF ACRONYMS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ARD</td>
<td>Admission, Review and Dismissal Committee</td>
</tr>
<tr>
<td>CEE.CIS</td>
<td>Central and Eastern Europe and Commonwealth of Independent States</td>
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<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<tr>
<td>DS</td>
<td>Down Syndrome</td>
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<tr>
<td>ECI</td>
<td>Early Childhood Intervention</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>ECCD</td>
<td>Early Childhood Care and Development</td>
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<tr>
<td>ECE</td>
<td>Early Childhood Education</td>
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<tr>
<td>ECCE</td>
<td>Early Childhood Care and Education</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>IBFAN</td>
<td>International Baby Food Action Network</td>
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<tr>
<td>IDP</td>
<td>Individual Development Plan</td>
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<tr>
<td>IEP</td>
<td>Individualised Education Programme</td>
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<tr>
<td>IFSP</td>
<td>Individualised Family Service Plan</td>
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<tr>
<td>ISSA</td>
<td>International Step by Step Association</td>
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<tr>
<td>IT</td>
<td>Inter-disciplinary Team</td>
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<tr>
<td>ITP</td>
<td>Individualised Transition Plan</td>
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<tr>
<td>ITP</td>
<td>Individualised Transition Team</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Surveys</td>
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<tr>
<td>MOE</td>
<td>Ministry of Education</td>
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<tr>
<td>MOF</td>
<td>Ministry of Finance</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOLSP</td>
<td>Ministry of Labour and Social Protection</td>
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<tr>
<td>NIE</td>
<td>National Institute of Education, Belarus</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>OT</td>
<td>Occupational Therapy</td>
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<tr>
<td>PALS</td>
<td>Peer-Assisted Learning System</td>
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<td>PP</td>
<td>Para-professional</td>
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<td>PPP</td>
<td>Positive Parenting Programme</td>
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<td>PT</td>
<td>Physical Therapy</td>
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<tr>
<td>SC</td>
<td>Service Coordinator</td>
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<td>SEAC</td>
<td>Special Education Advisory Committee</td>
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<tr>
<td>S/LT</td>
<td>Speech/Language Therapist (sometimes referred to as Therapist)</td>
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<tr>
<td>TOT</td>
<td>Training of trainers</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</table>
ANNEX II

OFFICIAL BELARUSIAN ECI DOCUMENTS: MAIN INTER-AGENCY AGREEMENTS, REGULATIONS AND GUIDELINES

The documents listed below have been placed on a CD ROM that may be obtained from the UNICEF Country Office of Belarus.

3. Annexes 1, 2, 3 and 4 to the Regulations on the Correction and Development Training and Rehabilitation Centre: Child Examination Record (Year One of Life; Year One to Three; Preschool Child; Year 6 to 18) by the Psychological/Medical/Pedagogical Panel.
4. Annex 5 to the Regulations on the Correction and Development Training and Rehabilitation Centre: Opinion of the Correction and Development Training and Rehabilitation Centre (region, town, district).
5. Annex 6 to the Regulations on the Correction and Development Training and Rehabilitation Centre: Parental consent to the opinion of the Correction and Development Training and Rehabilitation Centre (region, town, district).
6. Ministry of Education, Resolution No. 85: Approving the Instruction on Procedure of Establishing and Functioning of Special Classes (Groups) and Integrated (Joint) Education/Training Classes (Groups), 28 August 2006.
10. Ministry of Health, Regulation on Early Intervention Cabinet (Department) as a structural division of polyclinics.
Population: 9,714 million (1.01.2007)
Population below 18 years: 1,868 million (1.01.2007)
Infant Mortality Rate: 5.2 per 1000 (2006)
Under 5 Mortality Rate: 7.2 per 1000 (2006)
Literacy: 99%
Maternal Mortality Ratio: 10 per 100,000 live births (2005)
One-year-olds immunised against DPT3: (100%) 1999
One-year-olds immunised against measles: (100%) 1999
Children with special needs below 18: 125,981 or 6.74% (15.09.2006)
Preschool attendance: 80.3% (2006)
Locations visited by researchers in red

Emily Vargas-Barón & Ulf Janson
with Natalia Mufel

EARLY CHILDHOOD INTERVENTION,
SPECIAL EDUCATION AND INCLUSION:
A FOCUS ON BELARUS

Printed and bound in Belarus
«Altiora – Live Colours»
Circulation 700 copies; order 7136.
In countries of the CEE/CIS region, well over a million children live in institutions. Many of these children were abandoned at birth and a large proportion of them have disabilities. In fact disability is one of the most frequent causes of abandonment. Institutionalisation deprives children of a family environment and most often, especially in the case of very young children, has a VERY negative impact on their development. The General Comment No. 7 on the UN Convention on the Rights of the Child states that “young children should never be institutionalized solely on the grounds of disability. It is a priority to ensure that they have equal opportunities to participate fully in education and community life, including by the removal of barriers that impede the realisation of their rights.”

This study takes an in-depth look at how Belarus is moving along the path of providing inclusive, child-centred and family-focused services to address the needs and rights of children with developmental delays and disabilities. In many cases, Early Childhood Intervention (ECI) services, which arguably need to be expanded to cover more and more children, are working to make early diagnoses and remediate existing or emerging delays and disabilities in conjunction with and respecting the rights of parents and children. The study discusses the “defectological” tradition, extant in most countries of the CEE/CIS region, which although evolving and changing, tends to focus on “correcting deficits.” Modern, scientific approaches, the study emphasises, characterise the children as capable of learning and focusing on their competencies.

Two very talented and experienced child development and special needs professionals, Dr. Emily Vargas-Barón and Prof. Ulf Janson were responsible for conducting this study. They were assisted in their endeavours by Natalia Mufel, a Belarusian psychologist, working with UNICEF. Together the team visited examples of different services for special needs children in Belarus, conducted interviews, made observations, and profiled the services based on criteria such as parental participation, interdisciplinarity, and flexibility. The authors make a number of important recommendations towards aligning services even more closely with child rights principles. They also provide a set of practical guidelines that can assist other countries in the region to re-examine and transform their services for children with special needs.

It is hoped that this informative document will benefit health, education and welfare professionals and decision makers, and that its rich insights will help spur the necessary changes that will lead to better protecting the dignity and rights of children with special needs and their families.