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EMERGING PRACTICES IN COMMUNITY-BASED SERVICES FOR VULNERABLE GROUP

A STUDY OF SOCIAL SERVICES DELIVERY SYSTEMS IN EUROPE AND EURASIA

June 2006

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EMERGING PRACTICES IN COMMUNITY-BASED SERVICES FOR VULNERABLE GROUPS

A Study of Social Services Delivery Systems in Europe and Eurasia

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EXECUTIVE SUMMARY

This report, prepared for the Social Transition Team of the USAID Bureau for Europe and Eurasia (E&E), is the result of a study of promising practices in community-based care for vulnerable groups conducted in five countries (Armenia, Azerbaijan, Bosnia, Romania, and Russia) in the E&E Region between September 2004 and March 2005. Of particular interest is how these countries are moving from residential care to family-focused, community care models utilizing internationally recognized standards for children and youth, elderly, disabled, and minority groups (with an emphasis on Roma).

A. Country Selection Process

To initiate the selection of countries for the study, general information about the study's goal and objectives was sent by the Social Transition Team Leader to all of the Missions in the E&E Bureau to solicit their participation. Countries were then selected based on:

- The Mission's expressed interest in identifying and describing emerging best practices in community care for vulnerable groups;
- Inclusion of countries that represented different stages of implementation of community care policies and programs, and
- In selected cases, the Mission's specific request for technical assistance in designing program activities.

The five countries selected for the study represent different points of entry for reforming social services, and they are at varying stages of the reform process. Armenia has invested significantly in targeting social services benefits and emphasizes social services for the elderly. Azerbaijan has focused on transitioning its community mobilization initiatives into a strategy for developing social services for vulnerable groups, specifically children and youth. Bosnia is developing follow-on programs to a recent child welfare initiative. Romania has a decentralized system of community-based services for institutionalized children and is now following this system in providing services for disabled persons and the elderly. Russia's strengths include the development of rehabilitative and empowerment models of community-based services for institutionalized and special needs children through early intervention programs, advocacy for disabled persons, and psychosocial services for mothers and infants infected with HIV/AIDS.

This report presents the specific findings for each country organized around a four-pillar framework of analysis of promising practices in community-based services, and it highlights the progress each country has made compared to the necessary elements of best practices in the four-pillar model. While the countries in the study vary widely in their approaches to and progress toward community-based care, they all demonstrate practices that can be built upon to continue the movement toward community care models. The specific findings and promising practices

detailed in Parts Three and Four of this report support some general conclusions regarding the transition to community care in these countries. These conclusions are listed below, grouped by the four-pillar framework.

B. Conclusions

Pillar 1: Policy and Legal Framework

- The most cited issue in this pillar is the gap that exists between social services policy and reality. Policy design, often done with external assistance, is not followed by sufficient strategic planning that includes implementation planning.
- International standards have become the basis for knowledge and skills transfer in model programs in all countries, with strong influence from Western professional schools and associations, governments, and donor groups.
- Each country's definition of priority vulnerable groups results from a combination of political, economic, and social factors. Overall, definitions tend to emphasize more concrete factors such as income rather than overall well-being. Most attention has been focused on institutionalized children although there is increased emphasis on institutionalization of disabled and elderly persons.
- The overarching structures for financing, administration, and management have begun to reflect principles of democracy and shift from centralized to decentralized decision-making mechanisms with national oversight and accountability.

Pillar 2: Structure and Types of Programs and Services

- All countries increasingly have examples, primarily through NGOs, of vocational programs for disabled persons, Roma, and youth aging out of institutional care.
- The non-profit sector is emerging as the primary provider of social services in the region; however, there is limited information about services and the effectiveness of their work. Public policy and financing mechanisms in some countries allow out-sourcing (or contracting) of some social protection programs to local, indigenous NGOs.
- Lack of financial resources is a major contributor to child and family problems. Programs are being developed that increase self-reliance by incorporating income generation initiatives such as vocational training and retraining, small business development, and micro-finance for small businesses in rural communities.
- Local governments, social service organizations, and communities are developing mechanisms to engage beneficiaries in policy and program formation and increase access to services for those most likely to be disenfranchised.
- The media, public figures, and community volunteers are emerging as spokespersons for the disenfranchised and marginalized, initiating changes in societal attitudes and behavior.

Pillar 3: Human Capacity

- All countries have emphasized human capacity-building through transfer of technical knowledge and skills for transforming systems of care.
- There is recognition that a qualified workforce that represents a range of human service professionals is critical for quality service.
- Social work development has emerged as a primary agent of change for social services reform.

Pillar 4: Performance Outcomes and Measures

- There is recognition that the development of client and service monitoring and tracking systems is critical for determining the impact of programs and services, although this area has not received equal attention in all five countries.
- Monitoring is no longer seen as a method of "control" but rather as a way to ensure program quality and safety.
- The public services and civil society organizations, including professional and consumer associations, provide key mechanisms for ensuring that standards of care and standards of practice are developed and enforced.

The transformation of systems of care in Europe and Eurasia is multi-faceted and complex, involving "dismantling the old system" while designing and implementing new structures and financing mechanisms. While there are variations in how governments and stakeholders transform systems of care, the consensus in the region is that basic services are a fundamental right.

INTRODUCTION

The purpose of this report is to identify and compare promising practices emerging in the Europe and Eurasia (E&E) Region that are consistent with international standards of best practices in community-based social services for vulnerable groups. Of particular interest is how countries in the region are moving from residential care to family-focused, community care models utilizing internationally recognized standards for children and youth, elderly, disabled, and minority groups (with an emphasis on Roma). The five countries selected for comparative assessments are Armenia, Azerbaijan, Bosnia, Romania, and Russia. This study is written as a stand-alone report and also serves as a companion volume to a report on the evolution of community-based social services in the E&E region (*Promising Practices in Community-Based Social Services in CEE/CIS/Baltics)*, which is available from the Social Transition team in the E&E Bureau at USAID/Washington. The report is organized into four parts and five appendices.

- **Part One: Objectives and Methodology of the Study** describes the objectives and methodology of the study including data collection procedures for each country.

- **Part Two: Transforming Systems of Care** provides a brief description of social services under the communist system, a westernized model, and an overview of barriers to change in the region. It presents the framework for analysis of best practices of care using a four pillar system.

- **Part Three: Individual Country Reports** describes how each of the five countries "stacks up" as compared to the necessary elements of best practices in the four-pillar model. This section is organized by country.

- **Part Four: Promising Practices from the Field** presents examples of best practices encountered in the country visits and is structured around the four pillars. This section is intended to provide examples of emerging best practices that could serve as successful models in the development of social services for selected vulnerable groups.

- **Appendices** include the In-Country Study Guide, Study Protocols, Data Collection Schedule and Study Collection Teams, List of Persons Interviewed in Each Country, and References.

PART ONE

OBJECTIVES AND METHODOLOGY OF THE STUDY

This study of emerging best practices in community-based social services for vulnerable groups was conducted in the region between September 2004 and March 2005 in five countries: Armenia, Azerbaijan, Bosnia, Romania, and Russia. The specific focus of each country assessment and team composition varied from country to country depending on the specific need of each USAID Mission and the agreed upon scope of work. The data collection methods utilized individual and group interviews of donors, implementers, and beneficiaries; document review; and, in the case of Armenia, focus groups. An *In-Country Study Guide*[1] was developed , which provided a common framework of assessment and analysis for the five selected countries and which serves as a guide for this report. The diverse nature of the social, cultural, economic, and political situations in each country provided a rich backdrop for studying the uniqueness of each country's road to reform.

This study analyzes the country assessments, utilizing the framework detailed in the companion report, *Promising Practices in Community-Based Social Services in CEE/CIS/Baltics*[2]. It also reviews perceptions, processes, policies, and practices of social services in the five countries against the backdrop of international standards, with emphasis being primarily, but not exclusively, on USAID-funded programs.

The overall objectives of this report are to:

- Describe country-specific examples of the shift from residential to community care for vulnerable children and youth, disabled persons, elderly, and Roma, highlighting the current thinking about and experiences with the transformation process in each country;
- Identify examples of best practices in selected community-based services that reflect internationally recognized standards; and
- Inform stakeholders about best practices that could be employed to further the development of social services within their own countries.

The report is a "snapshot" at a given point in time. Changes in these countries continually occur in response to their dynamic political, economic, social, and cultural situations. Although the information contained in this study may soon be dated, it is important to document the trends and incremental changes taking place to highlight the incorporation of best practices into systems of care for vulnerable groups.

[1] See Appendix A for the Scope of Work/In-Country Study Guide.

[2] The report, *Promising Practices in Community-Based Social Services in CEE/CIS/Baltics,* is a desktop study that describes and analyzes information obtained from web-accessible documents and reports on vulnerable groups and social services delivery systems in the 27 transition countries in the region. It is available from the Social Transition Team in the E&E Bureau at USAID.

Selection of Countries for the Study

To initiate the selection of countries for the study, general information about the study's goals and objectives was sent by the Social Transition Team Leader to all of the Missions in the E&E Bureau to solicit their participation. Countries were then selected based on:

- The Mission's expressed interest in identifying and describing emerging best practices in community care for vulnerable groups;
- Inclusion of countries that represented different stages of implementation of community care policies and programs, and
- In selected cases, the Mission's specific request for technical assistance in designing program activities.

The countries included in this report represent different points of entry for reforming social services, and they are at varying stages of the reform process. Armenia has invested significantly in targeting social services benefits and emphasizes social services for the elderly. Azerbaijan has focused on transitioning its community mobilization initiatives into a strategy for developing social services for vulnerable groups, specifically children and youth. Bosnia is developing follow-on programs to a recent child welfare initiative. Romania has a decentralized system of community-based services for institutionalized children and is now following this system in providing services for disabled persons and the elderly. Russia's strengths include the development of rehabilitative and empowerment models of community-based services for institutionalized and special needs children through early intervention programs, advocacy for disabled persons, and psychosocial services for mothers and infants infected with HIV/AIDS.

For further discussion of data collection and composition of the study teams, please refer to Appendix C.

PART TWO

TRANSFORMING SYSTEMS OF CARE

A. Shift in the Social Contract

The Soviet Bloc countries relied heavily on government programs, particularly government operated institutions, to care for vulnerable individuals such as children separated from their parents (orphans), youth in trouble with the law, and disabled and special needs children, adults, and the elderly. Under the communist ideology, the family was not recognized as an integral part of the welfare system—a basic principle in community-based models. The social contract under the socialist regime required the government to take care of the needs of the people, and it was assumed that all people had the same needs.

B. Barriers to Change

The political transition and economic downturn in the region has increased human suffering and strained the informal networks to the point of individual and family crisis. Universal access to social services is not part of the public ideology since improving quality of life as a shared public/private responsibility was not part of Socialist thinking. Protective care has traditionally been limited to custodial care without rehabilitative services to individual and family. *Poverty* has been the common thread for defining vulnerability through all social groups. Poverty, coupled with other risk factors, leads to poor quality of life outcomes such as poor nutrition, inadequate living conditions, substandard housing, exposure to environmental hazards, poor school attendance, stigma and marginalization, dysfunctional family relationships, and gender issues that put women at greater risk of being poor. Low pay and wage arrears are also significant economic factors in the region.

Policy and financing systems favor institutional care over family-focused, community-based models. Additional strain is placed on public and private resources as attempts are made to transition to more humane systems of care while, for a period of time, continuing the old systems.

The *pool of human resources* for delivery of a prevention-focused system of services at the community and family level is limited. Many of the educational programs for the range of human services professionals were either closed or limited in scope under the communist regime. Social work, the primary discipline that provides direct service delivery, is not clearly understood and not well-developed. Job functions tend to be highly bureaucratized and administrative, rather than process and treatment-oriented.

Public attitudes reflect a narrow view of the potential elements and outcomes for a social services delivery system. Public attitudes generally perpetuate the notion that "government" is responsible for people in crisis, limiting the role of citizens and community in providing individuals and families support and care when they are in need. The view that people are in

crisis because of their own deficits reflects a limited awareness of the human potential for growth and development.

Along with system changes, there is a need to introduce *new conceptual frameworks and language.* The introduction of new words and conceptual frameworks will accompany a shift from the relief model to a self-reliance framework. Terms that connote social problems and social groups serve to perpetuate the marginalization of individuals and groups, for example, "gypsy," "poor families," "large families," and "abandoned children." The use of "orphan" has now been replaced with "children deprived of parental care," a term which more accurately reflects the risk situation. Quality of life indicators such as individual and family well-being have not been used as part of the language of programs and services. A focus on the economic measures of one's existence denies the resilience of the human spirit.

While deeply ingrained attitudes and practices have slowed the establishment of systems of family-focused, community care models in the region, a shift *is* taking place. With the fall of communism, the shift in the social contract from the command economy to a market-oriented society included a shift to personal and community responsibility for individuals and families at risk. Current policy and practice reflect a change in the basic values, structures of services, human resource needs, and outcomes of those services.

The table below outlines the characteristics of programs and services as they shift from a communist ideology, which promotes government responsibility, to a democratic one, which encourages personal and community responsibility.

Services for Vulnerable Individuals and Families under Communism	Services for Vulnerable Individuals and Families in a Democracy
• Humans are valued for production and relationships are hierarchical • Social problems are unrecognized or minimized • Models of service are based on political and social control needs • Institutional models supplant families and communities • Management and financing structures are centralized and hierarchical • Workers' job functions are administrative and procedural • The purpose of monitoring is for political and social control	• Humans have intrinsic value and relationships are reciprocal • Social problems are collective action problems • Models of service are based on evidence-based, best practices • Community based, family-focused models are supportive and supplemental • Management and financing structures are decentralized and participatory • Human service workers are professionalized • The purpose of monitoring is for protection and quality

C. Framework for Analysis of Best Practices

The best practices identified in this study are analyzed using a framework that consists of four pillars, deemed a comprehensive model of community-based social services for vulnerable groups. The framework incorporates common elements of need for various risk groups across the life cycle from infancy to late adulthood, and highlights preventative and home-based care over institutional care. The four pillars are identified and defined below.

Pillar 1: Policy and Legal Framework. The policy and legal framework pillar includes the identification of policies and laws that reflect internationally recognized best practices and trends for individuals and families in crisis, development and implementation of standards for care, strategies for implementing policies, and centralized and decentralized functions for public entities (potentially including linkages with county and municipal budgets).

Pillar 2: Structure and Types of Programs and Services. This pillar includes types and ranges of programs and services, for example client-based, public/private oversight, source of financial support, community-focused with outreach capacity, and accessibility. This pillar may also include the implementation of standards of care models, certification and licensing practices for programs, local citizen involvement, and public awareness initiatives such as volunteerism.

Pillar 3: Human Capacity. As the programs and services change, a shift in job functions occurs, which requires a different skills and knowledge base. Pillar 3 focuses on the people who provide the services (front-line workers), supervisors, managers, and administrators. The training and re-training of professional and paraprofessional workers is important in shifting from institution-based to community-based models. This pillar includes professional education and training; curriculum development activities; professional regulation such as licensure, certification, registration, and practice standards; and monitoring of performance.

Pillar 4: Performance Outcomes and Measures. This pillar describes how outcomes are defined, measured, and monitored by government policies and strategies and by donor interventions (i.e., reduced dependency on institutionalization and increased utilization of community-based care). Outcome measures that promote family and community reintegration and that are supported by systems designed to monitor individual results and quality of programs and services are consistent with best practices standards.

D. Promising Practices in Community-Based Services

The table below presents a range of practices that are indicative of progress in reform in each of the four pillars.

Range of Practices Indicative of Progress in Reform
Policy and Legal Framework:
Identifies and defines priority groups at-risk Promotes family and community care over residential and institutional-based care Identifies internationally recognized standards of care and professional practice Establishes a mechanism for partnering and/or contracting with NGOs to provide social services Establishes accountability and sanctioning mechanisms Engages consumers and advocacy groups in designing and evaluating public policy
Structure and Types of Programs and Services:
Programs range from prevention to protection and reflect international standards Mechanisms in place to shift from residential care to community care Principles and values of practices reflect capacity-building over "relief and rescue" Assessment processes in place for targeting those whom the program is designed to serve Client accessibility mechanisms in place, such as client outreach and citizen awareness/public education At-risk groups have influence in decisions of service providers Integrated approach to assessment, planning, and intervention Mechanisms in place for community participation and volunteerism Public awareness and public education campaigns influence public attitudes and citizen involvement
Human Capacity:
Job functions reflect an integrative approach to assessment, planning, intervention, and follow-up (social work case management and multidisciplinary planning) Workforce includes treatment and rehabilitation professionals Practitioners are regulated through licensing or certification procedures Human services professionals such as social workers, psychologists, and health professionals are educated and trained Curricula reflect principles and values of human capacity building, prevention, and community care Curricula and programs promote professional standards of practice Partnerships between universities, advocacy groups, and public and private service delivery organizations focus on performance improvement through workforce development Professional associations advocate to promote quality of service through quality workforce development
Performance Outcomes and Measures:
Indicators measure reduced risk and/or improved well-being Information systems monitor programs and services Information systems monitor clients

PART THREE

INDIVIDUAL COUNTRY REPORTS

A. Armenia

Armenia, a country of three million people, is a strategically important country in the Caucasus that is progressing towards becoming a stable, democratic society. The large Armenian-American Diaspora that remains loyal to personal connections, as well as commercial and political incentives in Armenia bring special U.S. interest to the country. Armenia, which regained its independence in 1991, suffered a devastating earthquake in 1988 and has one of the highest rates of poverty in Eurasia. It is estimated that 50 percent of people live in poverty. A high concentration of the poor live in the rural areas with limited access to public services such as clean water, transportation systems, education, social services, and health care. Also living in Armenia are an estimated 11,000 refugees, primarily from Abkhazia (Georgia) and Chechnya (Russia), in addition to about 50,000 Internally Displaced Persons (IDPs) from Nagorno-Karabakh.

The country team's findings for Armenia, as they relate to each pillar, are presented below. Following the findings, a table summarizes Armenia's progress in transforming its social services system compared to best practices in each pillar.

Findings by Pillar

Pillar 1. Policy and Legal Framework. The Ministry of Labor and Social Issues of Armenia has identified 17 **vulnerable groups**, including children separated from their parents, disabled persons, families living with a single parent, refugees, those living in poverty, and elderly living alone.

Although Armenian social policy, in principle, supports **de-institutionalization** and emphasizes keeping individuals within their communities, there is no system-wide effort to reunite children, the disabled, or the elderly with their families and reintegrate them into the family and community. Investments continue to be made to improve basic living conditions in institutional settings although public policy supports home-based and community care.

Armenia ratified the Convention on the Rights of the Child in 1992 and passed the Law of the Republic of Armenia on the Rights of the Child in 1996; however, a comprehensive plan to implement these policies has not yet been developed. Currently, there are more than 12,000 **children** in 60 residential care facilities, nearly 1.2 percent of the child population. Although not as high as in other transition countries, the rate of child institutionalization, including infant placement, is increasing. There are few incentives or systems in place to connect children with their families or communities, and existing family reunification services are limited to a few NGOs. Reunification is not linked with de-institutionalization and does not appear to exist as a

strategic plan. In general, the focus of government efforts is on improving child care institutions through renovation, construction of schools within the institutions, and increasing the capacity of staff.

Foster care is recognized as a child protective measure, and there are pilot programs that demonstrate the positive outcomes of foster care, but no national system of foster care exists. The legal mechanism for alternative family placement is guardianship, a form of foster care provided by extended family members.

Programs and services aimed at **disabled children** are included primarily in education initiatives. The Ministry of Education strategy mainstreams disabled children from community and institutional settings into regular classrooms.

While community-based social services are few in Armenia, those that exist are provided primarily by the emerging **NGO community**. Political conditions in Armenia are favorable for the development of NGOs as social service providers, and there are currently more than 3,400 of them,[3] however, institutional capacity and funding are still primary concerns.[4] The Government recently has developed a mechanism for contracting with NGOs, although the concern is that the government's financial resources are not adequate to meet the contracting needs. Formally, the government is responsible for overseeing NGO activities, but no monitoring authority has yet been created.[5]

Pillar 2. Structure and Type of Program and Services. Programs and services in Armenia focus on poverty alleviation through the effective **targeting** of means-tested benefits. Targeting ensures that programs and services are utilized by those in need. Outreach and case-finding of people in greatest need are integrated into the structure of services through a comprehensive system of community-based approaches to service delivery. Public social services in Armenia heavily emphasize targeting of financial benefits to the disabled, the elderly, the poor, and children-at-risk. Currently, about 115,000 disabled and 500,000 elderly receive benefits. Approximately 140,000 families receive child benefits. Financial benefits targeted at poor families with children are well developed and have been reported to alleviate poverty.[6]

The changes that have resulted from the partnership among the U.S.-based international consulting firm PADCO, the Ministry of Labor and Social Issues, and local government have demonstrated how leveraging public services can contribute to effective targeting of benefits. Targeting is a significant focus of the USAID-funded Integrated Social Services Center "One-Stop-Shop" program in Vanadzor. This program utilizes a strong outreach and case-finding methodology. It has piloted a system for targeting social assistance benefits and services for families, disabled, and elderly in vulnerable situations. The center improves access by

[3] Karen Asatryan. Interview with author, September 20, 2004. For additional information, see http://www.advocacy.ge/magazine/NGOsinArmenia.shtml.
[4] A. Aleksanyan. *New Perspectives on Armenian NGOs*. (Washington, DC: IREX Contemporary Issues, undated), http://armenianstudies.csufresno.edu/hye_sharzhoom/vol24/october79/ngos.htm.
[5] For additional information, see http://www.legislationline.org/index.php.
[6] World Bank. Human Development Sector Unit, Europe and Central Asia Region. *Armenia Child Welfare Note* (Report No. 24491-AM). (Washington, DC: the World Bank, 2002)

integrating the application process for consumers and by providing information, outreach, and system coordination for social security, labor, and health benefits and for social service NGOs.

NGOs demonstrate some understanding of a continuum of care that includes a range of psychosocial interventions. This has been formalized in the Integrated Social Services Program, in which NGO representatives function as team members side by side with public sector representatives. The NGO Training and Resource Center,[7] created by the Armenian Assembly of America through USAID funding under the Social Transition Program in Armenia, is a valuable resource for the community of service providers. Its website includes a database of NGOs (currently 469) and provides up-to-date information about public awareness and advocacy issues.

A study conducted by the Practical Psychologists Association[8] indicated that only a few NGOs have qualified professional social work and psychological staff. The study concluded that NGOs that provide services aimed at vulnerable groups are not well-targeted (compared to government programs) to meet the needs of vulnerable women and children, refugees, "freedom fighters," and the disabled. NGOs involved in community rehabilitation and mental health have few qualified staff as well.

The country-study team held two focus groups in Armenia—one with NGO administrators and one with direct service providers—to learn the perceptions of each group's members concerning the country's capacity to provide assistance to vulnerable populations, and then to examine these perceptions according to the analytical framework outlined in Part 2. The two groups differed in their view of Armenia's most pressing social problems. The NGO administrator group named broader issues such as the need for a middle class and stronger NGO sectors, while the provider group named more specific issues such as homeless people and street children. However, both groups agreed on two causes of Armenia's critical problems: the lack of knowledge of civil rights among citizens and the lack of citizen participation in the development of programs and services. The groups agreed that there were sufficient laws to protect vulnerable groups, but felt that these laws were not always implemented. Both groups listed their own organizations' programs and services as addressing Armenia's problems and did not feel that more programs were needed.

The NGO community provides many examples of **advocacy** efforts for identified vulnerable groups in Armenia. CRINGO Network[9] focuses on refugees, Internally Displaced Persons (IDPs), and other vulnerable groups; *Pyunic* advocates for the disabled; and Mission Armenia advocates for the elderly. The emphasis of these organizations is on providing access to public services and community life for the vulnerable groups they represent.

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[7] For additional information, see http://www.ngoc.am/.

[8] Practical Psychologists Association. *The Challenges of Psychological and Social Services NGOs and the Issue of Professional Licensing*. (Yerevan, Armenia: Practical Psychologists Association, 2002)

[9] Caucasian Refugee and IDP NGO Network (CRINGO Network) is a voluntary, independent, non-commercial, non-political network of organizations that work in the territory of the Caucasus with refugees, IDPs, and other persons with a common status. CRINGO Network was officially started in September, 2001 and unites more than 60 NGOs from the North and South Caucasus. See www.cringo.net for more information.

Although **microfinance** programs seldom are considered to be part of a social services delivery system, microfinance has emerged in Armenia as a model for poverty alleviation and is one method for targeting the rural poor. Important outcomes of social services such as building self-reliance and reducing dependency on the system can be achieved through programs such as the Microenterprise Development Fund (MDF) program, *Kamurj*. *Kamurj* uses a solidarity group lending methodology, which relies on a group loan repayment guarantee rather than traditional collateral. The MDF-*Kamurj* mission is to "provide accessible, long-term financial and non-financial services to Armenian micro-entrepreneurs, particularly women." In addition to targeting women entrepreneurs, *Kamurj* hopes to provide loans to disabled people through Armenia's disabililty NGOs. *Kamurj* has found, however, that the NGOs prefer grant financing to credit fnancing mechanisms, so these programs have been slow to develop. Despite this, microfinance is a viable and integral part of the social services delivery system and an innovative model that has considerable potential, especially for youth, the disabled, and women.

Pillar 3. Human Capacity. Social work has developed into a viable profession in Armenia as a response to the social and psychological needs of the 1988 earthquake victims. The development of social work in Armenia has great potential, particularly in the practice of case management. At the time this study was conducted, all of the country's more than 700 social workers from the public and NGO sectors had received some professional education through USAID's Participant Training Program with the Academy for Educational Development (AED). This national training program was established to support the development of a basic curriculum on case management, but, unfortunately, it no longer functions. Training and education programs have been established in private universities, but high tuition costs limit access for many students. Strong linkages exist, however, between academia and practice. Training and education in social work integrates participatory methods and practical experiences into the curriculum

The profession of psychology has taken root and has an active association, but the development of rehabilitative professions such as occupational and physical therapy, which are critical to de-institutionalization and implementation of community care, is limited. Several NGOs advance social work and psychology through professional training that continues throughout the practitioner's work experience. Community rehabilitation is in the development stage.

Pillar 4. Performance Outcomes and Measures. Computer-based monitoring systems that track clients, costs, and administration of programs and services are in limited use. The monitoring system at the Integrated Social Services Center in Vanadzor provides one model in this area. Mission Armenia also tracks its services to the elderly and the disabled on an organization level.

Armenia's progress in transformation compared to the necessary elements of best practices in the four pillar model:

Armenia		
Pillars	**Progress Made Toward Best Practices**	**Factors Limiting Progress**
Policy and legal framework	• The Ministry of Labor and Social Issues has identified 17 vulnerable groups • Social policy framework supports the transition to community care for the elderly, the disabled, and children • Several model rehabilitative programs exist for developmentally delayed children • Restrictive laws have recently been changed to permit contractual arrangements with NGOs • Children's rights laws passed in 1996 • Ministry of Education strategy mainstreams disabled children into regular classrooms	• There is no national law or policy supporting the transition to community care for the elderly, the disabled, or children • There is no national law or policy related to foster care services • Investments continue to be made to improve the conditions in institutions rather than to improve community care • There is a gap between policy and practice: implementation strategies with clearly defined outcomes and human and financial resource needs are the next step in implementing the existing policy framework
Structure of Programs and Services	• Model programs have been developed for improved targeting of benefits and services • Programs and services focus on poverty alleviation through the effective targeting of means-tested benefits • Outreach and case-finding of people in greatest need are integrated into the structure of services • Economic development is emerging as an integral part of social services programs through microfinance programs integrated into community development initiatives • An array of community-based services exist for elderly and disabled persons • Mission Armenia provides standards of home-based care for elderly and disabled persons	• Existing programs that are improving conditions in institutions have not been linked to family and community reintegration programs • The knowledge and skills acquired through the Integrated Social Services Program has not been scaled up into de-institutionalization initiatives • Donor development initiatives are not integrated into existing public structures
Human Capacity	• There is an emphasis on development of social work at the practice and university levels, with a focus on case management • Training and education programs have been established in private universities • Strong linkages exist between academia and practice • The profession of psychology is recognized and has an active professional association	• There is no monitoring system for management and supervision of social work interventions • Research on the professional practice of social work including job functions is lacking • Development of rehabilitation professionals critical to de-institutionalization is limited
Performance Outcomes and Measures	• The computer-based monitoring system demonstrated in Vanadzor provides an integrated model for tracking client eligibility and access to services • Mission Armenia tracks services and programs on an organization level	• Client outcomes continue to be measured by economic and quantitative indicators rather than quality of life and well-being factors

B. Azerbaijan

Azerbaijan is a country that presents unique development challenges. Although the country is rich in petroleum resources, 60 percent of its population lives below the poverty line. One of the greatest challenges facing the country is to ensure that a greater portion of the population derives some benefits from the new oil wealth. The economic blockade of Armenia by Azerbaijan due to the continuing dispute over the Nagorno-Karabakh region led to the U.S. Congress imposing restrictions against assistance to the Azerbaijan government under the Freedom Support Act (FSA) in 1992. This measure prohibited USAID from assisting the Azerbaijan government directly with development programs. Consequently, all U.S. Government assistance in Azerbaijan was directed at NGOs, community groups, and private sector enterprises. In 2002, this restriction was lifted, but it is still reviewed annually. Since Section 907 of the FSA has been waived, allowing USAID to work directly with governments,[10] USAID/Azerbaijan has moved toward determining ways that community development activities might be transformed into assistance in the development of a social services delivery system.

The country team's findings for Azerbaijan, as they relate to each pillar, are presented below. Following the findings, a table summarizes Azerbaijan's progress in transforming its social services system compared to best practices in each pillar.

Findings by Pillar

Pillar 1. Policy and Legal Framework. Although there is a public policy statement on the development of community-based services,[11] there is no system-focused reform effort. Reform efforts are primarily focused on improved targeting and access to social assistance benefits.

International donors have made **Internally Displaced Persons** (IDPs) and **refugees** the priority groups for provision of basic services. Official data on IDPs and refugees puts their numbers at just over 1 million. The government recently has increased assistance by providing permanent housing and access to services. Housing conditions for IDPs are considerably worse than for the rest of the population. Women and children IDPs are considered the most vulnerable subgroup,[12] and there is much concern among IDP women about child and family health. Representatives from some social service organizations express concern that the needs of IDPs and refugees have been emphasized at the expense of many other Azerbaijanis living in vulnerable conditions. The term *reverse discrimination* is used to describe the situation of local Azerbaijani vulnerable and poor residents having fewer benefits than IDPs and refugees.

Other vulnerable groups in Azerbaijan are not as clearly identified among local and national government representatives. Unemployment and lack of income generating activities were the most frequently cited reasons for vulnerability among Azerbaijani citizens. There is limited awareness of those not in the labor market, such as individuals with chronic mental and physical

[10] USAID Caucasus. *Azerbaijan: Country Strategy FY 2005-FY 2009*. (Baku, Azerbaijan: USAID Caucasus, 2004)
[11] UNDP. *State Programme on Poverty Reduction and Economic Development (SPPRED) 2003-2005*. (Baku, Azerbaijan: UNDP, 2003)
[12] Ibid.

illnesses. Statistics indicate that the elderly and disabled live alone and many are housed in institutional settings. Youth,[13] which make up approximately 60 percent of the Azerbaijan population, are most often cited as the most vulnerable group in Azerbaijan, and two million are unemployed. There are currently 75 active youth NGOs, and 54 of them are members of the National Assembly of Youth organizations.

Documentation indicates that violence against **women and children** exists, but it is primarily a private family matter. According to a recent report by the International Rescue Committee,[14] little programming has been done in service delivery to this area, with most efforts being focused on public awareness and public information on the issues related to women and violence. A Women's Crisis Center provides psychological and social assistance.

The increased drug traffic from Central Asia to Europe via Azerbaijan has caused a sharp increase in drug addiction.[15] Although much of the emphasis has been on drug trafficking, law enforcement, and linkages to crime, increased access to drugs and drug addiction will amplify the need for community-based models for drug prevention and treatment.[16] The Ministry of Youth, Sport, and Culture, the entry point for youth initiatives, was often mentioned as engaged and interested in providing assistance to **drug addicts**.

Pillar 2. Structure and Types of Programs and Services. Services for individuals and families within the public arena appear to provide economic and material assistance on a case-by-case basis for subsistence-level requests, such as medical costs, funeral expenses, and school expenses.

Services for IDPs and refugees have focused on housing and living conditions, employment, education, and food provisions. Limited attention, primarily from a few NGOs, has been given to psychological issues such as loss, trauma, and tentative status. The Government of Azerbaijan is investing heavily in building new housing and infrastructure in some border territories controlled by Azerbaijan for resettlement of IDPs. For some, these new settlements are a major improvement in living standards. For others, especially those who have migrated to Baku, these settlements are a less favorable alternative. Many of the needs identified for IDPs emphasize infrastructure and economic necessities. The Head of the Cabinet of Ministers' Department for Problems of Refugees, IDPs, Migration and Work with International Organizations has identified these as areas that could benefit from USAID technical assistance.

The government recognizes that institutional care has detrimental effects on children and aims to prevent **institutionalization** and provide alternatives for families in need. While new laws

[13] Azerbaijan defines "youth" as individuals between the ages of 15 and 30.
[14] International Rescue Committee. *Assessment on Violence and Women in Azerbaijan*. (Washington, DC: International Rescue Committee, June 2004). http://www.theirc.org/resources/IRC-20Azerbaijan-20VAW-20Assessment-20June-202004-20English.pdf
[15] D. Karakmazli. "The Number of Drug Addicts in the CIS Countries Is on the Increase, Almas Imenbayev, Representative of the European Region Office of the WHO, Believes," *Ekho*, 21, May 2002.
[16] Glenn Curtis. *Involvement of Russian Organized Crime Syndicates, Criminal Elements in the Russian Military, and Regional Terrorist Groups in Narcotics Trafficking in Central Asia, the Caucasus, and Chechnya*. (Washington, DC: Library of Congress Federal Research Division, October, 2002) http://www.isn.ethz.ch/pubs/ph/details.cfm?lng=en&id=10325.

address family support services and foster care, the laws have not yet been implemented. Guardianship, a form of foster care provided by extended family members or other community members, provides a limited alternative to institutionalization. Statistics on the number of elderly and disabled persons housed in institutions and other medical facilities were not readily available.

Funding is shifting from institutional care towards supporting families and re-integrating children. The integration of the disabled into local rehabilitation services and the matching of vocational training with labor market needs also are included as part of this shift to the **community management of risks**.[17]

United Aid for Azerbaijan (UAFA), an international NGO with specific interests in Azerbaijan, works closely with UNICEF to reduce the number of **children** in state care, to raise the level of institutional care, and to develop social services for children in need of special protection. There are more than 8,000 children in institutions in Azerbaijan and more than 70 percent of these children have parents. UAFA and UNICEF are collaborating on a project to integrate disabled children into public education settings. USAID's Displaced Children and Orphans Fund supports a three-year initiative, the Community-Based Support Services for Marginalized Children, that promotes the social integration and community capacity for care for marginalized children in Azerbaijan. This recently initiated project (September 2004) is being implemented by Save the Children Federation and has a geographic focus on Goranboy, Mingechevir, and Shuvalan (Baku). Their emphasis is on improving psychosocial and economic support to marginalized children.

Local and international **NGOs** recognize the need for capacity building in service provision and for public awareness campaigns on child protection.

Social assistance benefits for the social protection of vulnerable groups are provided categorically without being **targeted** to those who are most in need. The programs target risk groups rather than the poor across different risk groups. In 2001, 56 percent of the poor were not covered by any of the child allowance program funding. The State Program on Poverty Reduction and Economic Development (SPPRED)[18] strategy to reduce poverty includes a targeted program of benefits. Although SPPRED aims to reform the existing system of social protection, their emphasis is on social integration of the most vulnerable groups rather than on introducing community-based care. Statistics from the Ministry of Labor and Social Protection (MLSP) show that in 74 regional and city departments there are 1,621 social employees who provide 15,289 elderly and disabled persons with social services in their homes, at least twice a week. Other services include medical treatment, repair of apartments, and arrangement of mourning ceremonies.[19]

[17] UNDP. *State Programme on Poverty Reduction and Economic Development (SPPRED): Azerbaijan Progresses toward the Achievement of the MDG's, Annual Report 2003-2004*. (Baku, Azerbaijan: United Nations Development Programme, 2005)
[18] Ibid.
[19] World Bank. *Poverty Assessment Report No. 24890-AZ, Volume II: The Main Report.* (Washington, DC: the World Bank, 2003)

A plan for **decentralizing** public services is on the books, which will follow the creation of municipalities. Municipalities will be the ideal entry point for technical assistance in the implementation of social policy reform aimed to create community-based support services, if they are given responsibility and access to resources.

Mobilization efforts have improved living standards by meeting the immediate needs of daily living, providing subsistence livelihoods, and stimulating communities with new skills. At the same time, **community mobilization** around microprojects has reinforced short-term survival strategies rather than longer term social and economic development. Local NGOs such as UMID and Community Empowerment Network have been working with and training communities around the country to apply community development methodologies. Changing community thinking around popular issues can provide sustainable change, leverage the government, and help to establish a long-term niche for community mobilization activities. Strong liaisons and networks have been formed that are the very basis of a community-based system of care.

One of the primary constraints to the use of **microenterprise development** as a poverty alleviation strategy is the fee structure for business development services and the accompanying perception of business development service providers that microenterprises are unable to pay for services. However, interviews with local microfinance institutions (MFIs) suggest that Azerbaijani borrowers now understand the importance of creditworthiness and thus sustain a high level of repayment. Interviews with national government stakeholders indicate a growing awareness of the importance of MFIs in reducing poverty and enabling entrepreneurship. Constraints that microenterprises face in Azerbaijan include: lack of capacity and inability to achieve scale; lack of market orientation and skills; lack of access to markets and financial services; and the weak regulatory environment for economic opportunities.

Pillar 3. Human Capacity. There are no schools of social work in Azerbaijan, and job skills such as interviewing, assessment, and planning are lacking in the social service workforce. A general lack of knowledge of human development and human relations exists among those labor and social protection officials who are basic to the implementation of a family-centered, community-based system of services. The need to make changes in job functions and in administrative and management structures to provide the necessary knowledge, skills, and values for community social services and monitoring programs is key for the system reform effort that has been outlined by the Ministry of Labor and Social Protection.[20]

Pillar 4. Performance Outcomes and Measures. Some organizations that provide social services have defined the desired outcomes of their programs, but systems to track clients, programs, and results are not yet widely developed.

[20] UNDP. *State Programme on Poverty Reduction and Economic Development (SPPRED): Azerbaijan Progresses toward the Achievement of the MDG's, Annual Report 2003-2004*. (Baku, Azerbaijan: United Nations Development Programme, 2005), 74-75.

Azerbaijan's progress in transformation compared to the necessary elements of best practices in the four pillar model:

Azerbaijan		
Pillars	**Progress Made Toward Best Practices**	**Factors Limiting Progress**
Policy and legal framework	• Decentralization of services is planned • Public policy supports the development of community-based services • Since 2002, the Government has brought the management of the State Social Protection Fund under the Treasury, although the respective policy functions remain under the auspices of the various agencies • Government project integrates institutionalized disabled children into public schools	• There is no system-wide effort to implement existing public policy related to community-based services • The needs of IDPs and refugees have been emphasized by international donors at the expense of other vulnerable groups • The number of children in institutions has been rising: currently, there are 17,000 children residing in various forms of institutions and boarding schools[21] • Government policies restrict partnerships and contracting with NGOs for services
Structure of Programs and Services	• The development of local community councils through community mobilization projects provides models for citizen involvement in services • Vocational programs serve the disabled, Roma, and youth in institutional care • Guardianship exists as a limited alternative to institutionalization	• Institutional care is the primary alternative for children whose parents are unable to manage alone • Social assistance benefits are not well-targeted • Microenterprise development is constrained by a fee structure for business services
Human Capacity	• Capacity for community-based services provision has been developed in local NGOs and includes interpersonal communications, teamwork, problem identification, and identification and utilization of community resources and planning • The value base that is critical for a community-based model of services is emerging through community mobilization efforts	• There are currently no schools of social work in the country • Necessary job skills such as interviewing, assessment, and planning are lacking in the social service workforce • Accountability mechanisms are lacking in the workforce • The knowledge of standards of practice necessary to design and implement capacity-building initiatives is lacking • The central government and municipalities are not substantively engaged in community mobilization efforts
Performance Outcomes and Measures	• Organizations that provide social services have defined performance outcomes	• No integrated computerized systems track clients, costs, and administration of programs

[21] UNDP. *State Programme on Poverty Reduction and Economic Development (SPPRED): Azerbaijan Progresses toward the Achievement of the MDG's, Annual Report 2003-2004*. (Baku, Azerbaijan: United Nations Development Programme, 2005), 59. The Government reports nearly 30,000 as a way to access more state funds, since the amount of funding is determined by the number of beds (similar to how hospitals are funded).

C. Bosnia

Bosnia and Herzegovina (BiH) is a country of four million people, divided into two entities: the Federation of Bosnia and Herzegovina with 51 percent of the population, made up of Bosniacs and Croats, and the Republic of Srpska (RS) with 49 percent of the population, made up of Bosnian Serbs. It has a mixed religious tradition with approximately 44 percent Bosniacs (Muslim), 31 percent Bosnian Serb (Eastern Orthodox) and 17 percent Bosnian Croats (Roman Catholic). Bosnia suffered many setbacks as a result of the war in 1992, which killed more than 200,000 and injured thousands more, and destroyed the infrastructure of public utilities and services. Peace came in 1995 with the signing of the Dayton Peace Accord, which resulted in BiH becoming a state with two largely self-governed entities, as well as an additional autonomous District of Brcko. BiH has ten cantons, and both entities are further subdivided into municipalities. Policy for social welfare and protection and the provision of social services to vulnerable groups is developed at the entity level or at levels below that: cantonical or municipal.

The country team's findings for Bosnia as they relate to each pillar are presented below. Following the findings, a table summarizes Bosnia's progress in transforming its social services system compared to best practices in each pillar.

Findings by Pillar

Pillar 1. Policy and Legal Framework. Bosnia's primary focus in this pillar has been on de-institutionalization and the development of standards of good practice; however, national policies and laws that provide an overarching framework to guide practice and provide standards of community care are still lacking.

The system of social protection is not **decentralized** in the sense that local governments are making the decisions. Rather it is multi-layered and fragmented, consuming much of the public resources in administrative and management costs. In BiH, the cantons hold 90 percent of the revenues, while the state has two percent and the municipalities have eight percent. The cantons are responsible for paying benefits to clients, including means-tested benefits and foster care payments, and the municipalities are responsible for covering the fixed costs, such as salaries and administrative costs of the Centers for Social Work. Some cantons have less revenue than others, which results in disparities and inconsistencies in benefits payments as well as staff salaries.

There is national legislation on **adoption**, but it does not reflect international standards, nor are laws linked to the range of community-based alternatives. Complicated and bureaucratic procedures make adoption difficult. Present legislation allows for children up to the age of five to be adopted nationally, with some indication that this will change to age ten. The World Bank currently has included changing the adoption laws as part of their national policy reform and legislative work.

Risk factors affecting **children** include parental poverty and unemployment, family violence, disability, family disruption due to divorce, early pregnancy, single motherhood, and social problems related to minority status, most particularly Roma. The number of children in risk

categories tends to be narrowly defined as children living without parental care, both in institutions and alternative family placement. The war in BiH resulted in an increase in the number of children without parental care, with current estimates at 3,000 to 3,500 children. Of that number, 1,130 children reside in **institutional care** and others are in foster care, most with extended family. Since the end of the war, the number of childcare institutions has grown from 5 to 17.[22]

The above estimate of children without parental care does not include children living in institutions for the disabled and the 260,000 children receiving cash benefits and social services who are potentially in risk situations. There are 41,204 child beneficiaries of child protection programs in BiH and 84,000 in RS.[23] The number of children in difficulty with the law and children living in violence has not been thoroughly studied, although Save the Children/UK has provided some data on these emerging problems.[24]

USAID/Bosnia supports a Children at Risk Program to help the Government of BiH address the special needs of children at risk, especially orphans. This program provides support to the Bosnian government to set up systems, mechanisms and institutions to protect and care for homeless children and to establish and provide family reunification services, foster care, and adoption services. The USAID funded project is helping the government and NGOs working in the area to better identify cases and provide services.

Save the Children/UK has developed a pilot foster care program in Tuzla Canton where a quarter of children are without parental care. Save the Children, working closely with UNICEF and local governments and national entities, has developed guidelines and standards on foster care for dissemination and replication in Centers for Social Work in other cantons. This systematic implementation of foster care for children without parental care includes promotional campaigns for recruitment, training of foster parents, verification of ability to ensure safety of the child, assessment of families, assessment of the children, and preparation for placement and follow-up.

Pillar 2. Structure and Types of Programs and Services. The alternatives to institutional placement are just beginning to be developed, most particularly **foster care**. Prevention and early intervention services are not available as part of the range of services for in-home and out-of-home care. For the most part, children who have been placed in alternative care are not provided with child or family assessments and have no care planning, follow-up services, or monitoring. Foster care services need to be scaled up in other areas of the country. The long term goal is to support the ministries at the federal level and to agree on a best practices framework for drafting a law on foster care.

[22] For more information, refer to Reima Ana Maglajlic and Taida Kapetanovic. *Assessment of the Children at Risk Program Strategy* (Sarajevo, Bosnia-Herzegovina: USIAD/BiH and UNICEF, February 2005)

[23] World Bank ECA, Poverty Reduction and Economic Management Unit. *Bosnia and Herzegovina: From Aid Dependency to Fiscal Self-Reliance. A Public Expenditure and Institutional Review, Report No. 24297-BiH*. (Washington, DC: the World Bank, 2002)

[24] Save the Children/UK. *Beyond Silence: A Study on Violence Against Children in BiH*. (London: Save the Children/UK, 2002)

According to a recent UNICEF study,[25] there are no separate homes for children and youth with disabilities in BiH. Most **children with disabilities** live with their families without any system of rehabilitation and support. Alternative placement models for disabled children deprived of parental care, such as specialized foster care, do not exist. Most disabled children do not attend school and have little chance for independent living in adulthood. Early intervention for children from birth to six years of age is virtually non-existent, except for the work of a few NGOs.

Children in conflict with the law have few community alternatives and often are placed in residential facilities such as detention centers or prisons. These children are at a higher risk of homelessness and joblessness after incarceration. The need exists for community alternatives that provide supervised treatment and rehabilitation services to allow children in risk categories to live in their family and community, attend school, and develop social and vocational skills.

The estimated **Roma** population in Bosnia is more than 100,000. Many do not have access to basic services such as education, health, and social assistance benefits. The lack of identity documents sometimes prevents Roma from receiving assistance.

Although much of the government's emphasis to date has been on strengthening public services, the **NGO sector** is a critical link in delivery of social services and must be held to the same standards as the public services. A number of local NGOs provide social services, particularly in the area of disability and special needs children,[26] but there is limited information about them.

Projects to develop NGO capacity in coalition-building[27] and association-building for user groups (primarily associations of foster parents and disabled children)[28] have resulted in organized **lobby and advocacy groups**. The associations of social work, although fragmented and with limited capacity to advocate, are important links in policy and practice change. Professional associations provide a valuable lobby for social policy reform.

Pillar 3. Human Capacity. The Centers for Social Work (CSW), which employ 991 workers in 97 centers throughout the country, are a resource with a great deal of potential to effect change. While center staff are engaged primarily in administrative and procedural tasks, much of the reform effort in BiH has been through these centers. Generally, staff lack the knowledge and skills necessary to provide prevention and early intervention services, but there are a number of efforts through various external donors to increase the capacity of the CSW.[29] A system is in place, and a cadre of people is ready to be developed if given the opportunity to provide a wider range of services.

Pillar 4. Performance Outcomes and Measures. The data on children without parental care are difficult to obtain, as there is no current accounting of them. Data on children living in families

[25] See *Children and Institutions in Bosnia and Herzegovina*, UNICEF/Bosnia, 2003, for a detailed description of disabled children without parental care.
[26] America's Development Foundation. *Democracy Network II Final Report*. (Sarajevo, Bosnia-Herzegovina: America's Development Foundation, 2004).
[27] A project of the Democracy Network Program funded by USAID/Bosnia.
[28] A project of Save the Children/UK.
[29] Reima Ana Maglajlic and Taida Kapetanovic. *Assessment of the Children at Risk Program Strategy* (Sarajevo, Bosnia-Herzegovina: USIAD/BiH and UNICEF, February 2005), 5.

in risk situations are even more difficult to find. The World Bank, through the Social Sector Technical Assistance Credit (SOTAC) Initiative, developed and disseminated a computer-based **monitoring system** that has the capacity to track children and families receiving benefits payments. However, the local Centers for Social Work indicate that they have limited information technology capacity and resources to enter data into the system and use the system for analysis. There is also concern that maintaining the database is costly, which is a disincentive for its use. Despite these problems, the system has the capacity to serve as a case management tool for monitoring service delivery and tracking clients' goals and progress.

An important **performance outcome** in the work of the Centers for Social Work is the integration of services for different risk groups within several Centers. This approach already has been demonstrated in selected centers.

Bosnia's progress in transformation compared to the necessary elements of best practices in the four pillar model:

Bosnia		
Pillars	**Progress Made Toward Best Practices**	**Factors Limiting Progress**
Policy and legal framework	• The primary emphasis in Bosnia has been on de-institutionalization and the development of standards of good practice • Child welfare standards have been developed • Partnership and contracting with NGOs is prevalent	• Multi-layered and fragmented government contributes to lack of strong national oversight of social services • Disparity in resources of cantons results in disparities in services to clients and salaries of social workers
Structure of Programs and Services	• Roma children have been integrated into public schools • Vocational programs serve disabled, Roma, and youth in institutional care • NGOs provide services, particularly for disabled people and special needs children • NGO coalition-building has resulted in advocacy and lobby groups	• Institutionalization used increasingly to care for children orphaned by war • Most children with disabilities have no system of rehabilitation or support • Partnerships between the NGO community and the Centers for Social Work have not been developed
Human Capacity	• A strong tradition of social work exists in the public sector, although the effects of war, subsequent emigration, and diminished quality of life have shifted the focus of social work to administrative areas • Social work training emphasizes basic case management	• Bosnia lacks education and training programs to develop the capacity of staff in the Centers for Social Work and NGOs
Performance Outcomes and Measures	• Computer-based client/services monitoring system provided by World Bank initiative has capacity to serve as case management tool	• Centers for Social Work have limited information technology knowledge and resources to use system effectively

D. Romania

Romania, with a population of 22.3 million people, became a full member of NATO in May 2004, and remains a strong ally of the United States. European Union (EU) accession is expected in January 2007. Romania has the largest Roma population in the region (estimated to be 2.5% of the country's population) and a large Hungarian population. The population is primarily Romanian Orthodox. Since suffering public exposure, in 1990, of the warehousing of more than 100,000 children in deplorable institutions, Romania has been held up as a model in its transition from institutional care of children to alternative, family-based care. Major developments that have affected the current state of social services in Romania are the child welfare reform initiatives of 1997 and the application of the principles of decentralization and community care to disabled persons initiated in February 2003.

The country team's findings for Romania, as they relate to each pillar, are presented below. Following the findings, a table summarizes Romania's progress in transforming its social services system compared to best practices in each pillar.

Findings by Pillar

Pillar 1. Policy and Legal Framework. Legislative and policy reform initiated by Romanian child advocates in 1997, combined with international exposure and external pressures, set in motion a process of devolving responsibility for child protection from the national government to local counties, municipalities, and villages. Institutionalized children became the priority group for implementing policy and practice reform. The policy changes to date have occurred in several stages of legislative and policy reform, all with the same goals of **decentralization, de-institutionalization, and "de-medicalization."**[30]

While the decentralization of child welfare services is considered to have been the most important change affecting reform, a change in tax collection procedures also had a major impact. It was anticipated that county budgets would continue to support some of the most important child welfare activities, but in 1999, tax collection was also decentralized at the county level. The lack of knowledge and infrastructure needed by county authorities to collect taxes resulted in a dramatic financial shortfall in the child welfare system. In 2000, the Romanian government declared child welfare a priority for Romania and started to re-allocate funding from the central level to child welfare institutions. This resulted in a more financially secure child welfare system, but it also maintained a financial incentive for the perpetuation of institutions.[31]

Although many supported the changes in principle, the reforms placed a financial and social responsibility on local county systems, for which they were ill-prepared. Some felt that policy changes were not accompanied by adequate implementation strategies for phasing out the costly institutions. In late 1999 and early 2000, child protection was reorganized at the national level. As part of this reorganization, 40,000 children from different ministries were transferred to the

[30] Child care services emphasized medical care with limited awareness of the social and psychological issues of child development and family relationships.

[31] Daniela Buzducea, Child Welfare Specialist, USAID Romania, Interview with author.

local county authorities from institutions for the disabled, hospitals, and special schools.[32] The new National Authority for Child Protection and Adoption prepared a new child protection strategy for 2000-2003. In 2001, the transfer process accelerated so that all children in residential care could benefit from reform.

Negotiations for Romania's integration into the EU led to a moratorium on international adoptions in 2001,[33] a response to increasing pressure surrounding corruption in international adoptions. Continued concern about this corruption led to further changes that moved adoptions into a separate agency and, in 2004, foreign adoptions were banned except for those by second-grade relatives.

On January 1, 2005, a very significant change in the child protection legislation went into effect,[34] prohibiting children under the age of three from entering institutional care. Out-of-home placement must now be either in a foster family or in small family group care. This legislation **might be considered "ambitious" compared to the current situation in Romania, as the appropriate foster care network to implement such a measure was not in place when the legislation came in effect and there was no transition period for implementation. The result is that newborn babies spend longer periods in maternity hospitals.**[35] Romania's transition from an institution-based to a family-based model of care continues.

Other issues (outside those most prevalent in child institutionalization), such as child exploitation and child neglect, are still to be addressed. The focus of policy and laws has been primarily on de-institutionalization; however, issues of health are critical for all groups, and education is critical for children and youth, especially for children with disabilities. Even though large numbers of children have moved back into their communities, their needs are not necessarily being met. Child neglect and child abuse result from family conditions such as poverty, alcohol and drug abuse, and poor parenting competencies.

The Romanian government plans to create local social services (down to the village level) to increase access to social assistance for all populations, especially the 45% of Romanians who live in rural areas. However, local authorities do not have the economic power to sustain such services, even with the national government investing in their creation, and the human capacity to implement such services is still lacking. Despite the barriers and difficulties, it is still an important step forward for Romanian society to recognize the need for social services and start assuming more responsibility for them.[36]

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[32] Although uncommon, in a few places such as Brailia, the institutions' staff refused to transfer all the children from the hospitals and from the specialized institutions for children with disabilities to the child welfare authorities. In other cases, the negotiations for this transfer took so long that some children were "forgotten." (Daniela Buzducea, Child Welfare Specialist, USAID Romania, intrerview with author.)

[33] For more information, see the official website of Romania's National Authority for the Protection of Children's Rights: http://www.copii.ro/working.htm.

[34] Law 272/2004 on the Protection and Promotion of the Rights of the Children.

[35] Daniela Buzducea, Child Welfare Specialist, USAID Romania, Interview with author.

[36] Ibid.

Sector One of Bucharest initiated **reforms to integrate social services** for children, the elderly, and disabled persons prior to the national legislation.[37] In 2003, a decision of the Local Council of Sector One was made to reorganize two departments (Child Protection and Social Protection) into one General Department for Social Assistance. It also integrated both social assistance payments and services and psychosocial support and care management. This change was meant to make services less fragmented, provide individualized case planning, improve quality and efficiency, and improve the ability to monitor both clients and service provision.[38] The emphasis was placed on developing community services in order to de-institutionalize the mentally and physically challenged child and adult populations. The expression most often heard was: "We have experience with child protection reform that we can apply to other vulnerable populations." With the official number of disabled children at 68,805,[39] de-institutionalization initiatives as well as in-home services are needed, since many of these children with formal certification are living in their communities, often isolated and excluded from school and other services.

Pillar 2. Structure and Types of Programs and Services. Child welfare programs in Romania utilize a continuum of care framework, with an increasing emphasis on **prevention services** for high risk families living in the community. The National Authority has elaborated a range of 20 different types of programs and services that emphasize psychosocial interventions and family and community support. Examples include mother and baby centers, day care, counseling and parent education, emergency and crisis services, prevention and early intervention for drug abuse, child maltreatment, and juvenile crime. Since 2000, the number of alternative services within the public sector has risen. The largest increase has been in the number of day care programs, specifically in day care for disabled children. Foster care services have grown, with 15,588 children in public foster care and 332 in private foster care. Another 27,017 children are placed in extended foster care, a priority placement over other substitute care options.[40] Community responsibility and involvement in social services was formalized by the creation of Community Boards, which aim to involve local citizens in advisory and public information roles.

The structure of services has not yet been defined for the **elderly** as it has for children and disabled persons. Romania has nearly four million elderly persons, and they could be utilized as an important volunteer resource in support of others in need. There are many isolated elderly, most particularly in rural areas, and there are also elderly who have the capacity to volunteer. Many have past professions and are a great resource. Pension reform has been identified as an important issue in improving the well-being of the elderly.

The emphasis of social service programs has shifted from treatment to prevention and early intervention, and **primary risk groups** have been expanded to include children at risk of abuse

[37] Since January 2005, reforms to integrate social assistance services for children and adults have become effective throughout Romania. Unfortunately, the funding needed to reform adult services is being taken from child welfare services because child services are in relatively better condition. (Daniela Buzducea, Child Welfare Specialist, USAID Romania, interview with author.)

[38] Mr. Danut Fleaca, Head of the Department of Social Services, Sector 1, Bucharest, Interview with author.

[39] Romania publishes statistical data on the numbers of children in protective care and the different types of protective care. The most recent data available on the public website is for August 2004, which was used for this study: http://www.copii.ro/eprotect.htm.

[40] Ibid.

and neglect in their own families, children with special needs including HIV/AIDS infected children, delinquent children, street children, and children "aging out" of long term residential care.[41]

The number of active programs providing social services in Romania is estimated to be between 450 and 700, but data on **NGOs** are limited. There is general agreement that between 1997 and 2004, tremendous growth of the non-profit sector took place in the delivery of social services for vulnerable groups, most particularly children, elderly, poor, victims of violence, and women and children at risk. In 1998, Public Law 34/1998 allowed local governments to to provide stipends to NGOs who provided residential services to children and adults. NGOs also have been very active in developing and advocating for policies on accreditation of social service providers and quality standards for social services (both public and private).[42] The state strongly supports NGO involvement in service delivery and plans to have 45 percent of community social services contracted out to NGOs by 2008. Just how this will be implemented and financed has not yet been fully planned. Currently, the USAID-ChildNet program is supporting the government of Romania in developing adequate legislation for contracting of child welfare services. The existing legislation related to contracting of public services formally excludes social services; therefore, specific legislation will have to be created for this area.[43]

Romania provides an example of the use of **microfinance programs** as a way to build self-reliance and capacity in persons of low income. CAPA, created by World Vision in 2001, is a microfinance institution based in Craiova, Romania, which provides loans and financial services to low income Romanians, especially those who live in rural areas. In keeping with World Vision's mission to serve the poor, CAPA loans are designed to help low income people provide their basic needs, for example to equip their homes with running water or add a room for children as the family grows, and to assist in the economic development of the area where the client lives. More than 50 percent of CAPA clients are women. CAPA has been successful because it works closely with the communities of the clients it serves. CAPA offers customized loan repayment plans and works to establish long-term relationships with borrowers. NGOs also have a great need for microcredit and loans since their grant money often is not immediately available, but currently only private businesses can get microfinance loans. A change in the law is needed to accommodate the non-profit sector.

Pillar 3. Human Capacity. The development of **social work** as a profession has received a great deal of attention in Romania since the early 1990s, with an emphasis on building human capacity to provide services to children and families at risk. Twenty-two Romanian schools and programs of social work provide Bachelor's and Master's degrees, and 10,000 social work professionals graduated from these programs between 1994 and 2004. Unfortunately, studies show that 30 percent of the professional graduates are working outside the field of social work or social

[41] Government of Romania, National Authority for Child Protection and Adoption. *Child Protection: Between Results and Priorities for the Future*. (Bucharest, Romania: Center for Resources for the Social Professions, undated ca. 2004)

[42] R. Negulescu. "NGOs in the Social Field and the Importance of Partnership between the Public and Private Sectors in Reform in the Social Field." *Dialogue* (June 2004), 2-9. [Newsletter published by Center of Resource and Information for the Social Professions (CRIPS)]

[43] Daniela Buzducea, Child Welfare Specialist, USAID Romania, Interview with author.

services. It is surmised that low pay is one of the motivations for people to move outside of the profession.

The Romanian Federation of Social Workers has the potential to develop the capacity of Romanian social workers, but currently the Federation's activities focus on the direct delivery of services rather than on members' professional development. This is partly because funding for services is easier to obtain than funding for professional development programs. The Federation consists of 11 loosely organized associations of social work. The associations function inconsistently but tend to work best at grassroots level efforts. Many association members see the need to begin a drive to push for licensure, with ways to monitor and sanction poor practice.

At the initiative of the Romanian Social Work Federation and with support from USAID, a National College of Social Work was created in March 2005. Among the roles of the College is to license social workers, sanction poor practice, and to represent their members in their relationships with employers. The College is young and there are still many things to be done to make it a functioning structure, but it is one of the first organizations of its kind in the region.[44]

Pillar 4. Performance Outcomes and Measures. One of the most significant changes in Romania's child protection system is the availability of statistical data on children and families in the social service system. Available in English on the Internet at **http://www.copii.ro**, the site (supported by USAID) provides baseline information on children in institutions in Romania's counties, which previously was extremely difficult to obtain. The data are not perfect, but they do show trends and changes in the social service system.

The closing of large orphanages is probably one of the best **indicators of change** in child protection in Romania: de-institutionalization has resulted in a substantial reduction in the number of children protected in institutional settings (31,107, in June 2005) and a corresponding increase in the number of children protected in community-based services (49,180).[45] The orphanages have been replaced by integrated social services centers for children, the elderly, and disabled. They now provide services such as community rehabilitation centers for children with developmental disabilities, shelters for mothers and children, and office space for NGOs that serve as advocates for vulnerable groups.

[44] Daniela Buzducea, Child Welfare Specialist, USAID Romania, Interview with author.
[45] For more information, see http://www.copii.ro.

Romania's progress in transformation compared to the necessary elements of best practices in the four pillar model:

Romania[46]		
Pillars	**Progress Made Toward Best Practices**	**Factors Limiting Progress**
Policy and legal framework	• De-institutionalization emphasized for children, disabled, and elderly • Strategic plan promotes NGOs as primary service providers at community level • Child welfare standards of care reflect internationally recognized standards • Lessons learned in the reform of child protection are being applied to other vulnerable groups • Policy emphasis has shifted to prevention and early intervention • The number of priority risk groups has been expanded	• Laws are implemented inconsistently across the country • The focus of laws has been on social conditions with lack of attention to health and education issues • Child exploitation and child neglect are not currently addressed by policies and laws • Current laws do not permit NGOs to obtain microfinance loans that would bridge periods between grant awards and the actual availability of funding • The major barrier to change in Romania has been identified as lack of resources, both human and financial
Structure of Programs and Services	• Community-based microcredit programs provide integrated social and economic model for reducing poverty • Social work case management is emphasized • National Training Organization provides curriculum development, training, and piloting of new social and human services jobs • Vocational programs serve disabled, Roma, and youth in institutional care • Integrated Social Services Centers provide model for decentralized social services • NGOs are promoted as primary service providers at the community level	• Out-of-home protection is emphasized rather than in-home family supports • Vocational education and employment programs are not integrated into community care • Local budgets do not currently include dedicated funding lines for program implementation
Human Capacity	• Social work profession developed at practice and university levels • Policy and procedure manual for social workers promotes the standardization of child welfare services	• Low salaries in social work positions result in 30% of trained social work professionals working outside the field • Licensure to monitor and sanction poor practice does not yet exist
Performance Outcomes and Measures	• National monitoring system has been implemented for children and families served in the public system	• The integration of social work case management, community nursing, and inclusive education programs is needed as outcomes shift to improved well-being

[46] A more detailed chart showing Romania's Best Practices in Child Protection is included in Part 4 of this report.

E. Russia

After the December 1991 dissolution of the Soviet Union, the Russian Federation became its largest successor state. Russia has an area of about 6.5 million square miles; in geographic terms, this makes Russia the largest country in the world by more than 2.5 million square miles. But with a population density of about 22 persons per square mile, it is sparsely populated, and most of its residents live in urban areas. Russia is a federation, but the precise distribution of powers between the central government and the regional and local authorities is still evolving. The Russian Federation consists of 89 regional administrative units, including two federal cities, Moscow and St. Petersburg.

The country team's findings for Russia, as they relate to each pillar, are presented below. Because USAID's social welfare services in Russia focus on child welfare, the findings reported below address primarily child welfare issues. Following the findings, a table summarizes Russia's progress in transforming its social services system compared to best practices in each pillar.

Findings by Pillar

Pillar 1. Policy and Legal Framework. Among the country's population of 144 million are large populations of **vulnerable groups**. Nearly 700,000 children, more than two percent of the child population of Russia, are orphaned or deprived of parental care. Approximately 500,000 children were living in institutions at the end of 2002. The estimated number of street children in Russia ranges from 40,000 to one million. Major risk factors for child abandonment exist, including unemployment, lack of housing, alcoholism, and HIV-infection.[47] The HIV/AIDS infected population is growing: 70 percent of the 7,600 children born to HIV positive mothers were born between 2002 and 2004. More than 20 percent of these children were abandoned to state care at birth. Child protection officials and professionals are very concerned about the increase in alcohol and drug addiction, HIV infection, and exploitation of children, including trafficking.[48] In one hospital setting visited by the country team, 30 percent of the women in delivery were active drug users.

In principle, the Russian government promotes a child-centered policy with **de-institutionalization** as a goal. Given that there are approximately 1,650 state institutions for children without parental care under three ministries, and an increase of approximately 5,000 institutionalized children each year, progress cannot occur without a comprehensive strategy to implement this relatively new legislation.

The size of the country and the complexity of the **administrative structure** add to the difficulty in providing social services. For example, in Tomsk Oblast, a shelter that is 700 kilometers away from Tomsk (the administrative center of the oblast) is accessible only a few months a year by ground transportation, and other communication methods are very limited. Because of the

[47] Dr. Elena Vinograndova, Head of the Mother and Baby Crisis Ward, AIDS Center, St. Petersburg, Russia, Interview with author, January 31, 2005.
[48] Carel de Rooy. *Children in the Russian Federation*. (Moscow, Russian Federation: UNICEF, 2004)

accessibility problem, officials are considering closing this and other more distant facilities and enlarging shelters and orphanages closer to Tomsk. Existing care located near to these outlying communities is now at risk of being moved further away.

Every year, each region in Russia analyzes the **child welfare** situation, and a profiled analysis of children in state care is drawn. The regional government produces publications on legislation and policy, including immigration policy, as there are a large number of immigrants in Russia from Central Asia, the Caucasus, and other regions. Information on entitlements and how people can access their benefits is also produced. These publications identify the specific services that are part of the community-based system, including day care, psychosocial counseling, medical services, unemployment, and administration.

Considerable emphasis has been placed on institutionalized children and children with disabilities. Pregnant women with HIV infection also are identified as a **priority group**. Overall, there is a lack of comprehensive local and regional social policy and lack of funding mechanisms for new services. Basically, funding streams continue to support institutional care models over residential care.

Pillar 2. Structure and Types of Programs and Services. Although developing a continuum of community-based services that can respond to local needs in a country that spans 11 time zones is challenging, there *are* emerging programs and services that reflect international standards of best practices.. While administrative responsibility for social services is becoming more centralized, operational responsibility for programs and services including crisis and counseling services[49] are the responsibility of the region (*oblast*) or territory (*krai*). Guardianship departments at the municipal level remain the sole entity responsible for child abandonment prevention. Despite the move toward centralization of services, programs have been developed that are responsive to local needs.

The city of St. Petersburg is described as having a more systematic approach to child welfare services than other Russian cities, including education, social protection, and health care for families-at-risk NGOs are very active and are seen as significant in delivering social services, NGOs can apply for state funding through a process for social contracting of services. A Committee on Youth Policy works closely with NGOs in the area.

USAID's Assistance to Russian Orphans 2 Program (ARO2), initiated in August 2002, builds on and expands the successes of ARO1 in promoting emerging child welfare reforms in Russia. It emphasizes proactive abandonment prevention activities to reverse the trend toward a growing number of abandoned children. Specifically, the ARO project fosters local child welfare initiatives aimed at abandonment prevention and de-institutionalization of children, disseminates best practices in child welfare services, promotes changes in public attitudes towards child abandonment, and improves related social policies. The ARO2 team provides training and technical assistance to Russian NGOs and their governmental partners, manages sub-grant programs, and monitors and evaluates the overall activity.

[49] The public crisis and counseling services include Center for Aid to Families and Children, Centers of Psychological Assistance, Crisis-Line Emergency Assistance Centers, Centers of Aid to Minors and Shelter.

The Mother and Baby Crisis Unit at the AIDS Center in St. Petersburg,[50] where many children are abandoned by female drug users, focuses on prevention of transmission and primary prevention. Through ARO funding, they are integrating a medical/social/psychological model into the outpatient and inpatient settings and incorporating an active community outreach program. They are using a continuum of care model for the mothers and children-at risk that includes early identification of HIV infected women, harm reduction/needle exchange programs, relapse prevention and prison aftercare programs. Other areas of intervention include employment, housing, medically-related issues such as Hepatitis C, and reducing the stigma of HIV. The overall goal is to work with HIV-infected pregnant women to reduce the potential for child abandonment, a model that can be applied to all categories of infants at risk of abandonment.

The Novgorod Children's Center[51] has a well-developed continuum of care model that ranges from early intervention for children with special needs 0-3 and rehabilitation for special needs children 4-7. An Older Children's Social Adaptation Group provides social rehabilitation for older children who have severe to moderate mental and/or physical disabilities. This includes vocational training, education, family involvement, and community-living skills.

Borovichi, a growing and thriving city that has a population of 80,000, has developed a range of social services initiated in 2001 with ARO I funding. They have developed a model of outreach and support for at-risk families through financial assistance, information and referral services, psychological counseling, and parent education and support. With alcohol and drug addiction identified as the number one problem, they respond to calls for help and provide information and outreach to help addicts access needed treatment programs.

Russia has some of the best treatment programs for alcohol and drug addiction, although they are described as medical and hospital-based with limited community-based rehabilitation and psychosocial aftercare programs.[52] Unfortunately, programs are also expensive and inaccessible to many. A major issue is that society is very tolerant of alcohol and drug use, and public awareness campaigns to change this attitude have had limited success. Although treatment for drug abuse, as well as depression and other mental health-related problems, tends to be punitive, there are advocates who support consumer involvement and community-based, outpatient treatment programs.

Many other programs that model international best practices are emerging as leaders and advocates for social change. Secures Future provides a range of services for children and youth in institutional care including foster care, peer-mentoring programs, and crisis shelters. *Perspectiva*, an advocacy group, engages youth and adults of all ages and with a range of mental and physical disabilities in self-advocacy and promotion of community rehabilitation and independent living models. In general, each of these programs believes, as one Secures Futures

[50] Dr. Elena Vinograndova, Head of the Mother and Baby Crisis Ward, AIDS Center, St. Petersburg, Russia, Interview with author, January 31, 2005.
[51] For a more detailed description, see the Promising Practices Matrix on p. 53.
[52] Interview with Dr. Eveny Krupitsky, Director of Addiction Medicine, Leningrad Regional Center of Addictions.

staff member stated, that "family support is the key: family support services need to be delivered in the community where the clients are and where they have families."

Pillar 3. Human Capacity. For the most part, training institutions in Russia continue to teach the old Soviet model of social work and psychology, and there is minimal in-service training in the institutions. Because of their autonomy, it is often difficult to work with higher education institutions. Linkages between formal education institutions and social service providers seldom exist. The publication of methodological materials is very limited. The existing methodological literature on current interventions focuses primarily on family therapy and early childhood development.

One institution that is contributing to the development of best practices in social work in Russia is the School of Social Work and Social Pedagogue[53] at the St. Petersburg Academy of Post Graduate Studies, which was founded in 1989 with 13 faculty members. The school receives technical assistance from a German social work school and presently has 16 faculty members. The Dean, Ludmila Nagavkina, feels they have a very efficient social work education and training program that is one of the best in Russia. The curriculum includes courses on social science, law, psychology, and social work methodology. The Master's Program is a two-year program that includes a diploma paper. Additionally, they have post graduate studies at the academy as well as short-term courses. The titles of recent student diploma papers reflect a wide range of concerns: Social Isolation of Children; Schools and Local Government Collaborate to Improve Quality and Access to Education; Ethics and Health Care of Children with Developmental Delays; Systems Approach to Working with Developmentally Delayed Children; Addictions; Dependant Behavior; and Stress, Mood and Motivation of Children with Developmental Delays.

The school has partnered with the local Department of Social Protection on a project, "A Good Beginning," to provide services and train staff in support and therapy techniques for families at risk. The Head of the Regional Center for Family Services, Viktor Lapan, supports the relationship with the school and advocates for improving the human capacity to deliver services for families with at-risk youth, particularly youth in conflict with the law, a growing phenomenon.

The Russian Association of Social Pedagogues and Social Workers (RASP&SW), founded in 1990, has a memorandum of understanding with the National Association of Social Workers (NASW) in the United States, and joined the International Federation of Social Workers (IFSW) in 1992. With 4,500 members, RASP&SW is a very active organization with a membership drawn from 104 towns and villages and 70 regions of Russia. Its aims include improving the social system, promoting social work as a profession, assisting with solutions to problems within the social welfare and social protection system relative to the individual in need, and inclusion of Russian social work in the world's professional community.

[53] Social work in Russia has distinguished between "social work," which is a general profession specializing in the welfare of people, and "social pedagogue," which specializes in working with children and their families to help them understand their situations and develop solutions. Social pedagogue seems to be similar to the "educator" function of social work as we know it in the United States.

Concerned about the limited level of social worker participation in RASP&SW throughout Russia, the President of RASP&SW, Antonina Dashkina, advocates for increased support from social workers globally, and most particularly from EU countries, to assist in professional development activities for social workers in Russia and in less developed countries.[54] Recent achievements of RASP&SW include the dissemination of best practices in social work through a partnership with the European Union TACIS Programme and Russian European Trust and the facilitation of a State Law on the Status of Social Work. Additional work has gone into improving the salary scale for social work and development of a students' movement to attract young professionals and advocates for social reforms in Russia. RASP&SW recently elaborated guidelines for ethical practice for members of the Russian Union of Social Educators and Social Workers[55] based on ethical standards and rules of the International Federation of Social Work.

Pillar 4. Performance Outcomes and Measures. While currently used outcomes continue to measure reduced use of institutions without addressing qualitative measures of child well-being, the Ministry of Health and Social Development[56] is developing a system to measure the quality and effectiveness of the many social services projects that have been implemented in Russia. This will serve as a tool for both federal and regional authorities in the evaluation of social projects—both their efficiency and their effectiveness in meeting their outcomes for target groups. Eleven indicators measure the level of quality of a social service: justification and relevance, acceptability, effectiveness, efficiency, quality development, accessibility, equity, sustainability, information/dissemination, external factors, and evaluation methods.

Systems for monitoring children in the protective system have not yet been developed, whether in institutional care or in community care. The result is that children are easily lost in the system, both from families as well as from those responsible for their care.

[54] Antonina Dashkina. *Strengthening the Social Workers' Organizations in the New Countries in Europe: National Capacity Building and Improved Inclusion of IFSW Europe*. (Berne, Switzerland: International Federation of Social Workers, 2004)

[55] Russian Union of Social Educators and Social Workers. *Ethical Guidelines of Social Educators and Social Workers*. (Moscow, Russia: Russian Union of Social Educators and Social Workers, 2004)

[56] The Developing Social Services for Vulnerable Groups II project, funded by the European Union, is in the process of testing a model for evaluating social services in Russia.

Russia's progress in transformation compared to the necessary elements of best practices in the four pillar model:

Russia		
Pillars	**Progress Made Toward Best Practices**	**Factors Limiting Progress**
Policy and legal framework	• Emphasis on de-institutionalization through family reunification and foster care • Partnership and contracting with NGOs is prevalent • Vocational programs serve disabled, Roma and youth in institutional care • Standards for early intervention services provide promising model • Information on entitlements and the process for accessing benefits is readily available	• Efforts to standardize policies and practices related to social services are limited. • Administrative responsibility for social services has been moved from the municipal to the regional level, distancing decision-making from those affected by policies • There is generally a lack of funding mechanisms for new services
Structure of Programs and Services	• Models of early intervention developed for developmentally delayed children • Programs for HIV-infected women provide a model for all programs addressing infant abandonment • Early intervention and rehabilitation models promote community care over residential care • New child welfare services include crisis intervention, mainstreaming of disabled children, foster care, and community reintegration of institutionalized youth • Public education materials are available • NGOs provide advocacy training for clients	• Services related to substance abuse, depression, and mental health are primarily punitive
Human Capacity	• Social work profession developed at practice and university levels • Emphasis on rehabilitation specialists and social pedagogues • National social work association promotes the profession	• Training institutions continue to teach the old Soviet model of social work, with minimal in-service training • Publication of methodological materials is limited
Performance Outcomes and Measures	• National system to measure the quality and effectiveness of social service projects is under development	• Currently, outcomes emphasize reduced use of institutions but do not reflect qualitative measures of child well-being. • Systems for monitoring children in the protective system have not yet been developed.

PART FOUR

PROMISING PRACTICES FROM THE FIELD

The purpose of this section is to provide examples of best practices that can be used by other E&E countries seeking to emulate successful development models of this type of social services system. It describes examples of best practices encountered in the five countries visited for the study and is organized using the four pillar framework for analysis of best practices.

Selected Promising Practices from the Field

ARMENIA	
Integrated Social Services Center (ISSC)[57], Vanadzor, Armenia	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Internationally recognized standards of care applied. • Public/private partnerships and contracting implemented. • Accountability and sanctioning enforced. • Consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • ISSC broadly defines potential target group as "most citizens of Armenia," as over 55 percent of the population is poor and, at some time or another, most Armenians will come into contact with Social Services. • Basic principles are to bring services closer to where the citizen lives and to integrate the services at the local community level so the citizen has to visit just one location to obtain services. • Goals reflect quality standards of improved access to services, improved access to information, services provided "close to the citizen," and promotion of referral and outreach. • Goal is to support increased use of NGOs in the social protection and health sectors through identifying the legal and regulatory barriers that prevent the national and local governments of Armenia from effectively contracting out for services. The project identifies "market opportunities" for NGOs to provide services and to leverage existing resources through donor groups and local NGOs. Three NGOs that utilize contracting mechanisms include Mission Armenia, *Asdghik*, and Women's Rights Center. • A global communications system for the Ministry of Social Security (MOSS) is being implemented that will meet the needs of information users in all levels of government, from the Ministry in Yerevan to local social services offices. This includes development of enhanced information, auditing, and management systems; setting up and maintaining the system; staffing; and training. • The initial planning was done with the Director of Social Work and Sociology at Yerevan State University, who provided the technical assistance in conducting focus groups with community leaders, NGOs, and public sector people, with additional input from customer surveys. Technical assistance advisory groups bring together NGO representatives in health and social service sectors, the Government of Armenia (GOAM), and local government counterparts to identify gaps and solutions.

[57] A partnership program between PADCO, USAID, and Government of Armenia (GOAM); Inclusive of the Ministry of Social Security (MOSS), State Social Insurance Fund (SIF), Regional Social Security Center (RSSC), Republic Employment and Labor Services (RELS), and Social Medical Expertise Commissions (SMEC).

ARMENIA	
Integrated Social Services Center (ISSC)[57], Vanadzor, Armenia	
Structure of Programs and Services • Services from prevention to protection. • Mechanisms for community reintegration, self-reliance and capacity-building implemented. • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• NGOs and Government of Armenia have generally well-targeted programs that provide assistance to the neediest Armenians; reach a large number of beneficiaries within the targeted area; provide social, health and nutritional benefits; and provide some limited employment opportunities. • Principle of building "self-reliance" among the most vulnerable through financial assistance (both entitlements and means-tested) and an integrated service system. • Outreach and home visiting by Regional Social Security Center (RSSC) staff utilize a case management approach that integrates a structured assessment process, case-planning and follow-up. All social work staff has been trained in this process. • Overall goal is to pilot systems for targeting and service provision for select vulnerable groups within the local community. The assessment method includes outreach and home-visiting by RSSC staff with a written procedural manual that provides instruction and training for staff and focuses on auditing benefit eligibility and social inspection. • Consumer satisfaction surveys provide feedback to government and NGO service providers. Advisory groups provide feedback about services that are, at least in principle, based on knowledge of how needs of vulnerable groups are being met. • The overall approach is assessment and service provision through a case management model that provides vulnerable groups with needed information, material and psychological support, and referral to other needed services, including health services, advocacy, and follow-up monitoring. • PADCO and the GOAM provide public education programs on pension reform, social assistance, and Personal Identification Numbers; the ISSC has written information posted about policies and procedures that guide client applications.
Human Capacity • Job functions integrate assessment, planning, intervention and monitoring/follow-up. • Professional rehabilitative and psychosocial practices promote capacity-building. • Curricula provide skills in rehabilitation, prevention, capacity-building, and community care. • Professional staff are licensed and certified. • Workforce development and performance improvement initiatives are implemented. • Professional associations provide advocacy function to promote quality of service through quality workforce.	• Staff is trained to approach citizens requesting assistance in an integrative way, assessing health, social, economic, and psychological factors. The staff includes 110 in public services: 32 social security, 19 unemployment, 5 medical/disability, and 46 in social services. • Social work staff within the Integrated Social Services Center is trained to do an assessment of need and refer clients to treatment and rehabilitative professionals through health services, employment offices, disability services, and NGOs. • Curricula for case management and social work training was designed and implemented with the assistance of the School of Social Work, Yerevan State University, which has a strong tradition in community care models. Training programs emphasize training of trainers and the creation of ongoing training capabilities and practices, to make skills acquisition and improvement an integral part of the MOSS operations and capabilities. • There is recognition of the need to develop formalized certification procedures. One way the project is setting precedence for this is by developing manuals outlining practice procedures as a way to standardize and monitor established good practices. • Yerevan State University has been a strong collaborator with the MOSS and PADCO in writing a manual on home-visiting that provides training and instruction within the ISSC. The Social Work training program serves as a model for a successful educational partnership to develop and implement training. PADCO provides the subject expertise in collaboration with the Ministry of Labor and Social Issues, Yerevan State University, and the University of Connecticut (in partnership with the Open University of UK) to develop an 11-month program. A training of trainers' session for 32 Armenians from Yerevan State University, various NGOs, and social service agencies served to develop local capacity that can sustain training over time. • Although the emphasis has been on NGO sector strengthening for social service

ARMENIA	
Integrated Social Services Center (ISSC)[57], Vanadzor, Armenia	
	NGOs rather than on professional associations, there has been considerable emphasis on professionalization of social workers and related professionals through knowledge and skills acquisition. This provides an important basis for capacity-building of professional associations.
Performance Outcomes and Measures • Indicators measure reduced risk and/or improved well-being. • Information systems monitor programs and services. • Information systems monitor clients.	• Primary indicators include poverty reduction, improved assessment, and linking to a full range of psychosocial and economic resources as a way to reduce risk. Risk management includes improved access to services by reducing bureaucratic steps, providing outreach, and improving customer service. • Overall aim of the information system is to reduce risk through monitoring economic and social problems, thereby managing the flow of funds within the social protection system and ensuring that benefits are paid. An additional outcome of the project has been to reduce corruption related to the award of benefits and services. There are 40 active NGOs in Vanadzor included in the database used by the NGO sector assistant. This serves as a referral base for those not eligible for other services. • The four staff members at the ISSC reception window, who represent the public services have access to a common database, sit together in one room, and provide accurate and current information on client applications and benefits. This results in increased efficiency for clients and public services by reducing bureaucratic procedures and improving administration of social benefits.

ARMENIA	
Mission Armenia[58]	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Internationally recognized standards of care applied. • Public/private partnerships implemented. • Consumer involvement increased.	**How Best Practices are Demonstrated** • Social workers use a structured process to target priority group: elderly living alone with an established need. • Provides care in communities rather than in institutional structures; promotes prevention services to keep people in their homes. • Quality Management Standards (International Organization for Standardization 2000) guide their work and measure quality and continuous performance improvement. • Mission Armenia has strong partnerships with the local government and their donors, including USAID. • Clients are engaged in public policy advocacy efforts at the national and local levels to promote rights of elderly.
Structure of Programs and Services • Services range from prevention to protection. • Mechanisms implemented for community reintegration, self-reliance and capacity-building. • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• Programs include the range of services with a primary focus on keeping elderly and other vulnerable groups living in their own communities or homes. • Utilizes "strength-based approach" to assessment and philosophy of life-long learning and skill-building in communication, self-advocacy, and problem-solving. • Social workers use a structured process for targeting potential clients who meet their criteria for priority population: elderly living alone with an established need. • Client is viewed as a partner and participates in decision-making of their plan of care. • Volunteer activity is promoted and utilized in programs. • Strong focus on public education and public awareness of rights of vulnerable groups as well as ways to access services (*change the way they think of themselves*).
Human Capacity • Job functions integrate assessment, planning, intervention and monitoring/follow-up. • Professional rehabilitative and psychosocial practices promote capacity-building. • Curricula provide skills in rehabilitation, prevention, capacity-building and community care. • Workforce development and performance improvement initiatives are implemented.	• Professional methods of services are very structured and include a history, care plan, regular reviews and follow-up visit/phone calls. • Multidisciplinary team approach includes a range of professionals (social workers, psychologists, nurses, doctors, lawyers) with the doctors and social workers as the team leaders. • Curricula promote home visiting, self-advocacy, and outreach with a focus on assessment and case planning. • Partnerships with public sector and university provide training/education. Staff is encouraged to participate in other advocacy organizations for elderly and disabled.
Performance Outcomes and Measures • Indicators measure reduced risk and/or improved well-being. • Information systems monitor programs and services. • Information systems monitor clients.	• Primary outcomes are to increase activity and healthy lifestyles, reduce social isolation, and reduce risk of placement in homes for the elderly. • Computerized database includes monitoring information for finance, administration, and evaluation. • Computerized database includes information on client assessment, case planning, reviews and follow-up; tracks professional visits.

[58] Mission Armenia officially registered in 1993 as an NGO to aid elderly, refugees, and disabled. Major donors include USAID, UNHCR, CARITAS, OXFAM, Eurasia Foundation, Swiss Agency for Development and Cooperation, Disability Rights Commission, and Tufenkyan Foundation.

ARMENIA	
MDF-*Kamurj* [59]	
Best Practices in MIcrofinance[60]	**How Best Practices are Demonstrated**
• Reduce the bureaucracy and tax burden placed on micro and small businesses.	• As a registered Armenian Foundation managed by Armenians, *Kamurj* is in a position to advocate for policy reforms for Armenian businesses.
• Improve the legal and regulatory environment for microfinance.	• In January 2004, *Kamurj* successfully lobbied to have tax/VAT laws changed so that microfinance institutions (MFIs) do not have to pay VAT, thereby preserving their capital. • Through its membership in the Microfinance Centre for CEE & NIS, *Kamurj* shares resources and information with other regional MFIs.
• Target subsidies toward institution building: MFIs should be financially viable.	• A 7 member Board of Directors was established in 2002 to guide policy and move *Kamurj* toward financial viability.
• Provide incentives to encourage greater focus and innovation in the development of financial services for the poor.	• Loan products include business loans, seasonal short-term loans, educational loans to students, and agricultural loans. • Non-financial services include trade fairs and legal counseling. • "Solidarity group" lending uses group guarantee to replace traditional collateral required by banks. • Disabled clients are offered 50% discount on monthly/weekly repayment of interest rates.
• Increase cooperation and partnership among microfinance providers and with mainstream banks, to increase financial service provision to the poor.	• *Kamurj* continually assesses private sector banking services to identify the gaps in services that will provide a niche for *Kamurj* to meet the needs of low income clients. • Organization will provide training to a group from Central Asia coming to Armenia to study the *Kamurj* service model.
• Capitalize MFIs through the innovative use of grants and equity-type products.	• *Kamurj* conducts periodic market research to ensure new loan products coincide with client needs.
• Increase commercial-bank funding coming into the microfinance sector.	• *Kamurj* is currently in competition with commercial banks.
• Increase private social investment in the microfinance sector.	• *Kamurj* is able to search for socially responsible investors through collaboration with leading networks in NIS and CEE.
• Improve the transparency of MFIs.	• Client outreach through community partners highlights product diversification and flexibility. • Marketing is done via media and loan promoters in various regions. • Four required pre-credit meetings with borrowers explain lending and repayment process.
• Improve the exchange of information between MFIs and funders.	• MDF is looking for potential grant financing from Cordaid (the Netherlands).

[59] *MDF-Kamurj* was created with funding from Save the Children U.S. and Catholic Relief Services.

[60] Sarah Forster, Seth Green and Justyna Pytkowska. *The State of Microfinance in Central and Eastern Europe and the New Independent States.* (Warsaw, Poland: Microfinance Centre, 2001), www.mfc.org.pl.

AZERBAIJAN	
Azerbaijan Humanitarian Assistance Program (AHAP)[61]	
Policy and Legal Framework • Priority groups identified. • Consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • The AHAP was designed to increase community development efforts to integrate, resettle, and provide economic opportunities and health care to internally displaced and conflict-affected populations within Azerbaijan. • The program established leadership groups in the community to address priority development issues.
Structure of Programs and Services • Mechanisms for community reintegration, self-reliance and capacity-building implemented.	• AHAP supported community development efforts to integrate, resettle, and provide economic opportunities and health care to internally displaced and conflict affected populations within Azerbaijan. It supported a range of activities including shelter construction, health care, economic opportunities, and community mobilization.
Human Capacity • Curricula provide skills in rehabilitation, prevention, capacity-building and community care.	• The AHAP Community Development program mobilized communities and empowered them with the skills, abilities and confidence to take charge of their own development process. Mobilization and consciousness-raising were achieved through extensive training in participatory methodologies such as Participatory Rapid Appraisal (PRA) and Participatory Learning in Action (PLA).
Performance Outcomes and Measures • Indicators measure reduced risk and/or improved well-being.	• The desired outcome of the AHAP Community Development Program was to empower communities, both IDPs and conflict-affected, with the skills, abilities, and confidence to make joint decisions and take actions to improve the quality of their community life. While the micro-project implemented was valuable to the community in developing their quality of life, the most significant output was considered to be an active and mobilized population.

[61] In 1998, USAID awarded an umbrella grant to Mercy Corps Azerbaijan to manage what would become the seven-year Azerbaijan Humanitarian Assistance Program (AHAP). At that time, AHAP was designed to support the USAID objective of Reduced Human Suffering in Conflict Affected Areas.

AZERBAIJAN	
NGO: BUTA[62]	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Internationally recognized standards of care applied. • Consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • BUTA started delivering psychosocial services to families-at-risk as an integral part of a community development initiative in 1996. They were registered in 1999 after a 2-3 year effort in a very restrictive environment for civil society development. • Although there is no legal and policy framework in place for community-based services, they have developed a philosophy for their own organization that promotes healthy living and non-blaming, non-aggressive, and solution-focused problem-solving processes. • They are attempting to influence policy development through demonstration of best practices and outcomes.
Structure of Programs and Services • Services range from prevention to protection. • Mechanisms for community reintegration, self-reliance and capacity-building implemented. • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• Programs and services emphasize early intervention and prevention. • They utilize a community mobilization method for engaging a community in needs assessment and designing interventions that improve the psychosocial functioning of those who are most vulnerable. *Social services provision*s include psychosocial support, legal information and support, human rights information, medical support, and recreation and leisure time activities. Primary model is psychosocial support to families in their communities utilizing both group and individual interventions. Initially they started providing psychosocial support to elderly people living alone and support groups for women dying of cancer. Programs focus on patient and family involvement and now include trauma and stress counseling for refugee adults and children. • They work at different levels: *community awareness* campaigns engage teachers, women, elderly, and youth; people are unaware of how to articulate their psychosocial problems and need assistance in understanding their needs and their rights.
Human Capacity • Professional rehabilitative and psychosocial practices promote capacity-building. • Curricula provide skills in rehabilitation, prevention, capacity-building and community care. • Workforce development and performance improvement initiatives are implemented.	• BUTA builds human capacity by organizing social workers and psychologists from other non-profits to improve their knowledge and skills. They promote community care values of competence and health rather than perpetuating victimization. • Experiential training methods are used to provide knowledge and skills in psychosocial support and community development to the people that are appointed as "psychologists" in the secondary schools. • They train caregivers in orphanages on stress management and burnout with emphasis on negotiation of needs (for example, a lower staff/child ratio), to improve their quality of work. They have trained 50 professional social workers and psychologists from 30 organizations in Azerbaijan and Tajikistan.
Performance Outcomes and Measures • Indicators measure reduced risk and/or improved well-being. • Information systems monitor programs and services.	• BUTA's stated outcomes for their clients include: - Increased self-esteem and self-confidence through mastery of interpersonal skills, self-reliance, and cooperation with members of their family and community group. - Research on displaced women to monitor need and determine outcome of intervention.

[62] Alexander Cheryomukhin, President, Azerbaijan Psychological Association, Baku, Azerbaijan, Interview with author, December 4, 2004. BUTA receives funding from a variety of donors including UNICEF.

BOSNIA	
Promotion and Development of Alternatives Forms of Care for Children Deprived of Parental Care in Bosnia-Herzegovina (Save the Children/UK) [63]	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Internationally recognized standards of care applied. • Public/private partnerships and contracting implemented. • Accountability and sanctioning enforced. • Consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • Save the Children has identified children deprived of parental care as a priority risk group for Tuzla Canton. • It partners with the Tuzla Canton Association of Foster Parents, Tuzla Canton Center for Social Work, and Ministry of Labor and Social Policy to develop and promote alternative forms of care, with an emphasis on foster care. • Models of best practice in foster care have been written for dissemination. • Standards and procedures for implementation based on international standards of care are written for dissemination. • Foster parents influence programs and services through participation in an association of foster parents. • Emphasis is on integrating the standard forms/instruments in the Law on Social Protection in Tuzla Canton for children in different risk categories. Save the Children/UK has standardized assessment and case planning forms for children, adults, and elderly in a range of risk situations.
Structure and Types of Programs and Services • Mechanisms for community reintegration, self-reliance and capacity-building implemented. • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• Foster care placement is the primary mechanism for community reintegration and building self-reliance in children who otherwise would live out their lives in institutional care. • Services for children deprived of parental care are integrated into the delivery of foster care services including: - child assessment and care planning - foster parent recruitment, evaluation, and selection - foster parent training - child placement and monitoring visits - follow-up and long-term planning. • Information systems monitor programs and services. Partnership with foster parent association, *Familija*, for a public awareness campaign (media and other mechanisms) for public education and foster parent recruitment.
Human Capacity • Professional staff are licensed and certified. • Workforce development and performance improvement initiatives are implemented. • Professional associations provide advocacy function to promote quality of service through quality workforce.	• Proposed certification of foster care workers and foster parents. • Strong workforce development program with emphasis on: - Capacity-building of social work staff in centers for Social Work, focusing on methodology of foster care services - Specific methodology and competencies integrated into the training curriculum. • Partnership with association of foster parents, *Familija*, in capacity-building on advocacy skills (policy and practice issues) and public information campaigns.
Performance Measures • Professional associations. • Indicators measure reduced risk and/or improved well-being. • Information systems monitor programs and services. • Information systems monitor clients.	• *Child Outcomes* include: - Development of professional associations - Improved well-being of children deprived of parental care - Decreased number of children deprived of parental care in institutions. • *System Outcomes* include: - Competence and capacity-building in the delivery of comprehensive range of foster care services within the public sector (up to 90 professionals to be trained in foster care services). - Monitoring and evaluation system being established by World Bank's SOTAC (Social Sector Technical Assistance Credit) program, which

[63] Program funded by USAID.

	provided each Center for Social Work in BiH with a personal computer and database software to create and manage up-to-date information on service users.

ROMANIA	
Best Practices in Child Protection[64]	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Accountability and sanctioning enforced. • Public/private partnerships and contracting implemented. • Advocacy, consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • National laws and policies are governed by the National Authority for Child Protection and Adoption. The Ministry of Labor, Social Protection and Family is responsible for strategy, regulation, administration, child representation and state authority. The implementation of the strategy is delegated to the local County Councils and county social services departments. • Principles of Child Protection in Romania (www.copii.ro): - Best Interests of the Child - Non-Discrimination and Equal Opportunity - Securing a Family Environment - Decentralization and Community Responsibility - Solidarity and Cohesion - Cross-sector and interdisciplinary Intervention - Partnerships. • Community Boards at the local level provide advisory services to the local authorities in child welfare. • The 31 standards for child welfare have been developed through a participatory process that was initiated by the state and local authorities and donor groups. USAID has provided technical assistance in developing 19 of those standards. Examples include: - Case management - Prevention and intervention for child abuse, neglect, and exploitation - Family integration and reintegration - Mother and Child Centers - Life skills for adolescents leaving institutional care - Foster care - Adoptions. • Website of the National Authority (www.copii.ro) provides statistical information on strategy, laws, and policies. • ProChild Federation, founded in 1998 and legally registered in 2001, is a network of 44 Romanian and American NGOs working in the field of child welfare in Romania. Primary goals are to influence policy, support the development and replication of quality practices through demonstration, technical assistance, and capacity-building activities. Recent projects include: - Networking with public and private child welfare organizations - Training for staff working with HIV-infected children - Training on motivating staff. Membership services include: - Presentation of member practices to public and private service providers - Listservs (child welfare practitioners, members, and board of directors) - Information regarding finance/programs - Technical assistance implementing new legislation and identified best practices - Research and evaluation. • A survey of 47 public child welfare departments revealed primary concerns at the local level include foster care, children with diabetes, HIV, domestic violence, street children, and services for youth. Other needs include a log of NGOs that do drug/alcohol treatment and prevention; technical assistance with models; and facilitated exchanges through network of NGOs; development of best practices and standards in community development; rural microcredit; and

[64] These practices represent the combined efforts of the Romanian government, international donor organizations, NGOs, and public-private partnerships.

ROMANIA	
Best Practices in Child Protection[64]	
	other initiatives that build community responsibility and expertise. Barriers to meeting these needs include the lack of money for public services to replicate "what we know."
Structure and Types of Programs and Services • Offers a range of services from prevention to protection. • Mechanisms for community reintegration, self-reliance and capacity-building implemented. • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• Child welfare programs and services utilize a continuum of care framework and a range of 20 different types of programs and services. Although the emphasis is on protection, there are efforts to emphasize psychosocial intervention that provide family support and prevention of child abandonment and placement. Examples include mother and baby centers; day care; counseling and parent education; emergency and crisis services; and prevention and early intervention for drug abuse, child maltreatment, and juvenile crime. • Social Services utilize a case management model, which is the foundation for an integrated approach to assessment, planning and intervention through outreach to those that are hardest to reach. • A system of *Integrated Social Services* was created in July, 2003 that required local child protection entities to merge child protection with other social welfare services into a single body for protection of children, disabled people, and elderly. The goal was to provide a more holistic approach to the provision of social services and reduce some of the fragmentation that was characteristic of services previously funded and administered under different national ministries and local entities. • Deinstitutionalization and services for disabled are modeled on child welfare reform strategies: decreasing rate of institutionalization through reducing abandonment rates, closing and/or restructuring institutions into family-type facilities, and developing a full range of alternative community services, with an emphasis on building community responsibility for vulnerable citizens. • Romania's use of microfinance programs as a way to build self-reliance and capacity in persons of low income is demonstrated by CAPA, created by World Vision in 2001. More information on CAPA is provided below. • Community responsibility and involvement in social services was formalized by the creation of Community Boards that aim to involve local citizens in advisory and public information roles. Romania also strongly supports involvement of the voluntary, non-profit sector in service delivery and plans to have 45% of community social services contracted out to voluntary NGO's by 2008.
Human Capacity: Training Practitioners • Curricula provide skills in rehabilitation, prevention, capacity-building and community care. • Professional staff are licensed and certified. • Workforce development and performance improvement initiatives are implemented. • Professional associations provide advocacy function to promote quality of service through quality workforce.	The Center of Resource and Information for the Social Profession (CRIPS) is a non-profit organization established in May 1997 as a collaborative initiative among public child welfare reform services, donor groups, and non-governmental organizations. Utilizing a strong partnership model, CRIPS aims to develop competent human resources in social services for the public and private sectors. Initially, the mandate was in child welfare, but with the recent changes in national legislation, they have now expanded to include training and curriculum in protective services for elderly and disabled persons. Human capacity development includes a range of programs and services on a national and county level: • Defining job functions and competencies for new positions • Curriculum development • Training of trainers • Education and training programs • Distance learning programs including computer mediated training • Facilitating work groups for policy and program design • Developing and disseminating standards of practice • Developing and disseminating policies and procedures • Monitoring training and education activities

ROMANIA	
Best Practices in Child Protection[64]	
	• Designing and piloting monitoring and tracking systems • Designing and implementing public information campaigns. The list of activities for 2004 included: • Training 1,018 individuals including members of child protection commissions, professional managers, and direct service providers including foster parents, special educators, NGO staff and local authorities • Involving 900 participants in national seminars and debates • Distributing 1,500 newsletters • Designing and implementing a database • Providing programs that involved at least one representative from public services in all 41 counties and 6 sectors of Bucharest • A public information campaign (in partnership with local authorities) to educate elderly about the new public social services • Disseminating information to national and local authorities and the NGO community about public awareness and media campaigns to promote services for disabled persons and employment opportunities for Roma. • Publication of three instructional documents: - *Strategies and Best Practices in Social Services for Elderly Persons* - *Mediation of Access to Employment for Disabled Persons* - *Citizen at the Center: Citizen Involvement in Community Care.*
Human Capacity: Academic Education • Curricula provide skills in rehabilitation, prevention, capacity-building and community care. • Professional staff are licensed and certified. • Workforce development and performance improvement initiatives are implemented. • Professional associations provide advocacy function to promote quality of service through quality workforce.	The School of Social Work at Babes-Bolyai University in Cluj demonstrates promising practices in curricula design and workforce development. They have up to 1,000 students at any given time, graduating about 300 per year. The program includes theological students (Romanian and Greek Orthodox, Roman Catholic, and Hungarian Reformed) and instruction is provided in Hungarian and Romanian. A large number of the faculty are adjunct, providing students contact with professors who are also practicing professionals. Besides the Bachelor's Degree, they offer Master's degrees in Child and Family, and Social Policy. The curriculum emphasizes community practice with vulnerable groups. Coursework content includes: family violence, clinical social work methods, mental health, crisis intervention, and interventions with disabled people. The School is very involved in workforce development through various distance learning and training programs: • Distance learning program that includes home-study and campus-based weekend instruction once a month • Management course for directors of social services (one-year Certificate Program) • Probation workers in the justice system • Supervisory training • Student placements are in public and private facilities and include mental health, juvenile justice, advocacy and community organizing, and child and family settings. The School is an advocate for change by promoting, designing, and implementing innovative services and standards for services. Future plans include the development of areas of concentration such as mental health, child and families, disability, and aging that will prepare social workers for more specialized areas of policy, research, and practice (with focus on treatment).

ROMANIA	
Best Practices in Child Protection[64]	
Performance Measures • Information systems monitor programs and services. • Information systems monitor clients.	• Indicators have tended to emphasize movement of children from institutional care back into the community, the number of institutions, and the numbers of available beds. The shift to monitoring children in their communities is taking place with an emphasis on well-being and safety issues. In order to begin to monitor at-risk children, a tracking system is being set up. About 75% of data on children has been entered and the system provides information on family members, parents, and extended family. It has both case planning and supervisory/management functions.

ROMANIA	
CAPA/World Vision[65]	
Best Practices in Microfinance	**How Best Practices are Demonstrated**
• Reduce the bureaucracy and tax burden placed on micro and small businesses.	• CAPA/World Vision takes a holistic approach to economic development and encourages local communities to take the initiative in changing tax and credit laws.
• Improve the legal and regulatory environment for microfinance.	• Taking part in a microfinance coalition that is lobbying for the establishment of a legal operating system for MFIs in Romania.
• Target subsidies toward institution building: MFIs should be financially viable.	• In 2005, CAPA anticipates creating a share-holding company (they are currently a foundation) to carry out the loan program. The CAPA Foundation will remain the primary share-holder, but private investment companies could then provide capital through investments.
• Provide incentives to encourage greater focus and innovation in the development of financial services for the poor.	• Will open two new rural offices in 2005 and 2006 to increase outreach.
• Increase cooperation and partnership among microfinance providers and with mainstream banks, to increase financial service provision to the poor.	• Microfinance coalition meets periodically to discuss challenges in Romania.
• Capitalize MFIs through the innovative use of grants and equity-type products.	• New CAPA share-holding company in 2005 will make private investment capital possible.
• Increase commercial-bank funding coming into the microfinance sector.	• Currently in competition with banks.
• Increase private social investment in the microfinance sector.	• Lending capital currently from Rabobank Foundation, Mennonite Economic Development Association, Romanian American Enterprise Fund, USAID, Sarona Fund, World Vision International, and World Bank.
• Improve the transparency of MFIs.	• Establish offices in rural areas; hire staff from villages; involve local key players in loan committees.
• Improve the exchange of information between MFIs and funders.	• In April 2004, won a World Bank rural development project grant that will provide loans up to $7,500 for trade and agricultural production.

[65] CAPA's partners include USAID, Canadian International Development Agency, Rabobank Foundation, Mennonite Economic Development Association, Romanian American Enterprise Fund, Sarona Fund, World Vision International, and World Bank.

RUSSIA	
Novgorod Children's Centre[66]	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Internationally recognized standards of care applied. • Public/private partnerships and contracting implemented. • Accountability and sanctioning mechanisms enforced. • Consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • The Novgorod Oblast passed a law that created early intervention centers and financing over the entire Oblast. • There are an estimated 6,000 children aged 0-3 in Novgorod, and approximately 600 children need some kind of intervention; 40-50 have severe disabilities. These children are at highest risk of being separated from their families and placed in institutional care. • Target population for services is developmentally disabled children ages 0-3 and 4-7. • Four basic principles guide programs and services: an early start; an individual approach; a partnership between family and specialist; and a multi-disciplinary approach to the habilitation process. • They utilize a "basic stimulation model," a Swedish model that is based on internationally recognized standards for early intervention and rehabilitation for children. • The center was initially started as a partnership between the Assistance to Russian Orphans Program and the government. Novgorod Children's Centre is now a Russian non-profit and operates very closely with the municipality of Novgorod and the Oblast of Novgorod. The government provides financial support for staff. • The initial idea of the center was the result of a local group interested in learning more about early intervention. It took two years of study with financing through USAID/ARO to convince the Oblast that this was an important issue and to pass legislation and provide funding.
Structure of Programs and Services • Services range from prevention to protection. • Mechanisms for community reintegration, self-reliance and capacity-building implemented. • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• The Novgorod Children's Centre has programs for children aged 0-3 and 4-7 who have developmental delays. They also have an Older Children's Social Adaptation Group that focuses on community and social reintegration skills, with an emphasis on independent living and self-support. • The early intervention and rehabilitation model promotes community care over residential care through early identification, screening, and evaluation of potential functional disabilities. It prevents functional disabilities and improves the functional capacity of parents and children to live at home and in the community. • Emphasis is on early identification of potential delays and on providing preventative and early intervention measures. Services include home visits for newborns that have been referred by health care providers and clinic-based rehabilitation with an emphasis on training parents/caregivers to apply early intervention methods in the home and community environment to sustain improved outcomes. • Referrals most often come from a health care provider, usually a pediatrician or geneticist, for an in-home screening. There is a very structured screening process that identifies at-risk infants and children who need a full evaluation and treatment plan. • There is close collaboration with pediatricians in the area, who identify infants at-risk of developmental delays. They are referred for a screening, which is initially done in the home/community rather than at a clinic. Evaluation and treatment planning follows, including home visits and family and community support. Brochures and flyers provide information to health care professionals and parents about screening and evaluation services. • There has been a tremendous amount of work in providing public information materials and public education about developmental disabilities and positive outcomes of early intervention and rehabilitation. The emphasis has been on high risk families, health care providers (most particularly pediatricians who

[66] The Centre is funded by USAID and local public services.

RUSSIA	
Novgorod Children's Centre[66]	
	potentially would be able to educate, support and refer parents/caregivers), and political and community leaders.
Human Capacity • Job functions integrate assessment, planning, intervention, and monitoring/follow-up. • Professional rehabilitative and psychosocial practices promote capacity-building. • Educational curricula provide skills in rehabilitation, prevention, capacity-building, and community care. • Professional staff are licensed and certified. • Workforce development and performance improvement initiatives implemented.	• A multidisciplinary approach to outreach and identification, screening, evaluation and treatment planning includes social workers, social pedagogues (educators), psychologists, rehabilitation specialists, and pediatricians. • They have developed a local capacity among social workers, educators, psychologists, and pediatricians. • A curriculum for pediatricians provides information on screening, early detection, and referral procedures for infants and children determined to be at high risk for delays. • Curriculum for training staff and parents provides knowledge about parent-child attachment and the impact on relationship and behavior. • Staff utilize the Internet to access knowledge about evidenced-based practices in early intervention. • Need recognized for standardization of practice through development of common terminology, defining program operational guidelines, and regulation of practice utilized evidence-based practices.
Performance Outcomes and Measures • Indicators measure reduced risk and/or improved well-being • Information systems monitor programs and services. • Information systems monitor clients.	The Centre's performance outcomes for clients include: • Early identification of high risk infants and children • Increased referral rates for high risk infants and children • Assisting parents in having more realistic expectations of children with developmental delays • Improved family functioning • Increasing the functional capacity of older children with developmental delays • Increasing access to quality services • Increasing public knowledge and public awareness about developmental disabilities

RUSSIA	
Promising Practices: Assistance to Russian Orphans 2 (ARO2)[67]	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Public/private partnerships and contracting implemented. • Accountability and sanctioning enforced. • Consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • Identified priority groups: children and families in crisis, disabled children and their families, children born to HIV-infected mothers, and orphans and children leaving long-term state care. • Agreement between ARO2 and the Federal Duma Health Committee Working Group promotes reforming child welfare services in health institutions. • Social Welfare Ministerial Working Group developing criteria and standards for child welfare services. • ARO2, in partnership with Transatlantic Partners Against AIDS, has initiated policy discussions at the federal level to promote legislation related to abandonment prevention and mainstreaming of children infected/affected by HIV/AIDS.
Structure of Programs and Services • Services range from prevention to protection. • Mechanisms for community reintegration, self-reliance and capacity-building implemented. • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• A range of new child welfare services has been developed including crisis intervention, early intervention and mainstreaming for disabled children, foster care, and community reintegration of institutionalized youth. • Development of new comprehensive services to prevent abandonment of children infected/affected by HIV/AIDS in Irkutsk and St. Petersburg. • Public education materials developed and disseminated.
Human Capacity • Job functions integrate assessment, planning, intervention, and monitoring/follow-up. • Professional rehabilitative and psychosocial practices promote capacity-building. • Educational curricula provide skills in rehabilitation, prevention, capacity-building, and community care. • Professional staff are licensed and certified. • Workforce development and performance improvement initiatives implemented.	• Five National Child Welfare Training Centers established to enhance professional capacity of service providers in priority regions and across Russia. • More than 500 regional child welfare practitioners in Khabarovsk, Magadan, and Tomsk trained. • Partnerships between Children's Aid Society, U.S.-based child welfare NGO, and child welfare professionals in the public and private sectors have resulted in improved knowledge and skills in service delivery. • Seminar topics include building institutional capacity of NGOs (including financial and personnel management), social marketing and media relations, coalition-building, social work interventions, and social partnerships in child welfare. • Curricula published and disseminated including a cadre of trainers prepared through training of trainers program. • Development and dissemination of professional literature on social and child welfare innovative practices.

[67] ARO2 is a partnership of USAID, IREX, National Society for the Prevention of Cruelty to Children, local child welfare NGOs, and regional governments.

Performance Measures	
• Indicators measure reduced risk and/or improved well-being. • Information systems monitor programs and services. • Information systems monitor clients.	Program outcomes: • Reducing rate of child abandonment. • Improving access to education, family life, and independent living for high-risk children and families. • Child abandonment and child abuse are problems of all sectors of society. • Child welfare reform through innovative model development. • Partnerships between governmental and non-governmental organizations impact social and child welfare programs and services.

RUSSIA:	
Promising Practices: *Perspectiva*[68]	
Policy and Legal Framework • Priority groups identified. • Principles of family and community care developed. • Accountability and sanctioning enforced. • Consumer and citizen involvement increased.	**How Best Practices are Demonstrated** • Advocacy training of disabled persons provides knowledge and skills to enable them to advocate for laws and policies that improve access and social inclusion for all disabled persons. • *Perspectiva* advocates have partnered with the governmental Committee of Public Affairs. • Russian law requires each company to hire 1 or 2 disabled persons or pay a fine, with the money going into a Committee fund. • The initiative is focused on access to services through litigation. At this visit, there were 11 cases in court.
Structure of Programs and Services • Mechanisms for community reintegration, self-reliance and capacity-building implemented. • Promotes improved accessibility, and client involvement in decision-making. • Public awareness and public education positively influence public attitudes and citizen involvement.	• Primary emphasis is on integration and access to existing public services. • Advocates for services related to vocational training and employment to build self-reliance and capacity among disabled persons, with an emphasis on youth. • Advocacy training of disabled persons provides knowledge and skills to improve access to public services. • Youth advocates engage businesses and public officials to increase public awareness and engage citizens in supporting employment and education opportunities for disabled persons.
Human Capacity • Curricula provide skills in rehabilitation, prevention, capacity-building and community care. • Professional associations provide advocacy function to promote quality of service through quality workforce.	• Disabled youth trained in advocacy and activism. • Cross-disability emphasis in human capacity building. • Disability awareness training of teachers and other professionals. • University course on rights of disabled integrated into law faculties. • Representatives from 150 NGOs trained in advocacy skills.
Performance Measures • Indicators measure reduced risk and/or improved well-being. • Information systems monitor programs and services.	• Outcomes include: – Increased access to public space, programs, and services for disabled youth and adults. – Inclusive education for disabled. – Emphasis on employment, independence and self-reliance. – Five databases of disabled youth (ages 20-25) looking for jobs, for monitoring and evaluation of outcomes.

[68] *Perspectiva* is an organization that advocates for changes in laws and policies and for the implementation of existing laws that protect disabled people. It is funded by USAID through the World Institute on Disability.

APPENDICES

APPENDIX A

SCOPE OF WORK AND IN-COUNTRY STUDY GUIDE

Emerging Practices in Community-Based Services for Vulnerable Groups:
A Study of Social Services Delivery Systems in Selected Countries of Europe and Eurasia

A. Overview

The Bureau for Europe and Eurasia seeks to study the institutional capacity of the former Soviet Bloc Countries to provide support and assistance to vulnerable populations within their borders. Of particular interest is how governments are moving from residential care to family-focused, community care models. Community care assumes the existence of a range or continuum of services from prevention to protection, with primary emphasis on prevention and early intervention over protection. An institutional capacity for utilizing evidence-based practices in community care necessitates the availability of human capital with specific knowledge, skills, and values. Internationally recognized community care models utilizing evidence-based practices serve as a standard by which programs and services will be identified and described.

B. Methodology

The Continuum of Care Model for a Community-Based System of Services will be the overarching framework for this study. This includes the range of services from prevention to ameliorative and restorative services. The analysis is based on four pillars that are basic to the functioning of a system of services.

Pillar 1: Policy and Legal Framework. This includes identification of policies and laws that reflect internationally recognized best practices and trends for individuals and families in crisis, development and implementation of standards for care, and centralized and decentralized implementation strategies (potentially including linkages with county and municipal budgets).

Study Questions:

- Which groups are identified as "at-risk" or "vulnerable" within country policy/ legislation? How are these groups identified and targeted? Please note that our priority groups are: families and individuals (includes elderly) living in poverty, children without parental care, maltreated children (abused and neglected), youth in difficulty with the law, children and adults with mentally and/or physically disabling conditions, and substance abusers (alcohol and drug addiction). These are not distinct categories as there is overlap, and the more we can capture this, the better; for example, the high incidence of substance abuse within poor families; or high rate of institutional placement of children from poor families.
- Are there recent policies and legislation that promote a paradigm shift from residential and institutional care to community-based care for the country's targeted populations, including economically disadvantaged people; children, youth, and elderly in need of protection; physically and/or mentally disabled; and substance abusers?

- Have these policies integrated international treaties, laws, and other mechanisms to protect Human Rights? (U.N. Convention on the Rights of the Child, The Hague Agreement on Inter-Country Adoptions, etc?)
- What specific policies/laws and strategic plans exist to close institutions and dismantle systems and practices that perpetuate the use of institutions?
- What are the policies and laws regulating NGOs? Is there a mechanism for contracting with NGOs to provide services? Is this actually implemented and working?
- What strategic plans for implementation have been developed for system changes?
- Are there standards of care that reflect internationally recognized standards for community care specified in policy, legislation, and/or strategic plans? What mechanisms for licensing and certification of facilities and programs exist?
- How are these centralized and decentralized functions (national, county, and city/town/commune) defined? What mechanisms for accountability and sanctioning of non-compliance exist (withholding funding, probationary status, withholding licenses or certifications)?
- What is the budget, and how is it allocated between the local and national levels? Does the way money is allocated support the development of community care over institutional care?
- What mechanisms exist for client-groups, families, professionals, and communities to influence policies and laws?

Pillar 2: System of Services. This includes types and range of services: client-based, public/ private, community-focused with outreach capacity, accessibility, etc. This can also include the implementation of standards of care models, certification and licensing practices for programs, local citizen involvement, and public awareness initiatives such as volunteerism.

Study Questions:

- How many people are identified within the different at-risk categories, and what are the trends within each population (increasing, decreasing, etc.)? How are they counted, and how realistic are the numbers thought to be?
- Use the Continuum of Community-Based Services as an outline and identify what programs and services are part of the structure of programs and services. This includes the number of residential institutions within the country, the size and numbers within those facilities as well as those being served within community-based programs, numbers of persons receiving targeted, means-tested benefits such as payments to poor children (not child benefits that all children have access to), families, elderly (not pensions). Include case examples of organization that provide a range of services for a given population, with special focus on family support and education and examples of case-finding and outreach: the services that they provide in homes, in the community, and not office-based.
- What assessment and planning processes are in place to target benefits and services to those who most need them?
- Show the trends for the use of residential institutions compared to development and use of community-based programs.
- What are the programs and services that are being provided by the non-profit sector (NGOs)? What associations of NGOs exist that provide support, capacity-building, and

advocacy as well as monitor activities? What are the number and types of consumer/parent/family associations that provide services and have an advocacy function?
- What are the examples of public/private partnerships?
- What are the estimates of numbers of persons being served in these programs?
- To what extent are these programs and services geared to promote self-reliance through economic development activities such as microenterprise development, job and skill training programs, or community development?
- Since public participation is important in community-based care, we need to look at volunteerism and public awareness. How is volunteerism measured and what is the degree of volunteerism? What are the relations between media and service providers, and what public awareness programs exist on a national or local scale?
- What mechanisms exist for client groups and families of clients to influence programs and practice? This includes any special programs and mechanisms to facilitate youth participation and youth advocacy.

Pillar 3: Human Capacity. As programs and services change, there must be a shift in job functions, which requires a different knowledge base and skills. This pillar focuses on the people providing the services (front-line workers), supervisors, managers, and administrators. The training and re-training of professional and paraprofessional workers is important in shifting from institution-based to community-based models. This includes professional education and training; curriculum development activities; professional regulation such as licensure, certification, registration, and practice standards; and monitoring of performance.

Study Questions:
- How many persons work in human services/social services programs? How large is the social services workforce compared to the workforce in general? This number should probably come from the Labor and Social Protection/Welfare Ministry, as well as an estimate of numbers of people that work in NGOs that deliver services. Is there any estimate of the percent of qualified personnel that work in these jobs?
- How are job functions defined by the government for different types of human services jobs? How are they categorized? Is there regulation of professional practice through licensing and/or certification requirements? How is "supervision" defined and practiced?
- What education and training programs exist for developing a qualified workforce that promotes community-based care over administrative and procedural job functions? This includes university and college programs that train social workers, sociologists, psychologists, and human development and rehabilitation specialists (occupational therapy, special education, etc.) For example, occupational therapy and social work are just developing in many of these countries. What are the trends in developing these professions in terms of capacity-building of education and training programs? Examples of curricula, curriculum reform initiatives, professor training and development, etc. are needed. Is there knowledge of competency-based education?
- What ongoing (continuing education) professional education and training programs exist and how many are being professionally trained through these programs? Is there regulation of professional training through certification or licensing of training programs?

- How many persons are being trained per year in each of these professions and to what degree are these numbers able to keep up with the need?
- What training and education programs are there to utilize youth as a resource in delivering human services? Youth ages 15-24 can be trained as peer educators and counselors in mentoring, counseling, and mutual support programs.
- What professional associations (NGOs) and trade unions exist for different professions (social workers, sociologists, psychologists, mental health and addictions counselors, psychotherapists, and psychiatrists) and how do they function?
- What models for professional and workforce development exist that function as partnerships among education, advocacy, and professional entities?

Pillar 4: Performance Measures. This includes information on what outcome indicators are used and how they are measured and monitored. This will include information from other donors such as UNICEF and World Bank regarding how they identify and measure indicators for programs and services. The description will discriminate between indicators that promote psychosocial well-being and those focused on status of placement/living condition, such as social indicators.

Study Questions:

- What are the stated outcomes for public and private programs for specific targeted populations? What indicators are used to determine the need for programs and services?
- How do programs and services know that they have achieved the desired outcome? What are the goals of the designed interventions? How are they measured and monitored?
- What systems are in place to monitor and track the targeted at-risk or vulnerable population?
- Are concepts such as quality improvement and performance improvement part of the language and strategy?
- What mechanisms are in place for evaluation of programs and services, both public and private? What is the capacity for organizations to design performance-based measures and evaluate and determine if performance measures are being met?

C. Data Collection Methods

The following methods were utilized in the collection of data for the study.

- Document review of relevant policies, laws, and strategic plans; descriptions of programs and services available for different groups (public and private); available data that included at-risk populations, workforce development, relevant evaluations of programs and services, curricula from education and training programs, and information on public awareness campaigns.
- Individual interviews with USAID implementing partners, the World Bank, ministry-level people in labor and social/child protection, university and college educators, in-country researchers, and NGOs—including those that provide direct services, advocacy groups, and professional associations. These interviews were aimed at getting factual information within the technical expert's area as well as perceptions and observations.

- Focus groups that brought together individuals from both the public and private sector to discuss a predetermined list of questions relative to the provision of social services to vulnerable groups within the Armenian context. The aim was to reveal perceptions, opinions, and ideas within a group format. Appendix B provides the discussion questions that were used with the two focus groups.

APPENDIX B

STUDY PROTOCOLS: INDIVIDUAL INTERVIEW AND DISCUSSION GROUP

This interview guide is to be used for individual or group, face-to-face interviews. Suggested targets might be professors of social work/psychology/sociology; direct service providers in public service and in NGOs; business persons; media persons; adult clients of a service; and political leaders, especially at the local level (mayor, county administrator, etc.).

Suggested Discussion Questions

The following is to be said at the beginning of the interview/discussion group:

"In this study, we are focusing on *people and the problems people face in your country*; the citizens of your country. We want to know your ideas and perceptions. The questions can relate to social, psychological, economic, spiritual, and emotional factors."

1. What are the three (3) most critical problems/concerns that your country must deal with over the next five (5) years? What are the indicators you use to determine the existence of these problems?
2. What are the causes of these critical problems? What do you think and what do others think?
3. What are the existing programs and services that can address these problems?
4. What programs and services need to be developed?
5. What are the barriers to developing the needed interventions?
6. What policies and laws have been (or have not been) implemented to address these problems?
7. How would you describe the values that are basic to the policies of your country related to these problems?
8. How do you think that needs to be changed? In other words, what values do you feel need to be reflected in the policies and laws?
9. What changes are needed and how are you going to measure them? In other words, what outcome indicators would you use?

APPENDIX C

DATA COLLECTION SCHEDULE AND STUDY TEAM COMPOSITION

The data collection effort for the Comparative Country Study consisted of U.S. and local experts conducting field visits to the five countries: Armenia, Azerbaijan, Bosnia, Romania, and Russia.

A. Armenia

The field visit to Armenia was conducted September 20-24, 2004. Team members included two U.S. consultants: Rebecca Davis and Kristine Aulenbach, and Anna Harutyunyan of the Armenian Sociological Association (ASA). Two Armenian consultants, Gagik Dumanian and Hasmik Hambarian, provided assistance during the National Holiday. The consultants met with national and local public authorities, USAID Mission staff and implementing partners, policy makers, and other experts. Most of the interviews were conducted in and around Yerevan, although several organizations interviewed delivered services throughout Armenia. A one-day field visit was made to PADCO, Inc.'s Integrated Social Services Program site in Vanadzor. The Armenian Sociological Association (ASA) held two focus groups—one with administrators of NGOs and one with direct service providers from NGOs and public social service institutions.

B. Azerbaijan

The information for the study in Azerbaijan was obtained as part of a community development assessment completed by a team that included Rebecca Davis, Aguirre International, Faye Haselkorn, USAID/Washington, Elmir Ismayilov, Consultant, USAID/Azerbaijan, and Gulnara Rahimova, USAID/Azerbaijan. The field work was carried out December 1-14, 2004, and included interviews with more than one hundred key informants from national and regional government, community representatives, local NGOs, international NGOs, other donors, USAID staff, and implementing partners in the cities and towns of Baku, Barda, Ganja, Agjabadi, Shemkir, Samukh, and Shamakhi. This assessment also drew upon the findings of an economic opportunities assessment carried out by Terrence Miller from November 22 to December 3, 2004.

C. Bosnia

Data for the Bosnia study was obtained as part of an assessment by USAID/Bosnia to plan a two-year follow-on activity to the existing Children at Risk Program being implemented by Save the Children (UK). The in-country visit took place March 5-16, 2005, by U.S. consultant Rebecca Davis. Additional information for this report was obtained from an in-depth assessment by two local consultants, Reima Ana Maglajlic and Taida Kapetanovic, conducted during February, 2005.[69] In addition, the two consultants provided technical support along with Emir Gazic, USAID/Bosnia.

[69] Reima Ana Maglajlic and Taida Kapetanovic provided valuable assistance in data collection and analysis during February, 2005. The information in their report submitted to USAID, *Assessment of Children At Risk Program Strategy* (February, 2005), was utilized for the in-country consultation and for this report.

D. Romania

The in-country visit to Romania took place September 26-October 1, 2004. The team was comprised of two U.S. consultants, Rebecca Davis and Kristine Aulenbach, and one Romanian consultant, Nina Petre of World Vision, Romania. The emphasis of this study was a follow-up of child welfare reform efforts initiated by a number of implementing partners in 1997, when child welfare reform was decentralized to the local level.

E. Russia

This study focused on USAID/Russia's projects on de-institutionalization, early intervention services for special needs children, and integrative medical and psychosocial models of care for HIV/AIDS infected mothers and children. The field work took place January 31-February 10, 2005. Team members included two representatives of the Bureau for Europe and Eurasia, USAID/Washington: Randal Thompson, Social Transition Team Leader and Cathy Cozzarelli, American Association for the Advancement of Science Fellow and social science advisor; and Rebecca Davis, Consultant, Aguirre International. The team was assisted by Olga Kulikova, Project Management Specialist for Assistance to Vulnerable Children's Programs, Health Office, USAID/Russia, and Alla Samoletova, Consultant.

APPENDIX D

INTERVIEWS AND APPOINTMENTS

A. ARMENIA

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APPENDIX E

BIBLIOGRAPHY

In addition to the references included in the footnotes, the author found the following resources helpful in the development of this report.

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