



The voice of blind and partially sighted people in Europe

Monitoring of the Rights of Blind and Partially-Sighted People in Europe: An Analysis of the European Blind Union CRPD Database

Article 26: Habilitation and Rehabilitation

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February 2018

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Purpose of the Report

This report provides an overview and comparative analysis of habilitation and rehabilitation for blind and partially sighted people in European countries, as reported by country authors in the EBU database. The EBU database aims to provide information on progress that has been made towards implementation of Articles of the Convention on the Rights of Persons with Disabilities (CRPD), in order to support EBU's membership, campaigners and policy makers.

The main section of this report presents and compares the information provided by participating countries. To introduce this, there is a description of how Article 26 of the CRPD relates to other United Nations and European Union policies and an explanation of how the questionnaire was developed. The report concludes with a discussion of relevant issues arising from the analysis.

Article 26 of the CRPD

The text of Article 26 of the Convention states that:

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:
 - a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
 - b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.
2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Other CRPD Articles

As well as Article 26, three other Articles explicitly mention rehabilitation.

Article 22: Respect for Privacy, states that:

States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

Article 25: Health states:

States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.

Finally, Article 27: Work and Employment requires States Parties to:

safeguard and promote the realisation of the right to work
.....including through legislation, to, *inter alia*:.....

(k) Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.

The right to habilitation and rehabilitation also has links to other articles especially Article 20 on Personal mobility, Article 9 on Accessibility, Article 19 on Living independently and being included in the community and Article 4 on General obligations.

Under Article 20, States Parties must take effective measures to ensure personal mobility according to the choice of disabled people, ensuring access to quality devices and training to use them. The link to Article 19 is important, not least because of the poor history of rehabilitation services in ensuring that disabled people have full enjoyment of this right without being required to live in segregated settings. Too often disabled people have been required to meet certain rehabilitation goals as a pre-requisite for accessing life in the community, with this goal often not met.

Third, Article 9 Accessibility is complementary to Article 26 in that it requires design of the environment in such a way that disabled people have access to it. Similarly, Article 4 requires the promotion of “universally designed goods, services, equipment and facilities” to allow for the least amount of adaptation and associated costs for disabled people, and standards and guidelines to support this. These Articles are essential compliments to Article 26 to ensure that rehabilitation is not carried out regardless of context or purpose.

The CRPD Committee

Concluding observations of the CRPD Committee, which are developed following national reporting on progress, point out the issues that most urgently need to be addressed for each country. In preparing this report, documents from the past three years on European and EBU countries were reviewed (2014 – 2017)¹. At the time of writing this report, no meetings had been held in 2018.

The Committee noted several violations of Article 26 for the European countries they reviewed. In Sweden (2014), the Committee recommended that rehabilitation and vocational training were increased. For Italy (2016) concrete measures were recommended to ensure the teaching of standardised Braille to blind persons and tactile communication to deaf-blind persons to enable access to information, instead of relying on assistive technology alone. Conversely, a new law that included rehabilitation was commended in Montenegro although at the same time concern was also expressed about employment rights. Insufficient access to rehabilitation services for people with psychosocial impairments was criticised in Luxembourg (2017) and in Latvia (2017) the Committee commented on the long waiting times for receiving rehabilitation services throughout the country, especially people with severe impairments.

The CRPD Committee has also reviewed the EU² as a body as it is a signatory to the Convention in its own right. The Committee drew attention to the need to ensure equality and non- discrimination for

¹ Concluding observations of the CRPD Committee
http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=5

² Committee on the Rights of Persons with Disabilities (2015) Concluding Observations on the initial report of the European Union

disabled people in some Council directives³ and to provide reasonable accommodation in rehabilitation among other areas.

Other UN Legal Instruments

Considerable debate has accompanied the development of the right to habilitation and rehabilitation, particularly the degree to which rehabilitation is linked to specific areas of policy and the extent to which services are controlled by disabled people or professionals. These debates will not be reviewed here, except to note that understanding of rehabilitation as a human right has developed considerably in recent decades.

The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities⁴ have provided a definition framed in terms of improved health, stating that disabled people should be provided with rehabilitation services that would enable them “to reach and sustain their optimum level of independence and functioning.”⁵ Similarly, the International Covenant of Economic, Social and Cultural Rights General Comment 5⁶ on Persons with Disabilities recognises health based rehabilitation as well as its application in employment.⁷

In comparison with these other measures therefore, the CRPD frames habilitation and rehabilitation as a stand – alone measure that is not subsumed as part of health or employment. Links to community participation are explicit.

³ Council directives 2000/43, 2004/113 on equal treatment between persons irrespective of racial or ethnic origin and 2006/54 concerned with equal treatment between men and women

⁴ UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities <https://www.un.org/development/desa/disabilities/standard-rules-on-the-equalization-of-opportunities-for-persons-with-disabilities.html>

⁵ Annex to General Assembly resolution 48/96 of 20 December 1993 <http://www.un.org/documents/ga/res/48/a48r096.htm>

⁶ General Comment 5: Persons with Disabilities, International Covenant of Economic, Social and Cultural Rights http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?TreatyID=9&DocTypeID=11

⁷ See for example the ILO’s Convention No. 159 (1983)

The UN 2030 Agenda for Sustainable Development⁸ does not mention rehabilitation directly but supports this view of the purpose of knowledge and skills acquisition. In particular, it says that:

All people.... should have access to life-long learning opportunities that help them to acquire the knowledge and skills needed to exploit opportunities and to participate fully in society.⁹

Disabled people are also mentioned in Goal 4 in relation to ending inequalities in access to all levels of education and training and, in Goal 4a safe, non-violent, inclusive and effective learning environments. Goal 8 concerns “full and productive employment and decent work for all women and men.....including for persons with disabilities” and Goal 11 aims to “provide access to safe, affordable, accessible and sustainable transport systems”¹⁰ and public spaces.

European Policy on Rehabilitation

The European Commission has dealt with rehabilitation mainly by linking it to health and to some extent work. The European Disability Strategy 2010 – 2020¹¹ includes a commitment to “affordable quality health and rehabilitation services which take their needs into account”.¹² The Strategy notes that the responsibility here is primarily that of Member States, while the Commission aims to support efforts to provide adequate services. The Commission has reported on progress on the implementation of the Disability Strategy and describes actions taken on various issues. The yearly campaign “Healthy Workplaces for All Ages”¹³ mentions rehabilitation and return-to-work policies and measures, with an emphasis on health and safety at work in the light of rising retirement

⁸ 2030 Agenda for Sustainable Development
http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1

⁹ 2030 Agenda for Sustainable Development p7/35

¹⁰ 2030 Agenda for Sustainable Development p. 12/35

¹¹ European Disability Strategy 2010- 2020 A Renewed Commitment to a Barrier – Free Europe <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0636:FIN:en:PDF>

¹² European Disability Strategy 2010- 2020, p8

¹³ See European Agency for Safety and Health at Work
<https://osha.europa.eu/en/healthy-workplaces-campaigns/2016-17-campaign-healthy-workplaces-all-ages>

ages. Rehabilitation in health is also included, although measures are described in general rather than specific terms.¹⁴

The European Platform on Rehabilitation¹⁵ is a focus for activities in this area. Representing the interests of vocational service providers, it has a focus primarily on employment and health.

The Council of Europe Disability Strategy 2017 - 2023¹⁶ gives five priority areas as a focus. These are: equality and non-discrimination; awareness raising; accessibility; equal recognition before the law and freedom from exploitation, violence and abuse. Within these measures access to rehabilitation is included as a means of preventing exploitation, violence and abuse.

Taken together, habilitation and rehabilitation are now being more explicitly framed in international law and policy as human rights, rather than as interventions aimed at addressing perceived deficits, as has often been the case in the past.

Analysis of Habilitation and Rehabilitation in the EBU Database

Introduction to the Findings

A questionnaire was sent to EBU members to ask for information about progress towards the implementation of Article 26 in each country from the point of view of people with visual impairments. The questionnaire was devised by EBU experts, including the EBU expert low vision group, in collaboration with the author of this report and it, and the accompanying guidance, underwent a number of revisions and refinements as issues were clarified. We were particularly interested in gaining information about all people with visual impairments, and any

¹⁴ Commission Staff Working Document. Progress on the implementation of the European Disability Strategy 2010 – 2020
[file:///C:/Users/Owner/Downloads/VERSION%20II%2020170206%20SWD%20Progress%20Report%20EDS_EN%20\(2\).pdf](file:///C:/Users/Owner/Downloads/VERSION%20II%2020170206%20SWD%20Progress%20Report%20EDS_EN%20(2).pdf)

¹⁵ European Platform on Rehabilitation <http://www.epr.eu/index.php/about-epr>

¹⁶ Council of Europe Disability Strategy 2017 – 2023
<http://www.coe.int/en/web/disability/strategy-2017-2023>

differences generally experienced by blind and partially sighted people in each country. The questions were specific in asking for this information.

In the event, we did not receive as much information on the differences in provision for blind and partially sighted people as we had hoped. One reason for this is that this kind of information is not always readily available in each country and additional research was not part of the brief. However, it is also likely that a reason why this was difficult for people to answer was because it concerned eligibility and the processes for determining this are often complicated, variable and difficult to pin down. Typically judgements about eligibility involve an interaction between many different issues (for example, how much money is available, the policy of the current government or funder, the means of distributing resources, the agencies involved, the judgement of the assessor and so on). Eligibility may also differ for different kinds of services or technology, or may be allocated according to different criteria by organisations. Several countries indicated this complexity in their answers. However, of necessity, our questions were more general. Therefore, although a small amount of information was gained, this was insufficient for the purpose of gaining a clear idea of the overall situation. Further more detailed efforts to investigate this important aspect of access to rehabilitation would be warranted.

A total of 17 countries replied to the request and have been included here. One reply, from Croatia, was received too late for inclusion in this report.

The following abbreviations are used for the countries in this report: AT – Austria; CH – Switzerland; CZ – Czech Republic; EE – Estonia; HU – Hungary; IE – Ireland; IS – Iceland; KZ – Kazakhstan; ME – Montenegro; NL – The Netherlands; NO – Norway; PL – Poland; RO – Romania; RS – Serbia; SE – Sweden; SK – Slovakia, UK – United Kingdom.

Footnotes are used to provide details of laws and policies and to qualify the answers given. They are used quite extensively in the first sections because this has been judged to be useful as a source of further information. They are used less extensively in other sections and where it is practical to do so. Where authors gave additional information that applied both to people who are blind and people who are partially sighted, the footnote link is just shown once rather than twice and is shown at the first opportunity.

Finally, the terms and definitions used in this report are those that have been adopted by the EBU. It is recognised that terms used to refer to people with visual impairments have a range of different cultural meanings in various countries as do definitions of rehabilitation and other concepts used in the report. The terms and definitions used here may not be the preferred or most respectful ones in every country.

Section 1 Law and Policy

Question 1 asked:

Is there a legal right to habilitation and rehabilitation services in your country? Please describe relevant laws and give links to further information for a) health; b) education, c) employment and d) social services.

Answers were given for each section as follows:

a) Health

	Yes, a legal right	No legal right or law unclear	Question not answered
For blind people	AT ¹⁷ , CH ¹⁸ , CZ ¹⁹ , EE ²⁰ , HU ²¹ , IS ²² , KZ ²³ , NL ²⁴ , NO ²⁵ , RO ²⁶ , RS ²⁷ , SE ²⁸ , SK ²⁹ , UK ³⁰	IE, PL, UK	ME

¹⁷ In Austria the General Social Insurance Act (ASVG) and regional laws apply.

¹⁸ The federal law *Bundesgesetz über die Invalidenversicherung IVG* (1959), Article 74 regulates the financing of services and general conditions for rehabilitation.

¹⁹ In the Czech Republic, the Act on Public Health Insurance (48/1997 Coll.) regulates use of a guide and equipment during hospitalisation. The Act on Medical Devices (268/2014 Coll.) provides for some assistive aids.

<https://portal.gov.cz/app/zakony/>

²⁰ The general policy is described in Health Insurance Act

<https://www.riigiteataja.ee/en/eli/ee/Riigikogu/act/526062017002/consolide>

²¹ Fundamental Law of Hungary (25 April 2001) and Act CLIV of 1997 on Health, Section 100 – Rehabilitation

²² Health Service Act No. 40/2007, Article 1; Act on the Affairs of Disabled People, No. 59/1992 Article 7

²³ Law of the Republic of Kazakhstan of April 13, 2005 N 39

²⁴ General Laws include: De Zorgverzekeringswet (ZVW); for health care including assistive devices and De Wet Langdurige Zorg (WLZ) for long standing care e.g. nursing homes, personal budgets.

²⁵ Act relating to special health services https://lovdata.no/dokument/NL/lov/1999-07-02-61/KAPITTEL_2#§2-1a; Regulations concerning habilitation and rehabilitation <https://lovdata.no/dokument/SF/forskrift/2011-12-16-1256?q=rehabilitering>

²⁶ In Romania Law 448/2006 covers rehabilitation in all fields.

²⁷ Through the CRPD

²⁸ The Swedish Health Care Act: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag-201730_sfs-2017-30

²⁹ Among others, Act No. 576/2004 Coll. on health care and on services related to health care.

For partially sighted people	AT, CH, CZ, EE, HU, IS, KZ, NL, NO, RO, RS, SE, SK, UK	IE, PL, UK	ME
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b) Education

	Yes, a legal right	No legal right or law unclear
For blind people	CH ³¹ , CZ ³² , EE ³³ , HU ³⁴ , IS ³⁵ , KZ, ME ³⁶ , NL, NO ³⁷ , RO, RS ³⁸ , SE, SK ³⁹	AT, IE, PL, UK
For partially sighted people	CH, CZ, EE, IS, KZ, ME, NL, NO, RO, RS, SE	AT, IE, PL, UK

³⁰ Care Act 2014 (Department of Health) statutory guidance acknowledges vision rehabilitation services for blind and partially sighted people.

³¹ The Federal Government and the 26 local government Cantons have to offer rehabilitation for pupils with visual impairments. There are 26 laws for this, which makes the system complex.

³² Education Act No 561/2004 Coll., Articles 16 to 19 are titled Education of children, pupils and students with special educational needs. This law covers nursery schools, primary and secondary education.

³³ Support services provided by both local authorities and the state.

³⁴ Act CCIV of 2011 On National Higher Education, Act CXC of 2011 on National Public Education and Act CLXXXVII/2011 on Vocation Training

³⁵ The Act on the Center No. 160/2008 Article 1 and Article 4

³⁶ Law on Education and Training of Children with Special Needs. The author notes that although the word 'rehabilitation' is not used, this is what is covered in the legislation <http://www.sluzbenilist.me/PravniAktDetalji.aspx?tag=%7BEDE5557B-4CEA-4A81-A273-FFA24DC9B101%7D>

³⁷ Act relating to primary and secondary education [Education Act] <https://www.regjeringen.no/en/dokumenter/education-act/id213315/>

³⁸ Law on pre-school education, primary-school education.

³⁹ General information about the state programme: <https://www.minedu.sk/8387-sk/statne-vzdelavacie-programy/>; Educational programme related to children with VI: <http://www.statpedu.sk/clanky/statny-vzdelavaci-program-vp-pre-deti-ziakov-so-zdravotnym-znevychodnenim/vp-pre-deti-ziakov/>

c) Employment

	Yes, a legal right	No legal right or law unclear
For blind people	AT ⁴⁰ , CH ⁴¹ , CZ ⁴² , EE ⁴³ , HU ⁴⁴ , IS ⁴⁵ , KZ, ME ⁴⁶ , NL ⁴⁷ , NO, RO, RS ⁴⁸ , SE	IE, PL, SK, UK
For partially sighted people	AT, CH, CZ, EE, IS, KZ, ME, NL, NO, RO, RS, SE	IE, PL, SK, UK

d) Social Services

	Yes, a legal right	No legal right or law unclear
For blind people	AT ⁴⁹ , CH ⁵⁰ , CZ ⁵¹ , EE, HU ⁵² , IS ⁵³ , KZ, NL, NO, RO, RS ⁵⁴ , SE, SK ⁵⁵	IE, ME, PL, UK

⁴⁰ General Social Insurance Act and also the 'Behinderteneinstellungsgesetz' employment law allows fines to be levied on employers for not meeting an employment quota

https://www.sozialministerium.at/site/Arbeit_Behinderung/Berufliche_Integration/Behinderteneinstellungsgesetz/Beschaefigungspflicht_und_Ausgleichstaxe/

⁴¹ Federal Law *Bundesgesetz über die Invalidenversicherung* IVG (1959)

⁴² Employment Act (Act No. 435/2004 Coll.)

⁴³ Significant changes noted since 2016. Vocational rehabilitation services are available through the social insurance system

<https://www.tootukassa.ee/eng/content/work-ability-reforms/services-people-decreased-working-ability>

⁴⁴ Act IV of 1991 on Job Assistance and Unemployment Benefits and Act CXCI of 2011 on Allowances for Persons with Disabilities and the Amendment of Certain Legislation

⁴⁵ Act on the Center No. 160/2008 Article 1 and Article 4

⁴⁶ Law of professional rehabilitation and employment of people with disabilities http://www.podaci.net/gCGO/propis/Zakon_o_profesionalnoj/Z-przlin04v0849-1073.html

⁴⁷ De Participatiewet (reducing unemployment of persons with disabilities)

⁴⁸ Law on Professional Rehabilitation and Employment of Persons with Disabilities.

⁴⁹ General Social Insurance Act

⁵⁰ Article 74 of the *Bundesgesetz über die Invalidenversicherung* IVG (1959)

⁵¹ Social Services Act (Act No. 108/2006 Coll.)

⁵² Act III of 1993 on Social Governance and Social Benefits.

⁵³ Act on the Affairs of Disabled People, No. 59/1992

⁵⁴ In the Law on Social Security, this is called "Training for Independent Life".

For partially sighted people	AT, CH, CZ, EE, IS, KZ, NL, NO, RO, RS, SE, SK	IE, ME, PL, UK
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Countries described various kinds of legislation for rehabilitation. In some countries, laws were general, offering overall rights across several areas (AT, CH, IS⁵⁶, KZ, NL, NO). In others, the law was partial and specific, covering a smaller number of issues or geographical areas. For example, in the Czech Republic, education law only covered children's schooling and did not apply at university level. In Switzerland and the Czech Republic the existence of a large number of more limited laws was considered by country respondents to be confusing.

Many countries pointed out that the same laws applied to both blind and partially sighted people. However, where the law covered types of benefit to be awarded, typically the amount of benefit was less for partially sighted people who were often categorised differently (CZ, EE, HU). This was especially the case where the assistance was provided via the social insurance system. In Poland, access to rehabilitation depended on first being assessed as eligible for a disability certificate, a situation that also applies in several other central and eastern European countries.

Ireland stated that there was not a legal right to rehabilitation but pointed out that people with visual impairments had access to services.

Question 1.2 asked:

Is there a legal right to assistive technology, aids and equipment, for a) blind people and b) partially sighted people?

Most countries again stated that there was not a difference in the formal rights of blind and partially sighted people, unless shown. Relevant laws were the same as given for the previous section in many instances.

⁵⁵ Act No. 448/2008 Coll. on social services – especially paragraph 21 on social rehabilitation.

⁵⁶ The Act on the Affairs of Disabled People, No. 59/1992, Article 8 states that disabled people shall be provided with services designed to enable them to live and work in an ordinary community with other people.

Answers were as follows:

Yes	No
CH, CZ ⁵⁷ , EE ⁵⁸ , IS ⁵⁹ , KZ, ME ⁶⁰ , NL, NO ⁶¹ , RO ⁶² , RS ⁶³ , SE, SK, UK	AT, HU ⁶⁴ , IE, PL ⁶⁵ , SE

In Serbia, the Law on Pension and Disability Insurance that governed reading and writing assistive technology was thought to be effective. However the Law on Health Insurance was considered ineffective because technical aids that were available were out of date. Conversely, in Sweden the type of equipment to be provided was not stipulated.

Question 1.3 asked:

Do laws on rehabilitation recognise and support participation in all aspects of community life for a) blind people, b) partially sighted people?

Answers were as follows:

Yes	No
EE, IS, KZ, ME, NL, NO, RO, RS, SE, SK, UK	AT, CH, CZ, HU ⁶⁶ , IE, PL

⁵⁷ Act on the Provision of Benefits to Persons with Disabilities (Act No. 329/2011 Coll. and Education Act.

⁵⁸ Welfare Act <https://www.tootukassa.ee/eng/content/work-ability-reforms/assistive-work-equipment>

⁵⁹ Act on the Center No. 160/2008

⁶⁰ Law on health insurance , Rulebook on Exercising the Right to Medical Devices

⁶¹ The Act relating to social security <https://lovdata.no/dokument/NL/lov/1997-02-28-19?q=folketrygd> applies to people who have sight reduced by at least 66%.

⁶² Law 448/2006. However, there are no subsidies.

⁶³ Law on Pension and Disability Insurance and Law on Health Insurance.

⁶⁴ Act LXXXIII of 1997 on the benefits of compulsory health insurance and the Fundamental Law of Hungary 2001 cover compensation for injury. There is no individual right to devices but a general aim to use assistive technology to minimise disadvantage.

⁶⁵ However, there is mention in the Regulation of the Minister for Labour and Social Policy on tasks and duties performed by a commune, and finance from the State Fund for Rehabilitation of Persons with Disabilities.

⁶⁶ Decision 15/2015 (of 07.04.) of the National Assembly on the National Disability Program (2015-2025) states: *Ensuring that people with disabilities can... exercise their political, economic and social rights... should be the fundamental value and aim of each administrative action affecting disabled people.*

While most countries answered ‘yes’, several countries raised additional issues. In Switzerland the reported aim of rehabilitation was financial independence and participation was said to be secondary and only partially supported in Montenegro and Switzerland. In the Czech Republic an allowance for assistive aids had been cancelled and Serbia reported the continued existence of many physical and social barriers.

Question 1.4 asked:

Are there policies on habilitation and rehabilitation services for blind and partially sighted people who are a) children, b) adults of working age, c) older people?

Age group	Yes	No	Not known or not answered
Children	AT, CZ ⁶⁷ , EE, HU ⁶⁸ , IE, IS, ME ⁶⁹ , NL, NO, PL ⁷⁰ , RO ⁷¹ , RS, SE ⁷² , SK		CH, KZ, UK
Adults of working age	AT, CZ, EE, HU, IE, IS, ME, NL, NO, RO, RS, SE ⁷³ , SK, UK ⁷⁴		CH, KZ, PL
Older people	AT, CZ, EE, HU, IE, IS, ME, NL, NO, RO, RS, SE ⁷⁵ , UK ⁷⁶		CH, KZ, PL, SK

In some countries policies differed from region to region (AT) and between institutions (EE, IE). This local level information was not always easily available. For example, Serbia stated that developments were at a

⁶⁷ National Plan for the Promotion of Equal Opportunities for Persons with Disabilities 2015-20.

⁶⁸ National Disability Program (2015-2025)

⁶⁹ Strategy for the Integration of Persons with Disabilities

<http://www.mrs.gov.me/biblioteka/strategije>

⁷⁰ The Regulation of the Minister for Education on organising early intervention care centres for children.

⁷¹ There is a national strategy for 2016-2020 but it does not specifically address the situation of blind and partially sighted people at different ages.

⁷² Local but not national policies, for all ages.

⁷³ There are standards but not policies for working age adults. Also there are national standards for orientation and mobility, for using video (CCTV).

⁷⁴ Statement on the Care Act from the Association of Directors of Social Services.

⁷⁵ National standards for adults apply also to older people.

⁷⁶ Statement on the Care Act from the Association of Directors of Social Services.

basic level only and sometimes policies did not extend beyond individual institutions. In Iceland it was easier to access information. Purposeful aims that focussed on learning for both blind and partially sighted children, support for employment for working age adults and independent living for older people were set out by the National Institute for the Blind, Visually Impaired and Deafblind⁷⁷ (known as the Centre).

Several national organisations of blind people stated that they were themselves involved in providing rehabilitation services and developed policies on this (CH, ME, RS, UK).

Question 1.5 asked:

Do policies recognise the importance of a personalised multidisciplinary assessment of each individual's needs and circumstances? Please describe the policies and give web links to more information, for people who are: a) blind b) partially sighted.

Yes	No	Not answered
AT, CH ⁷⁸ , CZ, EE, IE ⁷⁹ , KZ, ME ⁸⁰ , NL, NO, RS, SE, SK, UK ⁸¹	HU ⁸² , IS ⁸³ , RO	PL

Inter-professional rivalry was identified as a problem in several countries. The Czech Republic said that implementation of the national plan⁸⁴ was limited by communication problems between doctors and

⁷⁷ National Institute for the Blind, Visually Impaired and Deafblind <http://midstod.is/english>

⁷⁸ Only for children

⁷⁹ Recognised in the policies of individual agencies

⁸⁰ In principle in the strategy <http://www.mrs.gov.me/biblioteka/strategije>

⁸¹ Care Act <https://www.gov.uk/guidance/care-and-support-statutory-guidance/general-responsibilities-and-universal-services>, Community Care and Health (Scotland Act) <https://www.legislation.gov.uk/asp/2002/5/contents>; Health and Social Care Delivery Plan <http://www.gov.scot/Topics/Health/Policy/HSC-DeliveryPlan>

⁸² The National Disability Programme (2015 – 2025) frames this in terms of reasonable adjustments.

⁸³ Policies do not recognise this in rehabilitation although there are teachers, mobility officers, a social worker and a physiologist that provide services based on individual needs, in the environment the client requests.

⁸⁴ National Plan for the Promotion of Equal Opportunities for Persons with Disabilities 2015-20 https://www.vlada.cz/assets/ppov/vvzpo/dokumenty/National-Plan-for-the-Promotion-of-Equal-Opportunities-for-Persons-with-Disabilities-2015_2020.docx

social workers. Similarly, in Estonia, while the importance of a multi-disciplinary assessment was recognised in general terms, in practice assessments could be carried out by a single case manager. In Montenegro, while individual needs were recognised in theory, the author noted a lack of conformity in practice. The requirements of blind and partially sighted people were recognised in Serbia but often there was no account taken of people with multiple impairments. Staff shortages were problematic in Sweden, especially of physiotherapists and psychologists, although interdisciplinary work was carried out.

Question 1.6 asked:

Are there policies on developing peer support for habilitation and rehabilitation a) for children (please also include policies on family support), b) for adults of working age and c) for older people?

Countries answering this question did so slightly differently, depending on the interpretation of the authors. Most said that there was little explicit recognition of the importance of peer support by government bodies and that what existed was frequently informally organised by NGOs. The one exception was Norway, where national policy had led to funding for peer support services by of the Norwegian Association of the blind and partially sighted.

Government (national / local) policies	Policies developed by NGOs and projects	No policies	Question not answered
NO ⁸⁵	AT, IE, EE ⁸⁶ , KZ ⁸⁷ , RO, SE, UK	CH, HU, IS, ME, NL, RO, UK	CZ, PL, SK

⁸⁵ The government has funded both the Norwegian association of the blind and partially sighted and the Norwegian association of the hard of hearing to develop peer support.

⁸⁶ Children's peer counselling was not available, except for temporary projects. For working age adults and older people, 'first steps' to develop peer counselling had been taken.

⁸⁷ Referring to support from families.

Where countries answered 'no', this did not mean that no peer support activities took place on a self – help basis. Further details about this are given under the next question.

Question 1.7 asked:

Are there resources for peer support services? Please describe these and give web links where possible for people who are a) blind and b) partially sighted.

As noted above, only Norway stated that resources had been made available by the government for peer support. Other countries stated that there was no funding available (AT, HU, IS, NL, SE, SK) or limited to some time - limited projects (EE).

Examples of the kinds of peer support that NGOs organised themselves were given by a number of countries. Some arranged support for using technology (CH, EE, UK) and Switzerland mentioned leisure events and sports. Peer support for young children was also available in Serbia. In Romania, peer support was organised locally, through 35 member organisations. In the UK⁸⁸, online communities provided support and a free counselling and confidence building course was offered in Western Scotland.

Question 1.8 asked:

Do blind and partially sighted people and their organisations fully participate as equal partners in the development of policies and standards for habilitation and rehabilitation services? Please give details for people who are a) blind b) partially sighted?

Most countries understood this question as asking whether they and their organisations were equal participants in policy making. Some said that they were (IS, KZ, NL, SE, SK). For example, in Iceland, policy that laid the foundation for the Act on the National Institute for the Blind, Visually Impaired and Deafblind had been written in collaboration with Blindrafelagid, the Icelandic Association of the Visually Impaired. In Slovakia, disability organisations participated in the committee that monitors evaluation of the National Programme of Living Conditions for Persons with Disabilities 2014-2020. Estonia noted that progress towards more equal collaboration had been made in recent years.

⁸⁸ RNIB Connect <http://www.rnib.org.uk/rnibconnect> ; RNIB Youth Engagement <http://www.rnib.org.uk/scotland/youth-engagement>

The majority stated that although they were involved or consulted, this was often on an unequal basis or insufficient (AT, CH, CZ, EE, HU, ME, NO, PL, RO, RS). In many cases they might express an opinion or respond to consultations but actual decisions were taken by professionals and policy makers. Clearly there is scope for improvement in many countries.

Several of the groups answering also provided services themselves and two countries described their own involvement mechanisms (IE, UK). In Ireland the National Council for the Blind of Ireland had established a means of asking for feedback and in the UK the Royal National Institute for the Blind had an equal opportunities policy, although it was not stated how this had been developed.

Section 2A Access to Habilitation and Rehabilitation Services

Question 2.1 asked:

Are there dedicated services for both partially sighted and blind people that meet their distinct needs? Are these habilitation and rehabilitation services focussed on supporting independent living in the community for people who are: a) partially sighted, b) blind?

Most countries, but not all, outlined a number of services that were provided by their own organisations and others. Answers are shown in the table below, with countries giving a qualified answer in the ‘no definite answer’ column:

Yes	No	No definite answer
AT, CH ⁸⁹ , EE, IE, IS, KZ, NL ⁹⁰ , NO, SE, SK, UK.	ME	CZ, HU ⁹¹ PL, RO, RS.

All countries stated that there were services available to people with visual impairments. Some (AT, IS, NL, NO) said that independent living was a right, in terms of its meaning in the CRPD. Personal assistance was mentioned by Austria and Iceland and Romania the services provided by the Romanian Association of the Blind, who encouraged

⁸⁹ Applies to both blind and partially sighted people.

⁹⁰ This was qualified by the statement that access to centres should be easier and needs taken into account to a greater extent.

⁹¹ Services not specific for visually impaired people but designed for disabled people generally.

independent living. In other instances, the development of skills was seen as the route to independence (e.g. SK, UK). Some also described sheltered workshops (CZ).

Some countries mentioned areas where further work was needed. In Montenegro it was considered that not enough attention had been paid to solving the problem of access to services supporting independent living. The Netherlands and Switzerland stated that insufficient attention was paid to individual needs and Poland highlighted the problem of intermittent funding.

Question 2.2 asked:

What is the full range of services in your country, for a) blind people, b) partially sighted people?

A range of services were mentioned, including:

Advice and Information helplines (AT, CH, IE, IS, UK); loan of assistive devices (NO); training in use of technology and assistance (AT, CZ, HU, IE, IS, RS, SE, UK), personal assistants (NO), Braille training (IS, RS), counselling (IE, IS) and psychological support (RS, SE, UK).

Mobility training and support services included: general mobility training (AT, CZ, HU, IS, NO, SE, UK) and training for guide dogs (CZ⁹², IE, UK).

Self – care / daily living skills were offered in many countries (CZ, HU, IS, NO, SE, UK), as well as special education teachers for blind/visually impaired people, physiotherapists (EE, SE), social workers, occupational therapists, psychologists, speech therapists. (EE) and health resort treatment (KZ). Sheltered workshops were mentioned as offering vocational rehabilitation (CZ).

Leisure training and social interaction (IS), employment support (IE, UK), welfare rights support (UK), a library service (IE) and clubs for visually impaired professionals (CZ)⁹³ were also identified.

Just one country mentioned advocacy services (NO) and Kazakhstan mentioned the availability of generic community resources.

⁹² <http://www.vodicipsi.cz/> In the Czech Republic a guide dog is considered to be an assistance aid and costs may be subsidised up to 90 %.

⁹³ In the Czech Republic there are two professional clubs: one for visually impaired masseurs and a club of music teachers. These clubs provide individually tailored training to their members.

The Netherlands stated that all services were available, while Montenegro and Romania did not answer the question.

These answers should be viewed as indicative of the types of services available, as authors were not asked for a comprehensive list and in many countries there was considerable variation between areas and differing eligibility criteria.

Question 2.3 asked:

How is eligibility determined for access to habilitation and rehabilitation services for a) blind people, b) partially sighted people?

The complexity of many eligibility criteria for rehabilitation services was evident in the answers given. Different facets of the process were described, including the basis on which decisions were taken, the degree of impairment of applicants and who made the decisions.

Several authors mentioned the degree of loss of vision as important (CZ, IE, RS⁹⁴), while Switzerland stated that there were no pre-determined conditions. In other instances, the needs of applicants were important (CZ, SE).

Most countries mentioned the various decision makers, who often carried out individual examinations (AT, EE⁹⁵, IS⁹⁶, NL⁹⁷, NO⁹⁸, SK)

In Hungary, eligibility depended on possession of a State Certificate showing eligibility for Disability Allowance and in Montenegro, decisions were determined by a rulebook. Poland said that competitions for funding that were run for service providers rather than eligibility specified for individual services. The UK stated that there were no fixed criteria for rehabilitation services.

⁹⁴ In Serbia, eligibility is determined on the basis of degree of visual impairment, the expressed wishes of the applicants and their families, the availability of opportunities offered by service providers and funding availability..

⁹⁵ Decisions taken by a case manager.

⁹⁶ In Iceland, referral by an ophthalmologist to the Centre.

⁹⁷ Decisions taken by an ophthalmologist.

⁹⁸ Decisions taken by the municipality or Norwegian Association of the Blind and Partially Sighted.

Question 2.4 asked:

Who provides habilitation and rehabilitation services (for example, dedicated blindness and low vision rehabilitation and support centres, private and public hospitals, NGOs): a) for blind people, b) for partially sighted people?

Answers given are summarised in the table below, which shows the sectors concerned:

NGOs and charities ⁹⁹	Rehabilitation Centres	Schools	State run services
AT, CH, HU, IE, KZ, ME ¹⁰⁰ , NO, PL, RS, SK, UK	AT, EE ¹⁰¹ , HU, NL, SE	AT, RS, SE, SK	HU ¹⁰² , IS, NO ¹⁰³ , UK ¹⁰⁴

In Romania, the Romanian Association of the Blind had been trying for over two decades to build a rehabilitation centre for blind people, as the state did not provide one.

With a few exceptions, most countries had a range of provision with the state taking a greater or lesser role in funding and commissioning. NGOs clearly had an important role in service provision.

Question 2.5 asked:

Are services available locally in all parts of the country a) for blind persons, b) for partially sighted persons?

Some countries simply answered 'yes' or 'no' to this question, as follows:

Yes: CH, IE, NL, SE, SK.¹⁰⁵

⁹⁹ Includes organisations of blind people.

¹⁰⁰ Although the law provides for special support centres, in practice this work is done by NGOs.

¹⁰¹ Services are provided by officially recognised rehabilitation centres, which may be run by the public or private sector and by NGOs.

¹⁰² In Hungary, while other organisations may run services, these are funded by the State, to whom applications must be made.

¹⁰³ Includes eye departments in hospitals as well as national and local services.

¹⁰⁴ It is the responsibility of local authorities to provide vision rehabilitation services. However, they may provide them through an in-house team or commission an external provider, for example, a sight loss charity, the National Health Service or a private sector provider.

No: AT, ME, PL¹⁰⁶, RS.

Those providing more details noted the tendency for better facilities in large towns (CZ, EE, HU, IS, SK). In the Czech Republic, services were distributed through the country, albeit with some differences. A rehabilitation centre was only located in Prague but it offered accommodation to visitors. In Hungary, most services were located in the capital and larger cities but efforts were being made to redress the balance. In Iceland, Centre staff visited each quarter of the country every two years and more often if requested. Norway noted differences between localities due to differences in expertise and financial resources and the UK differences between local authorities.

Romania did not answer the question and Kazakhstan did not have the information.

Question 2.6 asked:

How are services funded (for example, free, paid for by the user, means tested) a) for blind persons, b) for partially sighted persons?

This question covers a wide range of services and therefore it is not surprising that almost all countries described funding from a range of sources: national and local government, private and charitable donations and payments by the visually impaired person themselves (AT, CH¹⁰⁷ CZ¹⁰⁸, EE¹⁰⁹, HU¹¹⁰, KZ¹¹¹, ME, PL¹¹², RS¹¹³, SE, SK¹¹⁴).

¹⁰⁵ Some visual impairment services in primary schools were only available in some towns.

¹⁰⁶ Poland noted rural – urban disparities.

¹⁰⁷ Switzerland reported a balance of about 40% state grant, 50% by NGOs and 10% paid by the user.

¹⁰⁸ In the Czech Republic the State funds vocational retraining through the Labour Office and occasionally employers. Support in primary and secondary schools has recently become State funded.

¹⁰⁹ Rehabilitation Centre services are free in Estonia but costs of local services (personal assistance, special transport) is partially met by users themselves.

¹¹⁰ In Hungary a percentage is paid by users. This is not means tested.

¹¹¹ Government medical services are free in Kazakhstan. In private clinics services must be paid for by users.

¹¹² NGO services in Poland are usually free although 50% of rehabilitation holiday costs must be paid for by service users.

¹¹³ In Serbia, services are mainly funded by state institutions and to a lesser extent by donations. Service users may contribute if they are able to do so. A small number of aids are free mainly through pension and health insurance. Customs and VAT charges are not paid for imported goods.

In a few countries, services were provided mainly or wholly free of charge (IE, NL, NO, IS¹¹⁵, UK¹¹⁶).

Romania did not answer the question.

Question 2.7 asked:

If services are not free have any problems of affordability been reported a) for blind persons, b) for partially sighted persons?

Not all countries were able to answer this question, but of those that did, the answers are summarised below, with further details in footnotes.

Yes	No	Not answered, not known or not applicable
AT, CZ ¹¹⁷ , HU, IE, KZ, SE ¹¹⁸	CH, RS, SK ¹¹⁹	EE, IS, ME, NL ¹²⁰ , NO, PL ¹²¹ , RO, UK.

Question 2.8 asked:

Are services available for all age groups: children, adults and older people, a) for blind persons, b) for partially sighted persons?

Answers were given as follows:

Yes	No	Question not answered
AT, CH, EE, IE, IS, KZ, ME, NL, NO, RS, SE, SK, UK	CZ, HU	RO

¹¹⁴ In Slovakia, school and education services are funded by the state, health services through national insurance and social services on the basis of agreements in local governments.

¹¹⁵ Refunds are offered in Iceland for lenses (not for frames).

¹¹⁶ The UK report states that vision rehabilitation services under the Care Act 2014 should be provided free of charge.

¹¹⁷ Problems reported in covering the costs of training for technological aids.

¹¹⁸ For some people.

¹¹⁹ For social services, which are free.

¹²⁰ The author notes that that some people may be reluctant to go to a service centre due to a need not to exceed an annual funding cap of 380 euro for all services.

¹²¹ The author reports a lack of qualified personnel.

Several countries added further information. In practice there were shortages in services in some countries (e.g. CZ). In Estonia and Poland, better services were available for children than for older people. Estonia also stated that the need for services by partially sighted applicants was not recognised to the same extent as for people who are blind. In Hungary there were especially few services for older people. In Serbia, there was equal allocation in principle, but in practice services were not always available when needed.

Section 2B Access to Equipment and Technologies

Question 2.9 asked:

The CRPD states that governments should make sure disabled people know about aids, technology and assistive devices and how to use them. How is this done in your country a) for blind people, b) for partially sighted people?

Countries indicated the following sources of information:

Type of Organisation	Countries
Disabled People's Organisations	CZ, EE, HU, NL, NO, SE
NGOs and service providers	AT, CZ ¹²² , EE, IE, NL, PL, RS, UK
Children's services and schools	CZ, SK
Health Services	EE, NO, RS
Employment Services	NO
Regional Centres / Offices	CZ, EE, IS ¹²³ , KZ, SE
Manufacturers	CZ, EE, NL, PL, SE, SK
Internet	NO, SK ¹²⁴ , UK
No active promotion	CH, RO

¹²² Czech Blind United (SONS) runs shops in Prague http://www.tyflopomucky.cz/onas_pha.php and Olomouc http://www.tyflopomucky.cz/onas_ol.php and an online shop.

¹²³ In Iceland there is one national centre.

¹²⁴ Ministry of Labour, Social Affairs and Family of the Slovak Republic:

<https://www.employment.gov.sk/en/>

Centre of Labour, Social Affairs and Family:

http://www.upsvar.sk/statistiky.html?page_id=1247&lang=en

Ministry of Health of the Slovak Republic: <http://www.health.gov.sk/Index.aspx>

Montenegro indicated that details of technical aids were listed in the Rulebook on Exercising the Right to Medical Devices¹²⁵ but it is not clear what, if anything, was done to promote this as a source of information.

Question 2.10 asked:

What training is provided in the use of equipment and technology a) for blind persons, b) for partially sighted persons?

Some authors reported on the situation in the country as a whole, while others reported on the activity of particular organisations, where they were known to be involved in training.

A summary of sources of training is as follows:

Source of Training	Countries
Government (national or local)	NO, PL ¹²⁶ , UK ¹²⁷
Organisations of visually impaired people	CZ, EE, IE, NL, RO, RS, UK
Rehabilitation centres / services	AT ¹²⁸ , CZ, IS, KZ, NL, SE, SK ¹²⁹ , UK
Schools	EE ¹³⁰ , RS, SE
Computer based training	KZ, UK
Other unspecified training	AT, CH, HU ¹³¹ ME

Question 2.11 asked:

How is eligibility for equipment, technology and training determined a) for blind persons, b) for partially sighted persons?

The eligibility criteria described in answer to this question were in many countries the same as those described above in section 2.3 on services (AT, CH, HU, ME, TE, IS, KZ, SE).

¹²⁵ Rulebook on Exercising the Right to Medical Devices <http://www.sluzbenilist.me/PravniAktDetalji.aspx?tag=%7B3107BE09-12A7-444F-A728-D2D8751508FE%7D>

¹²⁶ This provision is fairly new in Poland, therefore not available in all areas.

¹²⁷ Some training is commissioned by the National Health Service and training is offered in use of magnification equipment.

¹²⁸ Self – funded courses.

¹²⁹ Some training is funded by local Labour Offices.

¹³⁰ Part of special education service.

¹³¹ Available for both groups and individuals.

Several countries added additional information or noted recent changes. In Estonia, a written assessment contributing to a plan was needed from a rehabilitation team, or medical professional. From 2018, physiotherapists and occupational therapists were also eligible to assess needs for equipment.

In the Czech Republic, a number of ad hoc projects had emerged that provided training in operating assistive aids, for example, through the Labour Office. Here training might be offered free and this was also the case for training under the auspices of 'social rehabilitation.' or a 'social activation' service. Where there was no such programme available locally, applicants had to meet the costs of this themselves.

In Norway, a tender system had been introduced, which had resulted in fewer options for applicants and the visually impaired person now usually had a choice between two or three assistive devices. Public officers (Hjelpemiddelsentralen) were meant to provide training. However, many were judged to lack relevant knowledge.

In Poland, there were differences according to who funded the devices and it was rare for one organisation to cover the needs of all disabled people. This contingent approach was also described by other countries (RS, SE), with decisions being made as a result of a number of criteria.

Question 2.12 asked:

How are aids, equipment and technology funded (for example, free, paid for by the user, means tested) a) for blind persons, b) for partially sighted persons?

In most countries the financial arrangements were complex and governed by a number of rules. The table below summarises the funding sources that were identified, while recognising that some may be organisations through whom funding is channelled rather than the original source.

Source of Funding	Countries
National and / or local government including state insurance	AT, CH, CZ, NO, PL, SE, SK, UK ¹³²
Labour market service providers	EE, SK
Paid for by users	HU, IE, RO, RS, SE ¹³³ , UK
Health services	HI, IE, IS ¹³⁴ , PL
Health insurance	HU, IS, ME, NL
Family aid centre	PL
Rehabilitation services	RS
Question not answered	KZ

In the Czech Republic children did not usually have problems accessing aids, compared with other age groups. However authorities often calculated the cost of equipment as lower than the sale price. In Estonia children also had to pay 10% of costs and some were means tested, resulting in additional reductions. Regional variations were noted in the UK.

Question 2.13 asked:

If services are not free have any problems of affordability been reported a) for blind persons, b) for partially sighted persons?

Yes	No	No information available	Question not answered
AT, CH, CZ ¹³⁵ , HU, KZ, NO ¹³⁶ , RO, SE, SK		EE, IS	IE, ME, NL, PL

¹³² In the UK equipment is mainly funded by local authorities that have different policies on charging in different areas.

¹³³ Mostly free in Sweden but some are paid for by users.

¹³⁴ The Icelandic Centre distributes assistive devices according to regulation 233/2010. Article 6 of the regulation requires that the devices are loaned for as long as needed rather than given to individuals. Devices are free with health insurance.

¹³⁵ Some people who do not receive a subsidy have to apply to charitable organisations for contributions.

¹³⁶ In Norway, those not granted government funds may apply for support from the Norwegian Association of Blind Persons (NABP). The author reports that NABP has received many applications.

Affordability was said to be a problem for some groups, including unemployed people (AT) those on low incomes (SK), older people (CH) and migrants (CH). In the Netherlands, the author suggested that the limit of ZVW insurance to 380 euro a year might deter applications. Sweden said that problems were sometimes reported. Differences were apparent in the UK, with entitlement unclear in some parts of England and no reported problems in Scotland.

Question 2.14 asked:

Are there any limitations on the choice of equipment? What are these a) for blind persons, b) for partially sighted persons?

Not all countries provided additional information for this question. Where visually impaired people paid for equipment themselves, choice was unsurprisingly greater in many countries. Where costs were met by organisations, the purpose of the equipment was important, with more generosity sometimes linked to work (e.g. CH). In Serbia, the choice was reported to be very limited and the costs high in relation to the standard of equipment provided. Sweden noted that older people and children sometimes found it more difficult to get the equipment they needed.

In several countries, provision of equipment was limited to items that were officially designated as permissible (EE, UK) and in some countries equipment could not be tried out before buying (IE, SK¹³⁷). A greater degree of impairment also meant greater eligibility for equipment (IS, NO, PL).

Section 3 Development of the Competence of Professionals

Question 3.1 asked:

Are there training programmes for rehabilitation professionals? Please describe these (If there is accredited training, the qualifications recognised, where people are trained, to what level etc.)

All countries confirmed that training programmes were available except Romania, which answered 'no' to the question.

¹³⁷ Slovakia noted that often equipment could only be seen in catalogues before buying.

Although higher level training was not available in all countries (AT) and some did not indicate the level of qualification (CH, NL, RS) most described training programmes that were available at different levels of education, ranging from short professional courses to post graduate masters level and professional training. The training often varied according to the type of rehabilitation work and sector the worker operated in and these were different across countries. So for example, higher levels of education were sometimes required for social workers (CZ), for rehabilitation workers (EE), for those working in health rather than social services (SK) and for those teaching mobility and Braille skills (CZ).

In Ireland, it was possible to be accredited as a certified low vision therapist.¹³⁸

Types of training at a lower level and that were less regulated were for use of computer based assistive technology (CZ), or peer support (EE). In Estonia, in service training was required for rehabilitation professionals. In Iceland¹³⁹, with a small population, there was no professional training except that provided through online courses and seminars. In the UK, an apprenticeship was being developed for vision rehabilitation workers with the aim of encouraging more people to enter the profession.

Problems with professional training were reported in Sweden, where master's level teaching, which was run jointly with Norway in one instance and with Denmark in another, was attended by only a few Swedes. Most received a short vocational course prior to working in low vision clinics.¹⁴⁰

Kazakhstan did not answer the question.

Question 3.2 asked:

Please describe how rehabilitation professionals are trained. Does training emphasise meeting needs on an individual basis?

¹³⁸ Through the Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP).

¹³⁹ The author notes that the Centre has professionals such as teachers, mobility officers, a social worker and a physiologist that provide services based on individual needs.

¹⁴⁰ In Sweden a working group had been set up to work on improvements to the system.

A number of countries stated that there was a definite emphasis on meeting individual needs. However, several either did not answer the question or did not give sufficient information to answer one way or another. It is also possible that some were not completely sure about what was being asked. A summary of answers is as follows:

Yes	No	Not answered or information not sufficient
CH, EE, HU, IS, NO, PL, SE, SK, UK.	ME	AT, IE, KZ, NL, RO, RS.

In Macedonia, it was reported that competitions for funding were held regularly with regard to rehabilitation, vocational training and employment of disabled people and in these there was insufficient opportunity for disabled people to express their priorities.

Overall, this suggests that training is not definite about the importance of recognising individuality in all countries or at least it is at times insufficiently put into practice.

Question 3.3 asked:

Does professional training incorporate human rights perspectives?

Answers are summarised as follows:

Yes	To some extent	No	Question not answered
AT, EE, KZ, ME, NL, SE, SK, UK	CH, IS, NO, RS		CZ, HU, IE, PL

Some countries gave qualified answers. Iceland stated that training in human rights was scheduled in the future and Switzerland answered ‘a little’. The Norwegian Association of the Blind and partially sighted said that it was the main provider of rehabilitation services through three centres and a large group of visually impaired peers was involved in this work. Poland offered no comment other than that this was a very important issue and Serbia that it was probable that human rights was recognised (for this reason it has been placed in the ‘to some extent’ column).

This was a broad question and the fact that there was a lack of certainty in the answers of several countries again indicates that there is scope for further implementation of a rights based perspective.

Question 3.4 asked:

Do you have additional comments on professional training?

Not all countries added additional comments. Those that did mainly discussed improvements to the system that could be made. In Austria there was considered to be a lack of professional training opportunities, resulting in a shortage of skilled trainers in all regions. Switzerland pointed out that training was not funded by the government, while Poland stated that help was needed to convince the government to provide core funding rather than assistance through occasional projects and grants. Continuous, guaranteed support was needed, especially in rural areas.

A few countries added further information about training courses, which has been incorporated into the relevant sections above.

Section 4 Organisations

Respondents were asked about the role of their organisations regarding rehabilitation for both blind and partially sighted people. This section of the report includes the information provided that has particular relevance to Article 26 of the CRPD.

Several countries questioned the degree to which they were able to make their voice heard in the development of policy and services. Montenegro stated that “unfortunately the NGO is not involved enough”. Slovakia requested assistance in making progress, through for example, receiving information about positive experiences in countries that had better provision and they welcomed recommendations about steps that should be taken in this area. Austria reported that although the national organisation was an active partner in the negotiation of laws and standards, their voice was not always heard. On the other hand, in the UK, the organisations had been actively involved and had influenced policy.

Shortcomings in service provision were also noted. Poland requested help with securing adequate availability of services. In Serbia, despite substantial improvement, there were still areas where improvements

were needed¹⁴¹, especially in education and rehabilitation support. Equity in service provision across regional areas was an issue in Slovakia.

Conclusion

Despite their importance to people with visual impairments, habilitation and rehabilitation have been accorded a lower profile in recent years compared with many other human rights issues. Differences in practice in health, education, employment and social services have contributed to difficulties in defining exactly what is meant by the terms. Earlier sustained criticism of the purpose and practice of rehabilitation services has also often contributed to this lower profile. Some of the issues in those debates still are evident in the country reported of EBU members and these are discussed below. It is however important to also acknowledge that there was evidence of good practice as well and an acknowledgement of many improvements that had been accomplished in recent years.

Access to services was raised as a problem in several respects. In some countries services were provided in an unpredictable way, for example through awarding funding to projects to provide rehabilitation only for defined periods of time. This led in turn to unpredictable and problematic gaps in services. Uneven service development was also apparent in differences in provision across urban and rural areas, although services made efforts in some cases to offset such problems.

Eight countries identified a lack of attention to the individual needs of visually impaired people in assessment processes. Further, as noted earlier in this report, authors were also not able to easily comment on differences in the entitlement of blind and partially sighted applicants to services. Eligibility criteria were often highly complex, unclear and subject to change. The effect of this was to make it difficult to get

¹⁴¹ Examples of improvements needed were: greater expertise and technical support for pupils in inclusive education, including pre-school classes, improvements to early intervention programmes and the establishment of at least one rehabilitation centre for people who had recently become blind.

information on what was happening, especially where there were inconsistencies.

Some authors raised the issue that the primary goal of rehabilitation services appeared to be to reduce financial dependence on the state rather than to ensure independent living in the community. Community participation was only partially supported in some countries. Here, more needs to be done to ensure that rehabilitation services are aligned with human rights perspectives, especially the right to independent living in the community in all its facets.

Tokenism was also commented on at the level of involvement of disabled people's organisations in policy making. Many, but not all, said that they were not listened to or only had nominal involvement in the development of policies that affected them.

In summary therefore, although it was recognised that progress had been made, there are still important issues that need to be addressed in order that the right of visually impaired people to access effective habilitation and rehabilitation is met in European countries and that the purpose of services is to support full community participation.



This report is co-funded by the "Rights, Equality and Citizenship Programme" Programme of the European Union.